2012 PRC Community Health Needs Assessment Report

UCMC Service Area

Sponsored by

University of Chicago Medical Center (UCMC)

In collaboration with the
Metropolitan Chicago Healthcare Council (MCHC)

Professional Research Consultants, Inc.
11326 "P" Street • Omaha, Nebraska 68137-2316
(800) 428-7455 • www.prconline.com • 2012-1072-02

Table Of Contents

INTRODUCTION

Project Overview

Project Goals

This Community Health Needs Assessment, a follow-up to a similar study conducted in 2009, is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the University of Chicago Medical Center Service Area. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

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

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

PRC is a nationally-recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments such as this in hundreds of communities across the United States since 1994.

Methodology

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

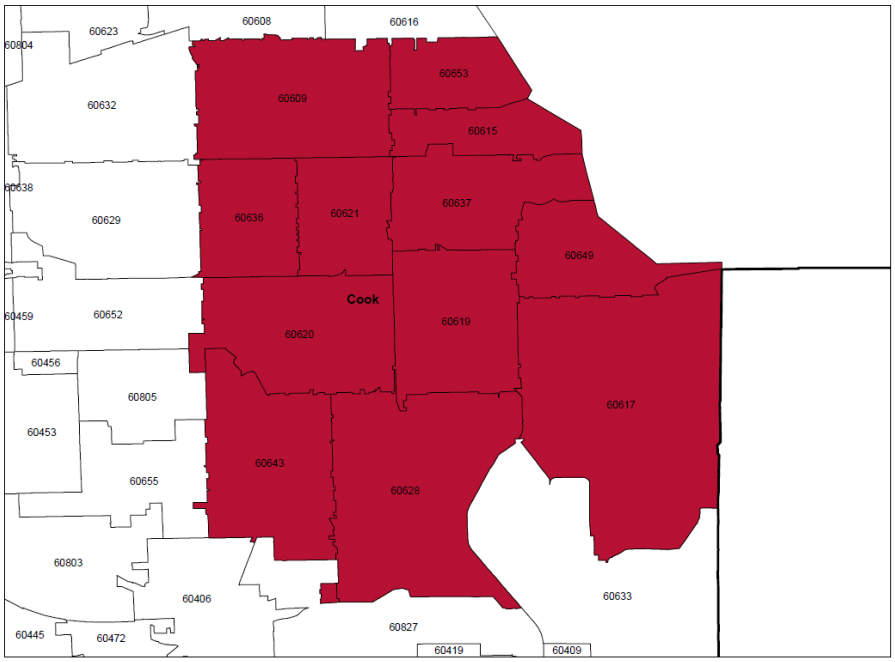
PRC Community Health Survey

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 University of Illinois Hospital and Health Sciences System and PRC, and is similar to the previous survey used in the region, allowing for data trending.

Community Defined for This Assessment

The study area for the survey effort (referred to as the "University of Chicago Medical Center Service Area," "UCMC Service Area" or "UCMCSA" in this report) includes each of the 12 residential ZIP Codes comprising the primary service area: 60609, 60615, 60617, 60619, 60620, 60621, 60628, 60636, 60637, 60643, 60649 and 60653. A geographic description is illustrated in the following map.



Sample Approach & Design

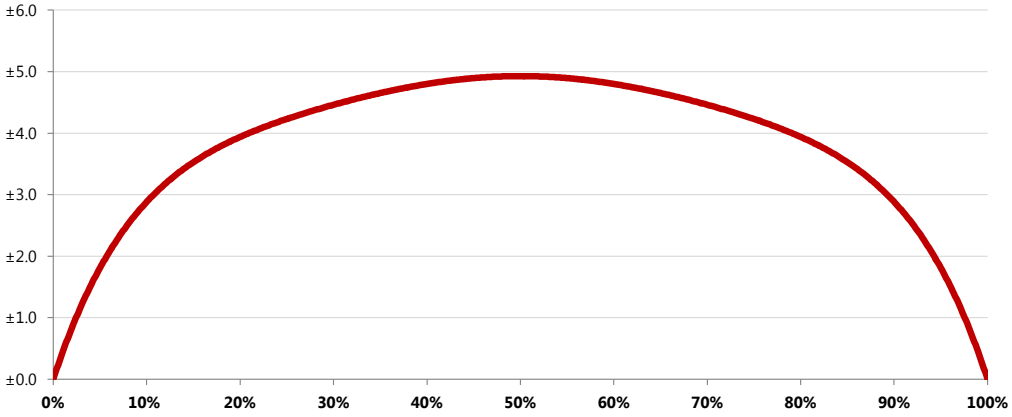
A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the *PRC Community Health Survey*. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews — was employed. The primary advantages of telephone interviewing are timeliness, efficiency and random-selection capabilities.

The sample design used for this effort consisted of a sample of 403 individuals age 18 and older in the UCMC Service Area. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

Sampling Error

For statistical purposes, the maximum rate of error associated with a sample size of 403 respondents is ±4.9% at the 95 percent level of confidence.

Expected Error Ranges for a Sample of 403 Respondents at the 95 Percent Level of Confidence



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

Examples:
- If 10% of the sample of 403 respondents answered a certain question with a "yes," it can be asserted that between 7.1% and 12.9% (10% ± 2.9%) of the total population would offer this response.
- If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 45.1% and 54.9% (50% ± 4.9%) of the total population would respond "yes" if asked this question.

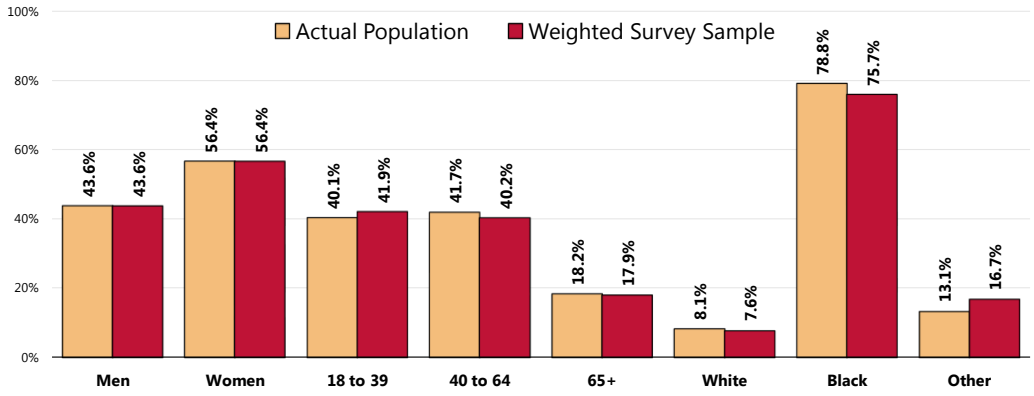
Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. And, while this random sampling of the population produces a highly representative sample, it is a common and preferred practice to "weight" the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias. Specifically, once the raw data are gathered, respondents are examined by key demographic characteristics (namely gender, age, race, ethnicity, and poverty status) and a statistical application package applies weighting variables that produce a sample which more closely matches the population for these characteristics. Thus, while the integrity of each individual's responses is maintained, one respondent's responses may contribute to the whole the same weight as, for example, 1.1 respondents. Another respondent, whose demographic characteristics may have been slightly oversampled, may contribute the same weight as 0.9 respondents.

The following chart outlines the characteristics of the UCMC 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 healthcare needs, and these children are not represented demographically in this chart.]

Population & Sample Characteristics

(University of Chicago Medical Center Service Area, 2012)



Sources:
- Census 2010, Summary File 3 (SF 3). U.S. Census Bureau.
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc.

Further note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household *(e.g., the 2012 guidelines place the poverty threshold for a family of four at $23,050 annual household income or lower)*. In sample segmentation: "**<200% FPL**" refers to community members living in a household with defined poverty status or living just above the federal poverty level, earning up to twice the poverty threshold; "**200%+ FPL**" refers to those households living on incomes which are twice or more the federal poverty level.

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

Key Informant Focus Groups

As part of the community health assessment, two focus groups were held: one on June 19, 2012, with key informants from South Chicago (including health professionals, social service providers, and other community leaders); and another on June 21, 2012, comprised of key informants from throughout Cook County (including representatives from public health; physicians, other health professionals, social service providers, and other community leaders).

A list of recommended participants for the focus groups was provided by the sponsors. 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. Participants included a representative of public health, as well as several individuals who work with low-income, minority or other medically underserved populations, and those who work with persons with chronic disease conditions.

Focus group candidates were first contacted by letter to request their participation. Follow-up phone calls were then made to ascertain whether or not they would be able to attend. Confirmation calls were placed the day before the groups were scheduled to insure a reasonable turnout.

Audio from the focus group sessions was recorded, from which verbatim comments in this report are taken. There are no names connected with the comments, as participants were asked to speak candidly and assured of confidentiality.

NOTE: These findings represent qualitative rather than quantitative data. The group was designed to gather input from participants regarding their opinions and perceptions of the health of the residents in the area. Thus, these findings are based on perceptions, not facts.

Public Health, Vital Statistics & Other Data

- Centers for Disease Control & Prevention
- National Center for Health Statistics
- Illinois Department of Public Health
- Illinois State Police
- US Census Bureau
- US Department of Health and Human Services
- US Department of Justice, Federal Bureau of Investigation

Note that secondary data reflect community-level data (City of Chicago) where possible, and county-level data (Cook County) where city data is unavailable.

Benchmark Data

Trending

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.

Regional MCHC Data

Because this survey was also conducted throughout the Metro Chicago area as part of a broader study facilitated by the Metropolitan Chicago Healthcare Council (MCHC), comparisons can also be made at the regional level. These regional data are referred to as the "MCHC Region" and include Cook, DuPage and Lake counties, Illinois.

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 are reported in the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trend Data* published by the Centers for Disease Control and Prevention and the US Department of Health & Human Services. 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 *2011 PRC National Health Survey*; the methodological approach for the national study is identical 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 provides science-based, 10-year national objectives for improving the health of all Americans. The Healthy People initiative is grounded in the principle that setting national objectives and monitoring progress can motivate action. For three decades, Healthy People has established benchmarks and monitored progress over time in order to:

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

Healthy People 2020 is the product of an extensive stakeholder feedback process that is unparalleled in government and health. It integrates input from public health and prevention experts, a wide range of federal, state and local government officials, a consortium of more than 2,000 organizations, and perhaps most importantly, the public. More than 8,000 comments were considered in drafting a comprehensive set of Healthy People 2020 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 a great number of medical conditions that are not specifically addressed.

Summary of Findings

Areas of Opportunity for Community Health Improvement

The following "health priorities" represent recommended areas of intervention, based on the information gathered through this Community Health Needs Assessment and the guidelines set forth in *Healthy People 2020*. From these data, opportunities for health improvement exist in the region with regard to the following health areas (see also the summary tables presented in the following section). These areas of concern are subject to the discretion of area providers, the steering committee, or other local organizations and community leaders as to actionability and priority.

Areas of Opportunity Identified Through This Assessment	

Access to Health Services	• Health Insurance Coverage
	  ○ Uninsured Residents
	  ○ Underinsured Residents *(focus group concern)*
	  ○ Insurance Instability
	  ○ Medicare Supplemental Insurance
	• Other Barriers to Accessing Healthcare Services
	  ○ Office Hours
	  ○ Cost of Doctor Visits
	  ○ Prescription Costs
	  ○ Lack of Transportation
	• Having a Medical Home/Usual Source of Care
	• Emergency Room Utilization
	• Availability of Trauma Care Services *(focus group concern)*

Cancer	• Cancer Deaths (Including Prostate, Female Breast and Colorectal Cancers)
Chronic Kidney Disease	• Kidney Disease Deaths
Chronic Pain	• Arthritis/Rheumatism (50+)
Family Planning	• Births to Unwed Mothers • Births to Teens
Heart Disease & Stroke	• Heart Disease Deaths • Stroke Deaths • Prevalence of Hypertension
HIV	• HIV/AIDS Deaths

Injury & Violence Prevention	• Violence
	  ○ Violent Crime (Offense Rate & Experience of Violent Crime)
	  ○ Domestic Violence (Offense Rate & Experience of Domestic Violence)
	  ○ Child Abuse Offense Rate
	  ○ Homicides
	• Firearm-Related Deaths

Maternal, Infant & Child Health	• Lack of Prenatal Care • Low Birthweight • Infant Mortality
Mental Health & Mental Disorders	• Chronic Depression • Stress *(focus group concern)* • Inadequate Number of Providers/Treatment Facilities *(focus group concern)* • Stigma *(focus group concern)*

— continued next page —

Areas of Opportunity Identified Through This Assessment (continued)	

Nutrition, Physical Activity & Weight	• Fruit/Vegetable Consumption
	  ○ Access to Affordable Fresh Produce/Food Deserts
	  ○ Need for Nutrition Education *(focus group concern)*
	• Overweight & Obesity (Adults & Children)
	• Low Levels of Physical Activity *(focus group concern)*
	  ○ Physical Activity Options for Youth *(focus group concern)*
	• Access to Safe, Affordable Places for Physical Activity
	• Children's Screen Time

Oral Health	• Recent Dental Care (Adults)
Respiratory Diseases	• Pneumonia/Influenza Deaths • Pneumonia Vaccinations (Age 65+) • Flu Shots (Age 65+) • Prevalence of Asthma (Adults)
Sexually Transmitted Diseases	• Gonorrhea Incidence • Syphilis Incidence • Chlamydia Incidence
Substance Abuse	• Cirrhosis/Liver Disease Deaths
Tobacco Use	• Exposure to Environmental Tobacco Smoke • Use of Cigars
Vision	• Blindness/Uncorrectable Vision Problems

Top Community Health Concerns Among Community Key Informants

At the conclusion of both key informant focus groups, participants were asked to write down what they individually perceive as the top five health priorities for the community, based on the group discussion as well as on their own experiences and perceptions. Their responses were collected, categorized and tallied to produce the top-ranked priorities as identified among key informants. These should be used to complement and corroborate findings that emerge from the quantitative dataset.

1. **Access (Including Transportation & Trauma Centers)**
   Mentioned resources available to address this issue: Schools; Faith-Based Organizations; Community Health Centers; Hospitals; UIC School of Public Health; Federally Qualified Health Centers

2. **Prevention**
   Mentioned resources available to address this issue: City of Chicago, Faith-Based Organizations; Physicians; Community-Based Organizations; UIC School of Public Health; Schools; Health Department; Hispanic Health Care Coalition

3. **Obesity, Including Nutrition**
   Mentioned resources available to address this issue: Hospitals; Schools; Non-Profit Agencies; Chicago Park District; Chicago Public Schools; Business Leaders; CTA; Health Clubs; Urban Vegetable Gardens

4. **Mental Health**

   Mentioned resources available to address this issue: Private Providers; County Providers; Federally Qualified Health Centers; School-Based Health Centers; Health Departments; Chicago Public Schools; City Colleges; Chicago Park District

Summary Tables: Comparisons With Benchmark Data

TREND SUMMARY
(Current vs. Baseline Data)

Survey Data Indicators: Trends for survey-derived indicators represent significant changes since 2009. *Note that survey data reflect the ZIP Code-defined UCMC 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 city-level data (City of Chicago) and county-level data (Cook County) where city data is unavailable.*

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

Reading the Summary Tables

■ In the following charts, UCMC Service Area results are shown in the larger, blue column.

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

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

Access to Health Services	UCMC Svc Area	UCMC Svc Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% [Age 18-64] Lack Health Insurance	**23.1**	16.6	15.3	14.9	0.0	15.2
% [65+] With Medicare Supplement Insurance	**44.3**	69.7		75.5		49.8
% [Insured] Insurance Covers Prescriptions	**94.3**	93.4		93.9		90.7
% [Insured] Went Without Coverage in Past Year	**9.3**	6.6		4.8		10.1
% Difficulty Accessing Healthcare in Past Year (Composite)	**44.1**	38.9		37.3		50.7
% Inconvenient Hrs Prevented Dr Visit in Past Year	**20.1**	17.1		14.3		17.6
% Cost Prevented Getting Prescription in Past Year	**23.5**	15.5		15.0		24.9
% Cost Prevented Physician Visit in Past Year	**20.4**	15.7		14.0		20.2
% Difficulty Getting Appointment in Past Year	**16.5**	14.4		16.5		28.7
% Difficulty Finding Physician in Past Year	**14.0**	9.4		10.7		16.4
% Transportation Hindered Dr Visit in Past Year	**12.9**	8.1		7.7		17.7
% Skipped Prescription Doses to Save Costs	**19.5**	14.9		14.8		23.0
% Difficulty Getting Child's Healthcare in Past Year	**4.7**	3.3		1.9		1.5
% [Age 18+] Have a Specific Source of Ongoing Care	**72.3**	75.7		76.3	95.0	79.7
% [Age 18-64] Have a Specific Source of Ongoing Care	**70.7**	75.2		75.1	89.4	
% [Age 65+] Have a Specific Source of Ongoing Care	**81.3**	79.0		82.6	100.0	
% Have Had Routine Checkup in Past Year	**78.6**	71.6		67.3		77.0

Access to Health Services (continued)	UCMC Svc Area	UCMC Svc Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% Child Has Had Checkup in Past Year	95.0	90.9		87.0		95.8
% Two or More ER Visits in Past Year	14.1	7.9		6.5		22.0
% Rate Local Healthcare "Fair/Poor"	23.2	15.5		15.3		31.3
			better	similar	worse	

Arthritis, Osteoporosis & Chronic Back Conditions	UCMC Svc Area	UCMC Svc Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% [50+] Arthritis/Rheumatism	42.9	37.3		35.4		43.6
% [50+] Osteoporosis	8.6	10.3		11.4	5.3	9.8
% Sciatica/Chronic Back Pain	13.7	16.0		21.5		21.4
% Migraine/Severe Headaches	13.3	13.2		16.9		17.6
% Chronic Neck Pain	9.7	8.5		8.3		9.2
			better	similar	worse	

Cancer	UCMC Svc Area	UCMC Svc Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
Cancer (Age-Adjusted Death Rate)	194.2	179.3	183.9	178.1	160.6	212.4
Lung Cancer (Age-Adjusted Death Rate)	51.6	46.9	52.1	50.5	45.5	
Prostate Cancer (Age-Adjusted Death Rate)	34.6	26.6	24.3	23.1	21.2	
Female Breast Cancer (Age-Adjusted Death Rate)	26.9	24.8	23.7	23.0	20.6	

Cancer (continued)	UCMC Svc Area	UCMC Svc Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
Colorectal Cancer (Age-Adjusted Death Rate)	21.8	18.0	18.1	16.8	14.5	
% Skin Cancer	1.2	2.9		8.1		0.8
% Cancer (Other Than Skin)	3.9	4.6		5.5		6.5
% [Men 50+] Prostate Exam in Past 2 Years	77.1	72.2		70.5		72.9
% [Women 50-74] Mammogram in Past 2 Years	84.4	77.6	73.0	79.9	81.1	92.8
% [Women 21-65] Pap Smear in Past 3 Years	88.7	85.9	83.2	84.7	93.0	82.6
% [Age 50+] Sigmoid/Colonoscopy Ever	69.0	68.3	61.9	72.0		75.5
% [Age 50+] Blood Stool Test in Past 2 Years	34.1	28.0	12.4	28.3		35.6
% [Age 50-75] Colorectal Cancer Screening	69.4	67.3			70.5	
			better	similar	worse	

Chronic Kidney Disease	UCMC Svc Area	UCMC Svc Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
Kidney Disease (Age-Adjusted Death Rate)	23.0	20.0	19.5	14.6		23.0
% Kidney Disease	1.4	2.0				
			better	similar	worse	

Diabetes	UCMC Svc Area	UCMC Svc Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
Diabetes Mellitus (Age-Adjusted Death Rate)	22.7	20.9	21.3	22.5	19.6	26.5
% Diabetes/High Blood Sugar	13.4	10.7	8.7	10.1		14.2
			better	similar	worse	

Dementias, Including Alzheimer's Disease	UCMC Svc Area	UCMC Svc Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
Alzheimer's Disease (Age-Adjusted Death Rate)	15.2	17.8	21.2	23.2		13.0
			better	similar	worse	

Educational & Community-Based Programs	UCMC Svc Area	UCMC Svc Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% Attended Health Event in Past Year	25.4	20.2		22.2		22.0
			better	similar	worse	

Family Planning	UCMC Svc Area	UCMC Svc Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% of Births to Unwed Mothers	52.6	41.6	38.0	40.4		51.5
% Births to Teenagers	12.8	9.7	9.9	10.3		15.3
			better	similar	worse	

General Health Status	UCMC Svc Area	UCMC Svc Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% "Fair/Poor" Physical Health	21.6	15.4	15.5	16.8		25.3
% Activity Limitations	21.6	19.0	17.8	17.0		21.2
			better	similar	worse	

Hearing & Other Sensory or Communication Disorders	UCMC Svc Area	UCMC Svc Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% Deafness/Trouble Hearing	5.0	5.8		9.6		11.1
			better	similar	worse	

Heart Disease & Stroke	UCMC Svc Area	UCMC Svc Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
Diseases of the Heart (Age-Adjusted Death Rate)	199.3	188.3	189.3	192.5	152.7	269.8
Stroke (Age-Adjusted Death Rate)	44.8	39.7	41.8	42.2	33.8	56.7
% Heart Disease (Heart Attack, Angina, Coronary Disease)	6.5	5.1		6.1		6.2
% Stroke	5.0	3.2	2.7	2.7		4.0
% Blood Pressure Checked in Past 2 Years	97.2	94.8		94.7	94.9	97.9
% Told Have High Blood Pressure (Ever)	47.1	33.0	28.9	34.3	26.9	40.2
% [HBP] Taking Action to Control High Blood Pressure	94.8	92.9		89.1		97.4
% Cholesterol Checked in Past 5 Years	91.9	91.4	75.7	90.7	82.1	93.8

Heart Disease & Stroke (continued)	UCMC Svc Area	UCMC Svc Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% Told Have High Cholesterol (Ever)	28.1	29.6	37.5	31.4	13.5	26.1
% [HBC] Taking Action to Control High Blood Cholesterol	84.5	88.6		89.1		83.7
% 1+ Cardiovascular Risk Factor	89.8	81.0		86.3		89.2
			better	similar	worse	

HIV	UCMC Svc Area	UCMC Svc Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
HIV/AIDS (Age-Adjusted Death Rate)	8.2	3.8	2.2	3.9	3.3	12.0
% [Age 18-44] HIV Test in the Past Year	41.6	26.6		19.9	16.9	37.3
			better	similar	worse	

Immunization & Infectious Diseases	UCMC Svc Area	UCMC Svc Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% [Age 65+] Flu Shot in Past Year	56.0	65.0	65.5	71.6	90.0	54.8
% [High-Risk 18-64] Flu Shot in Past Year	44.5	51.4		52.5	90.0	38.4
% [Age 65+] Pneumonia Vaccine Ever	49.6	57.1	61.9	68.1	90.0	64.9
% [High-Risk 18-64] Pneumonia Vaccine Ever	43.0	35.3		32.0	60.0	27.6
Tuberculosis Incidence per 100,000	6.9	4.9	3.3	4.1	1.0	12.7
% Ever Vaccinated for Hepatitis B	37.2	37.5		38.4		32.7
			better	similar	worse	

Injury & Violence Prevention	UCMC Svc Area	UCMC Svc Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
Unintentional Injury (Age-Adjusted Death Rate)	**33.9**	25.8	31.9	39.5	36.0	38.3
Motor Vehicle Crashes (Age-Adjusted Death Rate)	**7.8**	6.4	9.3	14.1	12.4	12.7
% "Always" Wear Seat Belt	**82.6**	88.7		85.3	92.4	89.7
% Child [Age 0-17] "Always" Uses Seat Belt/Car Seat	**95.9**	94.4		91.6		89.1
% Child [Age 5-17] "Always" Wears Bicycle Helmet	**28.6**	32.8		35.3		
Firearm-Related Deaths (Age-Adjusted Death Rate)	**10.9**	9.2	8.1	10.2	9.2	13.5
% Firearm in Home	**11.8**	12.4		37.9		5.7
% [Homes With Children] Firearm in Home	**6.1**	11.9		34.4		5.4
Homicide (Age-Adjusted Death Rate)	**15.1**	9.1	6.7	6.1	5.5	19.7
Violent Crime per 100,000	**785.3**	634.1	519.5	431.4		1009.3
% Victim of Violent Crime in Past 5 Years	**14.4**	5.9		1.6		13.2
% Perceive Neighborhood to be "Not At All Safe" from Crime	**19.9**	6.1				
Domestic Violence Offenses per 100,000	**1297.9**	1068.0	1224.3			1462.5
% Ever Threatened With Violence by Intimate Partner	**14.0**	10.6		11.7		27.0
% Victim of Domestic Violence (Ever)	**16.2**	12.1		13.5		26.0
Child Abuse Offenses per 1,000 Children	**21.9**	21.3	30.0	10.1		23.7
			better	similar	worse	

Maternal, Infant & Child Health	UCMC Svc Area	UCMC Svc Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% No Prenatal Care in First Trimester	**23.6**	20.1	19.1		22.1	24.9
% of Low Birthweight Births	**9.7**	8.8	8.4	8.2	7.8	9.9
Infant Death Rate	**7.4**	6.8	6.7	6.7	6.0	9.0
			better	similar	worse	

Mental Health & Mental Disorders	UCMC Svc Area	UCMC Svc Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% "Fair/Poor" Mental Health	**14.8**	12.5		11.7		17.1
% Major Depression	**9.1**	8.6		11.7		14.3
% Symptoms of Chronic Depression (2+ Years)	**32.0**	26.6		26.5		31.9
Suicide (Age-Adjusted Death Rate)	**6.5**	7.7	8.9	11.3	10.2	7.3
% Have Ever Sought Help for Mental Health	**21.5**	23.7		24.4		27.4
% [Those With Major Depression] Seeking Help	**81.2**	82.4		82.0	75.1	
% Typical Day Is "Extremely/Very" Stressful	**11.7**	11.7		11.5		10.8
% 3+ Days Without Enough Sleep in the Past Month	**65.6**	61.6				
% Child [Age 5-17] Takes Prescription for ADD/ADHD	**4.2**	4.6		6.5		
			better	similar	worse	

Nutrition & Weight Status	UCMC Svc Area	UCMC Svc Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% Eat 5+ Servings of Fruit or Vegetables per Day	**37.6**	44.4		48.8		34.7
% "Very/Somewhat Difficult" to Buy Fresh Produce Affordably	**24.8**	18.4				
% Medical Advice on Nutrition in Past Year	**46.4**	44.4		41.9		44.9
% Healthy Weight (BMI 18.5-24.9)	**26.8**	34.1		31.7	33.9	30.4
% Overweight	**72.4**	64.3	63.2	66.9		67.5
% Obese	**35.7**	29.0	28.7	28.5	30.6	38.0
% Medical Advice on Weight in Past Year	**29.3**	28.4		25.7		25.9
% [Overweights] Counseled About Weight in Past Year	**35.1**	38.4		30.9		29.8
% [Obese Adults] Counseled About Weight in Past Year	**50.4**	52.6		47.4	31.8	
% [Overweights] Trying to Lose Weight Both Diet/Exercise	**36.0**	47.2		38.6		40.9
% Children [Age 5-17] Overweight	**48.9**	32.5		30.7		
% Children [Age 5-17] Obese	**28.4**	18.2		18.9	14.6	
			better	similar	worse	

Oral Health	UCMC Svc Area	UCMC Svc Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% [Age 18+] Dental Visit in Past Year	56.8	68.8	69.7	66.9	49.0	53.3
% Child [Age 2-17] Dental Visit in Past Year	86.2	84.5		79.2	49.0	86.5
% Have Dental Insurance	57.5	65.2		60.8		61.4
			better	similar	worse	

Physical Activity	UCMC Svc Area	UCMC Svc Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% [Employed] Job Entails Mostly Sitting/Standing	68.5	66.4		63.2		63.2
% No Leisure-Time Physical Activity	27.1	17.8	25.7	28.7	32.6	27.9
% Meeting Physical Activity Guidelines	43.3	50.3	51.8	42.7		40.0
% Moderate Physical Activity	26.6	27.8		23.9		25.3
% Vigorous Physical Activity	33.5	39.0	31.8	34.8		28.6
% Medical Advice on Physical Activity in Past Year	52.6	49.9		47.8		53.0
% "Very/Somewhat Difficult" to Access a Place for Exercise	26.7	16.8				
% Child [Age 5-17] Watches TV 3+ Hours per Day	29.1	17.7		19.7		
% Child [Age 5-17] Uses Computer 3+ Hours per Day	25.9	17.5		9.9		
% Child [Age 5-17] 3+ Hours per Day of Total Screen Time	60.5	48.2		43.4		
			better	similar	worse	

Respiratory Diseases	UCMC Svc Area	UCMC Svc Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
CLRD (Age-Adjusted Death Rate)	**29.4**	31.5	39.9	41.8		33.0
Pneumonia/Influenza (Age-Adjusted Death Rate)	**23.1**	19.0	18.6	17.0		25.3
% Nasal/Hay Fever Allergies	**28.8**	25.3		27.3		26.0
% Sinusitis	**13.4**	12.5		19.4		16.1
% Chronic Lung Disease	**10.0**	7.4		8.4		14.6
% [Adult] Currently Has Asthma	**11.0**	8.2	9.2	7.5		15.5
% [Child 0-17] Currently Has Asthma	**12.8**	7.5		6.8		13.7
			better	similar	worse	

Sexually Transmitted Diseases	UCMC Svc Area	UCMC Svc Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
Gonorrhea Incidence per 100,000	**306.2**	160.1	127.3	103.2		427.9
Primary & Secondary Syphilis Incidence per 100,000	**29.2**	14.1	8.5	4.5		10.6
Chlamydia Incidence per 100,000	**884.8**	525.2	449.6	409.8		809.4
% [Unmarried 18-64] 3+ Sexual Partners in Past Year	**7.5**	10.6		7.1		12.6
% [Unmarried 18-64] Using Condoms	**45.7**	45.7		18.9		48.7
			better	similar	worse	

Sickle-Cell Anemia	UCMC Svc Area	UCMC Svc Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% Sickle-Cell Anemia	1.1	0.6				
			better	similar	worse	

Substance Abuse	UCMC Svc Area	UCMC Svc Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)	11.0	8.2	8.2	9.0	8.2	12.0
% Liver Disease	2.3	1.6				
% Current Drinker	50.2	61.3	59.1	58.8		50.3
% Chronic Drinker (Average 2+ Drinks/Day)	2.8	4.4	5.7	5.6		1.8
% Binge Drinker (Single Occasion - 5+ Drinks Men, 4+ Women)	11.7	19.8	17.8	16.7	24.3	11.6
% Drinking & Driving in Past Month	1.1	2.1		3.5		1.4
% Driving Drunk or Riding with Drunk Driver	4.4	5.8		5.5		3.4
Drug-Induced Deaths (Age-Adjusted Death Rate)	10.3	10.2	10.5	12.6	11.3	10.1
% Illicit Drug Use in Past Month	2.5	3.7		1.7	7.1	3.4
% Ever Sought Help for Alcohol or Drug Problem	4.9	3.6		3.9		6.0
			better	similar	worse	

Tobacco Use	UCMC Svc Area	UCMC Svc Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% Current Smoker	17.4	15.0	16.9	16.6	12.0	24.1
% Someone Smokes at Home	27.7	15.9		13.6		28.8
% [Non-Smokers] Someone Smokes in the Home	18.6	9.0		5.7		
% [Household With Children] Someone Smokes in the Home	31.3	13.8		12.1		35.7
% [Smokers] Received Advice to Quit Smoking	68.7	71.1		63.7		
% [Smokers] Have Quit Smoking 1+ Days in Past Year	52.3	57.5		56.2	80.0	
% Smoke Cigars	7.0	4.5		4.2	0.2	4.5
% Use Smokeless Tobacco	2.0	1.8		2.8	0.3	1.1
			better	similar	worse	

Vision	UCMC Svc Area	UCMC Svc Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% Blindness/Trouble Seeing	12.4	7.6		6.9		14.7
% Eye Exam in Past 2 Years	54.1	58.8		57.5		63.4
			better	similar	worse	

GENERAL HEALTH STATUS

Overall Health Status

Self-Reported Health Status

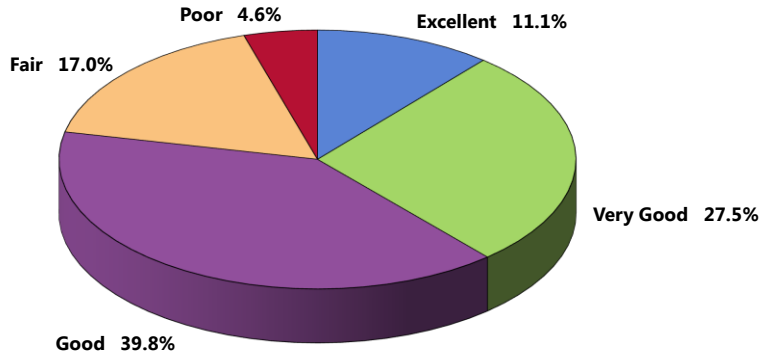
The initial inquiry of the PRC Community Health Survey asked respondents the following:

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

A total of 38.6% of UCMC Service Area adults rate their overall health as "excellent" or "very good."

- Another 39.8% gave "good" ratings of their overall health.

Self-Reported Health Status
(University of Chicago Medical Center Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: • Asked of all respondents.

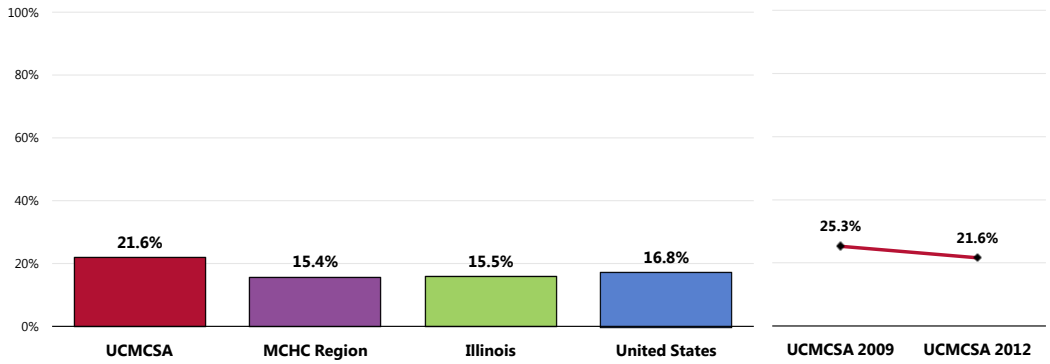
However, 21.6% of area adults believe that their overall health is "fair" or "poor."

- Less favorable than the MCHC regional results.
- Less favorable than statewide findings.
- Less favorable than the national percentage.
- No statistically significant change has occurred when comparing "fair/poor" overall health reports to previous (2009) survey results.

NOTE:

- Differences noted in the text represent significant differences determined through statistical testing.
- Where sample sizes permit, community-level data are provided.
- Trends are measured against baseline data – i.e., the earliest year that data are available or that is presented in this report.

Experience "Fair" or "Poor" Overall Health



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 5]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

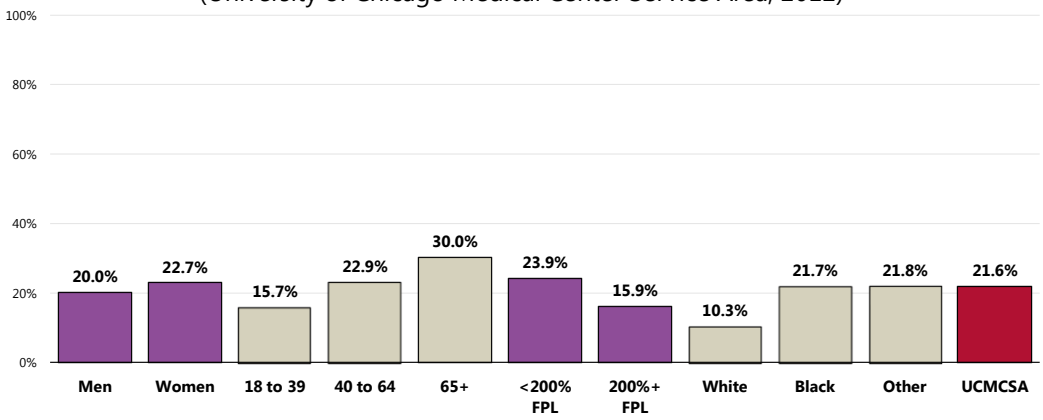
Adults more likely to report experiencing "fair" or "poor" overall health include:

- Adults age 40 and over (note the positive correlation with age).
- Non-Whites.
- Other differences within demographic groups, as illustrated in the following chart, are not statistically significant.

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

Experience "Fair" or "Poor" Overall Health

(University of Chicago Medical Center Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]

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

Activity Limitations

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

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

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

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

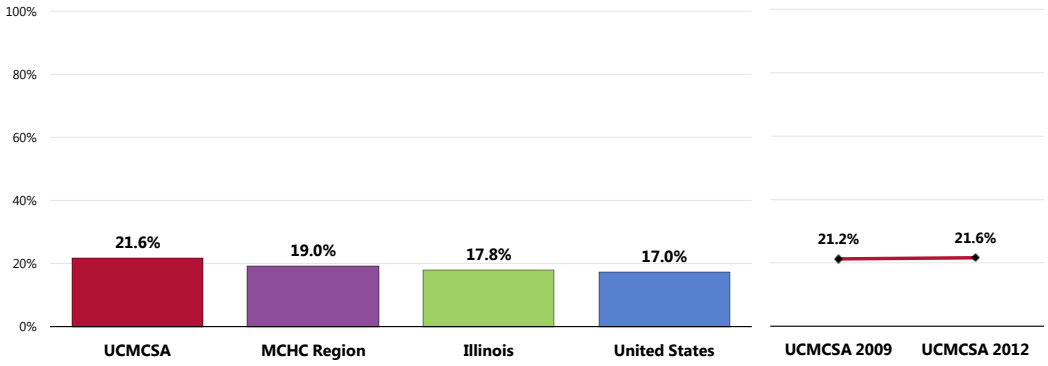
– Healthy People 2020 (www.healthypeople.gov)

A total of 21.6% of UCMC Service Area adults are limited in some way in some activities due to a physical, mental or emotional problem.

- Comparable to the MCHC regional prevalence.
- Comparable to the prevalence statewide.
- Comparable to the national prevalence.
- Statistically unchanged since 2009.

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

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



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 125]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

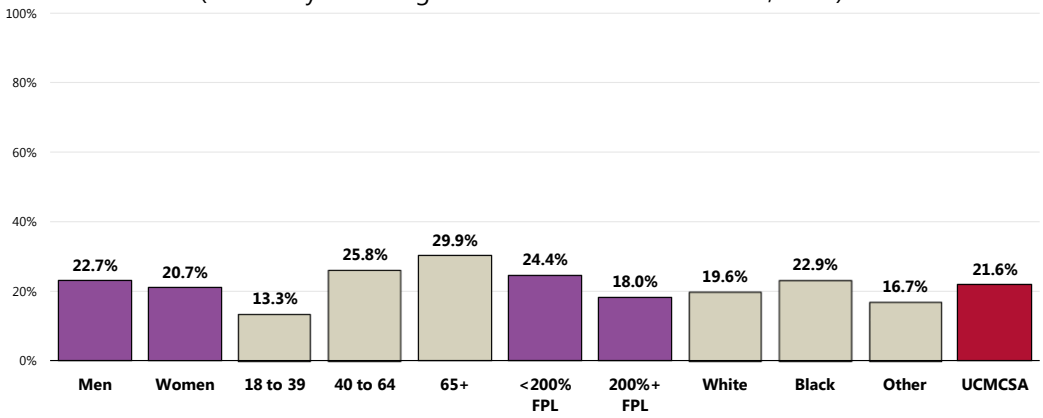
Notes:
- Asked of all respondents.

In looking at responses by key demographic characteristics, note the following:

- Adults age 40 and older are much more often limited in activities (note the positive correlation with age).

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

(University of Chicago Medical Center Service Area, 2012)



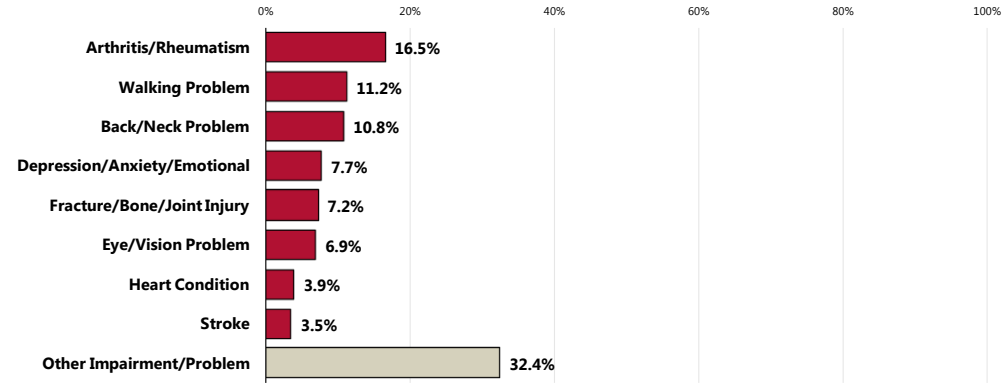
Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 125]

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

Among persons reporting activity limitations, these are most often attributed to **musculoskeletal issues**, such as arthritis/rheumatism, difficulty walking, back/neck problems, or fractures or bone/joint injuries. However, depression/mental health issues, problems with vision, heart conditions and stroke were also noted among residents with activity limitations.

Type of Problem That Limits Activities

(Among Those Reporting Activity Limitations; University of Chicago Medical Center Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 126]
Notes: • Asked of those respondents reporting activity limitations.

Mental Health & Mental Disorders

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

Mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases. According to the national Institute of Mental Health (NIMH), in any given year, an estimated 13 million American adults (approximately 1 in 17) have a seriously debilitating mental illness. Mental health disorders are the leading cause of disability in the United States and Canada, accounting for 25% of all years of life lost to disability and premature mortality. Moreover, suicide is the 11th leading cause of death in the United States, accounting for the deaths of approximately 30,000 Americans each year.

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

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

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

In addition to advancements in the prevention of mental disorders, there continues to be steady progress in treating mental disorders as new drugs and stronger evidence-based outcomes become available.

– Healthy People 2020 (www.healthypeople.gov)

Mental Health Status

Self-Reported Mental Health Status

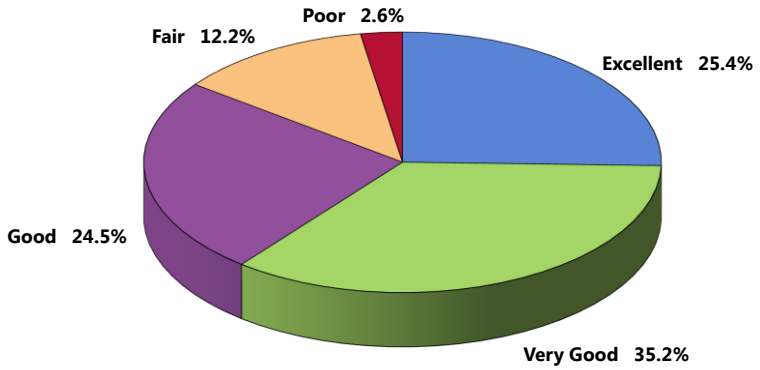
"Now thinking about your mental health, which includes stress, depression and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair or poor?"

A total of 60.6% of UCMC Service Area adults rate their overall mental health as "excellent" or "very good."

- Another 24.5% gave "good" ratings of their own mental health status.

Self-Reported Mental Health Status

(University of Chicago Medical Center Service Area, 2012)

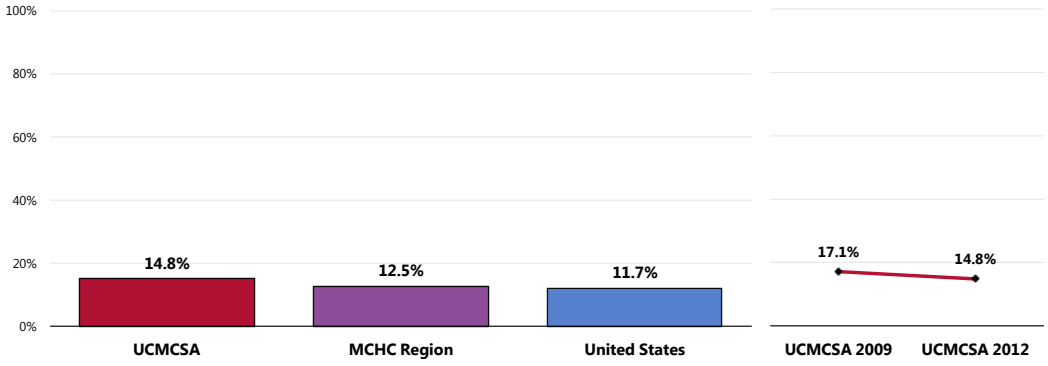


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 120]
Notes: • Asked of all respondents.

A total of 14.8% of UCMC Service Area adults, however, believe that their overall mental health is "fair" or "poor."

- Comparable to the MCHC Region percentage.
- Comparable to the "fair/poor" response reported nationally.
- Comparable to the "fair/poor" response recorded in 2009.

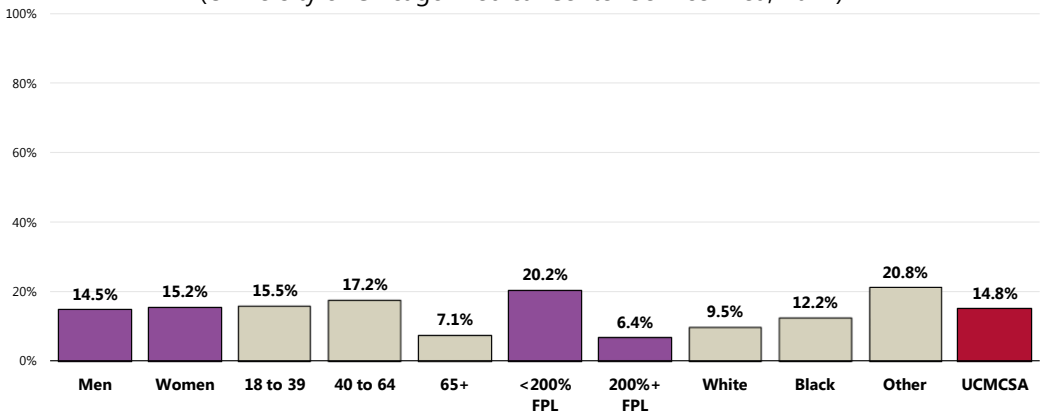
Experience "Fair" or "Poor" Mental Health



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 120]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

- Lower-income residents and those under age 65 are more likely to report experiencing "fair/poor" mental health than their demographic counterparts.

Experience "Fair" or "Poor" Mental Health
(University of Chicago Medical Center Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 120]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

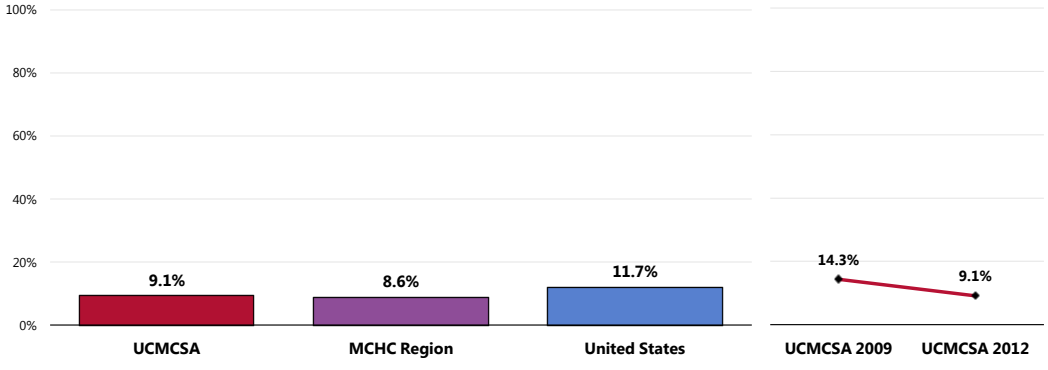
Depression

Major Depression

A total of 9.1% of UCMC Service Area adults have been diagnosed with major depression by a physician.

- Similar to the percentage found in the MCHC Region.
- Similar to the national findings.
- Similar to the 2009 findings.

Have Been Diagnosed With Major Depression



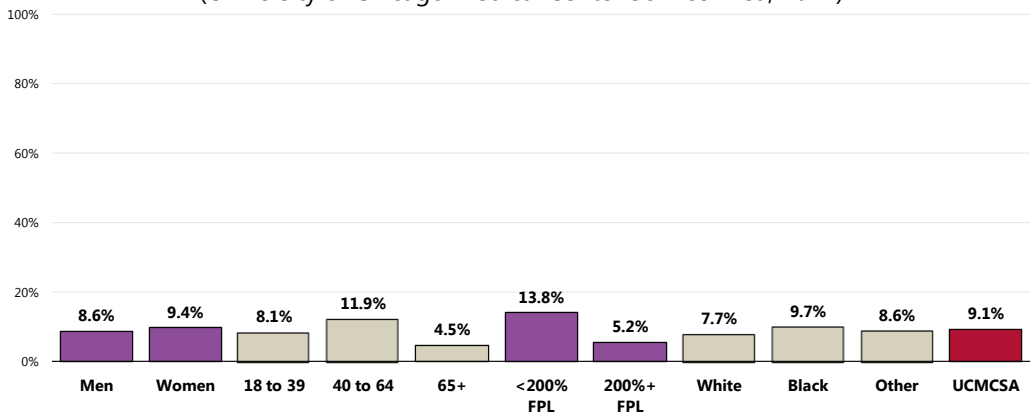
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 33]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

The prevalence of major depression is notably higher among:

- Adults between the ages of 40 and 64.
- Community members living at lower incomes.

Have Been Diagnosed With Major Depression

(University of Chicago Medical Center Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 33]

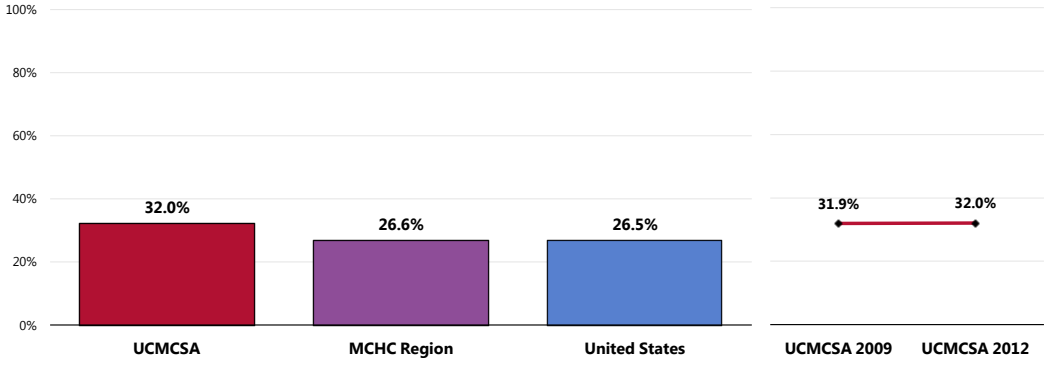
Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household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

Symptoms of Chronic Depression

A total of 32.0% of UCMC Service Area adults have had two or more years in their lives when they felt depressed or sad on most days, although they may have felt okay sometimes (chronic depression).

- Less favorable than regional findings.
- Less favorable than national findings.
- Similar to that reported in the UCMC Service Area in 2009.

Have Experienced Symptoms of Chronic Depression



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 121]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

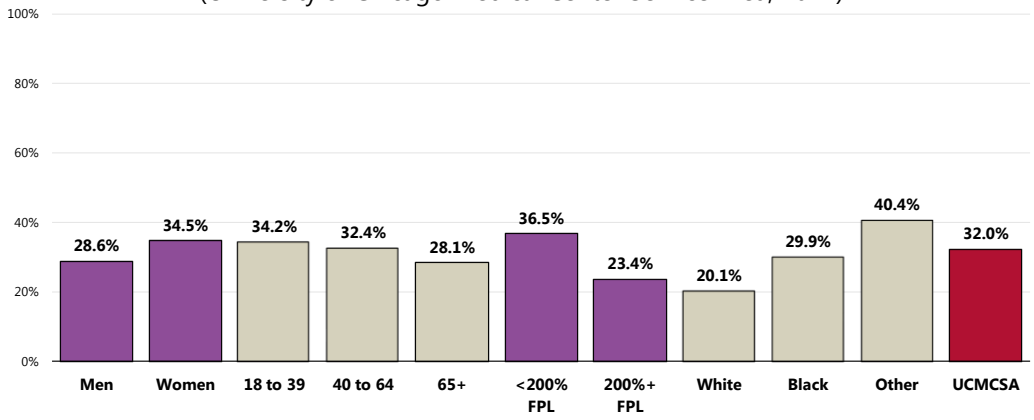
Notes:
- Asked of all respondents.

Note that the prevalence of chronic depression is notably higher among:

- Adults with lower incomes.
- Those in the "Other" race category.

Have Experienced Symptoms of Chronic Depression

(University of Chicago Medical Center Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 121]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Stress

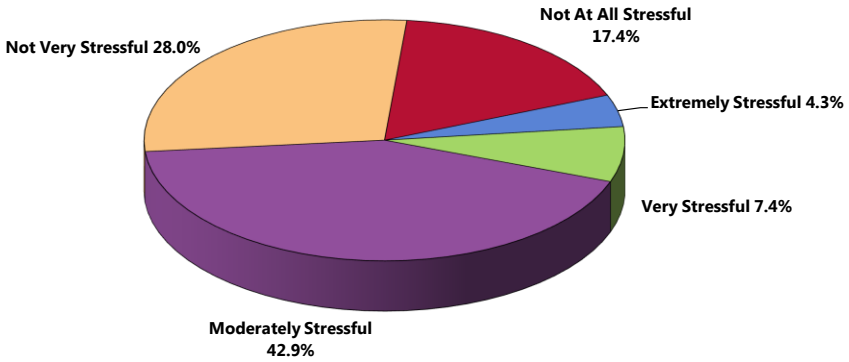
RELATED ISSUE:
See also *Substance Abuse* in the **Modifiable Health Risks** section of this report.

Of UCMC Service Area adults, 28.0% consider their typical day to be "not very stressful" and 17.4% consider it to be "not at all stressful."

- Another 42.9% of survey respondents characterize their typical day as "moderately stressful."

Perceived Level of Stress On a Typical Day

(University of Chicago Medical Center Service Area, 2012)

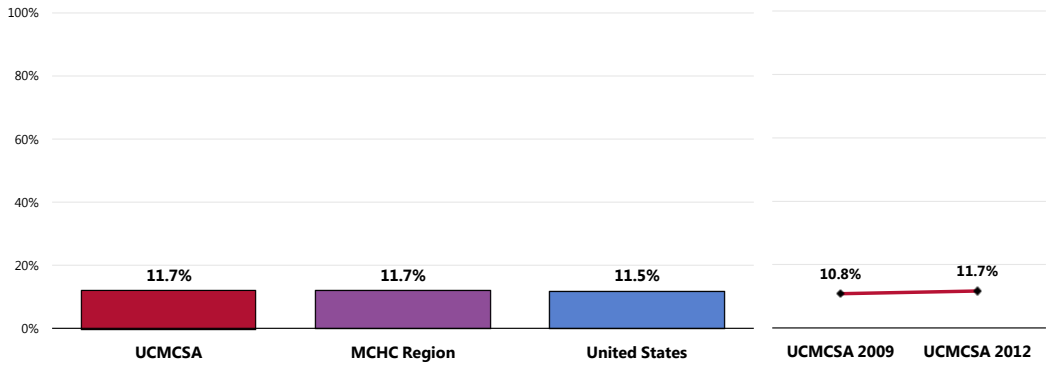


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 122]
Notes: • Asked of all respondents.

In contrast, 11.7% of UCMC Service Area adults experience "very" or "extremely" stressful days on a regular basis.

- Identical to the regional percentage.
- Similar to the national findings.
- Similar to the 2009 findings.

Perceive Most Days As "Extremely" or "Very" Stressful



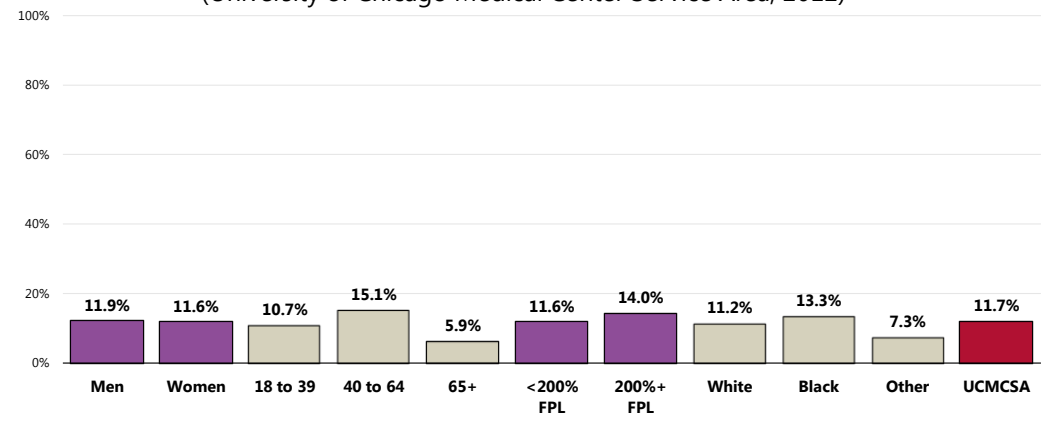
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 122]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Note that high stress levels are statistically high among adults between ages 40 and 64.

Perceive Most Days as "Extremely" or "Very" Stressful

(University of Chicago Medical Center Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 122]

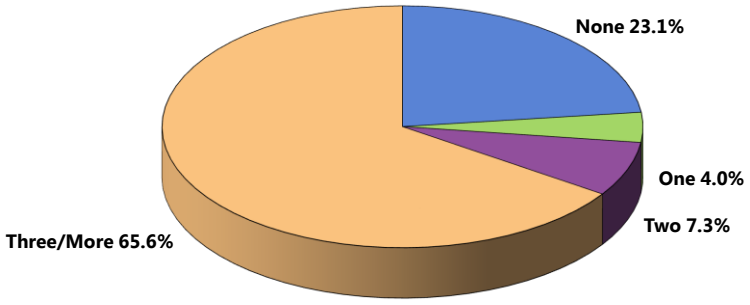
Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household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

Sleep

While 23.1% of survey respondents did not experience any days during the past month in which they did not get enough rest or sleep, 76.9% report having at least one day of poor rest or sleep in the past month.

Number of Days Without Enough Rest or Sleep in the Past Month

(University of Chicago Medical Center Service Area, 2012)

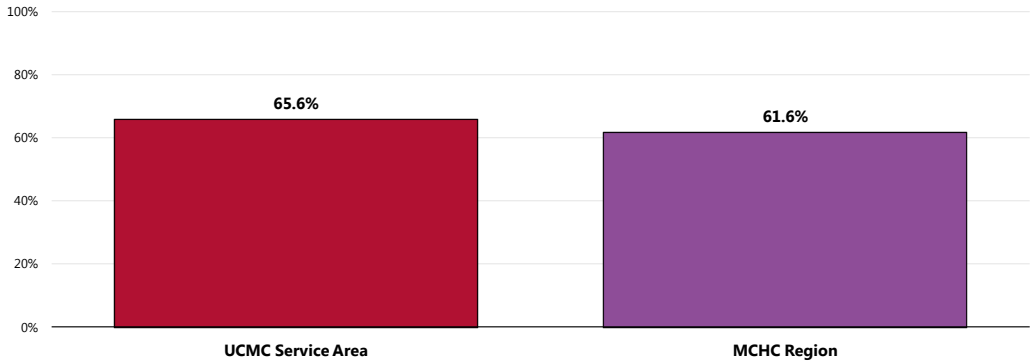


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 124]
Notes: • Asked of all respondents.

In fact, 65.6% of service area residents report 3+ days of poor rest or sleep in the past month.

- Similar to survey findings in the MCHC Region.

Had 3+ Days in the Past Month Without Enough Sleep

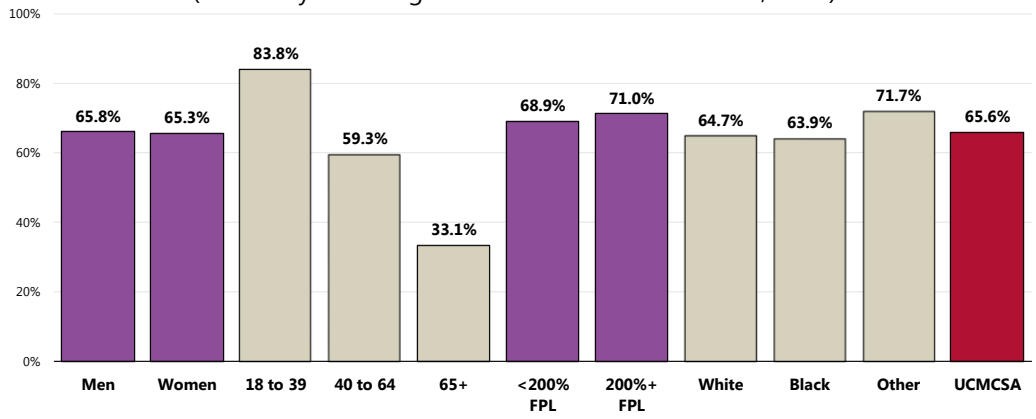


Sources: • 2012 PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 124]
Notes: • Asked of all respondents.

- Young adults are more likely to report experiencing 3+ days of poor rest or sleep in the past month (note the negative correlation with age).

Had 3+ Days in the Past Month Without Enough Sleep

(University of Chicago Medical Center Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 124]

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

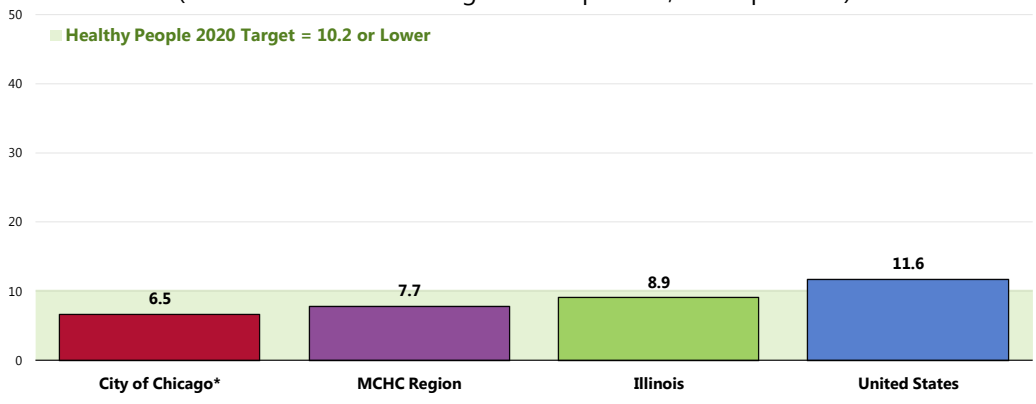
Suicide

Between 2006 and 2008, the City of Chicago experienced an annual average age-adjusted suicide rate of 6.5 deaths per 100,000 population.

- Lower than the regional rate (2007-2009 data).
- Lower than the statewide rate (2007-2009 data).
- Lower than the national rate data (2007-2009 data).
- Satisfies the Healthy People 2020 target of 10.2 or lower.

Suicide: Age-Adjusted Mortality

(2007-2009 Annual Average Deaths per 100,000 Population)



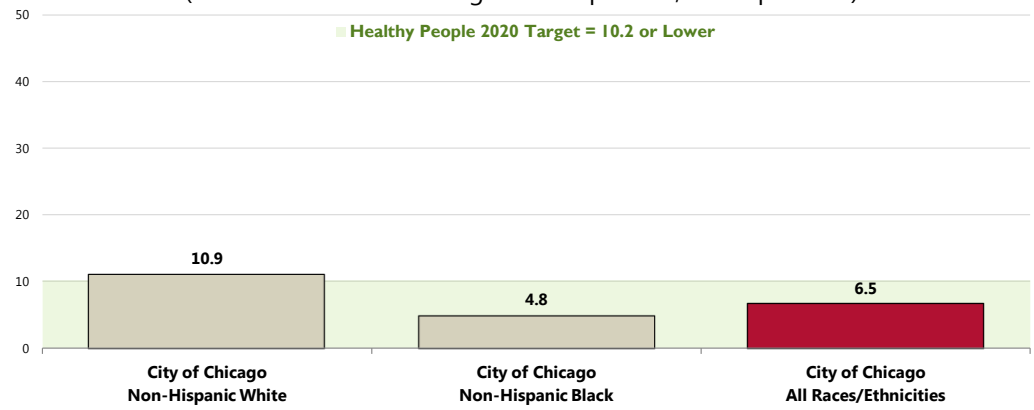
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MHMD-1]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- *City of Chicago rate represents 2006-2008 data.

The City of Chicago suicide rate is more than twice as high among Non-Hispanic Whites as among Non-Hispanic Blacks.

Suicide: Age-Adjusted Mortality by Race

(2006-2008 Annual Average Deaths per 100,000 Population)



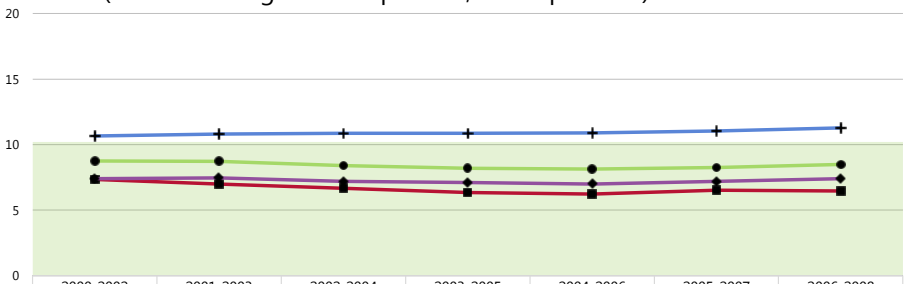
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MHMD-1]

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

The City of Chicago suicide rate has decreased overall, and is similar to the statewide trend. The national suicide rate has increased.

Suicide: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2020	10.2	10.2	10.2	10.2	10.2	10.2	10.2
City of Chicago	7.3	7.0	6.7	6.3	6.2	6.5	6.5
MCHC Region	7.4	7.5	7.2	7.1	7.0	7.2	7.4
Illinois	8.8	8.7	8.4	8.2	8.1	8.3	8.5
United States	10.7	10.8	10.9	10.9	10.9	11.0	11.3

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MHMD-1]

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

Mental Health Treatment

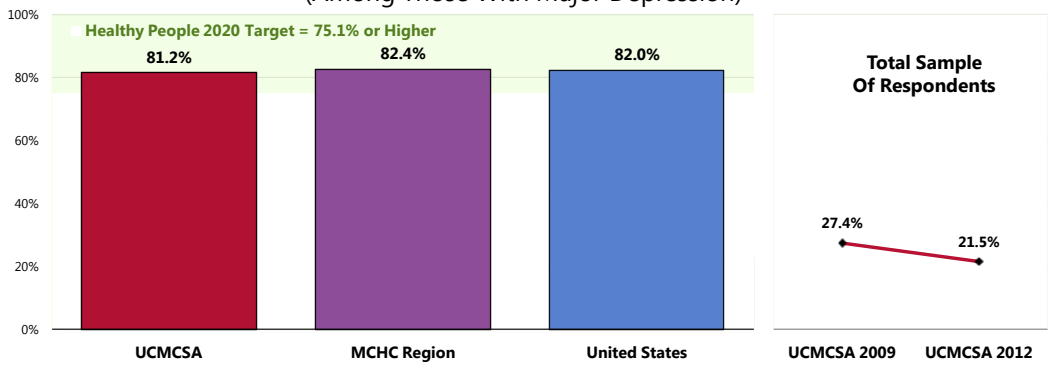
Among adults with diagnosed depression, 81.2% acknowledge that they have sought professional help for a mental or emotional problem.

"Diagnosed depression" includes respondents reporting a past diagnosis of major depression by a physician.

- Similar to the overall MCHC Region percentage.
- Similar to national findings.
- Similar to the Healthy People 2020 target of 75.1% or higher.
- Among the <u>total sample</u> of respondents, there has been no statistically significant change over time in the prevalence of those seeking professional help.

Have Sought Professional Help for a Mental or Emotional Problem

(Among Those With Major Depression)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 123, 150]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MHMD-9.2]

Notes:
- Asked of those respondents with major depression diagnosed by a physician.
- Trend data represent those adults with "recognized depression," including those who have been diagnosed with major depression OR have experienced 2+ years of depression at some point in their lives.

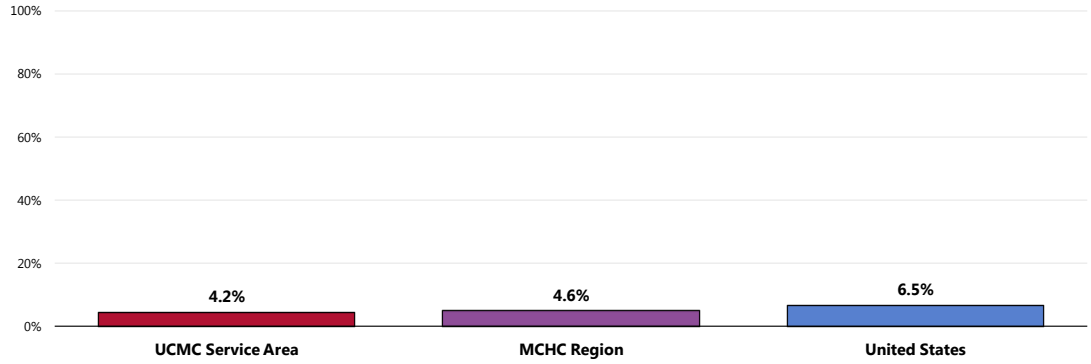
Children & ADD/ADHD

Among UCMC Service Area adults with children age 5 to 17, 4.2% report that their child takes medication for ADD/ADHD.

- Comparable to the regional percentage.
- Comparable to the national prevalence.

Child Takes Medication for ADD/ADHD

(Among Parents of Children 5-17)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 140]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents with children age 5 to 17.

Related Focus Group Findings: Mental Health

Mental health in the community arose often during discussion, with primary issues including:

- Inadequate number of psychiatrists and treatment facility options
- Mental illnesses co-occurring with substance abuse
- Stigma
- Stress

During the Cook County focus group, issues surrounding mental health coverage came up several times. Group attendees agree that persons suffering from mental illness are more likely to be vulnerable and less likely to successfully navigate the complex healthcare system. The participants feel that residents suffer due to a **limited number of psychiatrists and inpatient facilities** available to address behavioral healthcare needs. State budget cuts have affected the number of available mental health resources, and many times community members must enter into a crisis before they can access treatment, as one participant explains:

> *"Frequently the trigger to actually accessing some mental health services is a bad thing has to happen to you: you have to have HIV, you have to have been shot, and you have to precipitate a psychotic crisis. Then you get hooked up -- or you go to jail." — Cook County Key Informant*

Many local psychiatrists have long waiting periods before initial appointments take place, and generally insurance coverage for mental health services is inadequate.

> *"Well, congestive heart failure(CHF) treatment is through insurance so that's covered; that's a medical disease but when you try to give some kind of counseling for somebody it's a whole different thing as far as what insurance will cover. If you have a chronic mental illness they'll cover you for six visits. Well then why can you go forever with CHF? It's always been a stepchild." — Cook County Key Informant*

South Chicago participants agree that the community suffers due to an **inadequate number of psychiatrists, counselors, and treatment facilities** available to address residents' behavioral health needs. Residents must travel to other parts of the city to access quality care; many of the public mental health clinics have shut down on the South side of Chicago and there are very few, if any, options for uninsured persons. Both insured and uninsured patients may encounter long wait times before an initial psychiatric appointment. A focus group attendee describes the severity of the situation:

> *"So if you don't have insurance and you have a mental issue – sorry to hear that. And I think that's a problem. I mean, people have a lot of issues that need to be addressed. You've got alcoholism, you've got drug addiction, you're got trauma, you've got people who are schizophrenic, you just have plain old crazy people – I mean none of these people can get any help because there's no options – people that do not have insurance are not able to get assistance." — South Chicago Key Informant*

South Chicago participants also worry that many individuals struggling with mental illness have a **co-occurring substance abuse problem**. Many residents may be suffering from mental illness due to experiencing trauma, and substance use may be a way for these individuals to cope.

Cook County group attendees are also concerned that the **stigma** which still surrounds mental health may hamper an individual's ability or desire to access services. Participants believe that if psychiatrists worked in primary care physician offices, or if healthcare providers worked in teams, this might lessen the stigma attached to mental health. As one member describes:

> *"I used to work in Minnesota and in the diabetes program that I worked there we had a psychiatrist on our staff and everyone who came in had to see the psychiatrist because that was part of the team so that if they ever had problems there wouldn't be that stigma, that they would know that that's comfortable. I have been trying for 23 years to get a psychiatrist on my staff." — Cook County Key Informant*

Stigma surrounding behavioral health was also discussed during the South Chicago focus group, with attendees believing that stigma greatly impacts residents' and family members' desire to obtain mental healthcare:

> *"We (African Americans) don't go seek out psychiatric services anyway, especially if a child has been exposed to some type of trauma or experienced some type of trauma. So we'll basically push it under the rug or we're going to pray about it. We don't take the time to seek professional services to help with trauma. So that means whatever is going on is going to build up. So we might have violent behavior, we might have other risky behavior." — South Chicago Key Informant*

With the current economic climate, many residents live under a high level of **stress**. Cook County group attendees believe that stress contributes to high levels of obesity and other poor health outcomes.

Participants in South Chicago also consider the high levels of **stress** in the community to contribute to the high levels of mental illness. Many residents cannot meet their own basic needs, so they live in a state of constant stress, causing both physical and emotional

effects. Focus group attendees mentioned the following as major contributors to stress: unemployment, low socioeconomic status, violence in the neighborhoods, inability to fulfill basic needs, and lack of affordable childcare. As one member describes:

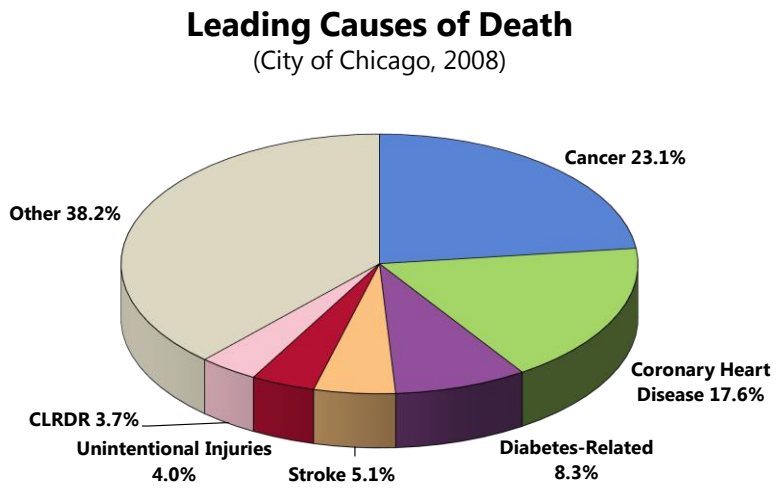
> *"Basic needs: food, clothing, shelter. Lack thereof. Just the basic stuff and living in an unsafe environment. And then for those that don't have those issues, it's you're overworked, you're worried about being able to pay your bills." — South Chicago Key Informant*

DEATH, DISEASE & CHRONIC CONDITIONS

Leading Causes of Death

Distribution of Deaths by Cause

Together, cardiovascular disease (coronary heart disease and stroke) and cancers accounted for nearly one-half of all deaths in the City of Chicago in 2008.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• CLRD is chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

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 2020* targets.

The following chart outlines 2006-2008 annual average age-adjusted death rates per 100,000 population for selected causes of death in the City of Chicago. Where city data is unavailable, Cook County rates are used (reflecting 2007-2009 data).

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

Age-adjusted mortality rates in the City of Chicago (or Cook County) are worse than national rates for heart disease, stroke, cancer, pneumonia/influenza, firearm-related deaths, kidney disease, HIV/AIDS and cirrhosis/liver disease.

Of the causes outlined in the following chart for which Healthy People 2020 objectives have been established, City of Chicago/Cook County rates fail to satisfy the related goals for heart disease, stroke, cancer, firearm-related deaths, homicide, diabetes mellitus, HIV/AIDS and cirrhosis/liver disease.

Age-Adjusted Death Rates for Selected Causes

(2007-2009 Deaths per 100,000)

	City of Chicago	MCHC Region	Illinois	United States	Healthy People 2020
Diseases of the Heart	**199.3****	188.3	189.3	185.8	152.7*
Malignant Neoplasms (Cancers)	**194.2**	179.3	183.9	175.6	160.6
Cerebrovascular Disease (Stroke)	**44.2**	39.7	41.8	40.6	33.8
Unintentional Injuries	**33.9**	25.8	31.9	38.7	36.0
Chronic Lower Respiratory Disease (CLRD)	**29.4**	31.5	39.9	42.4	n/a
Pneumonia/Influenza	**23.1**	19.0	18.6	16.4	n/a
Kidney Disease	**23.0**	20.0	19.5	14.7	n/a
Diabetes Mellitus	**22.7****	20.9	21.3	21.7	19.6*
Alzheimer's Disease	**15.2**	17.8	21.2	23.5	n/a
Homicide/Legal Intervention	**15.1**	9.1	6.7	5.8	5.5
Cirrhosis/Liver Disease	**11.0**	8.2	8.2	9.2	8.2
Firearm-Related	**10.9****	9.2	8.1	10.2	9.2
Drug-Induced	**10.3****	10.1	10.5	12.6	11.3
Motor Vehicle Crashes	**7.8**	6.4	9.3	13.0	12.4
Intentional Self-Harm (Suicide)	**6.5**	7.7	8.9	11.6	10.2
HIV/AIDS	**8.2**	3.8	2.2	3.3	3.3

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov.

Note:
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population and coded using ICD-10 codes.
- *The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart; the Diabetes target is adjusted to reflect only diabetes mellitus-coded deaths.
- Local, state and national data are simple three-year averages. City of Chicago data is 2006-2008. **Cook County data is used here; City of Chicago rates not available.

Related Focus Group Findings: Chronic Disease

All participants agree that chronic disease conditions persist in the community, with emphasis on diabetes, obesity, heart disease, hypertension, respiratory diseases, mental illness and substance abuse/addiction.

Cardiovascular Disease

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

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

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

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

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

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

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

– Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Heart Disease & Stroke Deaths

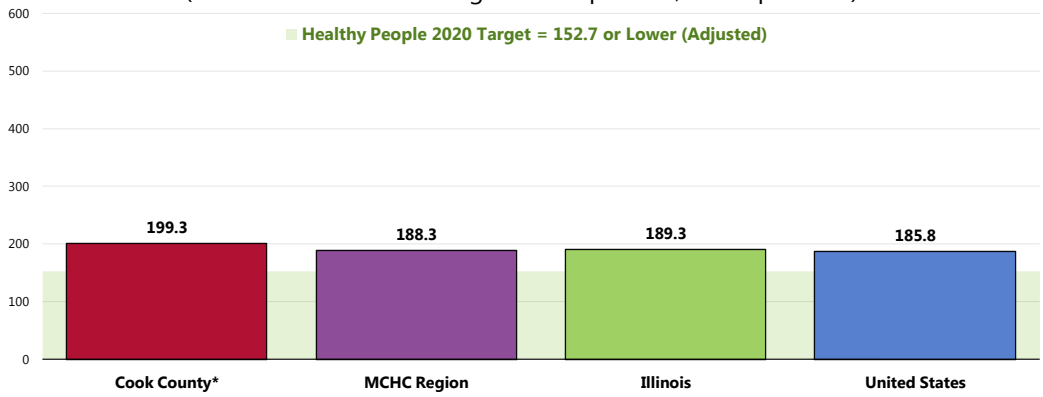
The greatest share of cardiovascular deaths is attributed to heart disease.

Between 2007 and 2009 there was an annual average age-adjusted heart disease mortality rate of 199.3 deaths per 100,000 population in Cook County (City of Chicago data not available).

- Higher than the regional rate.
- Higher than the statewide rate.
- Higher than the national rate.
- Fails to satisfy the Healthy People 2020 target (as adjusted to account for all diseases of the heart).

Heart Disease: Age-Adjusted Mortality

(2007-2009 Annual Average Deaths per 100,000 Population)



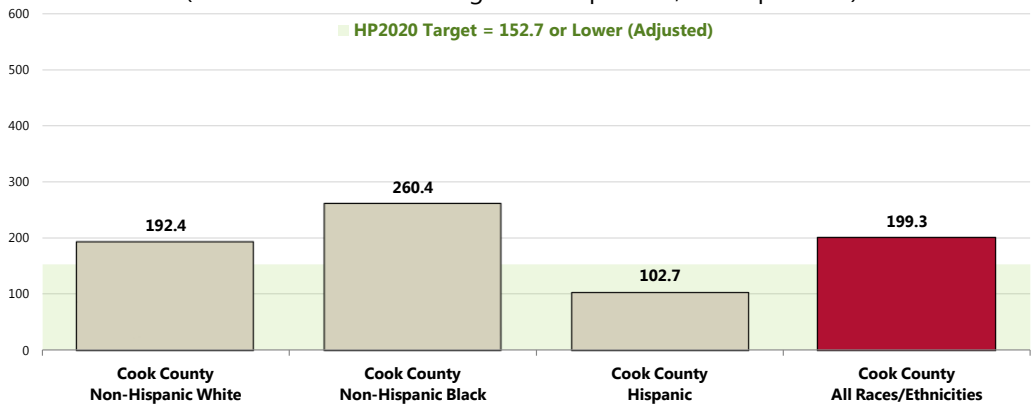
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-2]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.
- *City of Chicago rate not available; Cook County rate is shown here.

By race, Cook County heart disease mortality is unfavorably high among Non-Hispanic Blacks, and is much higher among Non-Hispanic Whites when compared with Hispanics.

Heart Disease Deaths: Age-Adjusted Mortality by Race

(2007-2009 Annual Average Deaths per 100,000 Population)



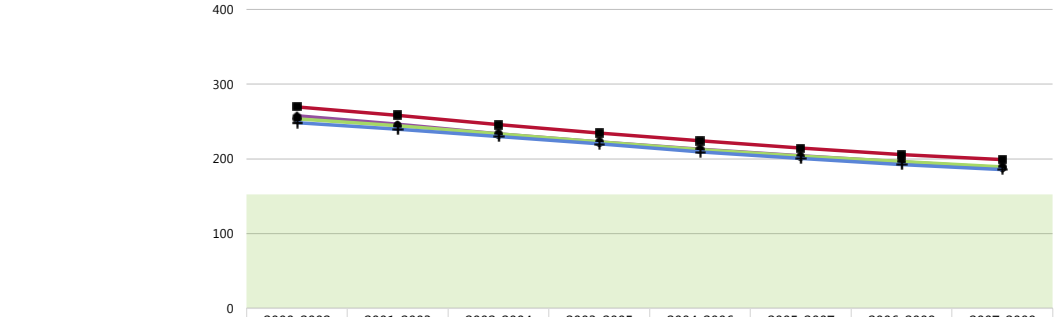
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-2]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.
- Local, state and national data are simple three-year averages.

- The heart disease mortality rate has decreased in Cook County, echoing the decreasing regional, state and national trends.

Heart Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
Healthy People 2020 (Adjusted)	152.7	152.7	152.7	152.7	152.7	152.7	152.7	152.7
Cook County*	269.8	258.5	245.9	234.9	224.2	214.4	205.8	199.3
MCHC Region	257.9	246.4	233.5	222.7	212.9	204.2	196.2	188.3
Illinois	253.9	244.3	233.5	222.8	212.6	203.8	196.4	189.3
United States	248.4	240.0	230.0	220.1	209.4	200.7	192.5	185.8

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-2]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.
- *City of Chicago data not available; Cook County rates are shown here.

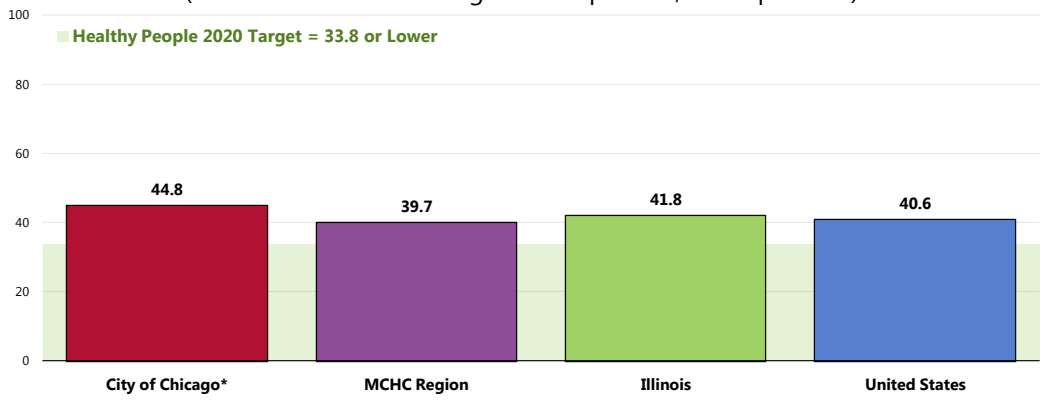
Stroke Deaths

Between 2006 and 2008, there was an annual average age-adjusted stroke mortality rate of 44.8 deaths per 100,000 population in the City of Chicago.

- Worse than the regional rate.
- Worse than the Illinois rate.
- Worse than the national rate.
- Fails to satisfy the Healthy People 2020 target of 33.8 or lower.

Stroke: Age-Adjusted Mortality

(2007-2009 Annual Average Deaths per 100,000 Population)



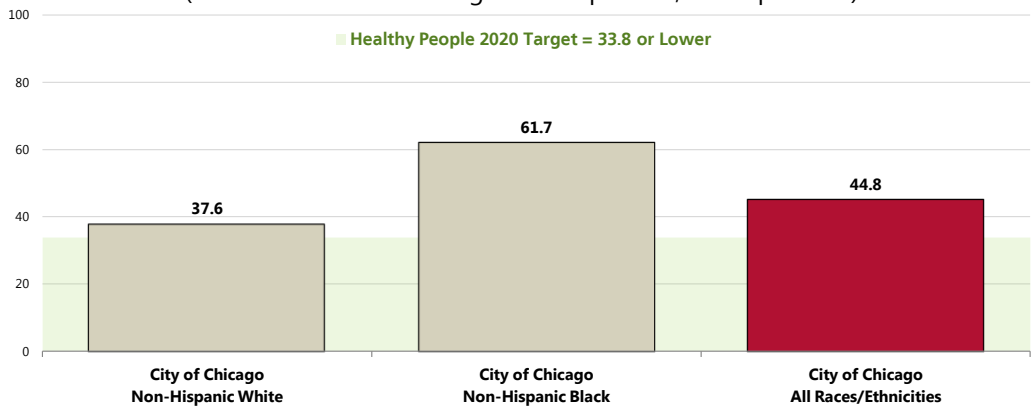
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-3]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- *City of Chicago rate represents 2006-2008 data.

Stroke mortality is much higher among City of Chicago Non-Hispanic Blacks than Whites.

Stroke: Age-Adjusted Mortality by Race

(2006-2008 Annual Average Deaths per 100,000 Population)



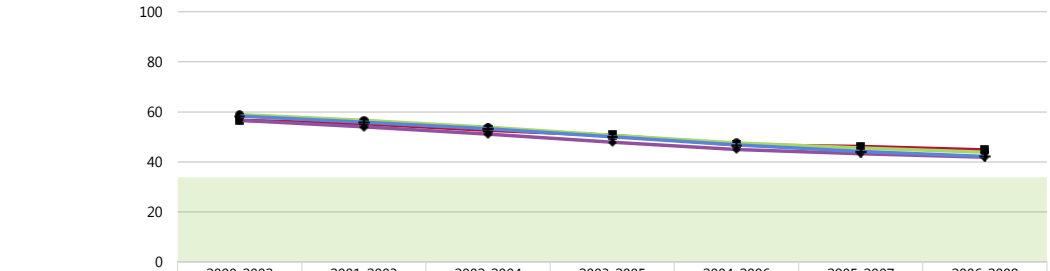
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-3]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.

The stroke rate has declined in recent years, echoing the trends reported across the MCHC Region, Illinois and the US overall.

Stroke: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2020	33.8	33.8	33.8	33.8	33.8	33.8	33.8
City of Chicago	56.7	55.3	52.7	50.7	46.8	46.1	44.8
MCHC Region	56.7	54.0	51.1	47.8	45.0	43.3	41.8
Illinois	59.0	56.6	53.8	50.6	47.6	45.6	43.9
United States	58.3	55.8	53.2	50.0	46.7	44.1	42.2

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-3]

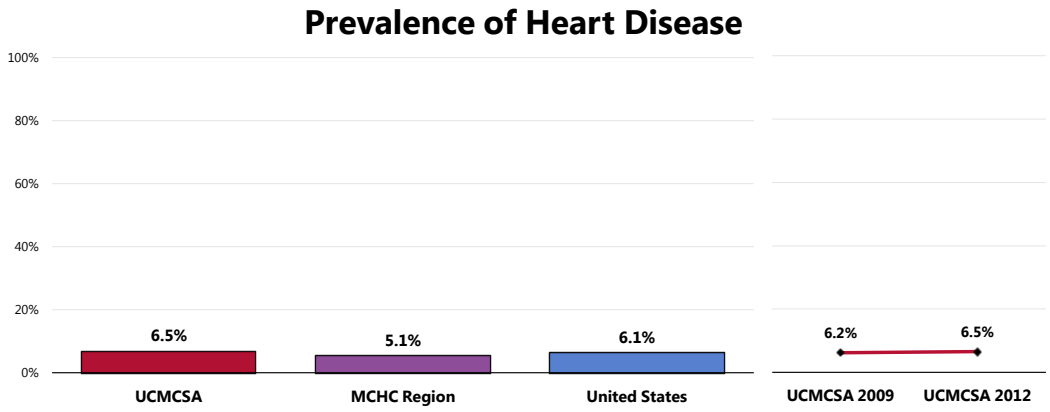
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.

Prevalence of Heart Disease & Stroke

Prevalence of Heart Disease

A total of 6.5% of surveyed adults report that they suffer from or have been diagnosed with heart disease, such as coronary heart disease, angina or heart attack.

- Similar to regional findings.
- Similar to the national prevalence.
- Statistically unchanged since 2009.

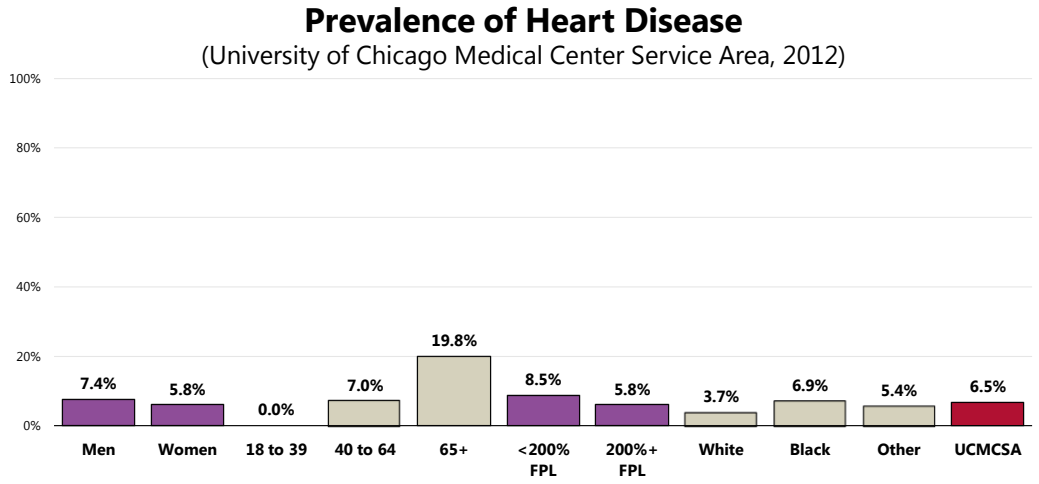


Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 151]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Adults more likely to have been diagnosed with chronic heart disease include:

- Residents age 65 or older (notice the positive correlation with age).



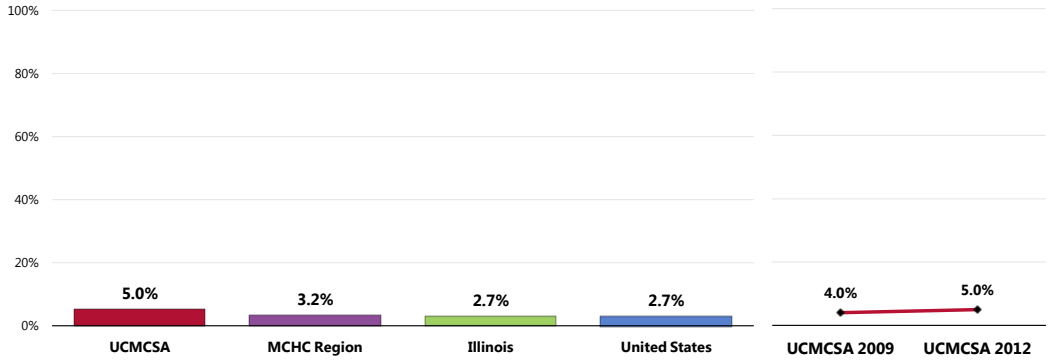
Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 151]

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

A total of 5.0% of surveyed adults report that they suffer from or have been diagnosed with cerebrovascular disease (a stroke).

- Similar to regional findings.
- Less favorable than statewide findings.
- Similar to national findings.
- Statistically unchanged over time.

Prevalence of Stroke



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 43]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.

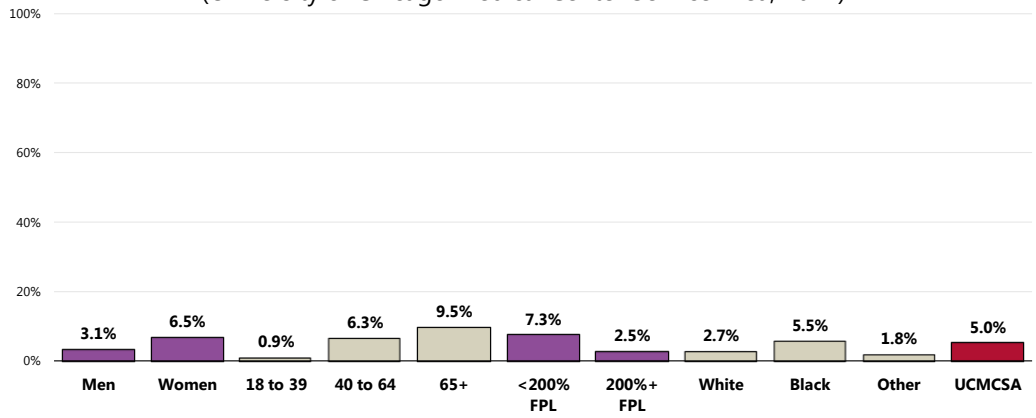
Notes:
- Asked of all respondents.

Adults more likely to have been diagnosed with stroke include:

- Community members age 40 or older (note the positive correlation with age).
- Residents in the lower income category.

Prevalence of Stroke

(University of Chicago Medical Center Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 43]

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

Cardiovascular Risk Factors

Hypertension (High Blood Pressure)

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

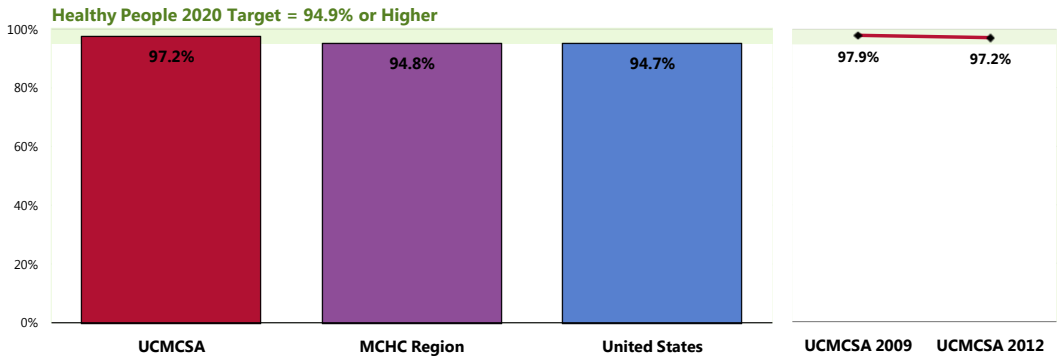
– Healthy People 2020 (www.healthypeople.gov)

High Blood Pressure Testing

A total of 97.2% of UCMC Service Area adults have had their blood pressure tested within the past two years.

- Better than the regional findings.
- Better than the national findings.
- Satisfies the Healthy People 2020 target (94.9% or higher).
- Unchanged over time.

Have Had Blood Pressure Checked in the Past Two Years



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 53]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-4]

Notes:
- Asked of all respondents.

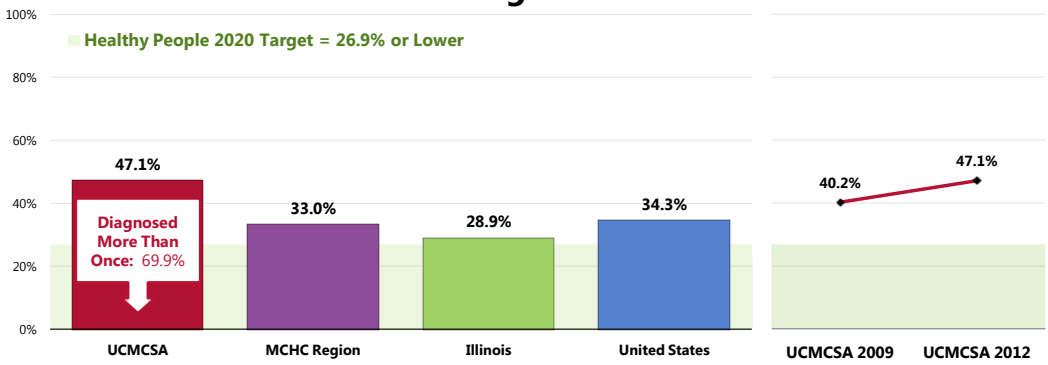
Prevalence of Hypertension

A total of 47.1% of adults have been told at some point that their blood pressure was high.

- Less favorable than the MCHC Region prevalence.
- Less favorable than the Illinois prevalence.
- Less favorable than the national prevalence.
- Considerably higher than the Healthy People 2020 target (26.9% or lower).

- Similar to the 2009 prevalence.
- Among hypertensive adults, 69.9% have been diagnosed with high blood pressure more than once.

Prevalence of High Blood Pressure



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 51, 152]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Illinois data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-5.1]

Notes:
- Asked of all respondents.

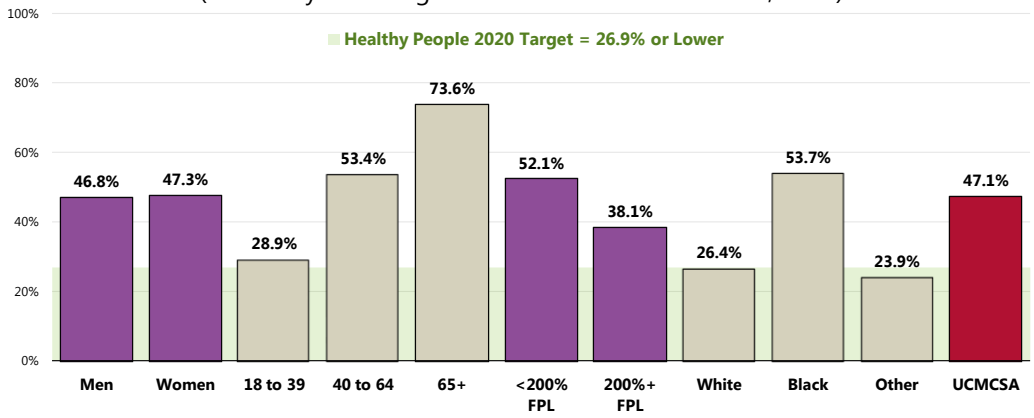
Note that 2.9% of UCMC Service Area adults report not having high blood pressure, but: 1) have never had their blood pressure tested; 2) have not been screened in the past 5 years; or 3) do not recall when their last screening was. For these individuals, current prevalence is unknown.

Hypertension diagnoses are higher among:

- Adults age 40 and older, and especially those age 65+.
- Lower-income residents.
- Blacks.

Prevalence of High Blood Pressure

(University of Chicago Medical Center Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 152]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-5.1]

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

Hypertension Management

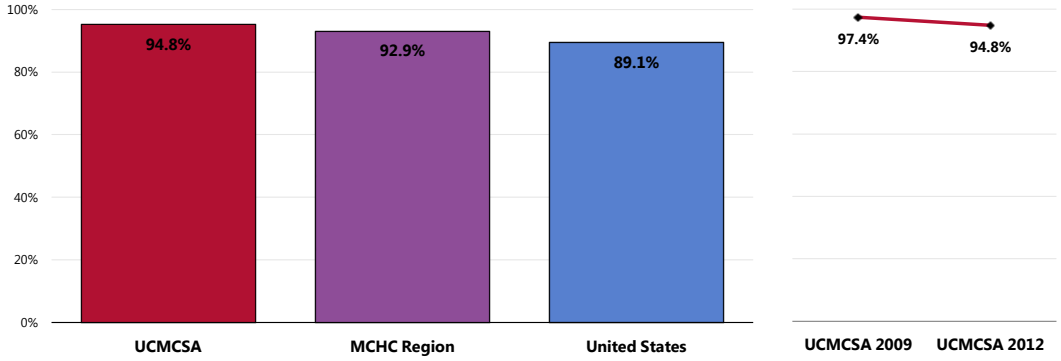
Respondents reporting high blood pressure were further asked:

"Are you currently taking any action to help control your high blood pressure, such as taking medication, changing your diet, or exercising?"

Among respondents who have been told that their blood pressure was high, 94.8% report that they are currently taking actions to control their condition.

- Similar to MCHC Region findings.
- Better than national findings.
- Statistically unchanged since 2009.

Taking Action to Control Hypertension
(Among Adults With High Blood Pressure)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 52]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents who have been diagnosed with high blood pressure.
- In this case, the term "action" refers to medication, change in diet, and/or exercise.

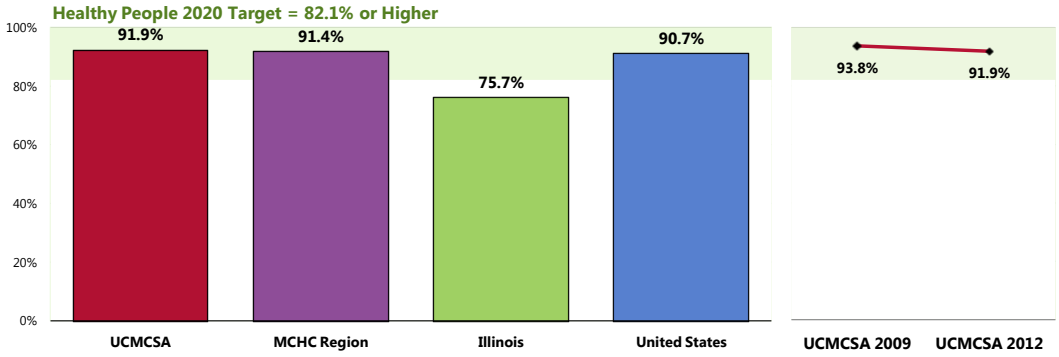
High Blood Cholesterol

Blood Cholesterol Testing

A total of 91.9% of UCMC Service Area adults have had their blood cholesterol checked within the past five years.

- Comparable to the MCHC Region findings.
- More favorable than Illinois findings.
- Comparable to the national findings.
- Satisfies the Healthy People 2020 target (82.1% or higher).
- No statistically significant change occurred since 2009.

Have Had Blood Cholesterol Levels Checked in the Past Five Years



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 56]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Illinois data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-6]

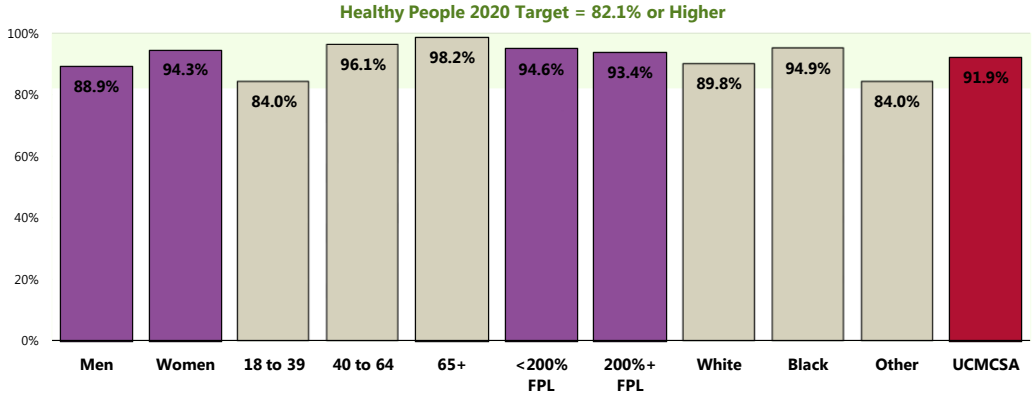
Notes:
- Asked of all respondents.

The following demographic segment reports lower screening levels:

- Adults under age 40.
- Community members in the "Other" race category.

Have Had Blood Cholesterol Levels Checked in the Past Five Years

(University of Chicago Medical Center Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 56]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-6]

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

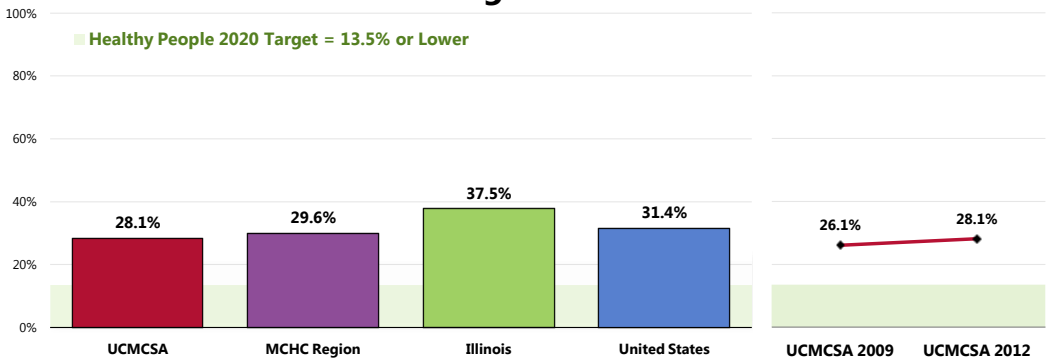
Self-Reported High Blood Cholesterol

A total of 28.1% of adults have been told by a health professional that their cholesterol level was high.

- Comparable to the regional prevalence.
- More favorable than the Illinois findings.
- Comparable to the national prevalence.

- More than twice the Healthy People 2020 target (13.5% or lower).
- Statistically unchanged since 2009.

Prevalence of High Blood Cholesterol



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 153]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Illinois data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-7]

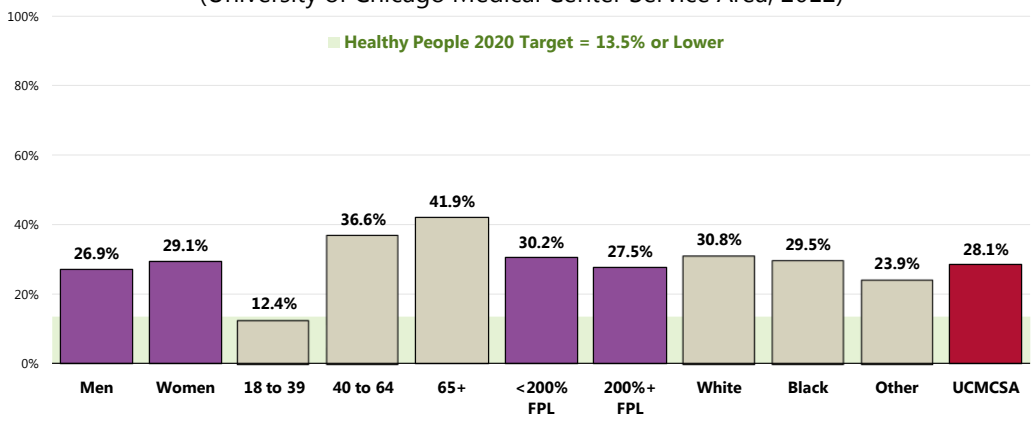
Notes:
- Asked of all respondents.
- *The IL data reflects those adults who have been tested for high cholesterol and who have been diagnosed with it.

Note that 16.6% of UCMC Service Area adults report not having high blood cholesterol, but: 1) have never had their blood cholesterol levels tested; 2) have not been screened in the past 5 years; or 3) do not recall when their last screening was. For these individuals, current prevalence is unknown.

- Considerably higher prevalence of high blood cholesterol was found among those age 40 and older (note the positive correlation between age and high blood cholesterol).
- Keep in mind that "unknowns" are relatively among area men, young adults (age 18-39), "other" races, and lower-income respondents.

Prevalence of High Blood Cholesterol

(University of Chicago Medical Center Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 153]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-7]

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

Respondents reporting high cholesterol were further asked:

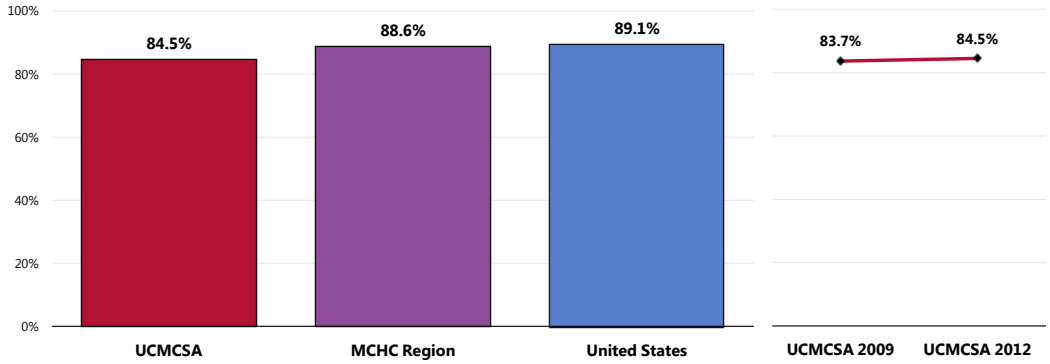
"Are you currently taking any action to help control your high cholesterol, such as taking medication, changing your diet, or exercising?"

Among adults who have been told that their blood cholesterol was high, 84.5% report that they are currently taking actions to control their cholesterol levels.

- Comparable to findings in the MCHC Region.
- Comparable to nationwide findings.
- High cholesterol management was stable between 2009 and 2012.

Taking Action to Control High Blood Cholesterol Levels

(Among Adults with High Cholesterol)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 55]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents who have been diagnosed with high blood cholesterol levels.
- In this case, the term "action" refers to medication, change in diet, and/or exercise.

Total Cardiovascular Risk

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

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

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

Three health-related behaviors contribute markedly to cardiovascular disease:

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

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

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

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

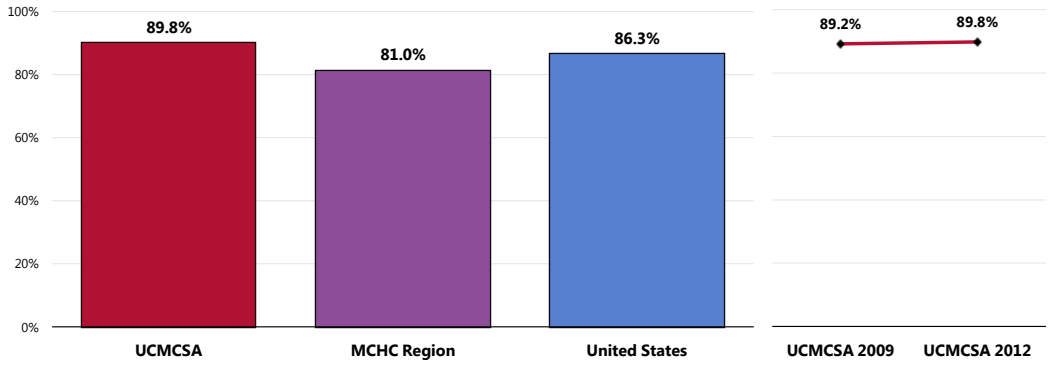
– National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

A total of 89.8% of UCMC Service Area adults report one or more cardiovascular risk factors, such as being overweight, smoking cigarettes, being physically inactive, or having high blood pressure or cholesterol.

- Notably higher than is found in the MCHC Region.
- Similar to the national findings.
- Statistically similar to the 2009 findings.

RELATED ISSUE: See also *Nutrition & Overweight, Physical Activity & Fitness* and *Tobacco Use* in the **Modifiable Health Risk** section of this report.

Present One or More Cardiovascular Risks or Behaviors



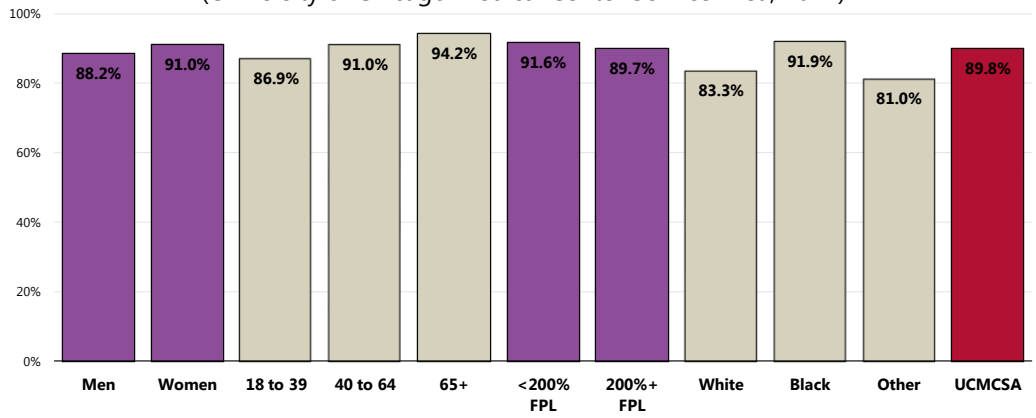
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 154]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.

Cardiovascular risk factors are no more or less likely by demographic groups.

Present One or More Cardiovascular Risks or Behaviors

(University of Chicago Medical Center Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 154]

Notes:
- Asked of all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Cancer

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

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

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

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

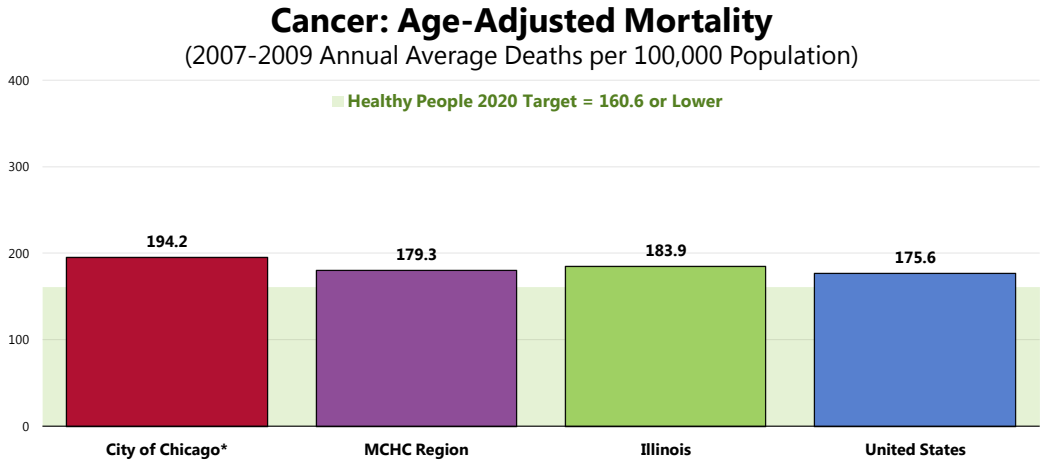
– Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Cancer Deaths

All Cancer Deaths

Between 2006 and 2008, the City of Chicago experienced an annual average age-adjusted cancer mortality rate of 194.2 deaths per 100,000 population.

- Higher than the regional cancer death rate.
- Higher than the statewide rate.
- Higher than the national rate.
- Fails to satisfy the Healthy People 2020 target of 160.6 or lower.



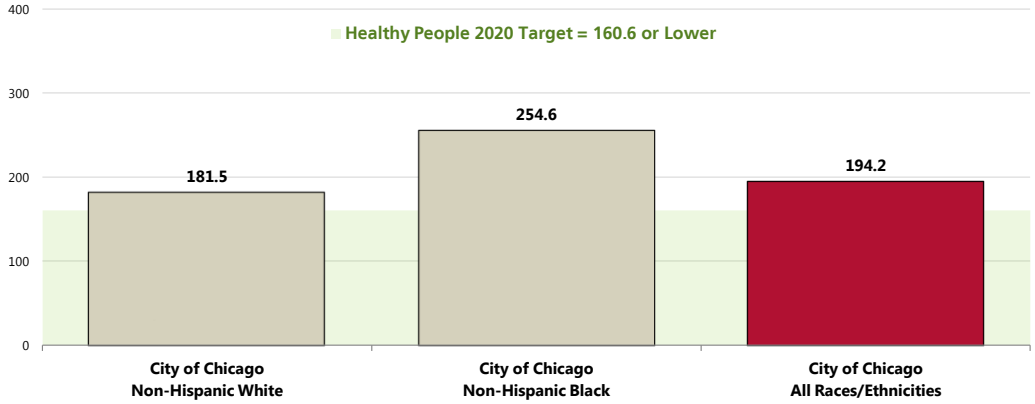
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-1]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- *City of Chicago rate represents 2006-2008 data.

The City of Chicago cancer mortality rate is notably higher among Non-Hispanic Blacks than Whites.

Cancer: Age-Adjusted Mortality by Race

(2006-2008 Annual Average Deaths per 100,000 Population)



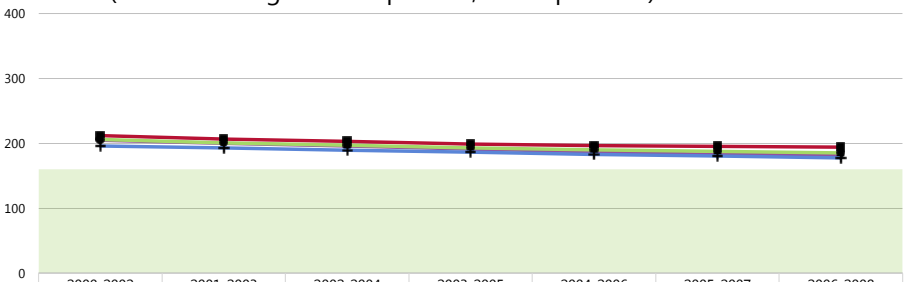
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-1]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.

Cancer mortality has <u>decreased</u> over the past decade in the City of Chicago; the same trend is apparent regionally and both statewide and nationwide.

Cancer: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2020	160.6	160.6	160.6	160.6	160.6	160.6	160.6
City of Chicago	212.4	207.0	203.4	199.4	197.1	195.9	194.2
MCHC Region	204.9	200.2	196.1	191.4	187.5	183.5	182.0
Illinois	206.1	201.2	197.4	193.5	190.2	187.7	185.8
United States	196.2	193.1	189.8	186.6	183.4	181.0	178.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-1]

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

Lung cancer is by far the leading cause of cancer deaths in the City of Chicago.

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

As can be seen in the following chart (referencing 2006-2008 annual average age-adjusted death rates):

- The City of Chicago **lung cancer** death rate is higher than the regional rate but similar to the state and national rates.
- The City's **prostate cancer** death rate is higher than regional, state and national rates.
- The City of Chicago **female breast cancer** death rate is also higher than regional, state and national rates.
- The City of Chicago **colorectal cancer** death rate is higher than regional, state and national rates.

Note that **each** of the City's cancer death rates detailed below fails to satisfy the related Healthy People 2020 target.

Age-Adjusted Cancer Death Rates by Site

(2007-2009 Annual Average Deaths per 100,000 Population)

	City of Chicago*	MCHC Region	IL	US	HP2020
Lung Cancer	**51.6**	**46.9**	**52.1**	**49.5**	**45.5**
Prostate Cancer	**34.6**	**26.6**	**24.3**	**22.6**	**21.2**
Female Breast Cancer	**26.9**	**24.8**	**23.7**	**22.6**	**20.6**
Colorectal Cancer	**21.8**	**18.0**	**18.1**	**16.4**	**14.5**

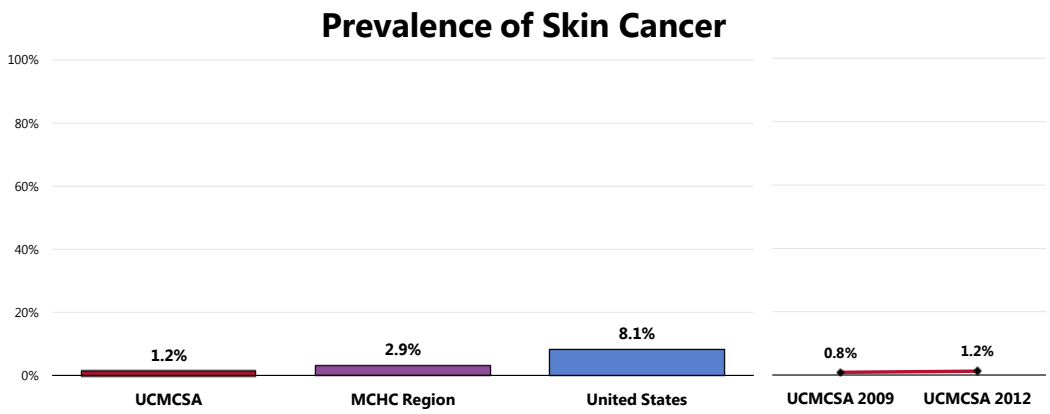
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov
- *City of Chicago rates represent 2006-2008 data.

Prevalence of Cancer

Skin Cancer

A total of 1.2% of surveyed UCMC Service Area adults report having been diagnosed with skin cancer.

- Better than the MCHC Regional prevalence.
- Better than the national average.
- The prevalence of skin cancer is unchanged from 2009.

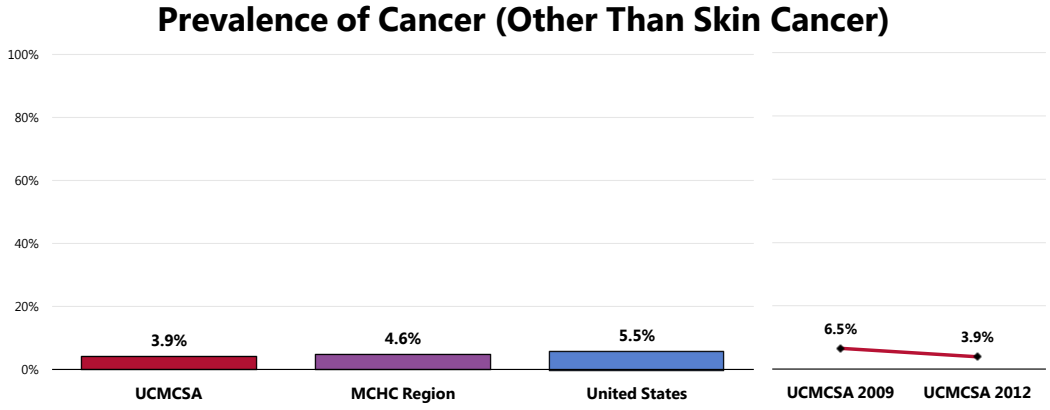


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 31]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Other Cancer

A total of 3.9% of adults have been diagnosed with some type of (non-skin) cancer.

- Comparable to the regional prevalence.
- Comparable to the national prevalence.
- The prevalence of cancer remained statistically unchanged over time.



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 30]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

RELATED ISSUE: See also *Nutrition & Overweight, Physical Activity & Fitness* and *Tobacco Use* in the **Modifiable Health Risk** section of this report.

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

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

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

Cancer Screenings

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

Screening levels in the community were measured in the PRC Community Health Survey relative to four cancer sites: prostate cancer (prostate-specific antigen testing and digital rectal examination); female breast cancer (mammography); cervical cancer (Pap smear testing); and colorectal cancer (sigmoidoscopy and fecal occult blood testing).

Prostate Cancer Screenings

The US Preventive Services Task Force (USPSTF) concludes that the current evidence is insufficient to assess the balance of benefits and harms of prostate cancer screening in men younger than age 75 years.

Rationale: Prostate cancer is the most common nonskin cancer and the second-leading cause of cancer death in men in the United States. The USPSTF found convincing evidence that prostate-specific antigen (PSA) screening can detect some cases of prostate cancer.

In men younger than age 75 years, the USPSTF found inadequate evidence to determine whether treatment for prostate cancer detected by screening improves health outcomes compared with treatment after clinical detection.

The USPSTF found convincing evidence that treatment for prostate cancer detected by screening causes moderate-to-substantial harms, such as erectile dysfunction, urinary incontinence, bowel dysfunction, and death. These harms are especially important because some men with prostate cancer who are treated would never have developed symptoms related to cancer during their lifetime.

There is also adequate evidence that the screening process produces at least small harms, including pain and discomfort associated with prostate biopsy and psychological effects of false-positive test results.

The USPSTF recommends against screening for prostate cancer in men age 75 years or older.

Rationale: In men age 75 years or older, the USPSTF found adequate evidence that the incremental benefits of treatment for prostate cancer detected by screening are small to none.

Given the uncertainties and controversy surrounding prostate cancer screening in men younger than age 75 years, a clinician should not order the PSA test without first discussing with the patient the potential but uncertain benefits and the known harms of prostate cancer screening and treatment. Men should be informed of the gaps in the evidence and should be assisted in considering their personal preferences before deciding whether to be tested.

– 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.

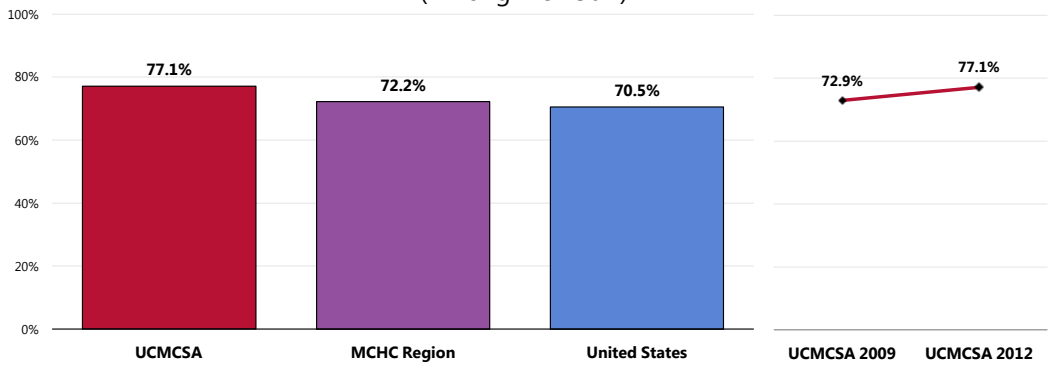
PSA Testing and/or Digital Rectal Examination

Among men age 50 and older, 77.1% had a PSA (prostate-specific antigen) test and/or a digital rectal examination for prostate problems within the past two years.

- Similar to findings in the MCHC Region.
- Similar to national findings.
- Statistically unchanged since 2009.

Have Had a Prostate Screening in the Past Two Years

(Among Men 50+)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 158]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all male respondents 50 and older.

Female Breast Cancer Screening

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

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

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

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

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

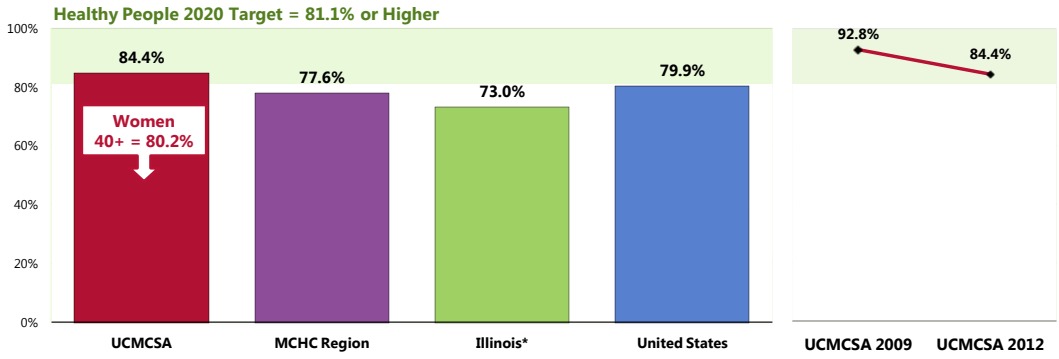
Mammography

Among women age 50-74, 84.4% had a mammogram within the past two years.

- Similar to regional findings.
- More favorable than statewide findings (which represent all women 50+).
- Similar to national findings.
- Similar to the Healthy People 2020 target (81.1% or higher).
- Similar to findings of the 2009 survey.
- Among women 40+, 80.2% had a mammogram in the past two years.

Have Had a Mammogram in the Past Two Years

(Among Women 50-74)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 155-156]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-17]

Notes:
- Reflects female respondents 50-74.
- *Note that state data reflects all women 50 and older (vs. women 50-74 in local, US and Healthy People data).

Cervical Cancer Screenings

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

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

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

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

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

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

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

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

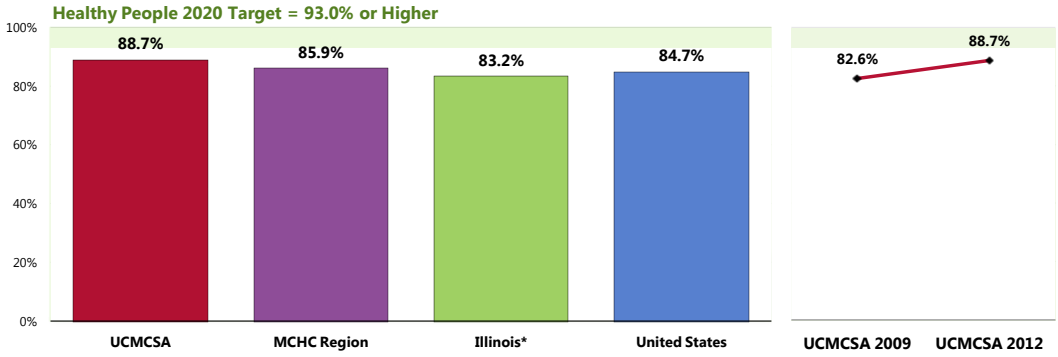
Pap Smear Testing

Among women age 21 to 65, 88.7% had a Pap smear within the past three years.

- Comparable to the MCHC Region findings.
- Better than the Illinois findings (which represents all women 18+).
- Comparable to national findings.
- Comparable to the Healthy People 2020 target (93% or higher).
- Statistically stable over time.

Have Had a Pap Smear in the Past Three Years

(Among Women 21-65)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 157]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-15]

Notes:
- Reflects female respondents age 21 to 65.
- *Note that the IL percentage represents all women age 18 and older.

Colorectal Cancer Screenings

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

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

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

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

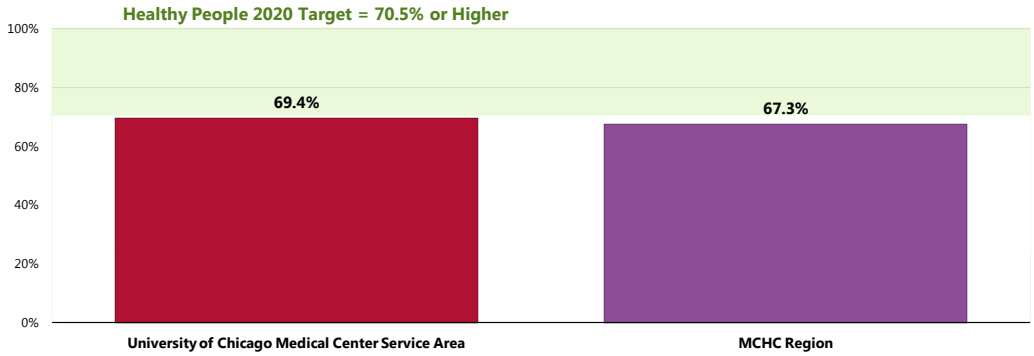
Colorectal Cancer Screening

Among adults age 50-75, 69.4% have had an appropriate colorectal cancer screening (fecal occult blood testing within the past year and/or sigmoidoscopy/ colonoscopy [lower endoscopy]) within the past 10 years.

- Similar to the MCHC Region percentage.
- Similar to the Healthy People 2020 target (70.5% or higher).

Have Had a Colorectal Cancer Screening

(Among Adults 50-75; 2012)



Sources:
- 2012 PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 161]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-16]

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

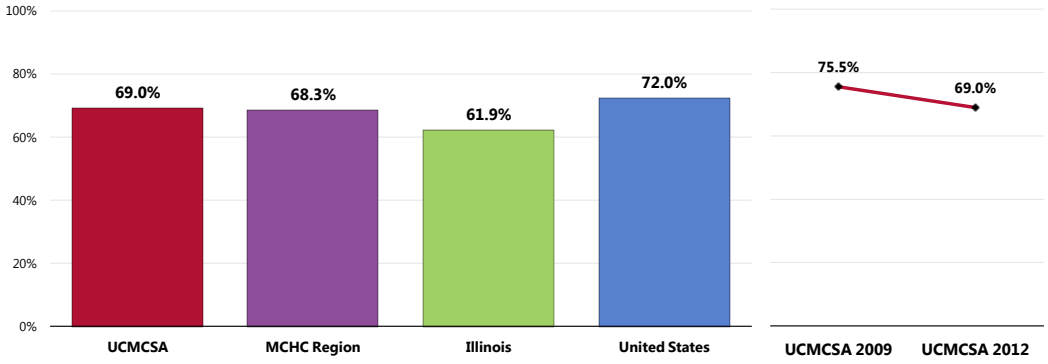
Lower Endoscopy

Among adults age 50 and older, more than two-thirds (69.0%) have had a lower endoscopy (sigmoidoscopy or colonoscopy) at some point in their lives.

- Comparable to the MCHC Region findings.
- Better than the Illinois findings.
- Comparable to national findings.
- Statistically similar to the 2009 survey findings.

Have Ever Had a Lower Endoscopy Exam

(Among Adults 50+)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 159]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

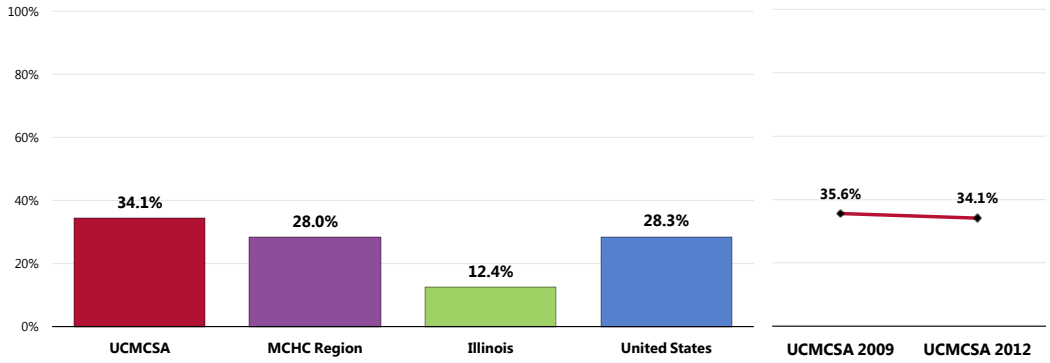
Notes:
- Asked of all respondents 50+.
- Lower endoscopy includes either sigmoidoscopy or colonoscopy.

Among adults age 50 and older, 34.1% have had a blood stool test (aka "fecal occult blood test") within the past two years.

- Comparable to regional findings.
- Better than the Illinois findings.
- Comparable to national findings.
- Statistically unchanged since 2009.

Have Had a Blood Stool Test in the Past Two Years

(Among Adults 50+)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 160]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents 50+.

Respiratory Disease

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

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

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

Several additional respiratory conditions and respiratory hazards, including infectious agents and occupational and environmental exposures, are covered in other areas of Healthy People 2020. Examples include tuberculosis, lung cancer, acquired immunodeficiency syndrome (AIDS), pneumonia, occupational lung disease, and smoking. Sleep Health is now a separate topic area of Healthy People 2020.

Currently in the United States, more than 23 million people have asthma. Approximately 13.6 million adults have been diagnosed with COPD, and an approximately equal number have not yet been diagnosed. The burden of respiratory diseases affects individuals and their families, schools, workplaces, neighborhoods, cities, and states. Because of the cost to the healthcare system, the burden of respiratory diseases also falls on society; it is paid for with higher health insurance rates, lost productivity, and tax dollars. Annual healthcare expenditures for asthma alone are estimated at $20.7 billion.

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

Risk factors for asthma currently being investigated include:

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

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

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

– Healthy People 2020 (www.healthypeople.gov)

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

Age-Adjusted Respiratory Disease Deaths

Note: COPD was changed to chronic lower respiratory disease (CLRD) in 1999 with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.

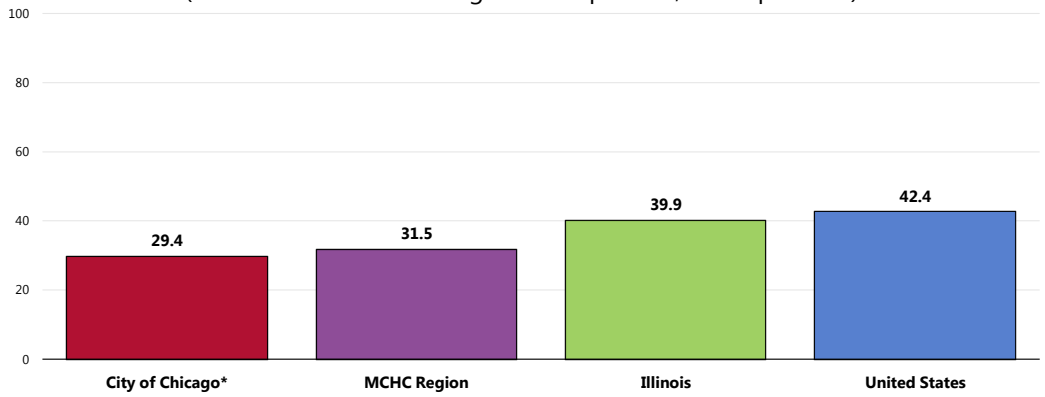
Chronic Lower Respiratory Disease Deaths (CLRD)

Between 2006 and 2008, there was an annual average age-adjusted CLRD mortality rate of 29.4 deaths per 100,000 population in the City of Chicago.

- Better than the regional rate.
- Better than found statewide.
- Better than the national rate.

CLRD: Age-Adjusted Mortality

(2007-2009 Annual Average Deaths per 100,000 Population)



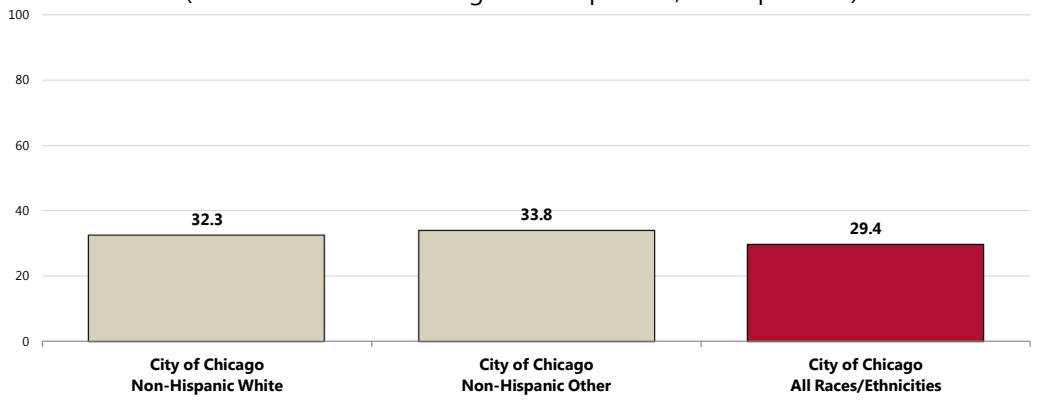
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- CLRD is chronic lower respiratory disease.
- *City of Chicago rate represents 2006-2008 data.

CLRD mortality does not appear to vary significantly by race in the City of Chicago.

CLRD: Age-Adjusted Mortality by Race

(2006-2008 Annual Average Deaths per 100,000 Population)



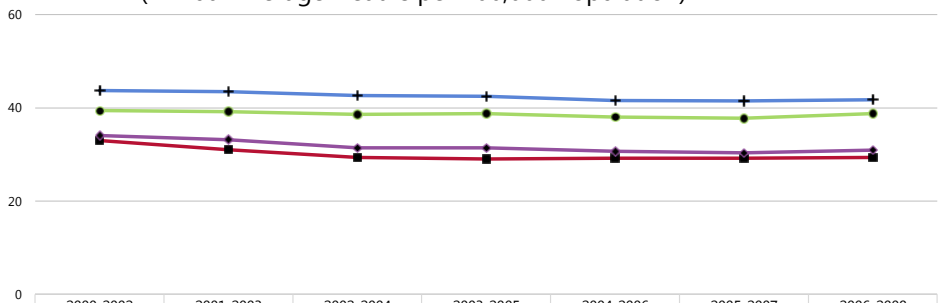
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- CLRD is chronic lower respiratory disease.

The City's CLRD mortality rate has decreased over the past decade, similar to the trends reported regionally and both statewide and nationwide.

CLRD: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
City of Chicago	33.0	31.0	29.3	29.0	29.2	29.2	29.4
MCHC Region	34.1	33.2	31.4	31.4	30.7	30.4	30.9
Illinois	39.4	39.2	38.6	38.8	38.0	37.8	38.8
United States	43.8	43.5	42.6	42.5	41.6	41.5	41.8

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.

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

Pneumonia/Influenza Deaths

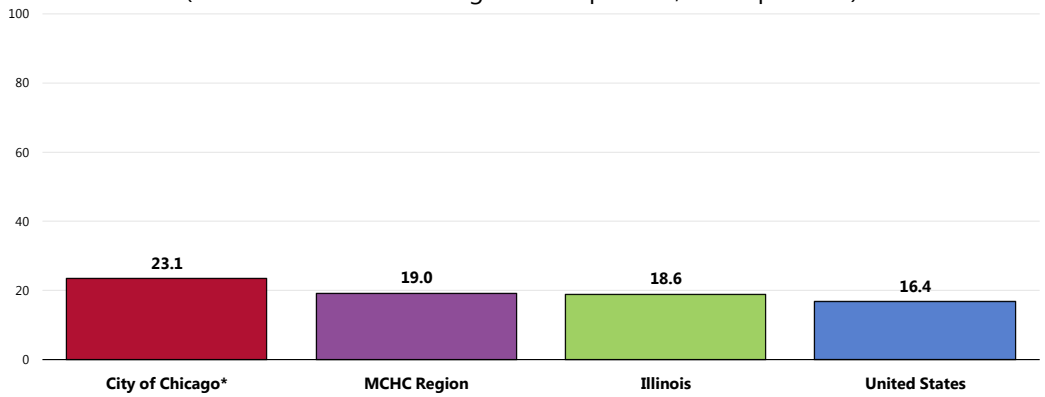
For prevalence of vaccinations for pneumonia and influenza, see also "Immunization & Infectious Disease."

Between 2006 and 2008, the City of Chicago reported an annual average age-adjusted pneumonia influenza mortality rate of 23.1 deaths per 100,000 population.

- Higher than the regional rate.
- Higher than the rate reported statewide.
- Higher than the national rate.

Pneumonia/Influenza: Age-Adjusted Mortality

(2007-2009 Annual Average Deaths per 100,000 Population)



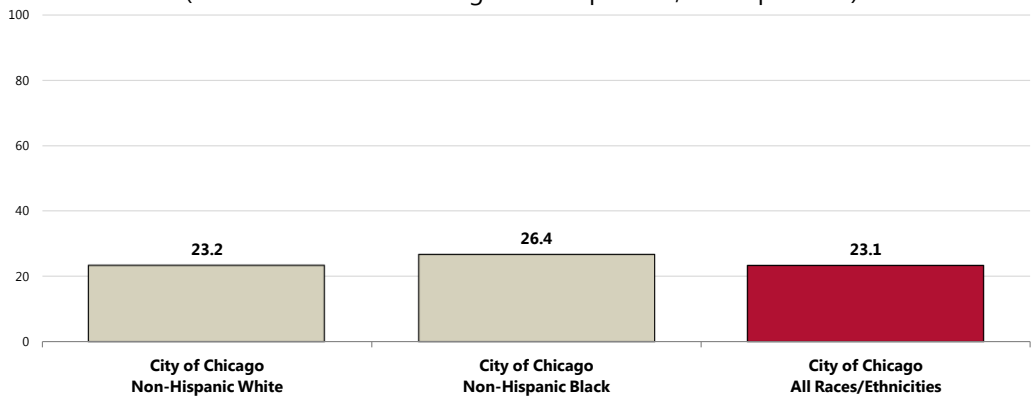
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- *City of Chicago rate represents 2006-2008 data.

The City's pneumonia/influenza mortality rate is higher among Blacks than Whites.

Pneumonia/Influenza: Age-Adjusted Mortality by Race

(2006-2008 Annual Average Deaths per 100,000 Population)



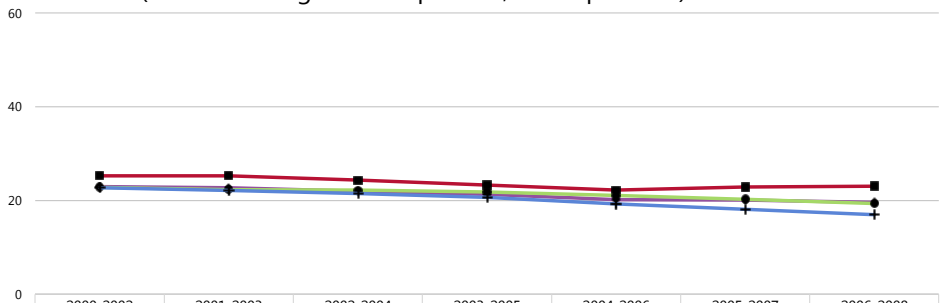
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.

City of Chicago pneumonia/influenza mortality has decreased over the past decade; a downward trend is evident across the MCHC Region, and is reported statewide and nationwide as well.

Pneumonia/Influenza: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
City of Chicago	25.3	25.3	24.3	23.3	22.2	22.9	23.1
MCHC Region	23.0	22.7	22.0	21.3	20.2	20.1	19.6
Illinois	22.8	22.3	22.2	21.8	21.1	20.3	19.4
United States	22.7	22.2	21.5	20.7	19.3	18.1	17.0

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.

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

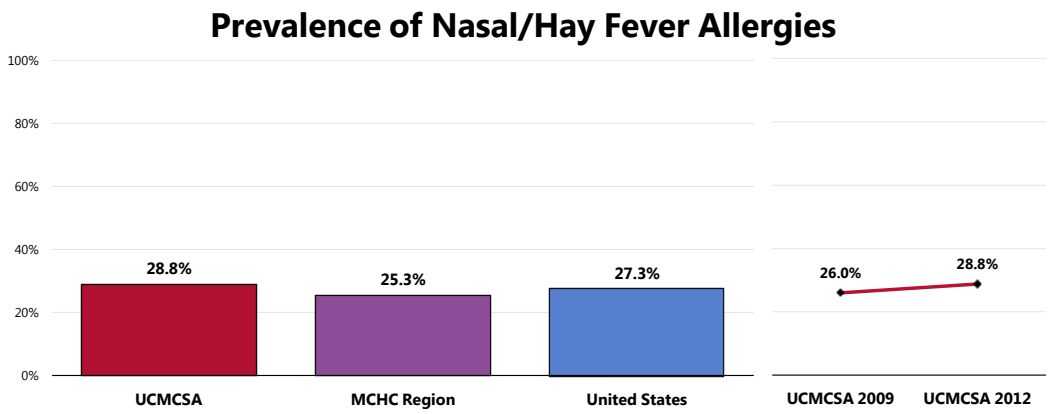
Prevalence of Respiratory Conditions

Survey respondents were next asked to indicate whether they suffer from or have been diagnosed with various respiratory conditions, including asthma, nasal/hay fever allergies, sinusitis, and/or chronic lung disease.

Nasal/Hay Fever Allergies

A total of 28.8% of UCMC Service Area adults currently suffer from or have been diagnosed with nasal/hay fever allergies.

- Similar to the regional prevalence.
- Similar to the national prevalence.
- The prevalence of nasal/hay fever allergies among UCMC Service Area residents is statistically unchanged over time.

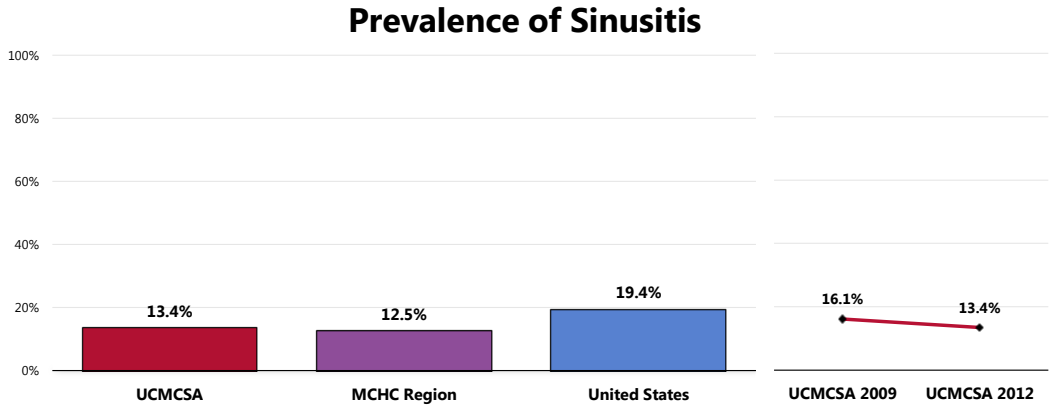


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 35]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Sinusitis

A total of 13.4% of UCMC Service Area adults suffer from sinusitis.

- Similar to the regional prevalence.
- More favorable than the national prevalence.
- Statistically unchanged over time.

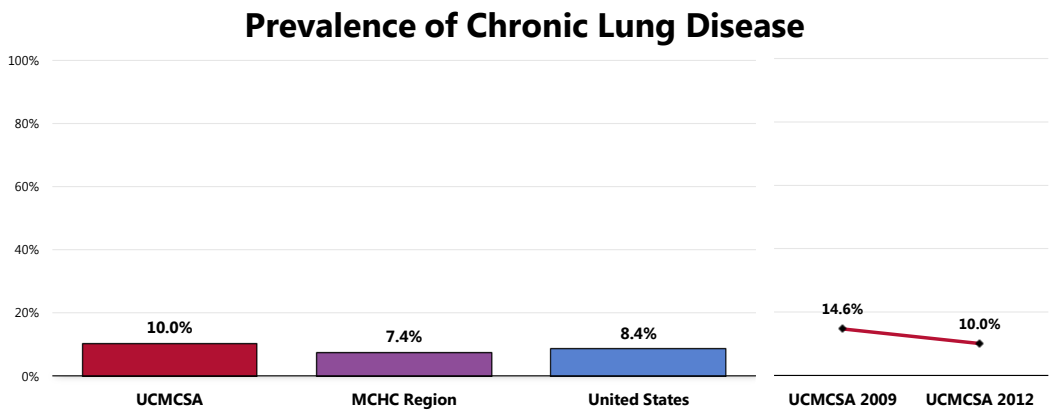


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 34]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Chronic Lung Disease

A total of 10.0% of UCMC Service Area adults suffer from chronic lung disease.

- Similar to the regional prevalence.
- Similar to the national prevalence.
- Statistically unchanged since 2009.



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 25]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

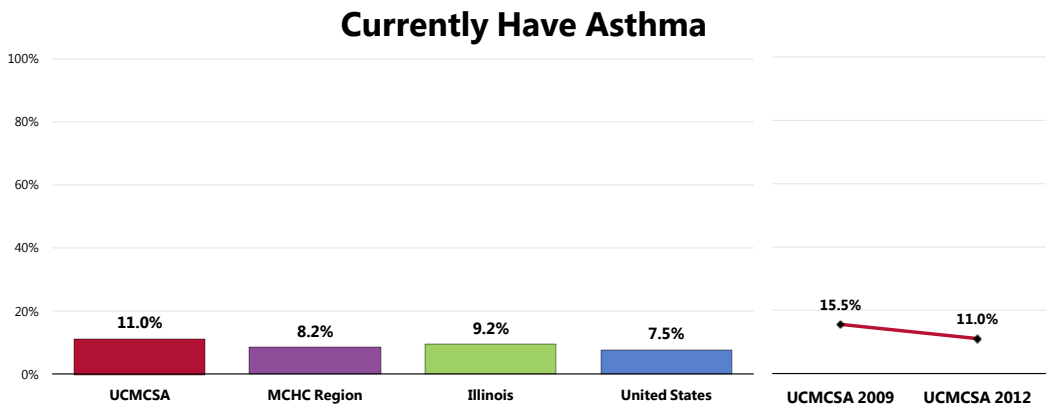
Notes:
- Asked of all respondents.

Asthma

Adults

A total of 11.0% of UCMC Service Area adults currently suffer from asthma.

- Similar to the regional prevalence.
- Similar to the statewide prevalence.
- Less favorable than the national prevalence.
- The prevalence of asthma has not changed significantly since 2009.

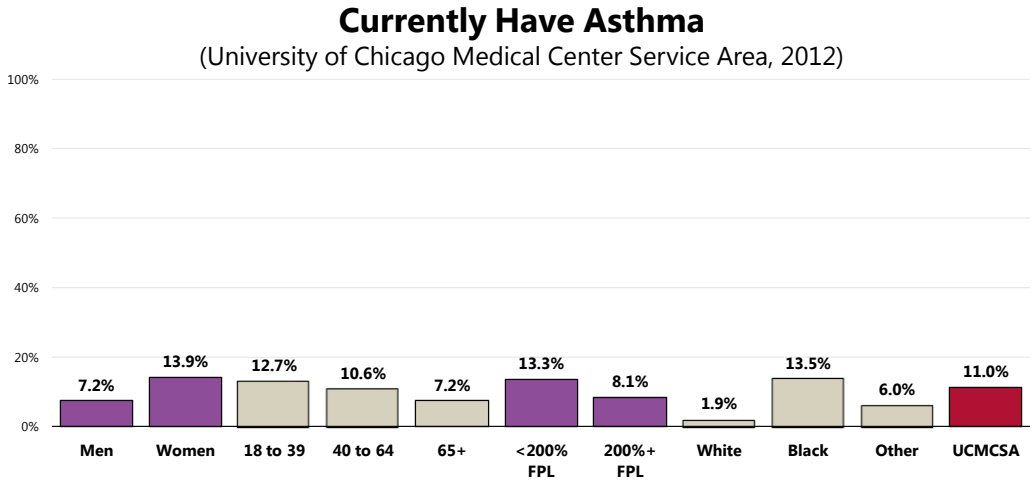


Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 162]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.

Notes:
- Asked of all respondents.

The following demographic groups are more likely to suffer from asthma:

- Women.
- Blacks.



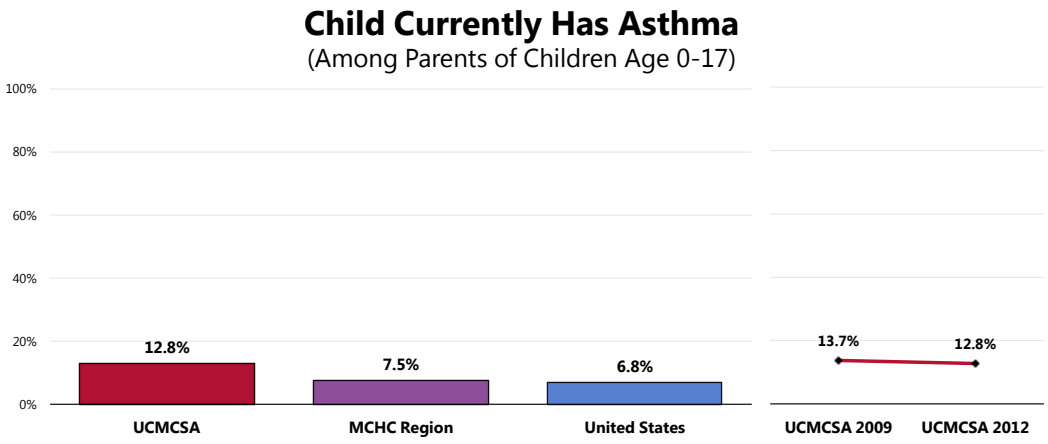
Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 162]

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

Children

Among UCMC Service Area children under age 18, 12.8% currently have asthma.

- Similar to regional findings.
- Similar to national findings.
- The prevalence of children with asthma has not changed significantly over time.



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 163]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.

Injury & Violence

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

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

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

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

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

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

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

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

Efforts to prevent violence may focus on:

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

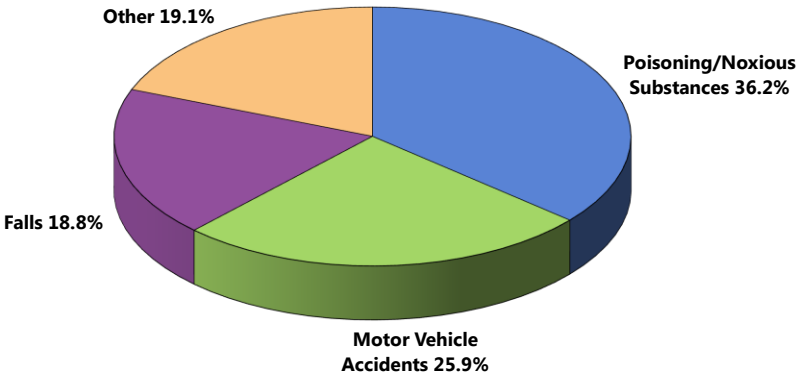
– Healthy People 2020 (www.healthypeople.gov)

Leading Causes of Accidental Death

Poisoning, motor vehicle accidents, and falls accounted for 80.9% of Cook County accidental deaths in 2009.

Leading Causes of Accidental Death

(Cook County, 2009)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

Unintentional Injury

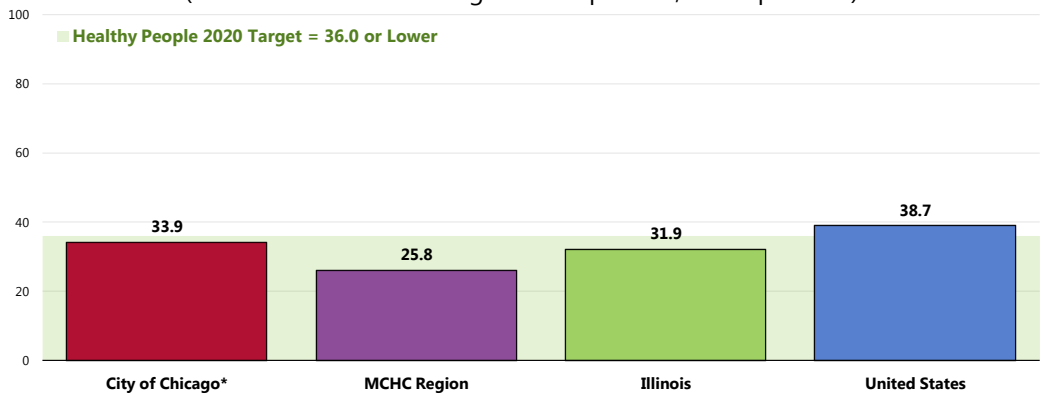
Age-Adjusted Unintentional Injury Deaths

Between 2006 and 2008, the City of Chicago reported an annual average age-adjusted unintentional injury mortality rate of 33.9 deaths per 100,000 population.

- Much higher than the regional rate.
- Higher than the Illinois rate.
- Lower than the national rate.
- Satisfies the Healthy People 2020 target (36.0 or lower).

Unintentional Injuries: Age-Adjusted Mortality

(2007-2009 Annual Average Deaths per 100,000 Population)

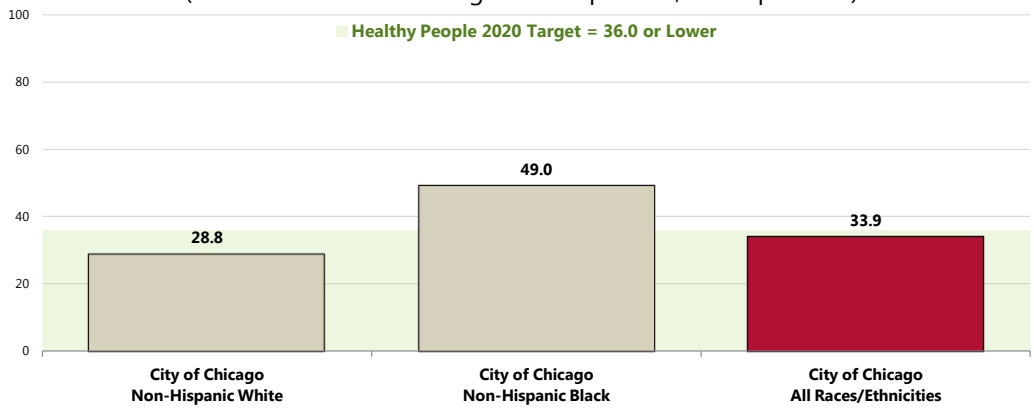


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-11]
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• Local, state and national data are simple three-year averages.
• *City of Chicago rate represents 2006-2008 data.

The mortality rate due to accidents is notably higher among Blacks than Whites in the City of Chicago.

Unintentional Injuries: Age-Adjusted Mortality by Race

(2006-2008 Annual Average Deaths per 100,000 Population)



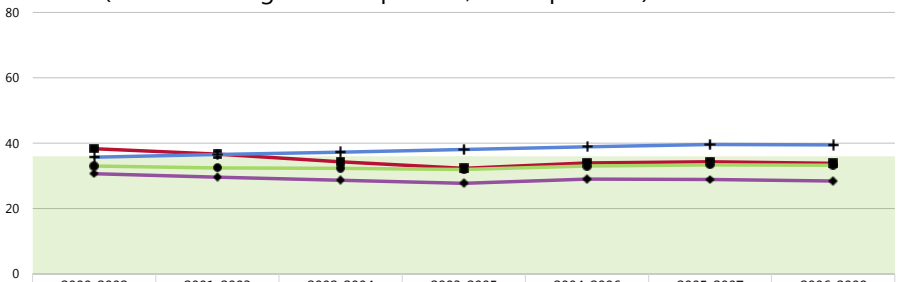
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-11]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.

The City's unintentional injury mortality rate declined early in the last decade, but has since increased slightly. Nationally, the trend has been consistently upward.

Unintentional Injuries: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2020	36.0	36.0	36.0	36.0	36.0	36.0	36.0
City of Chicago	38.3	36.7	34.3	32.3	34.0	34.3	33.9
MCHC Region	30.7	29.6	28.7	27.7	29.0	28.9	28.4
Illinois	33.0	32.4	32.3	31.9	33.0	33.4	33.3
United States	35.8	36.6	37.3	38.0	38.9	39.6	39.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-11]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.

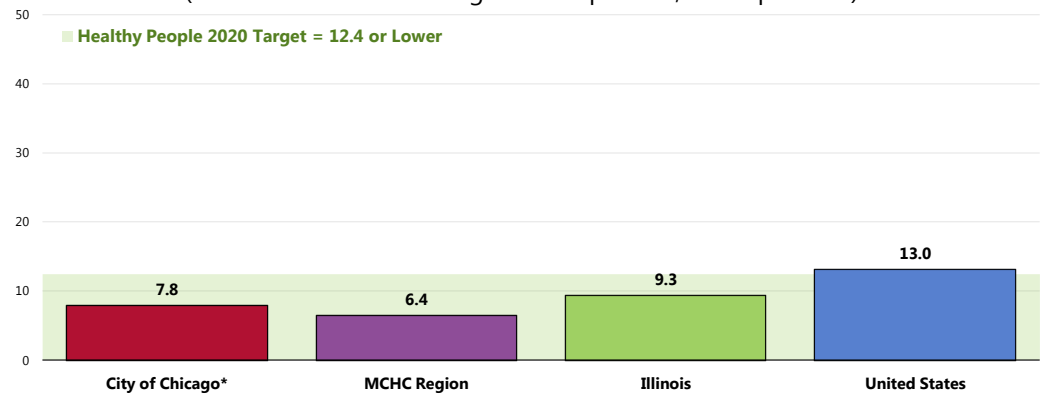
Age-Adjusted Motor-Vehicle Related Deaths

Between 2006 and 2008, there was an annual average age-adjusted motor vehicle crash mortality rate of 7.8 deaths per 100,000 population in the City of Chicago.

- Higher than the regional rate.
- Better than found statewide.
- Better than found nationally.
- Satisfies the Healthy People 2020 target (12.4 or lower).

Motor Vehicle Crashes: Age-Adjusted Mortality

(2007-2009 Annual Average Deaths per 100,000 Population)



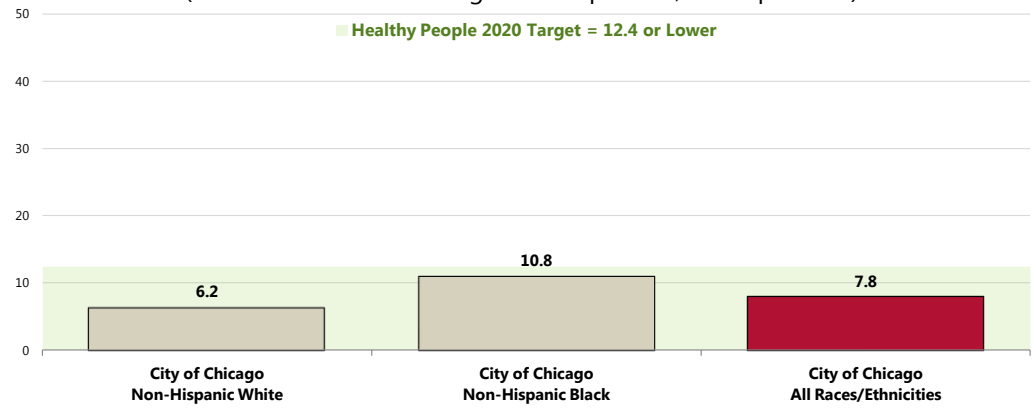
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-13.1]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- *City of Chicago rate represents 2006-2008 data.

The City's 2006-2008 motor vehicle crash mortality rate was higher among Blacks than among Whites.

Motor Vehicle Crashes: Age-Adjusted Mortality by Race

(2006-2008 Annual Average Deaths per 100,000 Population)



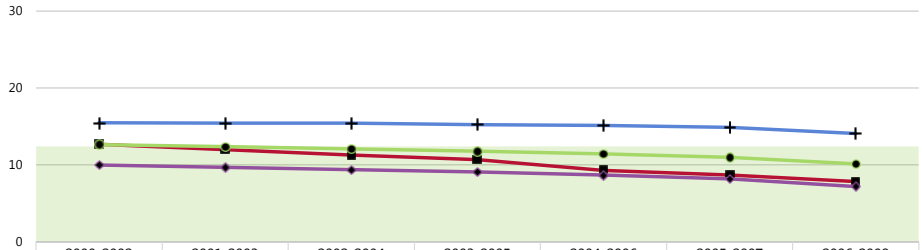
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-13.1]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.

- The motor vehicle accident mortality rate has decreased in Chicago over the past decade.

Motor Vehicle Crashes: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2020	12.4	12.4	12.4	12.4	12.4	12.4	12.4
City of Chicago	12.7	12	11.3	10.7	9.3	8.7	7.8
MCHC Region	10.0	9.7	9.4	9.1	8.7	8.2	7.2
Illinois	12.6	12.4	12.1	11.8	11.4	11.0	10.1
United States	15.5	15.4	15.4	15.2	15.1	14.9	14.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-13.1]

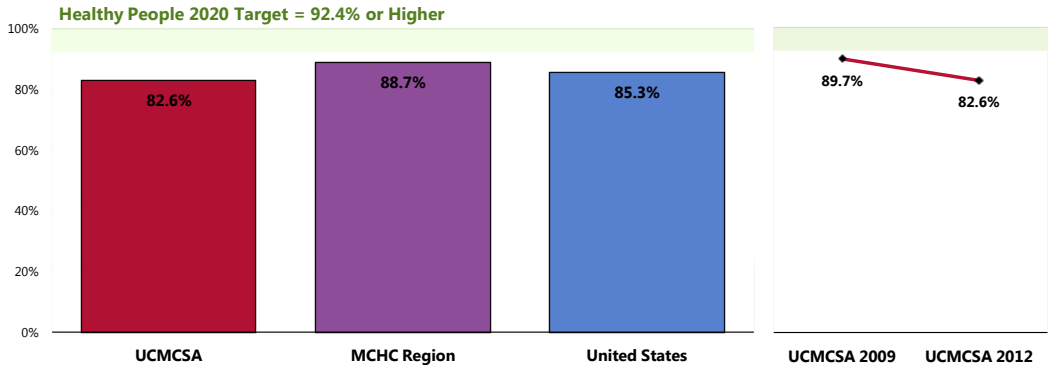
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.

Seat Belt Usage - Adults

Most UCMC Service Area adults (82.6%) report "always" wearing a seat belt when driving or riding in a vehicle.

- Less favorable than the percentage found in the MCHC Region.
- Comparable to the percentage found nationally.
- Fails to satisfy the Healthy People 2020 target of 92.4% or higher.
- Marks a significant <u>decrease</u> from 2009.

"Always" Wear a Seat Belt When Driving or Riding in a Vehicle



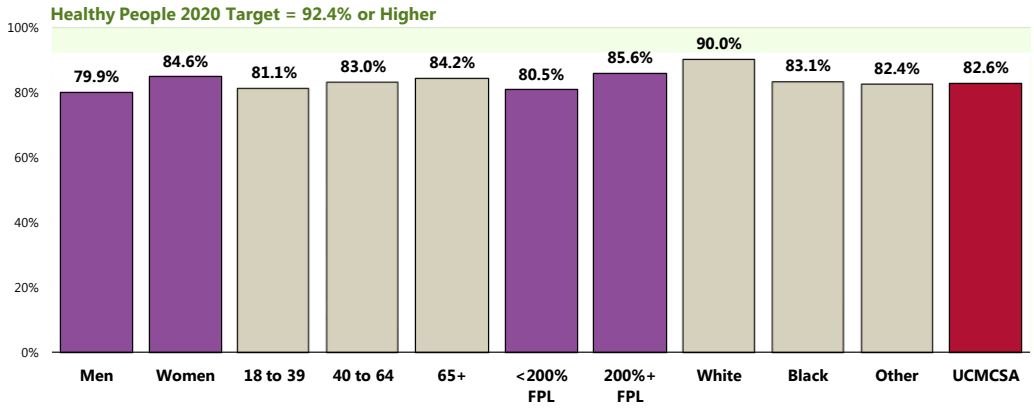
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 57]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IPV-15]

Notes:
- Asked of all respondents.

Consistent seat belt usage does not vary significantly within demographic categories.

"Always" Wear a Seat Belt When Driving or Riding in a Vehicle

(University of Chicago Medical Center Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 57]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IPV-15]

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

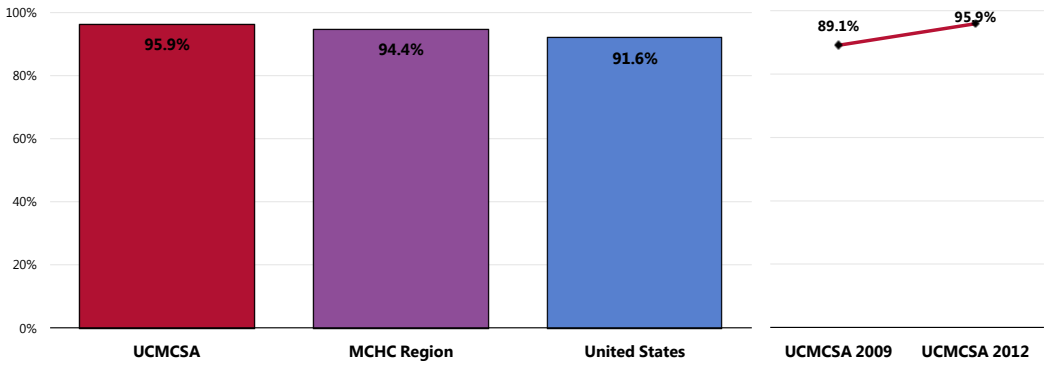
Seat Belt Usage - Children

A full 95.9% of UCMC Service Area parents report that their child (age 0 to 17) "always" wears a seat belt (or appropriate car seat for younger children) when riding in a vehicle.

- Comparable to the percentage found in the MCHC Region.
- Comparable to what is found nationally.
- Statistically unchanged since 2009.

Child "Always" Wears a Seat Belt or Appropriate Restraint When Riding in a Vehicle

(Among Parents of Children Age 0-17)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 141]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.

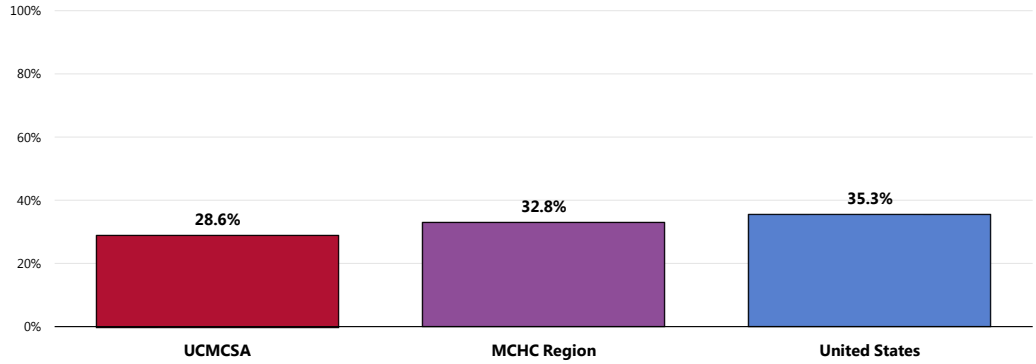
Bicycle Safety

A total of 28.6% of UCMC Service Area children age 5 to 17 are reported to "always" wear a helmet when riding a bicycle.

- Similar to the regional prevalence.
- Similar to the national prevalence.

Child "Always" Wears a Helmet When Riding a Bicycle

(Among Parents of Children Age 5-17)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 147]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents with children age 5 to 17 at home.

Firearm Safety

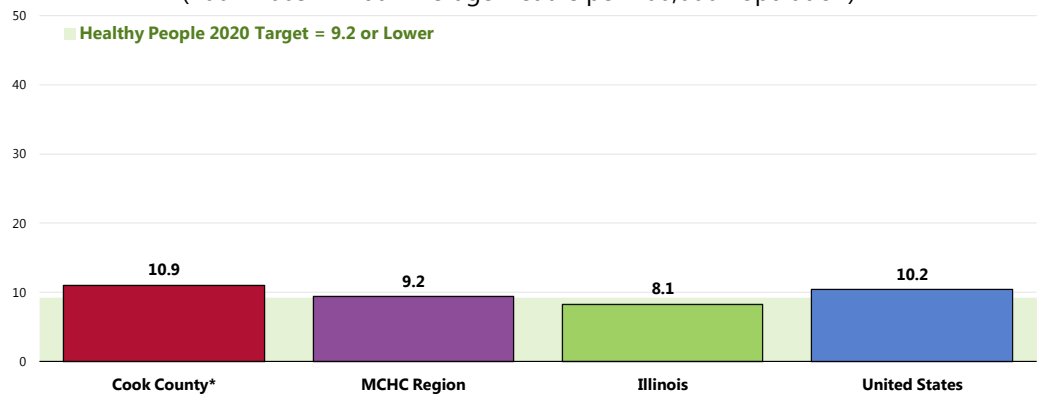
Age-Adjusted Firearm-Related Deaths

Between 2007 and 2009, there was an annual average age-adjusted rate of 10.9 firearm-related deaths per 100,000 population in Cook County (City of Chicago data not available).

- Higher than the regional rate.
- Higher than found statewide.
- Higher than found nationally.
- Fails to satisfy the Healthy People 2020 objective (9.2 or lower).

Firearms-Related Deaths: Age-Adjusted Mortality

(2007-2009 Annual Average Deaths per 100,000 Population)



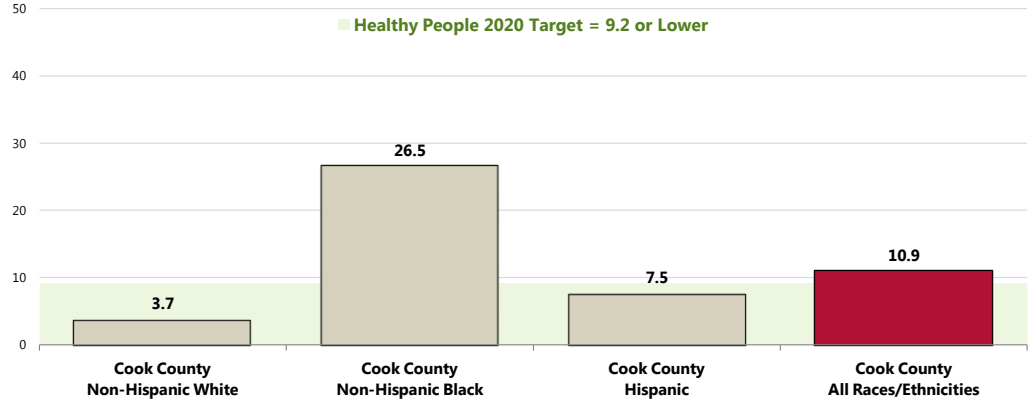
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-30]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- Local, state and national data are simple three-year averages.
- *City of Chicago data not available; Cook County data is used here.

The Cook County firearm-related mortality rate is dramatically higher among Blacks in Cook County than among Whites and Hispanics.

Firearms-Related Deaths: Age-Adjusted Mortality by Race

(2007-2009 Annual Average Deaths per 100,000 Population)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-30]

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

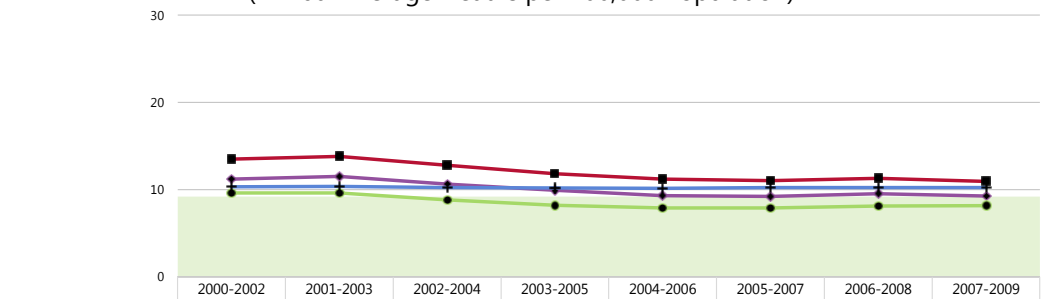
Survey respondents were further asked about the presence of weapons in the home:

"Are there any firearms now kept in or around your home, including those kept in a garage, outdoor storage area, truck, or car? For the purposes of this inquiry, 'firearms' include pistols, shotguns, rifles, and other types of guns, but do NOT include starter pistols, BB guns, or guns that cannot fire."

- The Cook County mortality rate decreased over the past decade, echoing the regional and state trends. Across the US, firearm-related mortality was more stable.

Firearms-Related Deaths: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
Healthy People 2020	9.2	9.2	9.2	9.2	9.2	9.2	9.2	9.2
Cook County	13.5	13.8	12.8	11.8	11.2	11.0	11.3	10.9
MCHC Region	11.2	11.5	10.6	9.9	9.3	9.2	9.5	9.2
Illinois	9.6	9.6	8.8	8.2	7.9	7.9	8.1	8.1
United States	10.3	10.3	10.2	10.2	10.1	10.2	10.2	10.2

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-30]

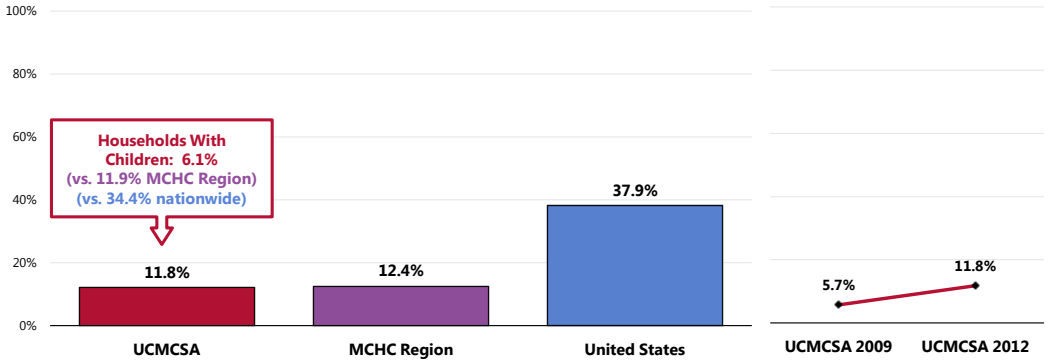
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- Local, state and national data are simple three-year averages.

Presence of Firearms in Homes

Overall, 11.8% area adults have a firearm kept in or around their home.

- Comparable to the regional prevalence.
- Much lower than the national prevalence.
- A significant increase compared to 2009.
- Among UCMC Service Area households with children, 6.1% have a firearm kept in or around the house (more favorable than reported both regionally and nationally).
- The prevalence of firearms in households with children has not changed significantly over time (not shown).

Have a Firearm Kept in or Around the Home



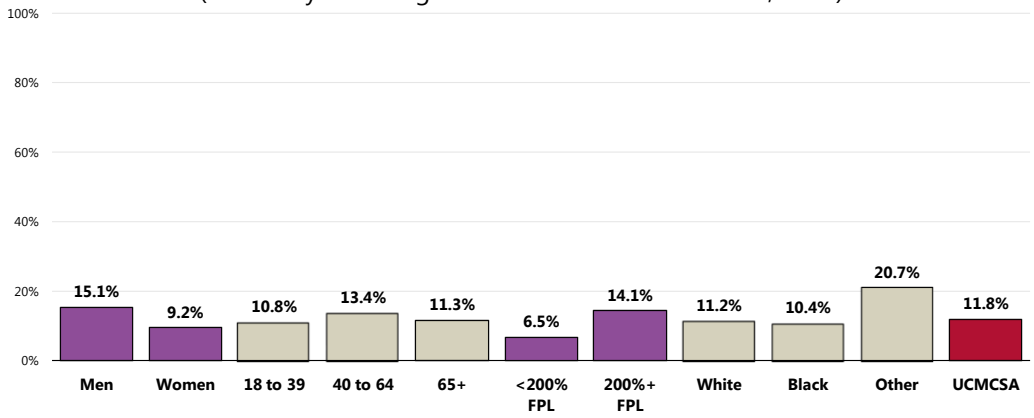
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 62, 164]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.

- Reports of firearms in or around the home are statistically high among higher-income respondents.

Have a Firearm Kept in or Around the House

(University of Chicago Medical Center Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 62]

Notes:
- Asked of all respondents.
- In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Intentional Injury (Violence)

Age-Adjusted Homicide Deaths

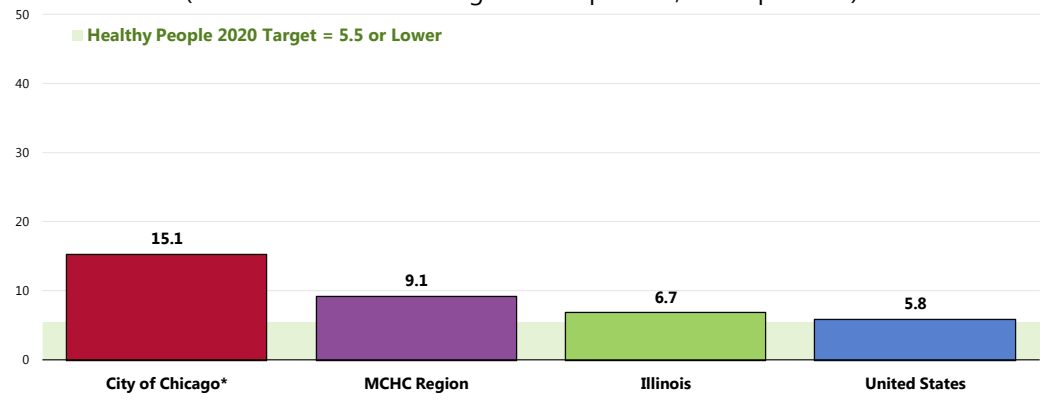
RELATED ISSUE:
See also *Suicide* in the **Mental Health & Mental Disorders** section of this report.

Between 2006 and 2008, there was an annual average age-adjusted homicide rate of 15.1 deaths per 100,000 population in the City of Chicago.

- Much higher than the regional rate.
- Much higher than the rate found statewide.
- Much higher than the national rate.
- Fails to satisfy the Healthy People 2020 target of 5.5 or lower.

Homicide: Age-Adjusted Mortality

(2007-2009 Annual Average Deaths per 100,000 Population)



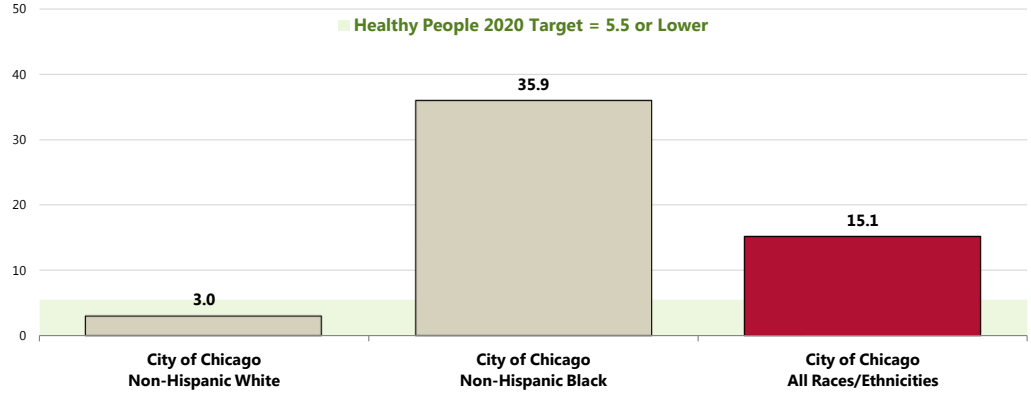
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IPV-29]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- *City of Chicago rate represents 2006-2008 data.

The homicide rate is dramatically higher among Blacks than Whites in the City of Chicago.

Homicide: Age-Adjusted Mortality by Race

(2006-2008 Annual Average Deaths per 100,000 Population)



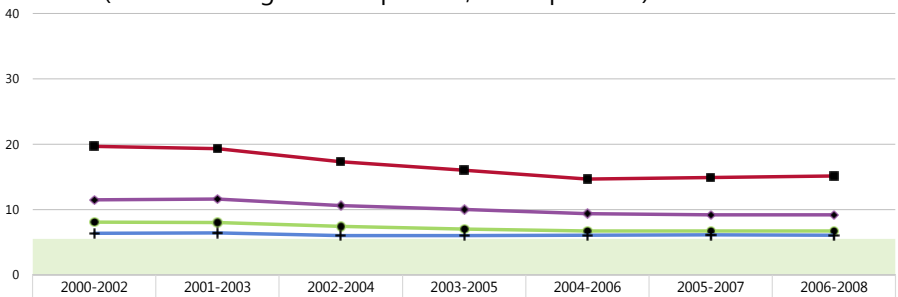
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IPV-29]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.

The City's homicide rate decreased over the past decade, following the downward trends reported regionally as well as statewide and nationwide.

Homicide: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2020	5.5	5.5	5.5	5.5	5.5	5.5	5.5
City of Chicago	19.7	19.3	17.3	16	14.7	14.9	15.1
MCHC Regioin	11.5	11.6	10.6	10	9.4	9.2	9.2
Illinois	8.1	8.0	7.4	7.0	6.7	6.7	6.7
United States	6.4	6.4	6.0	6.0	6.1	6.1	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 September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IPV-29]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.

Violent Crime Rates

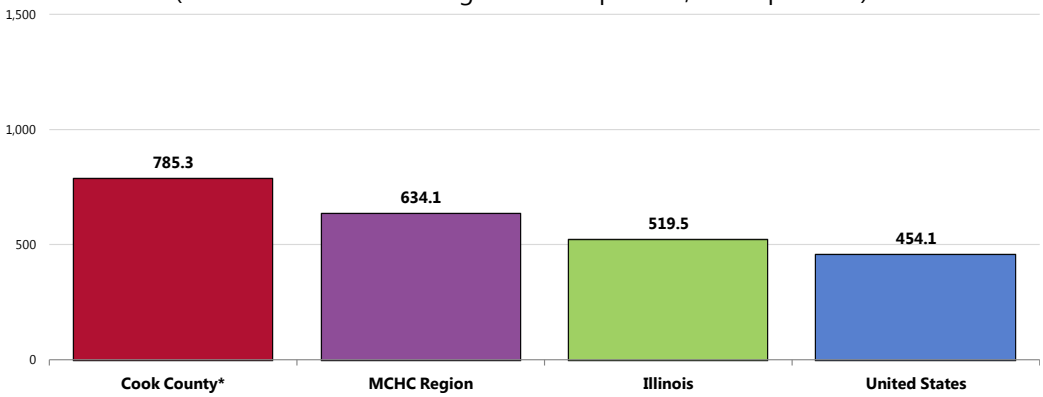
Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

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

Between 2007 and 2009, Cook County reported an annual average violent crime rate of 785.3 offenses per 100,000 population.

- Worse than the regional rate.
- Worse than the Illinois rate for the same period.
- Worse than the national rate.

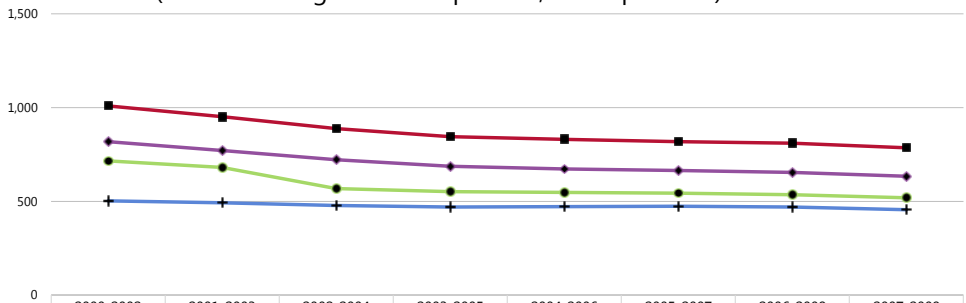
Violent Crime Rates
(2007-2009 Annual Average Offenses per 100,000 Population)



Sources: • Illinois State Police
• US Department of Justice, Federal Bureau of Investigation
Notes: • Rates are offenses per 100,000 population among agencies reporting.
• *City of Chicago data is unavailable; Cook County data is used here.

- The crime rate has declined in recent years, echoing the regional, state and national trends.

Violent Crime Rates
(Annual Average Offenses per 100,000 Population)



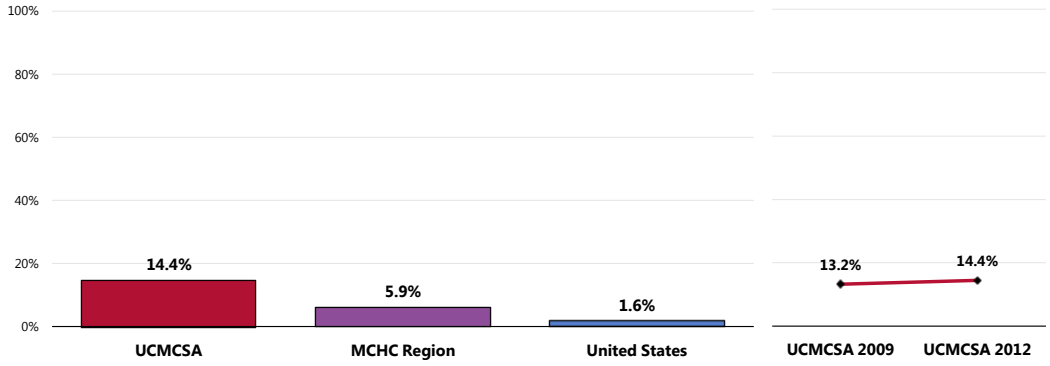
	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
Cook County	1009.3	950.7	888.8	845.4	829.7	818.3	810.4	785.3
MCHC Region	817.6	771.0	721.7	686.8	673.0	663.4	655.0	634.1
Illinois	715.2	681.7	568.0	551.4	546.5	542.3	534.3	519.5
United States	501.8	491.6	477.8	469.3	470.5	473.4	469.9	454.1

Sources: • Illinois State Police
• US Department of Justice, Federal Bureau of Investigation
Notes: • Rates are offenses per 100,000 population among agencies reporting.

A total of 14.4% of UCMC Service Area adults acknowledge being the victim of a violent crime in the past five years.

- Less favorable than the MCHC Region percentage.
- Less favorable than national findings.
- Statistically unchanged over time.

Victim of a Violent Crime in the Past Five Years



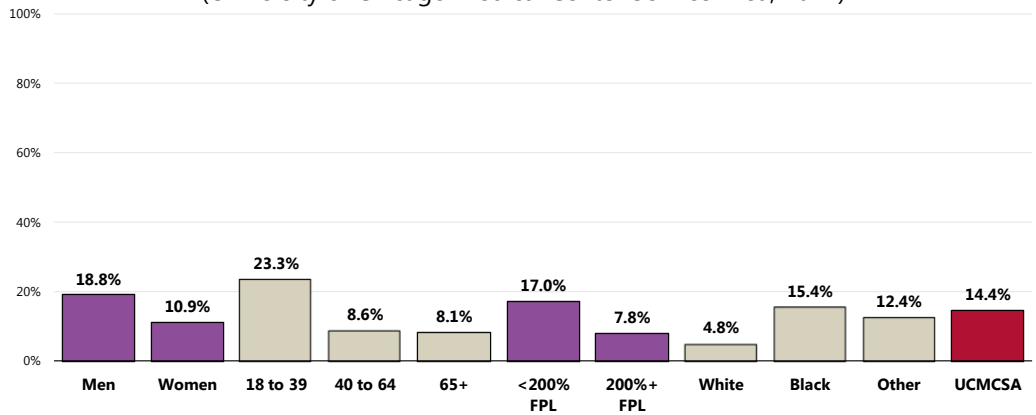
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 59]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

These population segments are <u>more</u> likely to report being a victim of a violent crime in the past five years:

- Men.
- Those between ages 18 and 39.
- Residents living in the lower income category.
- Black community members.

Victim of a Violent Crime in the Past Five Years

(University of Chicago Medical Center Service Area, 2012)



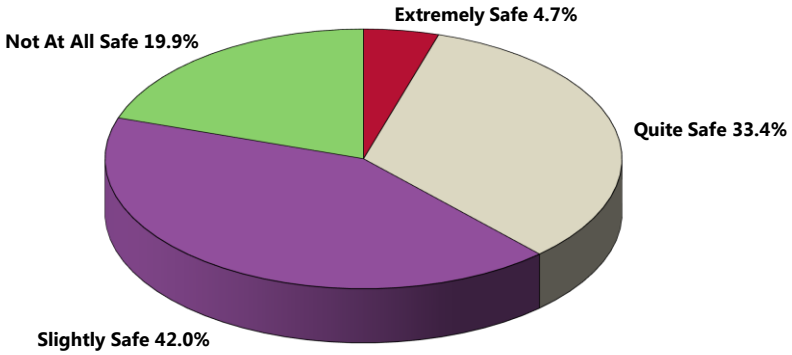
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 59]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

A total of 38.1% of service area adults gave "extremely" or "quite safe" evaluations of their own neighborhoods.

- Another 42.0% of respondents consider their neighborhoods to be "slightly safe" from crime.

Perceptions of Neighborhood's Safety From Crime

(University of Chicago Medical Center Service Area, 2012)

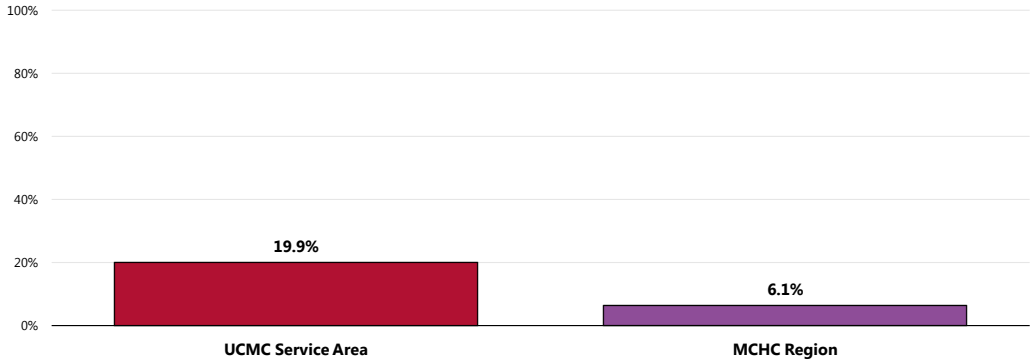


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 58]
Notes: • Asked of all respondents.

On the other hand, 19.9% of UCMC Service Area respondents gave "not at all safe from crime" ratings of their own neighborhoods.

- Much higher than the regional percentage.

Perceive Neighborhood to be "Not At All Safe" From Crime



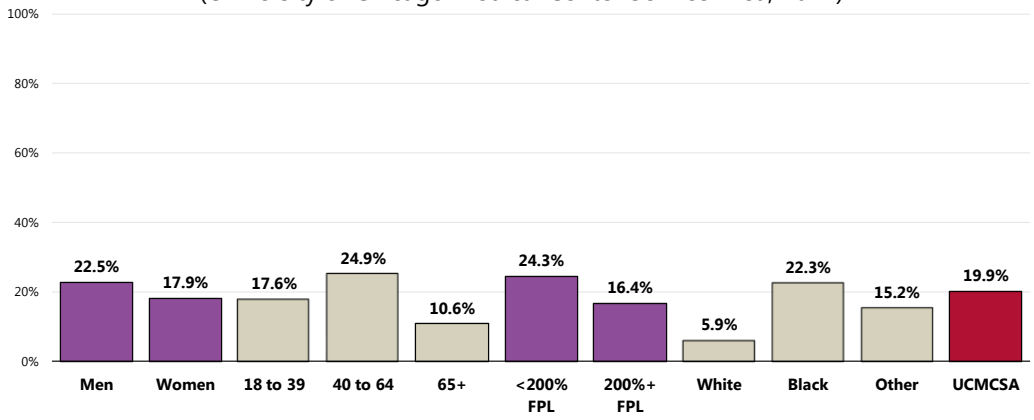
Sources: • 2012 PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 58]
Notes: • Reflects the total sample of respondents.

Adults more likely to consider their neighborhood to be unsafe include:

- Respondents age 40 to 64.
- Blacks.

Perceive Neighborhood to be "Not At All Safe" From Crime

(University of Chicago Medical Center Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 58]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Family Violence

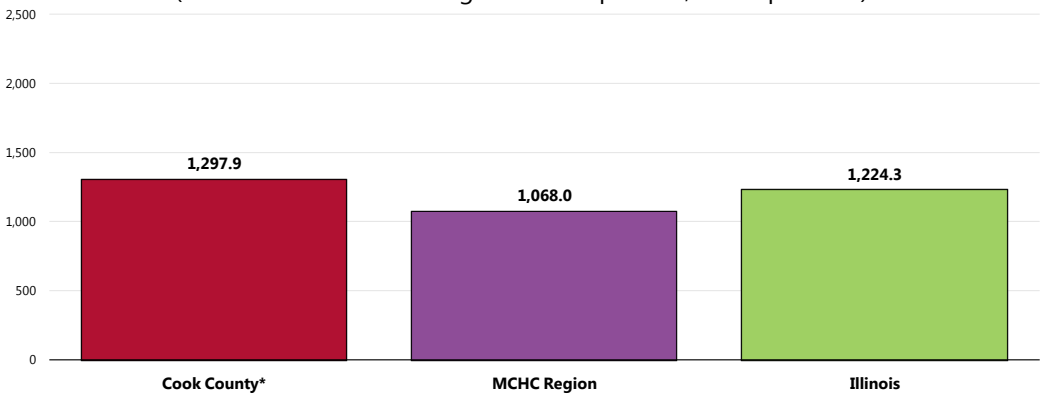
Between 2007 and 2009, there was an annual average domestic violence rate of 1,297.9 offenses per 100,000 population in Cook County.

Keep in mind that these data only reflect those incidents reported to law enforcement (offenses).

- Higher than the regional rate.
- Higher than the Illinois rate.

Domestic Violence Rates

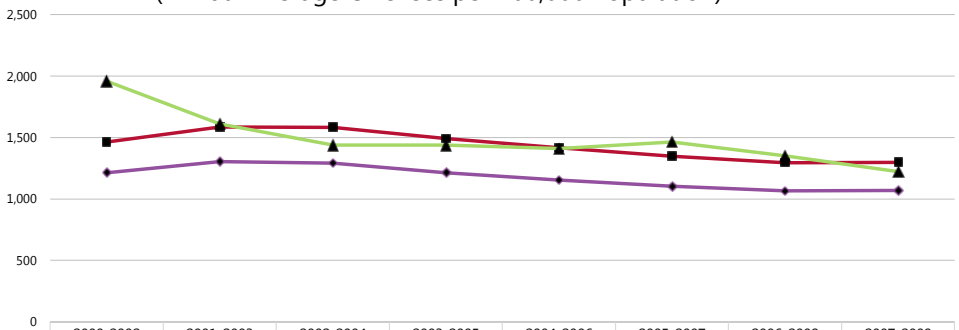
(2007-2009 Annual Average Offenses per 100,000 Population)



Sources: • Illinois State Police
Notes: • Rates are domestic calls for assistance per 100,000 population.
• *City of Chicago data not available; Cook County data is shown here.

- The domestic violence rate decreased overall in Cook County in the past decade. In Illinois, domestic violence decreased in recent years as well.

Domestic Violence Rates
(Annual Average Offenses per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
Cook County	1462.5	1586.2	1581.9	1491.4	1416.8	1348.0	1294.0	1297.9
MCHC Region	1213.2	1303.0	1292.3	1214.4	1154.9	1102.8	1064.8	1068.0
Illinois	1957.9	1609.4	1437.3	1439.4	1412.1	1462.5	1350.3	1224.3

Sources: • Illinois State Police
Notes: • Rates are domestic calls for assistance per 100,000 population.

Self-Reported Family Violence

Respondents were told:

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

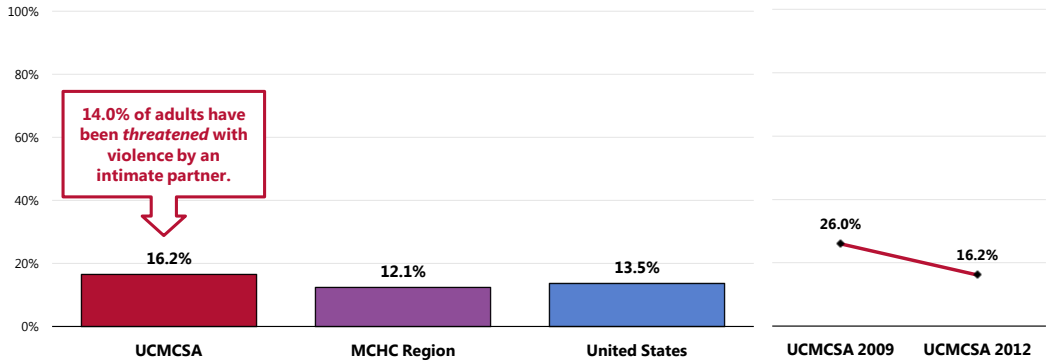
A total of 14.0% of UCMC Service Area adults report that they have been threatened with physical violence by an intimate partner.

- Comparable to the MCHC Region percentage.
- Comparable to the US percentage.
- Better than was found in 2009.

A total of 16.2% of respondents acknowledge that they have ever been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner.

- Higher than the regional percentage.
- Similar to the national findings.
- Marks a statistically significant decrease from 2009.

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

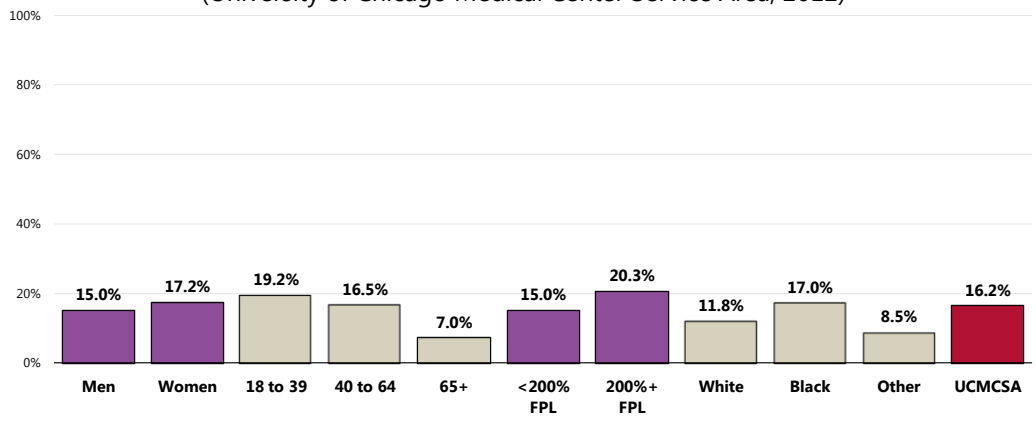


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 60-61]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Reports of domestic violence were higher among respondents under age 65 (note the negative correlation with age).

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

(University of Chicago Medical Center Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 61]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

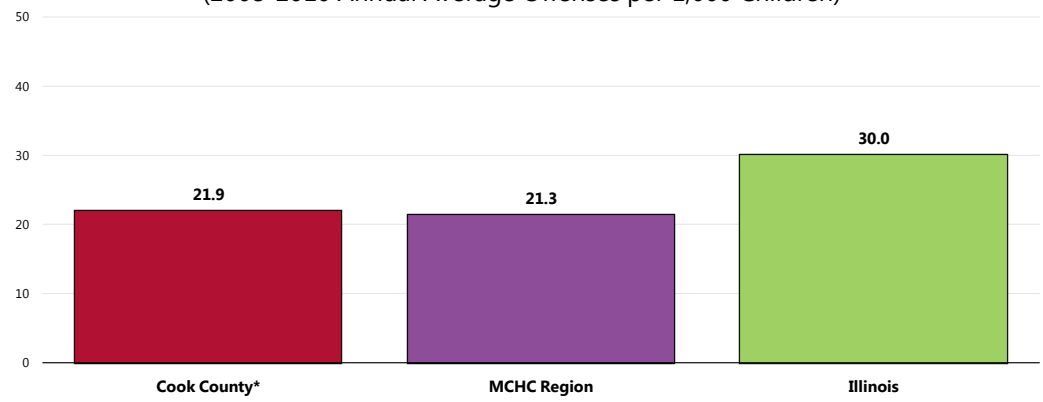
Keep in mind that these data only reflect those incidents reported to law enforcement.

Between 2008 and 2010, there was an annual average child abuse offense rate of 21.9 per 1,000 children in Cook County (City of Chicago data not available).

- Similar to the regional rate.
- More favorable than the Illinois rate for the same period.

Reported Child Abuse Rates

(2008-2010 Annual Average Offenses per 1,000 Children)

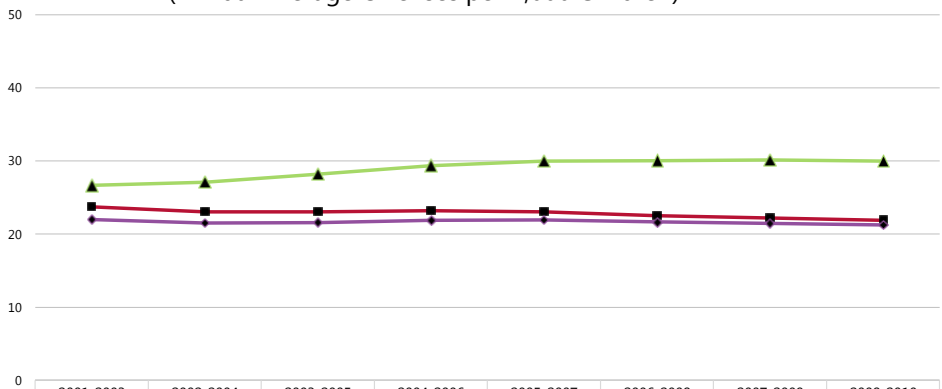


Sources: • Illinois State Police
Notes: • Rates are reports of child abuse per 1,000 children.
• *City of Chicago data unavailable; Cook County data is shown here.

- The reported Cook County child abuse rate has decreased slightly in the past decade. In contrast, rates increased across Illinois.

Reported Child Abuse Rates

(Annual Average Offenses per 1,000 Children)



	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010
Cook County	23.7	23.1	23.0	23.2	23.1	22.5	22.2	21.9
MCHC Region	22.0	21.5	21.6	21.9	21.9	21.7	21.5	21.3
Illinois	26.7	27.1	28.2	29.3	30.0	30.0	30.1	30.0

Sources: • Illinois State Police
Notes: • Rates are reports of child abuse per 1,000 children.

Related Focus Group Findings: Violence

Violence is a community health issue of concern to many focus group participants, with discussion centered on:

- Violence and its community impact
- Relocation of residents
- Gang violence
- Domestic violence

According to participants, **violence** is pervasive in Cook County, at a level impacting **both mental and physical health**. The mental health repercussions of trauma are countless, and the environment surrounding violence also inhibits community members' ability to improve physical health with physical activity because of safety concerns. A participant recalls a recent experience:

> *"The level of violence that a lot of my patients live within, within the neighborhoods around them, within their own homes and maybe the perimeter around the school is somewhat safe but once you leave that one-block area you're on your own." — Cook County Key Informant*

According to South Chicago participants, **violence** is common in the community and affects all community members. Participants expressed concern about how desensitized some community members (including children) are to violence due to the pervasiveness in their neighborhoods.

South Chicago group members agree that there are many reasons behind the increase in violence, including the poor economic climate, stress from a lack of basic needs, gangs and unsupervised youth. Focus group attendees spent some time discussing how **relocation of residents** has also been a contributor to the increase in violence, as one participant recalls:

> *"When we relocated individuals in different areas that they were not used to living in – that also caused the violence to escalate. Especially on the South side because you move people from the North side to the South side. So then you're a white teen and so we're going to fight you because we don't like you. So you're mixing all of these different developments that never got along, didn't get along before, didn't know each other before, and that's when you have a lot of friction." — South Chicago Key Informant*

In addition, South Chicago group members report that local schools are quick to expel problem students in order to maintain high graduation rates, so youth are out on the street unsupervised. A participant describes:

> *"A lot of the high schools are competing against the other high schools now. And so as opposed to putting students on corrective action plans, they're kicking them out. And so you have a student who's been expelled from school who contributes to finding additional ways to raise funds – or to entertain themselves." — South Chicago Key Informant*

Furthermore, there are limited after-school programs or safe spaces for South Chicago youth to be after school. Attendees believe that having supervised activities and keeping youth in school as long as possible would help decrease violence in their community.

South Chicago group discussion also focused on the number of **gangs** in the community. Gang violence continues to increase in South Chicago because of renegade gangs and a lack of leadership or consequences if a gang member acts out. A participant describes the current environment:

> *"There used to be a structure to the gangs; so when you had the projects and the high-rises and different things like that, you had this building belonged to this gang. They had a supreme captain and military rank. But now that all the high-rises have been knocked down you have rival gang members that are creating their own inner gang and they're the ones that's creating the violence on their block. So at least before if a murder happened or something happened, you could go to the head of that gang and find out who committed it and you would get justice. Now you can't do that." — South Chicago Key Informant*

Participants also express concern about the level of **domestic violence** in Cook County. The capacity of domestic violence shelters has been threatened due to budget cuts, so despite the prevalence of community shelters, there are fewer beds and they are farther away. Local agencies also must combat cultural beliefs and the internalization and normalization some women experience as victims of domestic abuse. These agencies must figure out ways to help residents realize the severity of a volatile home life:

> *"When you talk about shelters, well first the individuals would need to know and understand that this isn't the norm because it's really like business as usual, you hear these stories and it's so matter of fact, business as usual, that why would you think to go to a shelter if it's business as usual to have this going on?" — Cook County Key Informant*

South Chicago participants also have concern about the level of **domestic violence** occurring in the community. Attendees feel victims of domestic violence have limited choices for shelters because the beds fill up quickly and many victims may remain at home where it is unsafe.

Diabetes

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

Effective therapy can prevent or delay diabetic complications. However, almost 25% of Americans with diabetes mellitus are undiagnosed, and another 57 million Americans have blood glucose levels that greatly increase their risk of developing diabetes mellitus in the next several years. Few people receive effective preventative care, which makes diabetes mellitus an immense and complex public health challenge.

Diabetes mellitus affects an estimated 23.6 million people in the United States and is the 7th leading cause of death. Diabetes mellitus:

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

In addition to these human costs, the estimated total financial cost of diabetes mellitus in the US in 2007 was $174 billion, which includes the costs of medical care, disability, and premature death.

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

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

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

– Healthy People 2020 (www.healthypeople.gov)

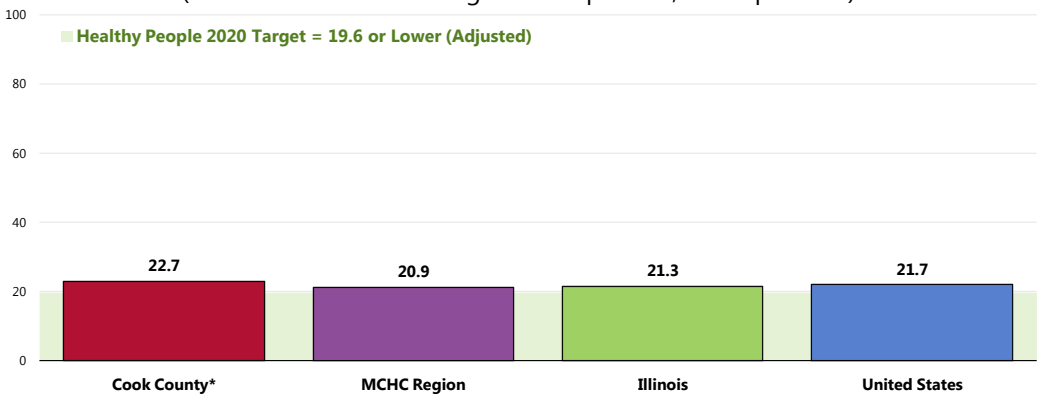
Age-Adjusted Diabetes Deaths

Between 2007 and 2009, Cook County reported an annual average age-adjusted diabetes mortality rate of 22.7 deaths per 100,000 population.

- Higher than the regional rate.
- Higher than the state rate.
- Comparable to the national rate.
- Fails to satisfy the Healthy People 2020 target (19.6 or lower).

Diabetes: Age-Adjusted Mortality

(2007-2009 Annual Average Deaths per 100,000 Population)



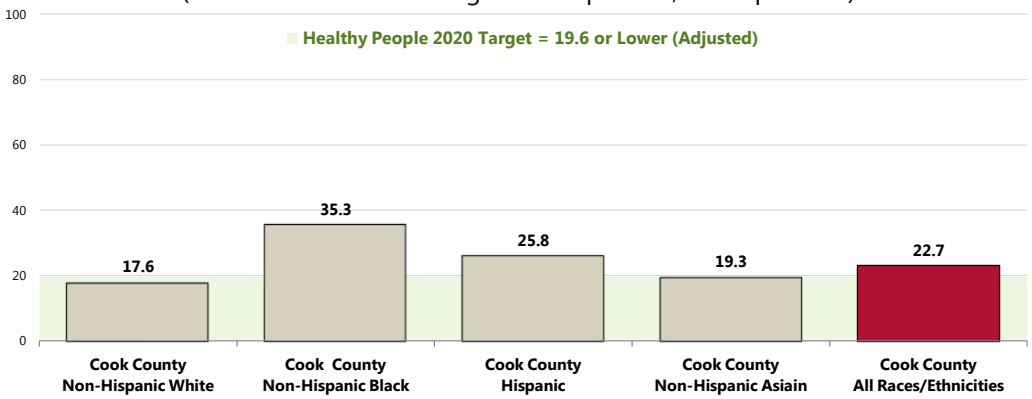
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective D-3]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.
- *City of Chicago data unavailable; Cook County data is used here.

The Cook County diabetes mortality rate is notably higher among Blacks and Hispanics when compared with Whites and Asians.

Diabetes: Age-Adjusted Mortality by Race

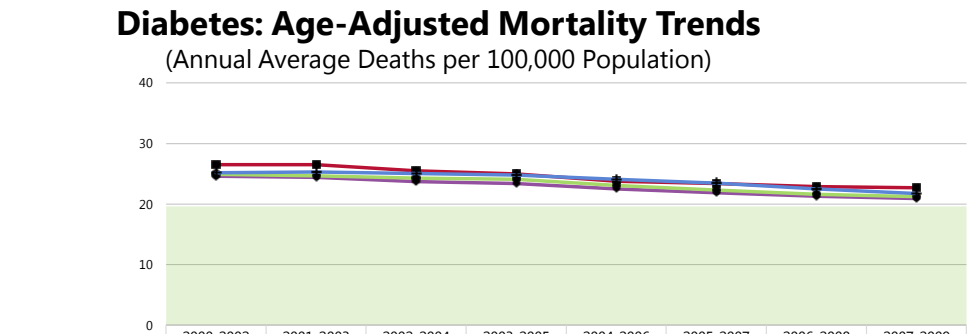
(2007-2009 Annual Average Deaths per 100,000 Population)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective D-3]

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

- Diabetes mortality decreased over the past decade for Cook County, echoing the regional, state and national trends.



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
HP2020 (Adjusted)	19.6	19.6	19.6	19.6	19.6	19.6	19.6	19.6
Cook County	26.5	26.5	25.5	25.0	23.8	23.4	22.9	22.7
MCHC Region	24.6	24.4	23.7	23.4	22.5	21.9	21.3	20.9
Illinois	24.9	24.7	24.3	24.1	23.1	22.3	21.6	21.3
United States	25.2	25.3	25.1	24.8	24.1	23.5	22.5	21.7

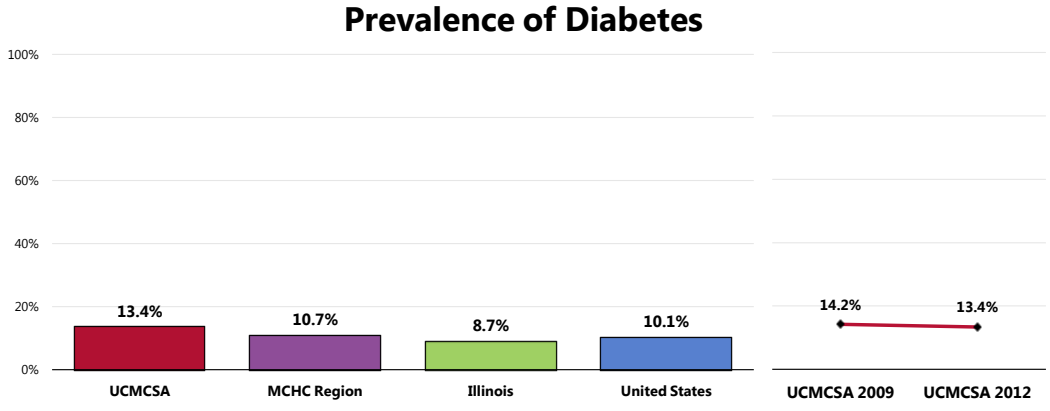
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective D-3]

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

Prevalence of Diabetes

A total of 13.4% of UCMC Service Area adults report having been diagnosed with diabetes.

- Similar to the MCHC Regional rate.
- Less favorable than the proportion statewide.
- Similar to the national proportion.
- Statistically unchanged since 2009.



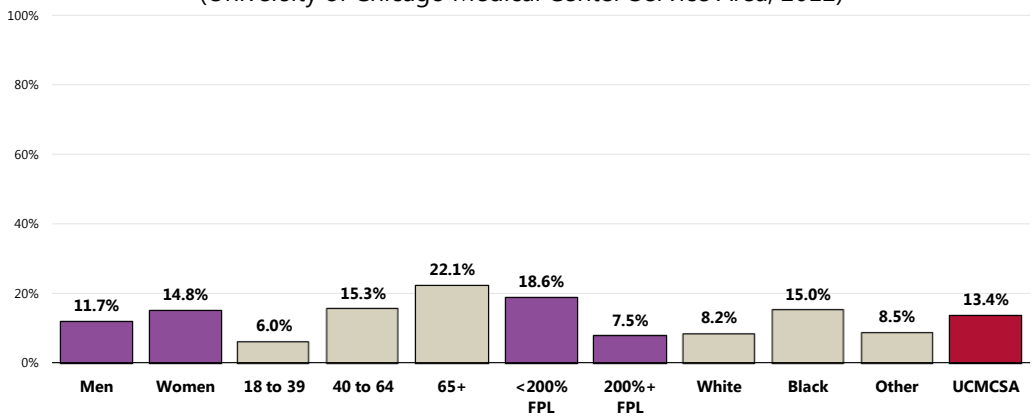
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 47]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.

Notes:
- Asked of all respondents.
- Local and national data exclude gestation diabetes (occurring only during pregnancy).

- The prevalence of diabetes is significantly higher among those age 40+ (note the positive correlation between diabetes and age, with 22.1% of seniors having diabetes).
- The prevalence of diabetes is higher among lower-income respondents.

Prevalence of Diabetes

(University of Chicago Medical Center Service Area, 2012)



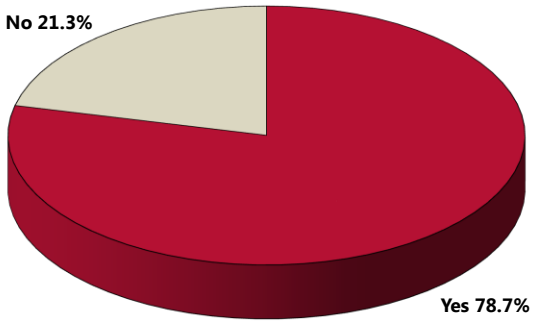
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 47]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.
• Excludes gestation diabetes (occurring only during pregnancy).

Diabetes Treatment

Among adults with diabetes, most (78.7%) are currently taking insulin or some type of medication to manage their condition.

Taking Insulin or Other Medication for Diabetes

(Among University of Chicago Medical Center Service Area Diabetics)

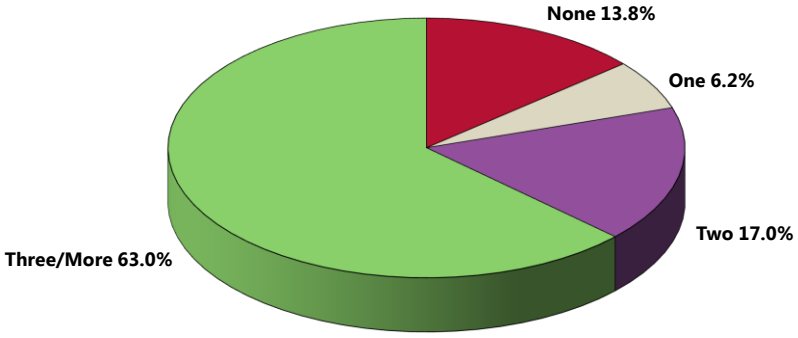


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 48]
Notes: • Asked of all diabetic respondents.

Note also that over 6 in 10 service area diabetics (63.0%) had 3+ medical visits in the past year related to their diabetes.

Number of Medical Visits Due to Diabetes in the Past Year

(Among University of Chicago Medical Center Service Area Diabetics)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 49]
Notes: • Asked of all diabetic respondents.

Alzheimer's Disease

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

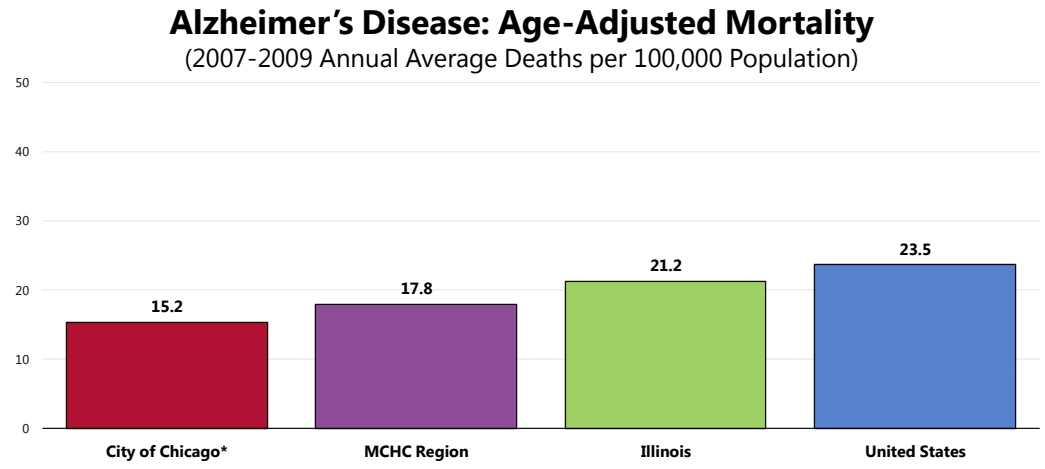
Alzheimer's disease is the 6th leading cause of death among adults age 18 years and older. Estimates vary, but experts suggest that up to 5.1 million Americans age 65 years and older have Alzheimer's disease. These numbers are predicted to more than double by 2050 unless more effective ways to treat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

– Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Alzheimer's Disease Deaths

Between 2006 and 2008, the City of Chicago experienced an annual average age-adjusted Alzheimer's disease mortality rate of 15.2 deaths per 100,000 population.

- More favorable than the regional rate.
- More favorable than the statewide rate.
- More favorable than the national rate.



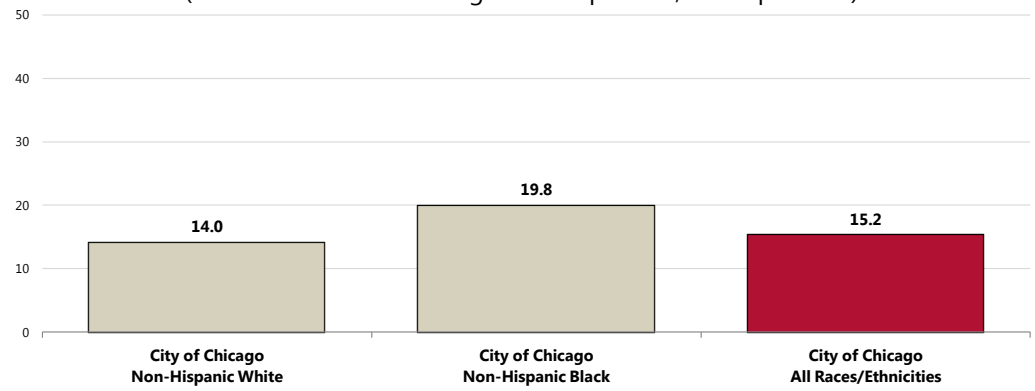
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- *City of Chicago rate represents 2006-2008 data.

The City's Alzheimer's disease mortality rate appears higher among Blacks than Whites.

Alzheimer's Disease: Age-Adjusted Mortality by Race

(2006-2008 Annual Average Deaths per 100,000 Population)

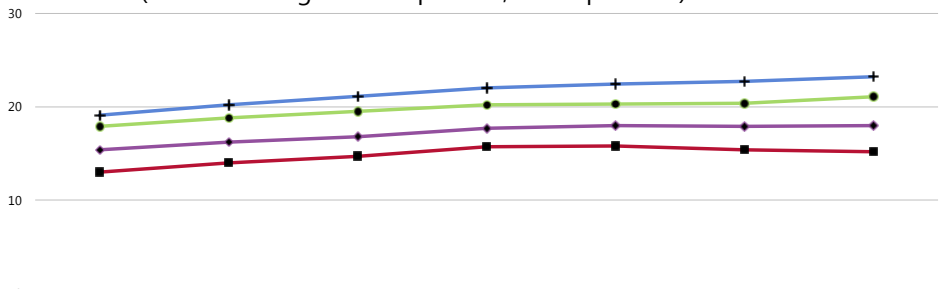


Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
● Local, state and national data are simple three-year averages.

Alzheimer's disease mortality rate in the City of Chicago generally increased over the past decade, echoing the regional, state and national trends.

Alzheimer's Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
City of Chicago	13.0	14.0	14.7	15.7	15.8	15.4	15.2
MCHC Region	15.4	16.2	16.8	17.7	18.0	17.9	18.0
Illinois	17.9	18.8	19.5	20.2	20.3	20.4	21.1
United States	19.1	20.2	21.1	22.0	22.4	22.7	23.2

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

Kidney Disease

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

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

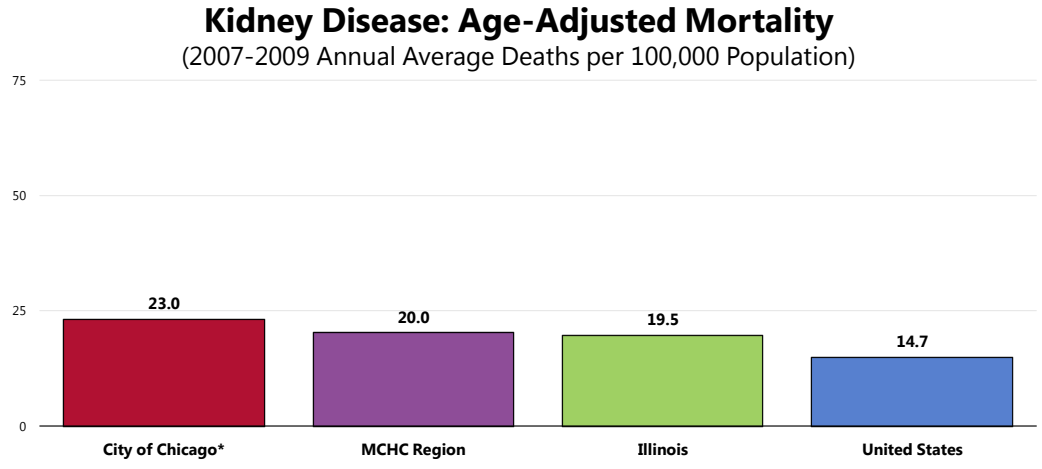
Diabetes is the most common cause of kidney failure. The results of the Diabetes Prevention Program (DPP) funded by the national Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) show that moderate exercise, a healthier diet, and weight reduction can prevent development of type 2 diabetes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

– Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Kidney Disease Deaths

Between 2006 and 2008 there was an annual average age-adjusted kidney disease mortality rate of 23.0 deaths per 100,000 population in the City of Chicago.

- Worse than the regional rate.
- Worse than the rate found statewide.
- Worse than the national rate.



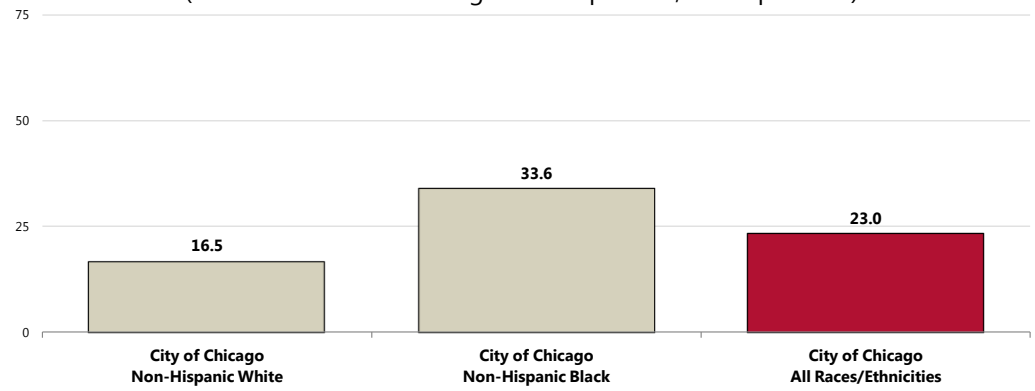
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- *City of Chicago rate represents 2006-2008 data.

The kidney disease mortality rate in the City of Chicago is twice as high among Blacks as among Whites.

Kidney Disease: Age-Adjusted Mortality by Race

(2006-2008 Annual Average Deaths per 100,000 Population)



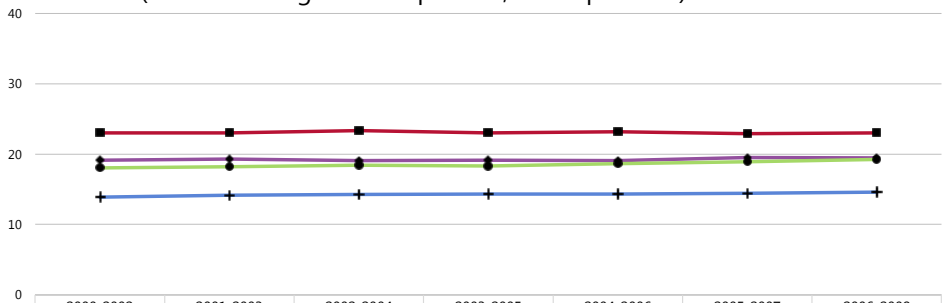
Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.

Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
● Local, state and national data are simple three-year averages.

The City's kidney disease mortality rate was stable over the past decade, while regional, state and national mortality rates increased.

Kidney Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
City of Chicago	23.0	23.0	23.3	23.0	23.2	22.9	23.0
MCHC Region	19.1	19.3	19.1	19.1	19.1	19.5	19.5
Illinois	18.0	18.2	18.4	18.3	18.6	18.9	19.2
United States	13.9	14.2	14.3	14.3	14.3	14.4	14.6

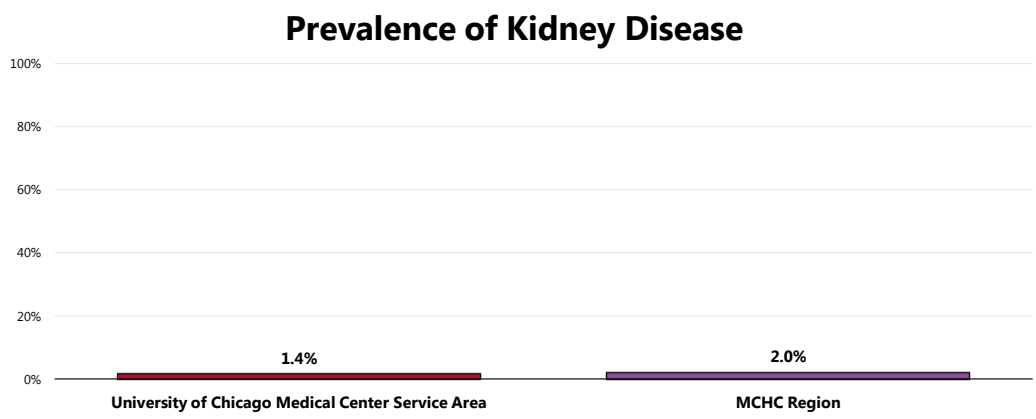
Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.

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

Prevalence of Kidney Disease

According to survey results, 1.4% of UCMC Service Area adults suffer from kidney disease.

- Similar to the regional prevalence of kidney disease.



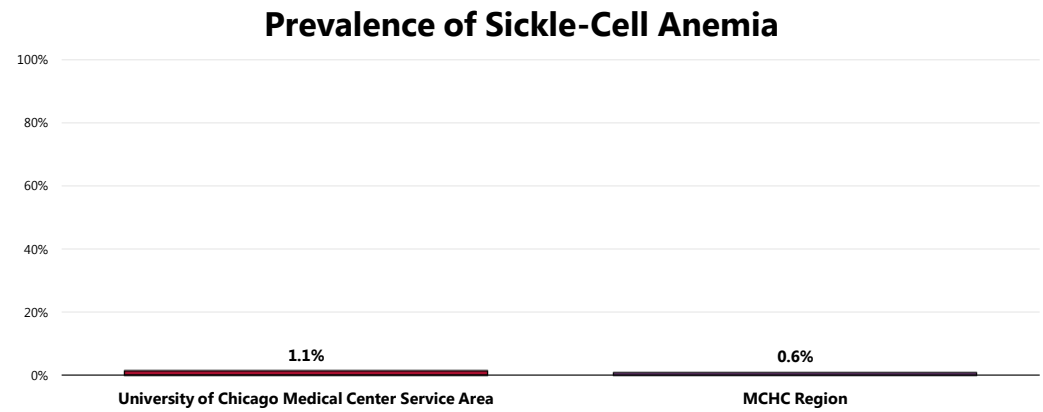
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 39]

Notes:
- Reflects the total sample of respondents.
- Does not include kidney stones, bladder infections or incontinence.

Sickle-Cell Anemia

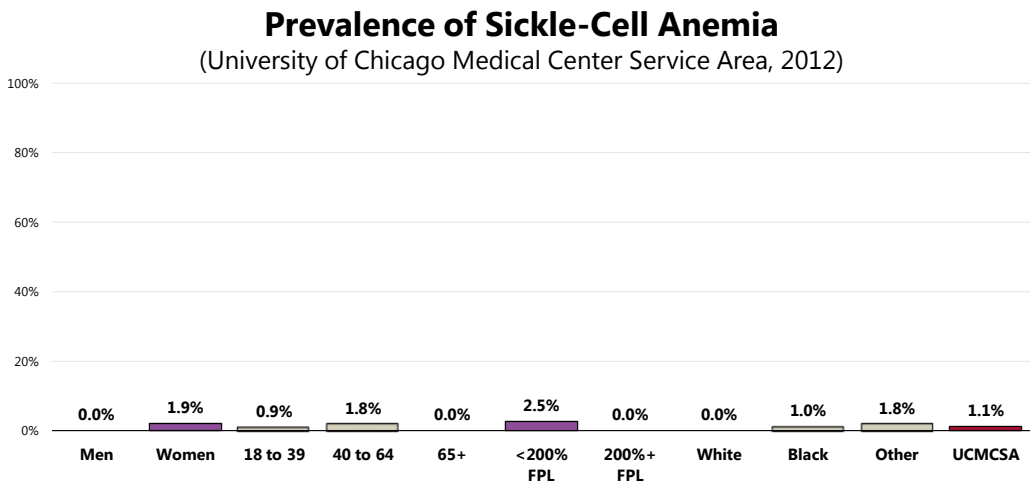
According to survey results, 1.1% of UCMC Service Area adults suffer from sickle-cell anemia.

- Similar to the MCHC Region prevalence.



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 40]
Notes: • Reflects the total sample of respondents.

- Sickle-cell anemia in the UCMC Service Area is statistically <u>high</u> among women and respondents between ages 40 and 64.



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 40]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Potentially Disabling Conditions

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

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

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

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

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

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

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

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

– Healthy People 2020 (www.healthypeople.gov)

Arthritis, Osteoporosis, & Chronic Pain

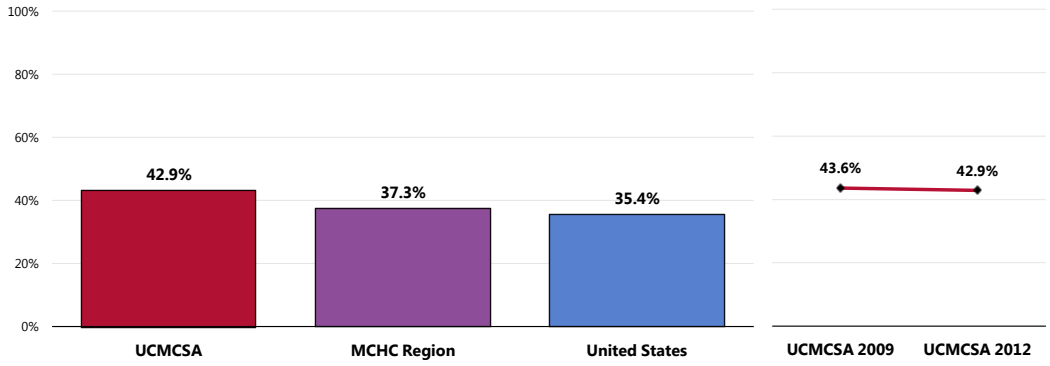
Prevalence of Arthritis/Rheumatism

A total of 42.9% of UCMC Service Area residents age 50 and older report suffering from arthritis or rheumatism.

- Similar to the MCHC Region prevalence.
- Less favorable than the prevalence found nationwide.
- The prevalence of arthritis/rheumatism is similar to that reported in 2009.

Prevalence of Arthritis/Rheumatism

(Among Adults 50+)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 168]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects respondents 50 and older.

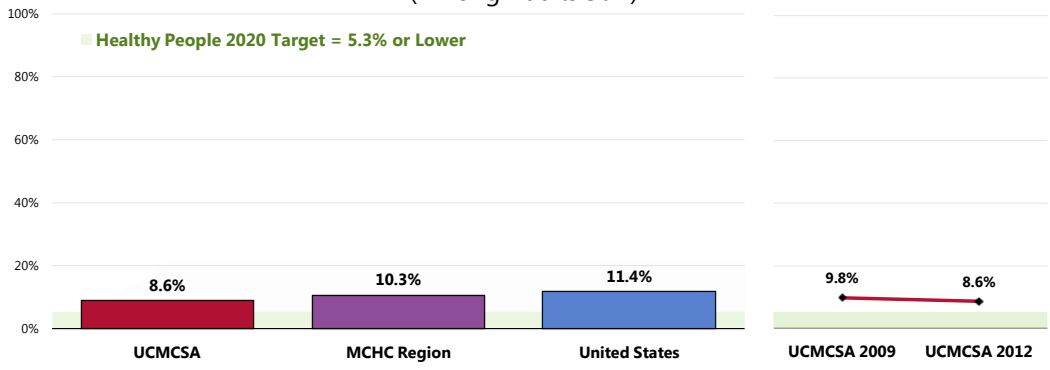
Prevalence of Osteoporosis

A total of 8.6% of survey respondents age 50 and older have osteoporosis.

- Comparable to the percentage found in the MCHC Region.
- Comparable to the prevalence found nationwide.
- Comparable to the Healthy People 2020 target of 5.3% or lower.
- Statistically unchanged over time.

Prevalence of Osteoporosis

(Among Adults 50+)



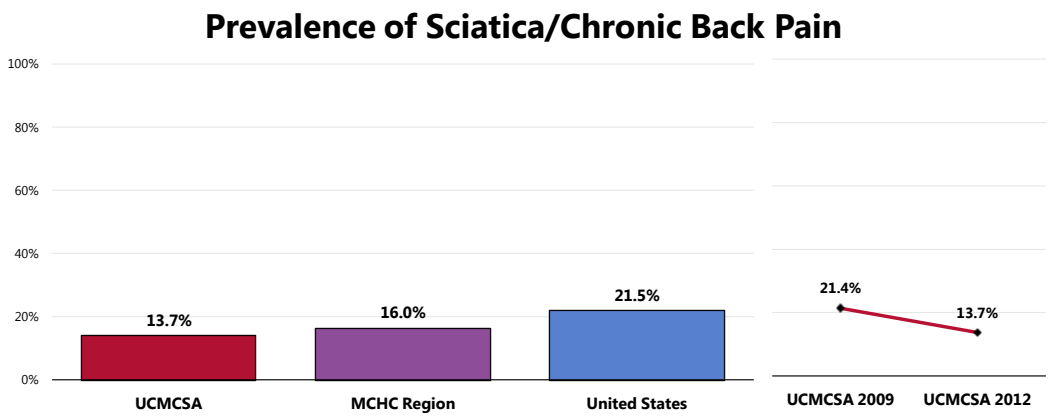
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 169]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AOCBC-10]

Notes:
- Reflects respondents 50 and older.

Prevalence of Sciatica/Chronic Back Pain

A total of 13.7% of survey respondents suffer from chronic back pain or sciatica.

- Similar to the percentage found in the MCHC Region.
- More favorable than is found nationwide.
- Reflects a decrease from 2009.

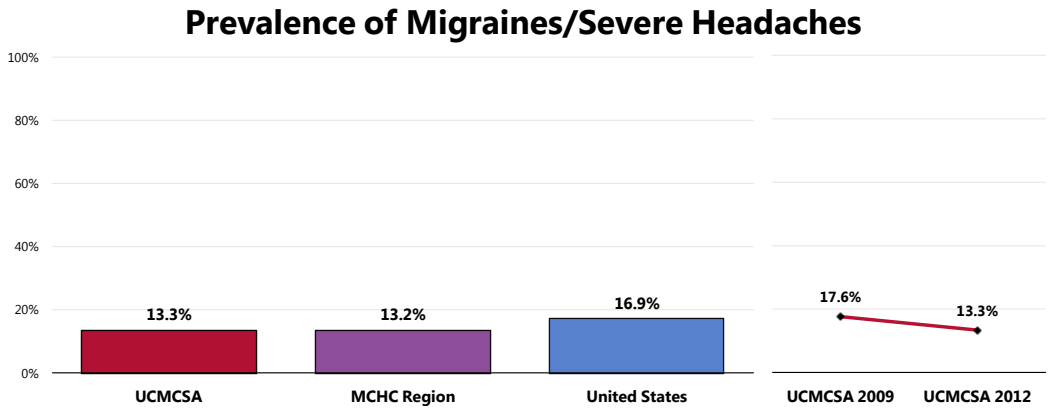


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 29]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Prevalence of Migraines/Severe Headaches

A total of 13.3% of survey respondents report suffering from migraines or severe headaches.

- Nearly identical to the regional prevalence.
- Similar to the prevalence found nationwide.
- Similar to what was reported in the UCMC Service Area in 2009.

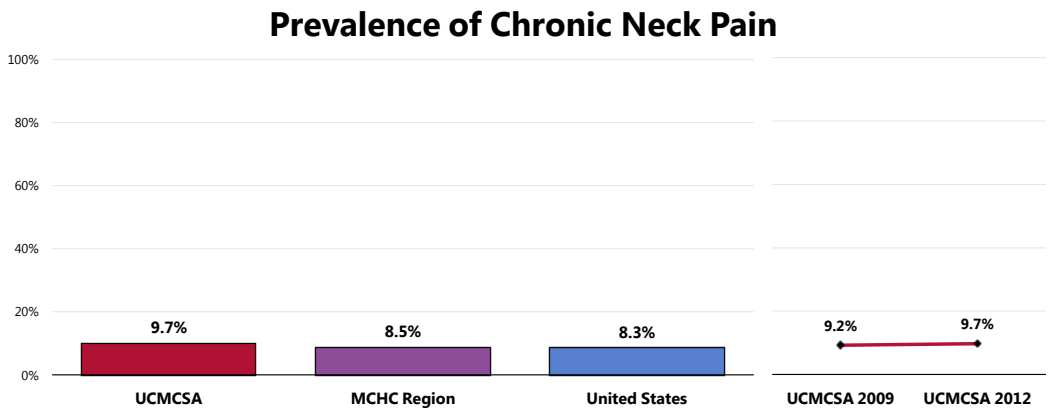


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 36]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Prevalence of Chronic Neck Pain

A total of 9.7% of survey respondents currently suffer from chronic neck pain.

- Similar to regional findings.
- Similar to nationwide findings.
- Statistically unchanged since 2009.



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 37]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Vision & Hearing Impairment

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

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

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

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

– Healthy People 2020 (www.healthypeople.gov)

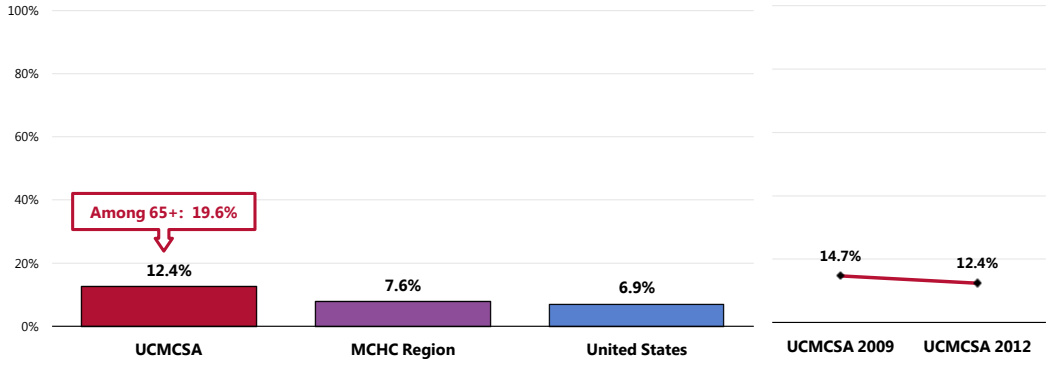
Vision Trouble

A total of 12.4% of UCMC Service Area adults are blind, or have trouble seeing even when wearing corrective lenses.

RELATED ISSUE: See also *Vision Care* in the **Access to Health Services** section of this report.

- Less favorable than found in the MCHC Region.
- Less favorable than found nationwide.
- Comparable to the 2009 findings.
- Among UCMC Service Area adults age 65 and older, 19.6% have vision trouble.

Prevalence of Blindness/Trouble Seeing



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 26]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Hearing Trouble

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

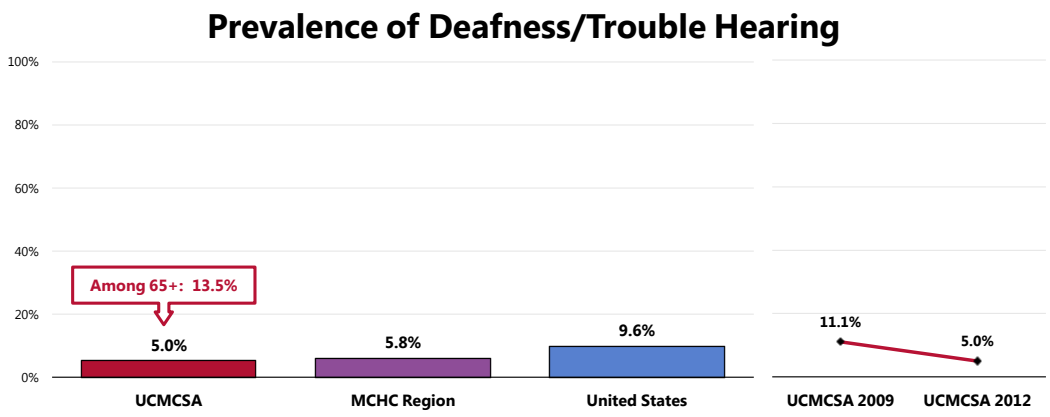
Many factors influence the numbers of Americans who are diagnosed and treated for hearing and other sensory or communication disorders, such a social determinants (social and economic standings, age of diagnosis, cost and stigma of wearing a hearing aid, and unhealthy lifestyle choices). In addition,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

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

– Healthy People 2020 (www.healthypeople.gov)

In all, 5.0% of UCMC Service Area adults report being deaf or having difficulty hearing.

- Similar to the regional percentage.
- More favorable than is found nationwide.
- Significantly lower than was found in 2009.
- Among Service Area seniors, 13.5% have partial or complete hearing loss.



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 27]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

INFECTIOUS DISEASE

Influenza & Pneumonia Vaccination

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

– Healthy People 2020 (www.healthypeople.gov)

Flu Vaccinations

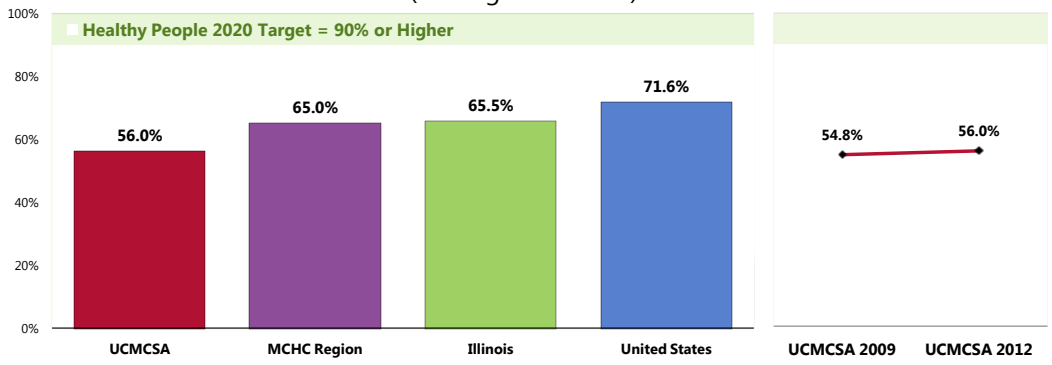
FluMist® is a vaccine that is sprayed into the nose to help protect against influenza; it is an alternative to traditional flu shots.

Among UCMC Service Area seniors, 56.0% received a flu shot (or FluMist®) within the past year.

- Similar to the MCHC Region results.
- Similar to the Illinois findings.
- Less favorable than the national findings.
- Fails to satisfy the Healthy People 2020 target (90% or higher).
- Statistically unchanged since 2009.

Have Had a Flu Vaccination in the Past Year

(Among Adults 65+)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 170]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-12.7]

Notes:
- Reflects respondents 65 and older.
- Includes FluMist as a form of vaccination.

High-Risk Adults

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

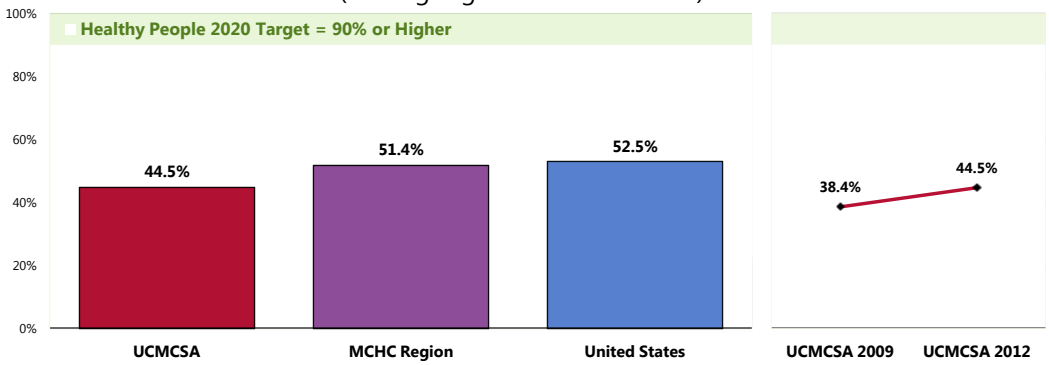
A total of 44.5% of high-risk adults age 18 to 64 received a flu vaccination (flu shot or FluMist®) within the past year.

- Similar to the MCHC Region findings.
- Similar to national findings.

- Fails to satisfy the Healthy People 2020 target (90% or higher).
- Similar to the 2009 survey findings.

Have Had a Flu Vaccination in the Past Year

(Among High-Risk Adults 18-64)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 171]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-12.6]

Notes:
- Reflects high-risk respondents age 18-64.
- "High-Risk" includes adults age 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.
- Includes FluMist as a form of vaccination.

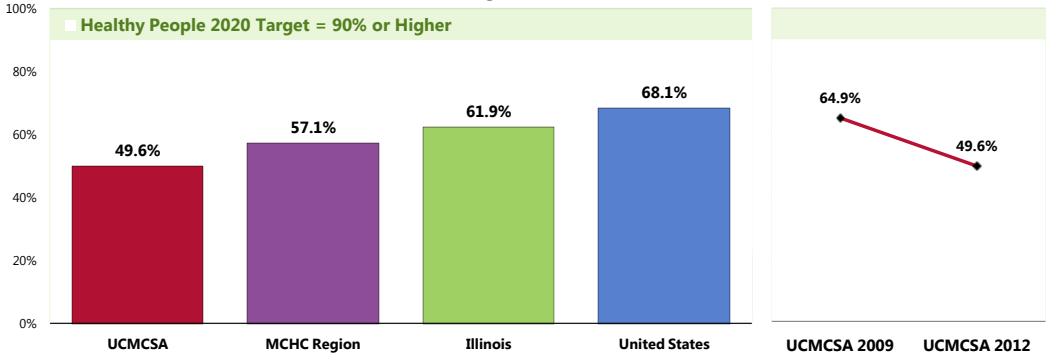
Pneumonia Vaccination

Among adults age 65 and older, 49.6% have received a pneumonia vaccination at some point in their lives.

- Comparable to the MCHC Region findings.
- Lower than the Illinois findings.
- Lower than the national findings.
- Fails to satisfy the Healthy People 2020 target of 90% or higher.
- Comparable to the 2009 findings.

Have Ever Had a Pneumonia Vaccine

(Among Adults 65+)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 172]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-13.1]

Notes:
- Reflects respondents 65 and older.

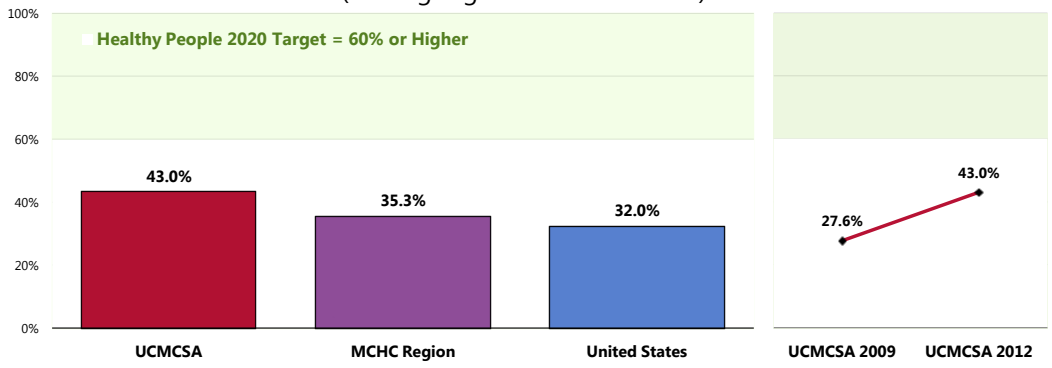
"High-risk" includes adults who report having been diagnosed with heart disease, diabetes or respiratory disease.

A total of 43.0% of high-risk adults age 18 to 64 have ever received a pneumonia vaccination.

- Similar to the MCHC findings.
- Similar to the national findings.
- Fails to satisfy the Healthy People 2020 target (60% or higher).
- Statistically unchanged since 2009.

Have Ever Had a Pneumonia Vaccine

(Among High-Risk Adults 18-64)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 173]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-13.2]

Notes:
- Asked of all high-risk respondents under 65.
- "High-Risk" includes adults age 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.

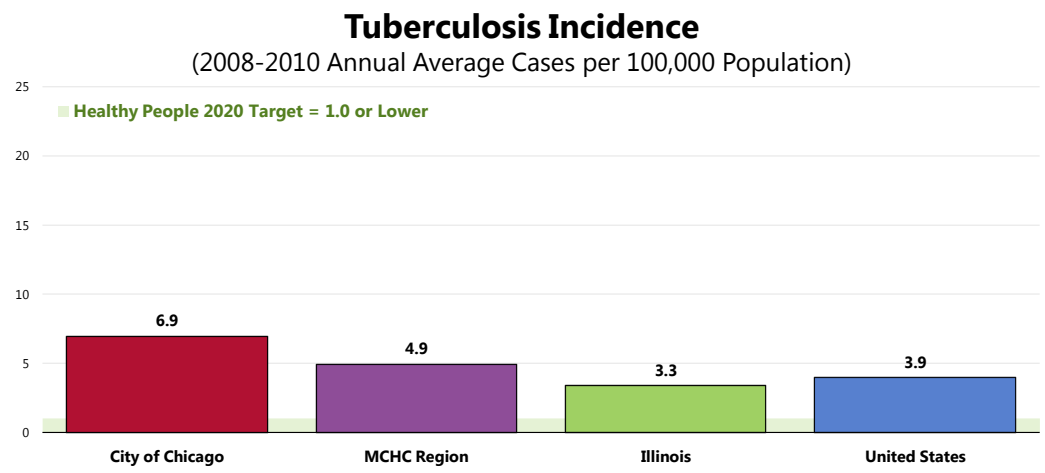
Tuberculosis

Viral hepatitis and tuberculosis (TB) can be prevented, yet healthcare systems often do not make the best use of their available resources to support prevention efforts. Because the US healthcare system focuses on treatment of illnesses, rather than health promotion, patients do not always receive information about prevention and healthy lifestyles. This includes advancing effective and evidence-based viral hepatitis and TB prevention priorities and interventions.

– Healthy People 2020 (www.healthypeople.gov)

Between 2008 and 2010, the annual average tuberculosis incidence rate (new cases per year) was 6.9 cases per 100,000 population in the City of Chicago.

- Above the regional incidence rate.
- Well above the Illinois incidence rate.
- Above the national incidence rate.
- Fails to satisfy the Healthy People 2020 target (1.0 or lower).



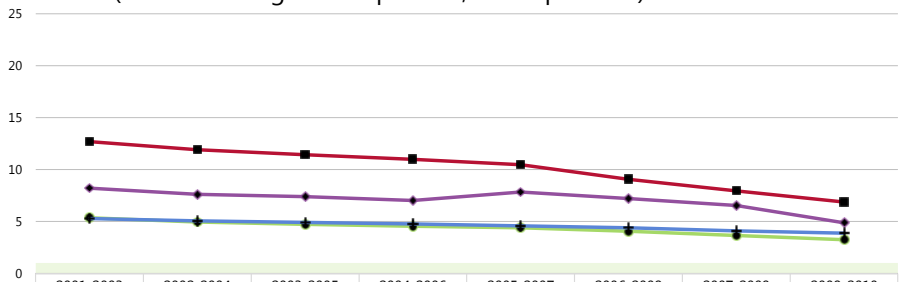
Sources:
- Illinois Department of Public Health
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-29]
- Centers for Disease Control and Prevention, Division of Public Health Surveillance and Informatics. Epidemiology Program Office.

Notes:
- Rates are annual average new cases per 100,000 population.

The City's tuberculosis incidence has decreased considerably in recent years. Downward trends in tuberculosis incidence are also evident across the region, as well as statewide and nationwide.

Tuberculosis Incidence

(Annual Average Cases per 100,000 Population)



	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010
Healthy People 2020	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
City of Chicago	12.7	11.9	11.4	11.0	10.5	9.1	7.9	6.9
MCHC Region	8.2	7.6	7.4	7.0	7.9	7.2	6.6	4.9
Illinois	5.4	5.0	4.7	4.6	4.4	4.1	3.7	3.3
United States	5.3	5.1	4.9	4.8	4.6	4.4	4.1	3.9

Sources:
- Illinois Department of Public Health
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-29]
- Centers for Disease Control and Prevention, Division of Public Health Surveillance and Informatics. Epidemiology Program Office.

Notes:
- Rates are annual average new cases per 100,000 population.

HIV

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

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

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

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

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

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

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

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

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

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

– Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted HIV/AIDS Deaths

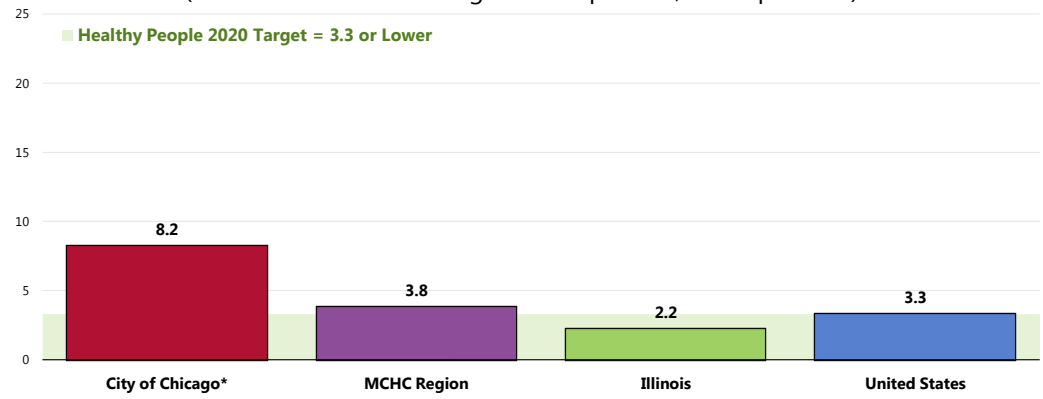
Between 2007 and 2009, there was an annual average age-adjusted HIV/AIDS mortality rate of 8.2 deaths per 100,000 population in the City of Chicago.

- More than twice the regional death rate.
- Much higher than found statewide.
- Much higher than the rate reported nationally.

- Fails to satisfy the Healthy People 2020 target (3.3 or lower).

HIV/AIDS: Age-Adjusted Mortality

(2007-2009 Annual Average Deaths per 100,000 Population)



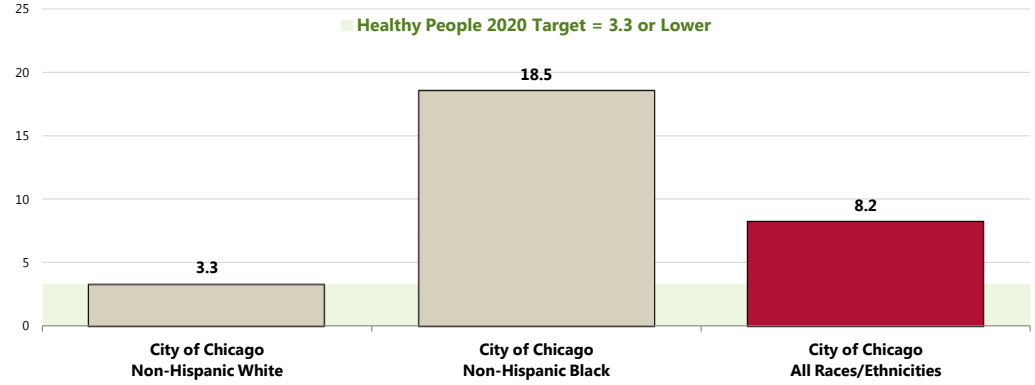
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HIV-12]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- *City of Chicago rate represents 2006-2008 data.

The HIV mortality rate among the City of Chicago Black population is more than five times the rate among Whites.

HIV/AIDS: Age-Adjusted Mortality by Race

(2006-2008 Annual Average Deaths per 100,000 Population)



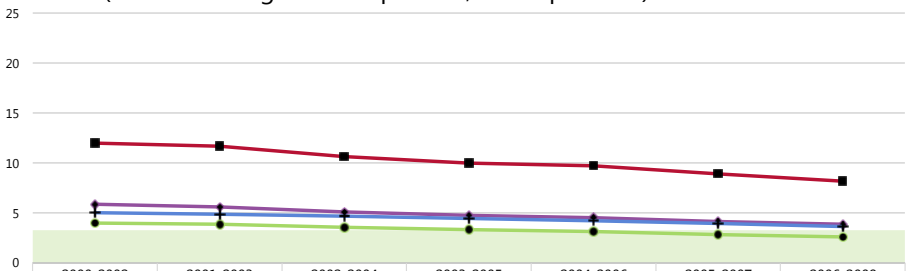
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HIV-12]

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

- HIV mortality has decreased in recent years in the City of Chicago. This decreasing trend is noted across the region, state and nation as well.

HIV/AIDS: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2020	3.3	3.3	3.3	3.3	3.3	3.3	3.3
City of Chicago	12.0	11.7	10.7	10.0	9.7	8.9	8.2
MCHC Region	5.9	5.6	5.1	4.8	4.5	4.2	3.9
Illinois	4.0	3.9	3.6	3.3	3.2	2.8	2.6
United States	5.0	4.9	4.7	4.5	4.2	4.0	3.7

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HIV-12]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.

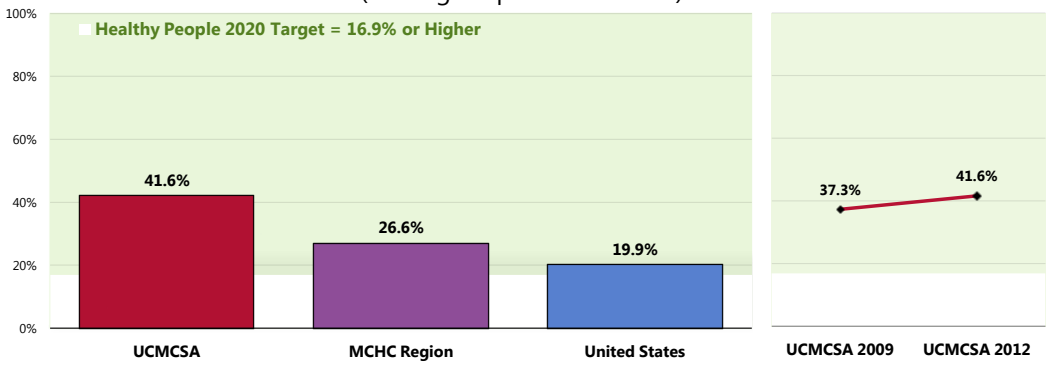
HIV Testing

Among UCMC Service Area adults age 18-44, 41.6% report that they have been tested for human immunodeficiency virus (HIV) in the past year.

- Better than regional findings.
- Much better than the proportion found nationwide.
- Satisfies the Healthy People 2020 target of 16.9% or higher.
- Comparable to the percentage reporting tests in 2009.

Tested for HIV in the Past Year

(Among Respondents 18-44)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 176]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HIV-14.1]

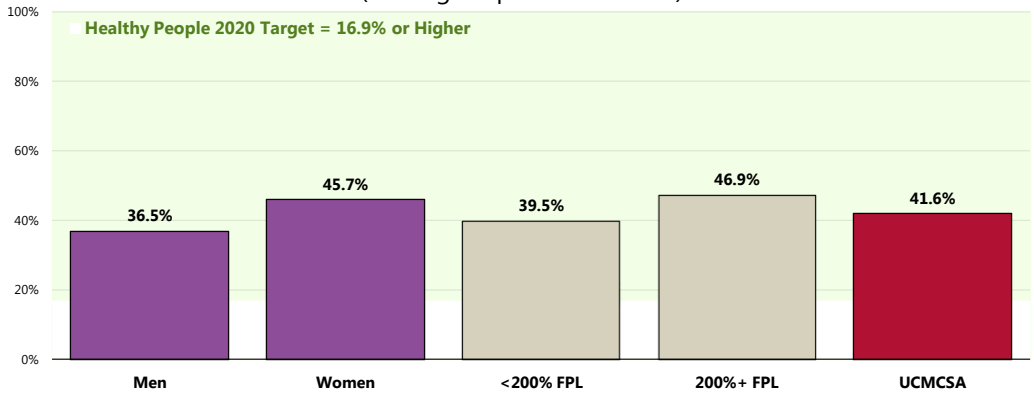
Notes:
- Reflects respondents age 18 to 44.
- Note that the Healthy People 2020 objective is for ages 15-44.

Those more likely to report having been tested for HIV include:

- Women.
- Community members living at higher incomes.

Tested for HIV in the Past Year

(Among Respondents 18-44)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 176]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HIV-14.1]

Notes:
- Reflects respondents age 18 to 44.
- Note that the Healthy People 2020 objective is for ages 15-44.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Sexually Transmitted Diseases

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

The Centers for Disease Control and Prevention (CDC) estimates that there are approximately 19 million new STD infections each year—almost half of them among young people ages 15 to 24. Because many cases of STDs go undiagnosed—and some common viral infections, such as human papillomavirus (HPV) and genital herpes, are not reported to CDC at all—the reported cases of chlamydia, gonorrhea, and syphilis represent only a fraction of the true burden of STDs in the US. Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women. CDC estimates that undiagnosed and untreated STDs cause at least 24,000 women in the United States each year to become infertile. Several factors contribute to the spread of STDs.

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

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

Social, Economic and Behavioral Factors. The spread of STDs is directly affected by social, economic, and behavioral factors. Such factors may cause serious obstacles to STD prevention due to their influence on social and sexual networks, access to and provision of care, willingness to seek care, and social norms regarding sex and sexuality. Among certain vulnerable populations, historical experience with segregation and discrimination exacerbates the influence of these factors. Social, economic, and behavioral factors that affect the spread of STDs include:

- **Racial and ethnic disparities**. Certain racial and ethnic groups (mainly African American, Hispanic, and American Indian/Alaska Native populations) have high rates of STDs, compared with rates for whites.
- **Poverty and marginalization**. STDs disproportionately affect disenfranchised people and people in social networks where high-risk sexual behavior is common, and either access to care or health-seeking behavior is compromised.
- **Access to health care**. Access to high-quality health care is essential for early detection, treatment, and behavior-change counseling for STDs. Groups with the highest rates of STDs are often the same groups for whom access to or use of health services is most limited.
- **Substance abuse**. Many studies document the association of substance abuse with STDs. The introduction of new illicit substances into communities often can alter sexual behavior drastically in high-risk sexual networks, leading to the epidemic spread of STDs.
- **Sexuality and secrecy**. Perhaps the most important social factors contributing to the spread of STDs in the United States are the stigma associated with STDs and the general discomfort of discussing intimate aspects of life, especially those related to sex. These social factors separate the United States from industrialized countries with low rates of STDs.
- **Sexual networks**. Sexual networks refer to groups of people who can be considered "linked" by sequential or concurrent sexual partners. A person may have only 1 sex partner, but if that partner is a member of a risky sexual network, then the person is at higher risk for STDs than a similar individual from a nonrisky network.

– Healthy People 2020 (www.healthypeople.gov)

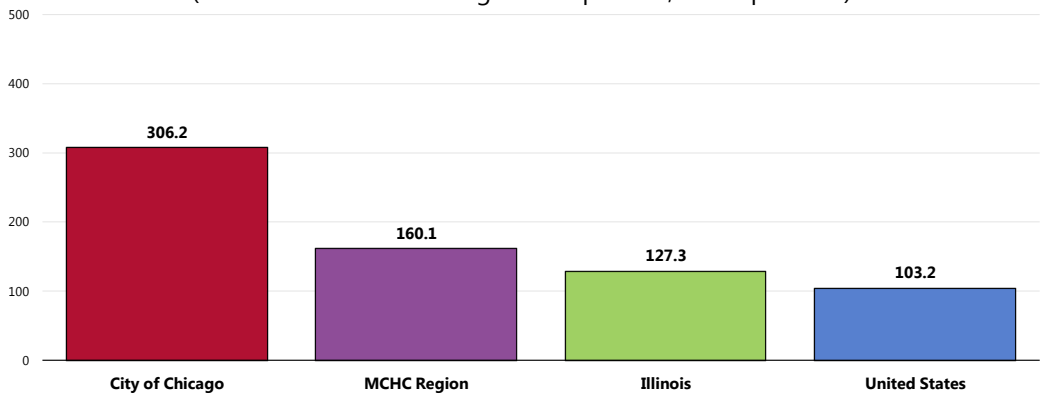
Gonorrhea

Between 2008 and 2010, the annual average gonorrhea incidence rate was 306.2 cases per 100,000 population in the City of Chicago.

- Notably higher than the regional incidence rate.
- Notably higher than the Illinois incidence rate.
- Notably higher than the national incidence rate.

Gonorrhea Incidence

(2008-2010 Annual Average Cases per 100,000 Population)

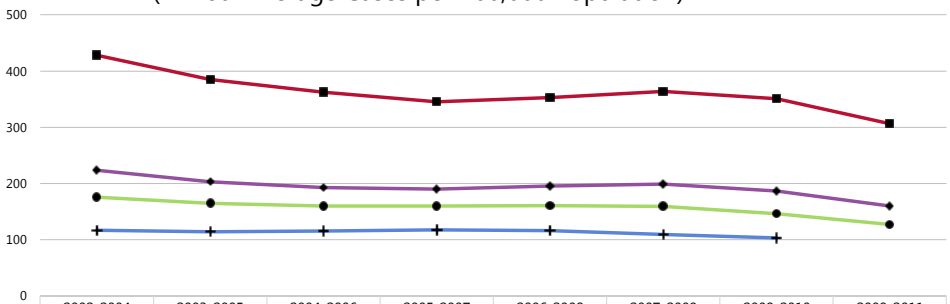


Sources: • Illinois Department of Public Health.
• Centers for Disease Control and Prevention, National Center for Health Statistics.
Notes: • Rates are annual average new cases per 100,000 population.

The City's gonorrhea incidence rate has decreased over the past decade, echoing the decreasing trends reported regionally, statewide and nationwide.

Gonorrhea Incidence

(Annual Average Cases per 100,000 Population)



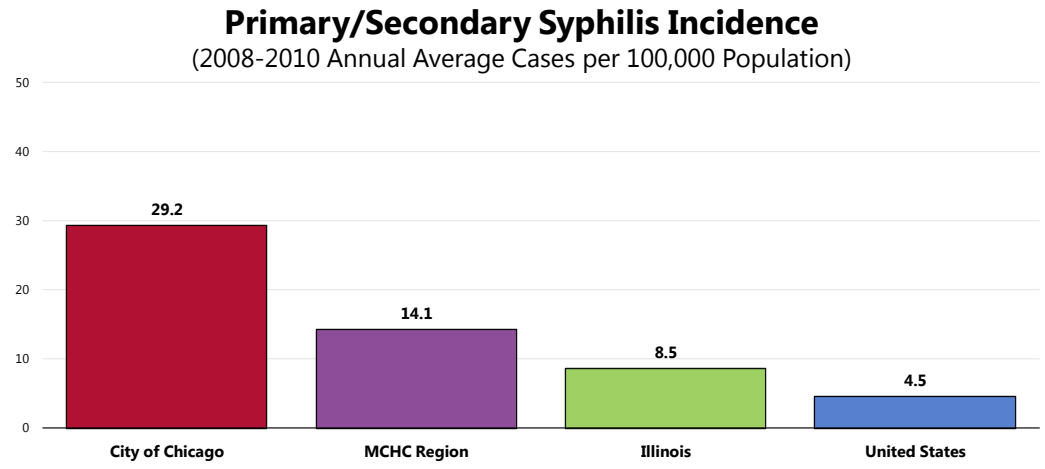
	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011
City of Chicago	427.9	384.9	362.2	345.5	352.7	363.9	350.9	306.2
MCHC	223.6	203.0	192.9	189.8	195.3	198.7	186.3	160.1
Illinois	175.8	164.7	159.9	159.8	160.9	159.5	145.9	127.3
United States	116.5	114.1	115.6	117.4	116.1	108.9	103.2	

Sources: • Illinois Department of Public Health
• Centers for Disease Control and Prevention, National Center for Health Statistics.
Notes: • Rates are annual average new cases per 100,000 population.

Syphilis

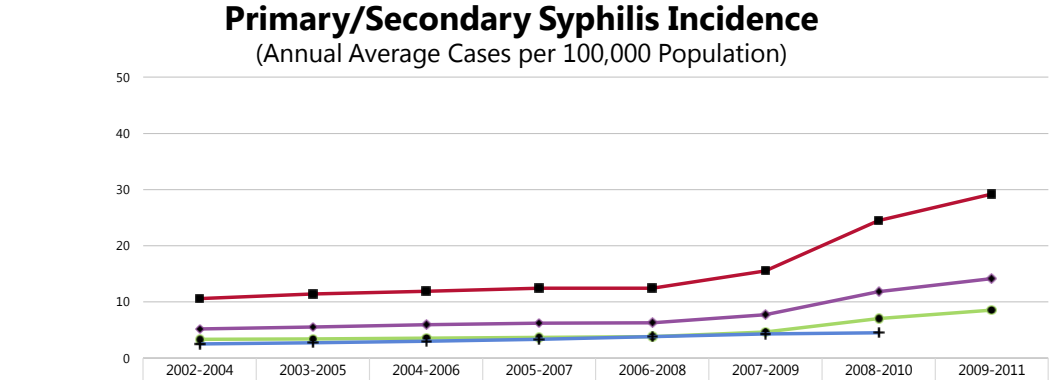
Between 2008 and 2010, the City's annual average primary/secondary syphilis incidence rate was 29.2 cases per 100,000 population.

- More than twice the regional incidence rate.
- Much higher than the Illinois incidence rate.
- Much higher than the national incidence rate.



Sources: ● Illinois Department of Public Health.
● Centers for Disease Control and Prevention, National Center for Health Statistics.
Notes: ● Rates are annual average new cases per 100,000 population.

Syphilis incidence has increased considerably in the City of Chicago in recent years, mirroring the regional and state trends. The national rate increased as well, although less notably.



	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011
City of Chicago	10.6	11.4	11.9	12.4	12.4	15.5	24.5	29.2
MCHC Region	5.2	5.5	5.9	6.2	6.3	7.7	11.8	14.1
Illinois	3.3	3.4	3.5	3.7	3.8	4.6	7.0	8.5
United States	2.5	2.7	3.0	3.3	3.8	4.3	4.5	

Sources: ● Illinois Department of Public Health
● Centers for Disease Control and Prevention, National Center for Health Statistics.
Notes: ● Rates are annual average new cases per 100,000 population.

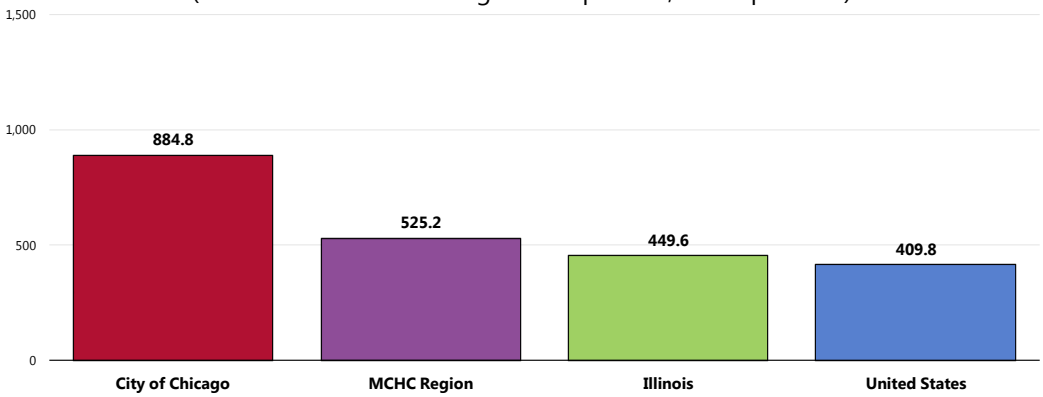
Chlamydia

Between 2008 and 2010, the annual average chlamydia incidence rate was 884.8 cases per 100,000 population in the City of Chicago.

- Worse than the regional rate.
- Worse than the Illinois incidence rate.
- More than twice the national incidence rate.

Chlamydia Incidence

(2008-2010 Annual Average Cases per 100,000 Population)

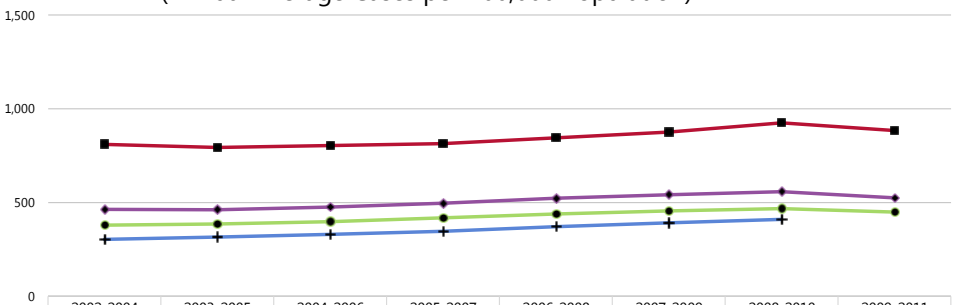


Sources: • Illinois Department of Public Health.
• Centers for Disease Control and Prevention, National Center for Health Statistics.
Notes: • Rates are annual average new cases per 100,000 population.

Chlamydia incidence has increased in the City of Chicago over the past decade; the same is true regionally, statewide and nationwide.

Chlamydia Incidence

(Annual Average Cases per 100,000 Population)



	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011
City of Chicago	809.4	793.5	803.1	813.6	844.0	876.5	925.6	884.8
MCHC Region	463.9	460.5	474.7	495.8	522.9	542.1	557.8	525.2
Illinois	379.8	385.1	397.8	418.1	438.7	454.6	466.5	449.6
United States	302.5	315.9	330.1	347.1	370.0	390.3	409.8	

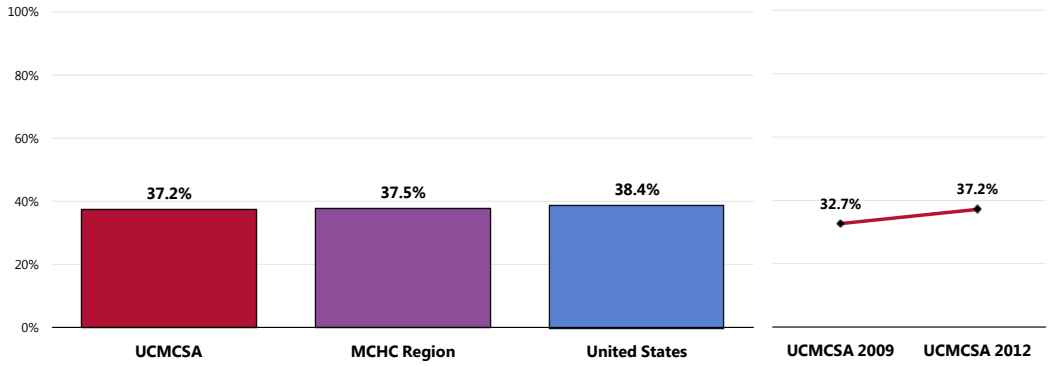
Sources: • Illinois Department of Public Health
• Centers for Disease Control and Prevention, National Center for Health Statistics.
Notes: • Rates are annual average new cases per 100,000 population.

Hepatitis B Vaccination

Based on survey data, more than one-third (37.2%) of residents report having received the hepatitis B vaccine.

- Nearly identical to the percentage found regionally.
- Similar to the rate reported nationwide.
- No statistically significant change has occurred since 2009.

Have Ever Received the Hepatitis B Vaccination



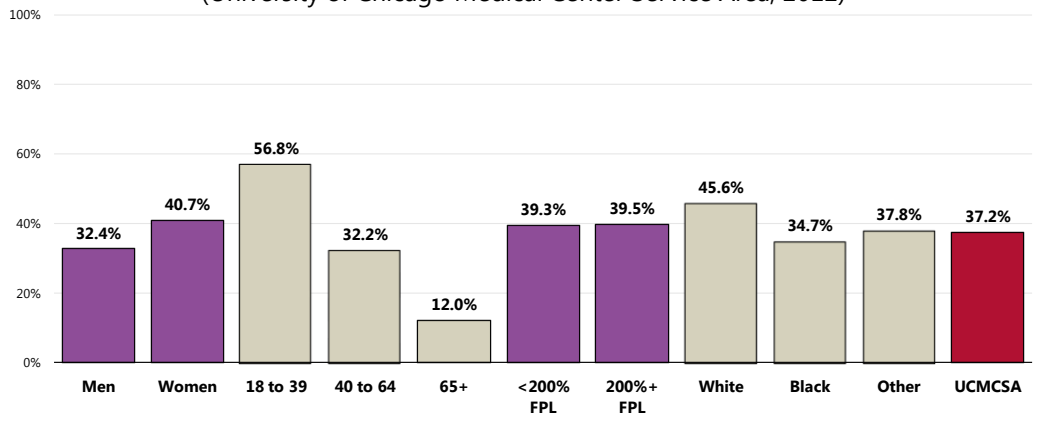
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 82]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Note the negative correlation between age and hepatitis B vaccination, with adults aged 40+ being considerably less likely to have received the vaccination.

Have Ever Received the Hepatitis B Vaccination

(University of Chicago Medical Center Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 82]

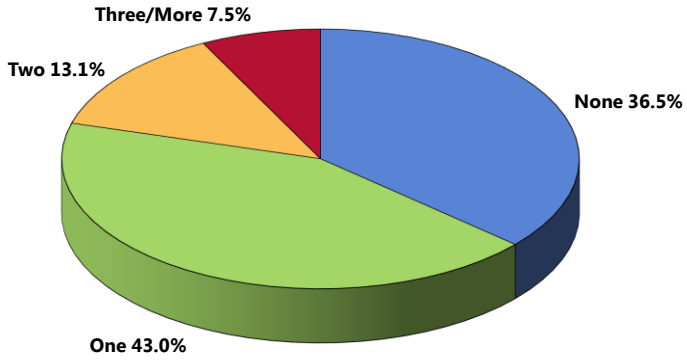
Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household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

Sexual Partners

Among unmarried UCMC Service Area adults under 65, the vast majority cites having one (43.0%) or no (36.5%) sexual partners in the past 12 months.

Number of Sexual Partners in Past 12 Months

(Among Unmarried Adults 18-64; University of Chicago Medical Center Service Area, 2012)



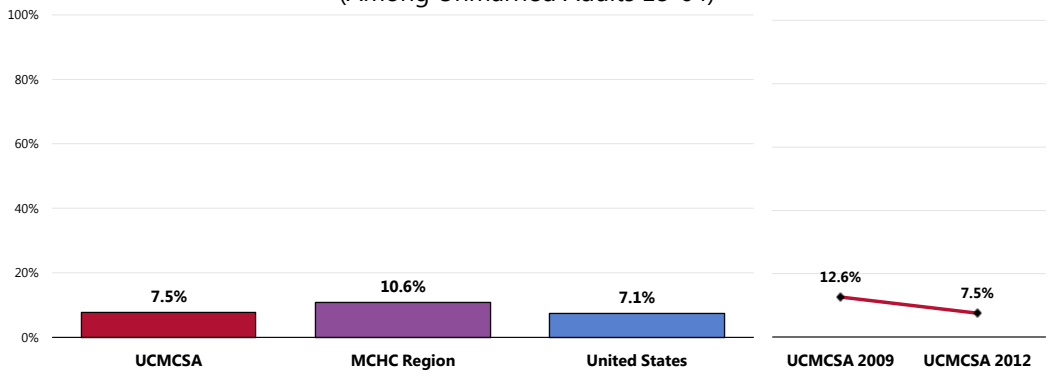
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 103]
Notes: • Asked of all unmarried respondents under the age of 65.

However, 7.5% report three or more sexual partners in the past year.

- Comparable to MCHC Region results.
- Comparable to that reported nationally.
- Statistically unchanged from the 2009 survey findings.

Had Three or More Sexual Partners in the Past Year

(Among Unmarried Adults 18-64)

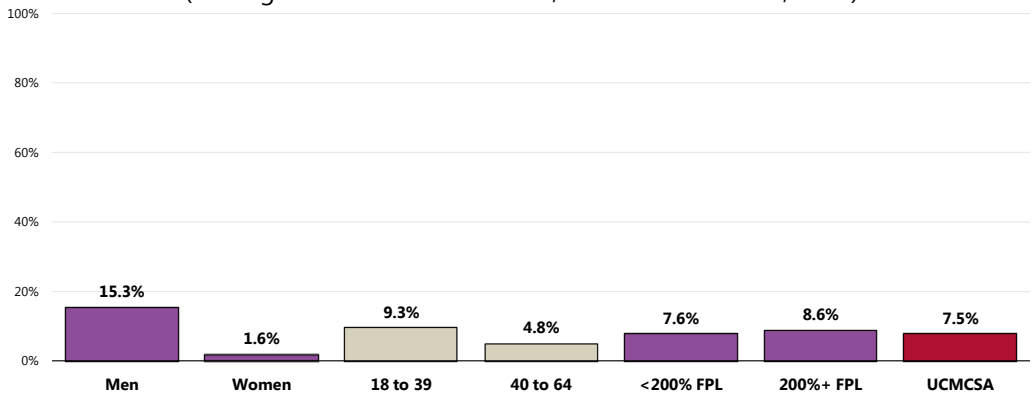


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 103]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all unmarried respondents under the age of 65.

- Among unmarried adults under 65, males and those age 18 to 39 are more likely to report having 3+ sexual partners over the past 12 months.

Had Three or More Sexual Partners in the Past Year

(Among Unmarried Adults 18-64; UCMC Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 103]

Notes:
- Asked of all unmarried respondents under the age of 65.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

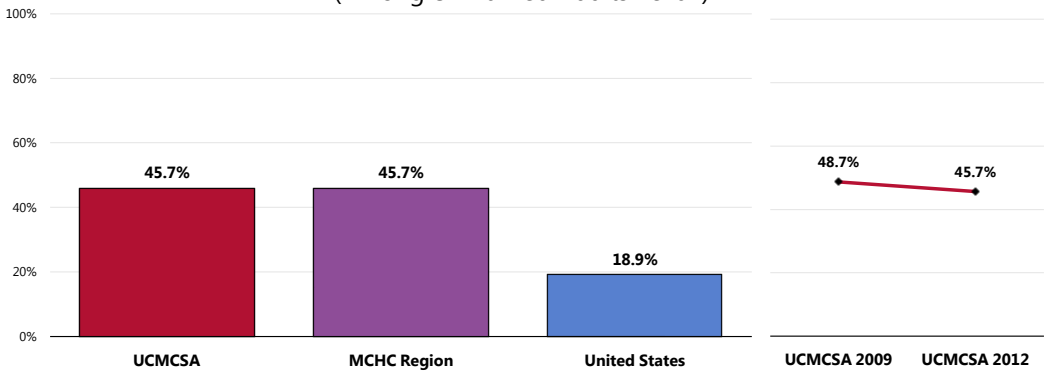
Condom Use

Among UCMC Service Area adults who are under age 65 and unmarried, 45.7% report that a condom was used during their last sexual intercourse.

- Identical to the MCHC Region findings.
- Much higher than national findings.
- Statistically unchanged since 2009.

Condom Was Used During Last Sexual Intercourse

(Among Unmarried Adults 18-64)



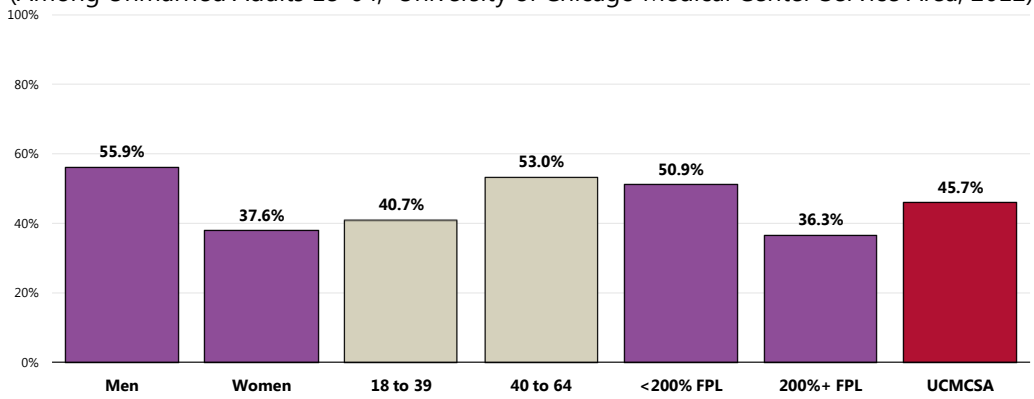
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 104]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

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

- Among unmarried adults under 65, women, residents under age 40, and those in the higher income category are less likely to report that a condom was used during their most recent sexual intercourse.

Condom Was Used During Last Sexual Intercourse

(Among Unmarried Adults 18-64; University of Chicago Medical Center Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 104]

Notes:
- Asked of all unmarried respondents under the age of 65.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

BIRTHS

Prenatal Care

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

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

– Healthy People 2020 (www.healthypeople.gov)

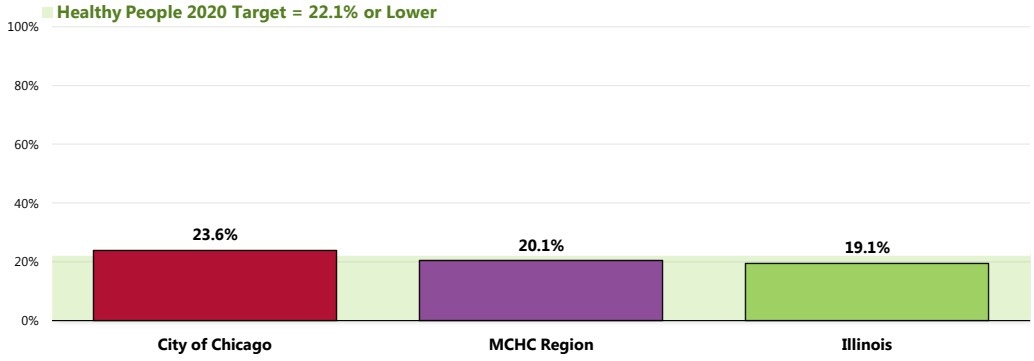
Early and continuous prenatal care is the best assurance of infant health.

Between 2007 and 2009, 23.6% of all City of Chicago births did not receive prenatal care in the first trimester of pregnancy.

- Less favorable than the regional proportion.
- Less favorable than the Illinois proportion.
- Fails to satisfy the Healthy People 2020 target (22.1% or lower).

Lack of Prenatal Care in the First Trimester

(Percentage of Live Births, 2007-2009)



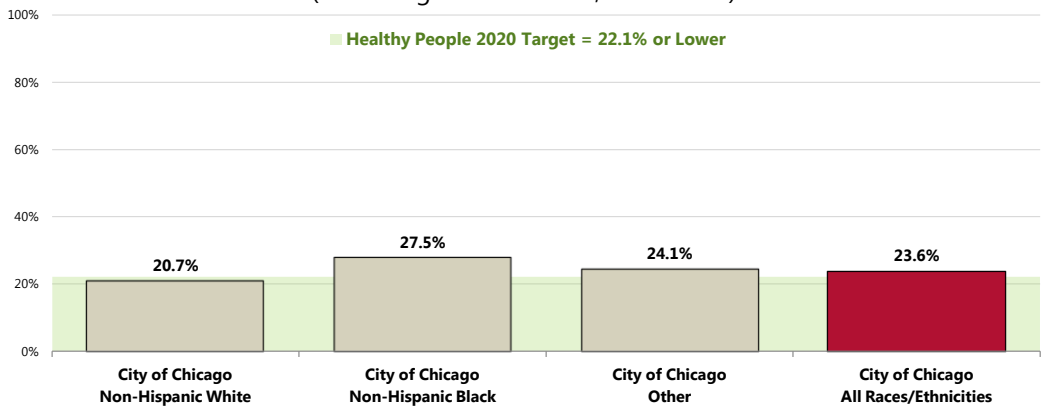
Sources:
- Illinois Department of Public Health.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-10.1]

Note:
- Numbers are a percentage of all live births within each population.

Lack of prenatal care is higher among City of Chicago Blacks than among Whites and Hispanics.

Lack of Prenatal Care in the First Trimester

(Percentage of Live Births, 2007-2009)

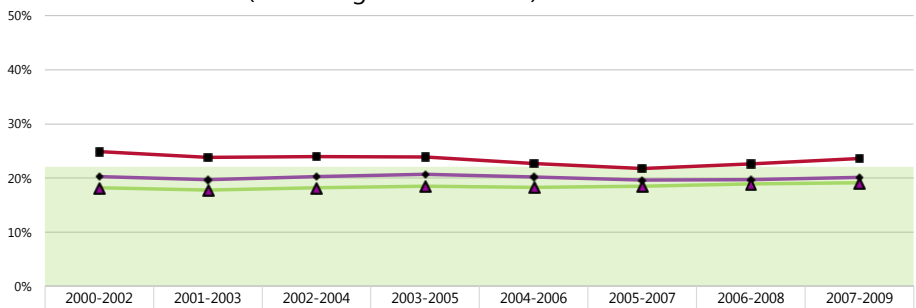


Sources: • Illinois Department of Public Health.
• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-10.1]
Note: • Numbers are a percentage of all live births within each population.

Receipt of prenatal care improved slightly for the City of Chicago during much of the past decade; however, lack of prenatal care proportions increased in the most recent reporting periods.

Lack of Prenatal Care in the First Trimester

(Percentage of Live Births)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
Healthy People 2020	22.1%	22.1%	22.1%	22.1%	22.1%	22.1%	22.1%	22.1%
City of Chicago	24.9%	23.8%	24.0%	23.9%	22.7%	21.8%	22.6%	23.6%
MCHC Region	20.3%	19.7%	20.3%	20.7%	20.2%	19.6%	19.7%	20.1%
Illinois	18.2%	17.8%	18.2%	18.5%	18.3%	18.5%	18.9%	19.1%

Sources: • Illinois Department of Public Health
• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-10.1]
Note: • Numbers are a percentage of all live births within each population.

Birth Outcomes & Risks

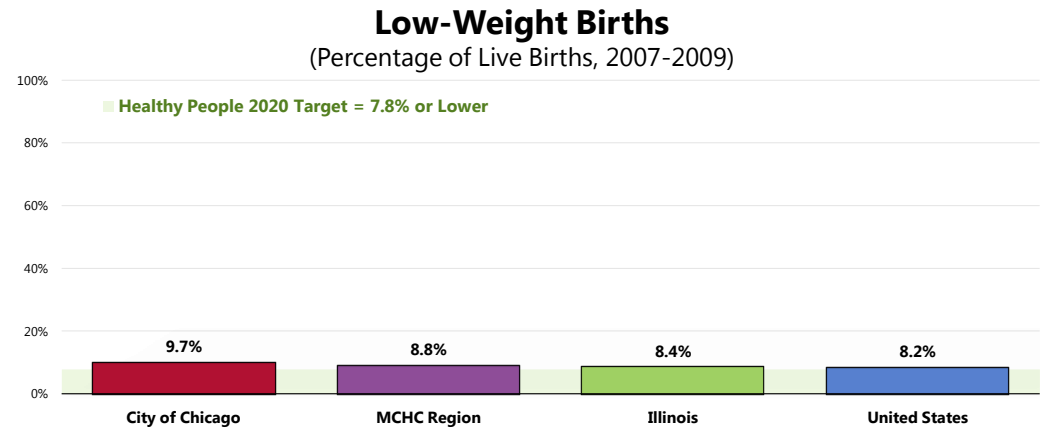
Low-Weight Births

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

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

A total of 9.7% of 2007-2009 City of Chicago births were low-weight.

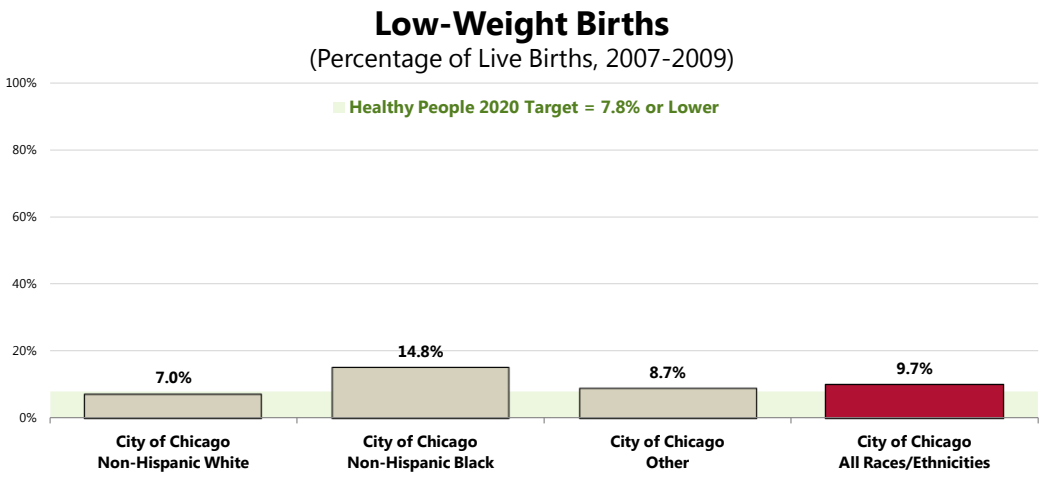
- Higher than the regional proportion.
- Higher than the Illinois proportion.
- Higher than the national proportion.
- Fails to satisfy the Healthy People 2020 target (7.8% or lower).



Sources:
- Illinois Department of Public Health.
- Centers for Disease Control and Prevention, National Vital Statistics System.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-8.1]

Note:
- Numbers are a percentage of all live births within each population.
- Defined as an infant born weighing less than 5.5 pounds (2,500 grams) regardless of gestational age.

Low-weight births are notably more prevalent among Blacks in the City of Chicago.



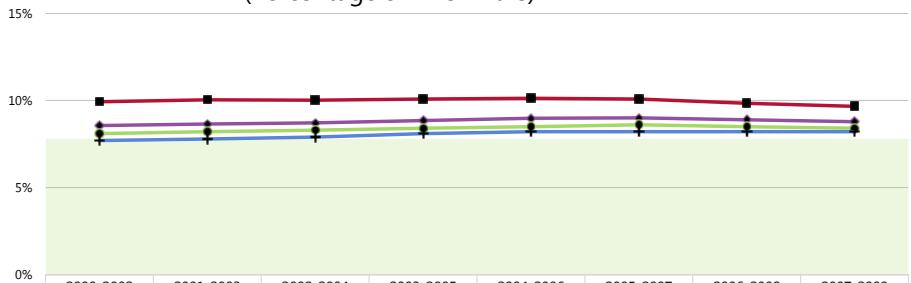
Sources:
- Illinois Department of Public Health.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-8.1]

Note:
- Numbers are a percentage of all live births within each population.

The City's proportion of low-weight births has been relatively stable over the past decade.

Low-Weight Births

(Percentage of Live Births)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
Healthy People 2020	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
City of Chicago	9.9%	10.0%	10.0%	10.1%	10.1%	10.1%	9.8%	9.7%
MCHC Region	8.6%	8.6%	8.7%	8.8%	9.0%	9.0%	8.9%	8.8%
Illinois	8.1%	8.2%	8.3%	8.4%	8.5%	8.6%	8.5%	8.4%
United States	7.7%	7.8%	7.9%	8.1%	8.2%	8.2%	8.2%	8.2%

Sources:
- Illinois Department of Public Health
- Centers for Disease Control and Prevention, National Vital Statistics System.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-8.1]

Note:
- Numbers are a percentage of all live births within each population.
- Defined as an infant born weighing less than 5.5 pounds (2,500 grams) regardless of gestational age.

Infant Mortality

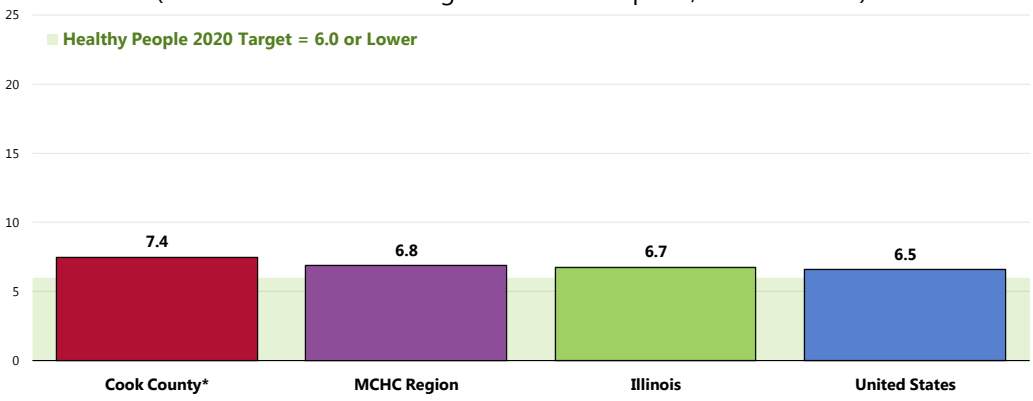
Infant mortality rates reflect deaths of children less than one year old per 1,000 live births.

Between 2007 and 2009, Cook County reported an annual average of 7.4 infant deaths per 1,000 live births.

- Worse than the regional rate.
- More favorable than the Illinois rate.
- More favorable than the national rate.
- Comparable to the Healthy People 2020 target of 6.0 per 1,000 live births.

Infant Mortality Rate

(2007-2009 Annual Average Infant Deaths per 1,000 Live Births)



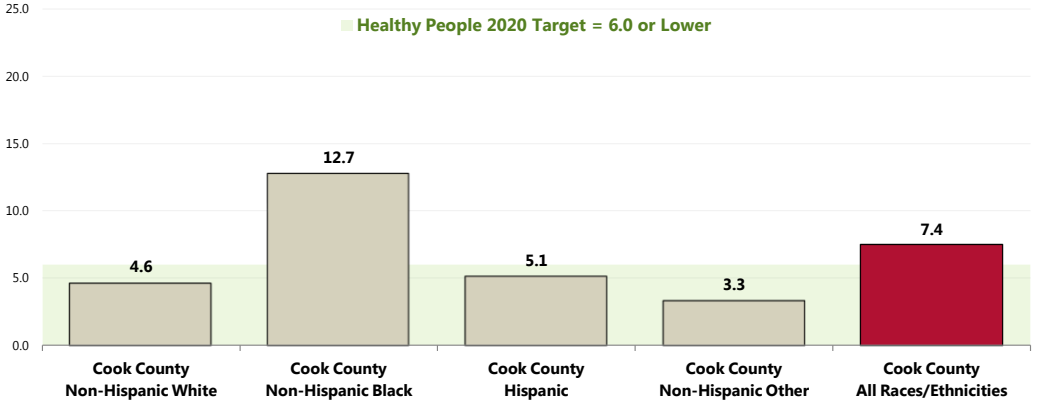
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-1.3]

Notes:
- Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.
- *Cook County data is used here; City of Chicago data is unavailable.

The infant mortality rate is notably higher among births to Black mothers when compared with Whites, Hispanics and Asians in the county.

Infant Mortality Rate

(2007-2009 Annual Average Infant Deaths per 1,000 Live Births)



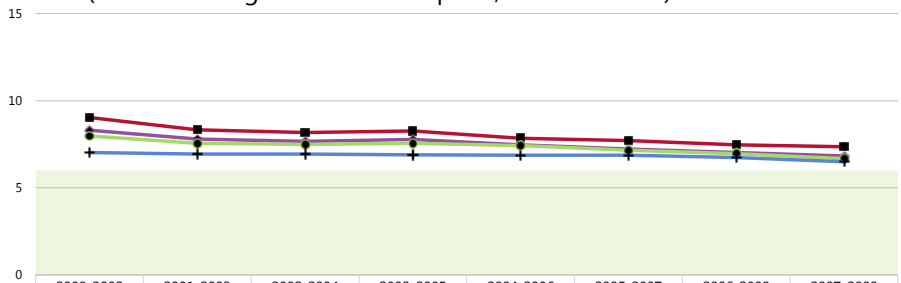
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-1.3]

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

The Cook County infant mortality rate trended downward over the past decade, echoing the trends reported regionally and for Illinois and the US overall.

Infant Mortality Rate

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



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
Healthy People 2020	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0
Cook County	9.0	8.3	8.2	8.3	7.8	7.7	7.5	7.4
MCHC Region	8.3	7.8	7.7	7.8	7.5	7.2	7.0	6.8
Illinois	8.0	7.6	7.5	7.6	7.4	7.2	7.0	6.7
United States	7.0	6.9	6.9	6.9	6.9	6.9	6.7	6.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-1.3]

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

Family Planning

Family planning is one of the 10 great public health achievements of the 20th century. The availability of family planning services allows individuals to achieve desired birth spacing and family size and contributes to improved health outcomes for infants, children, and women. Family planning services include contraceptive and broader reproductive health services (patient education and counseling), breast and pelvic examinations, breast and cervical cancer screening, sexually transmitted infection (STI) and HIV prevention education/counseling/testing/referral, and pregnancy diagnosis and counseling. For many women, a family planning clinic is their entry point into the healthcare system and is considered to be their usual source of care. This is especially true for women with incomes below the poverty level, women who are uninsured, Hispanic women, and Black women.

Unintended pregnancies (those reported by women as being mistimed or unwanted) are associated with many negative health and economic outcomes. In 2001, almost one-half of all pregnancies in the US were unintended. For women, negative outcomes associated with unintended pregnancy include:

- Delays in initiating prenatal care
- Reduced likelihood of breastfeeding
- Poor maternal mental health
- Lower mother-child relationship quality
- Increased risk of physical violence during pregnancy

Children born as a result of an unintended pregnancy are more likely to experience poor mental and physical health during childhood and poor educational and behavioral outcomes.

– Healthy People 2020 (www.healthypeople.gov)

Births to Unwed Mothers

According to the CDC, an unintended pregnancy is a pregnancy that is either mistimed or unwanted at the time of conception. It is a core concept in understanding the fertility of populations and the unmet need for contraception. Unintended pregnancy is associated with an increased risk of morbidity for women, and with health behaviors during pregnancy that are associated with adverse effects. For example, women with an unintended pregnancy may delay prenatal care, which may affect the health of the infant. Women of all ages may have unintended pregnancies, but some groups, such as teens, are at a higher risk.

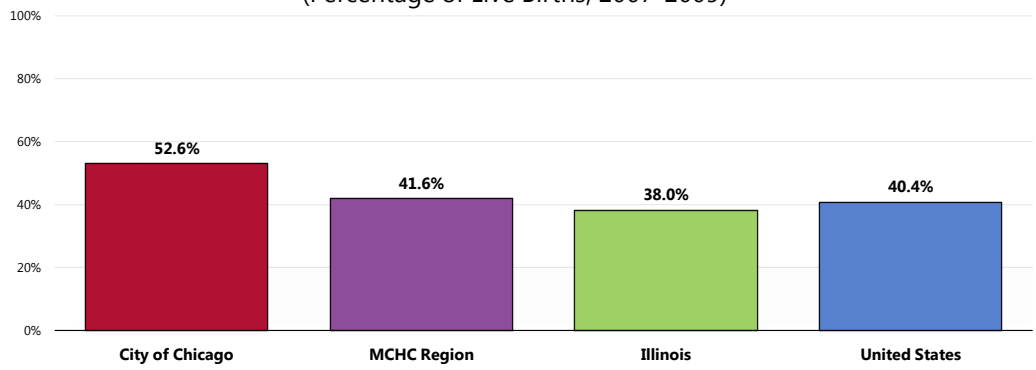
Because it is impossible to measure the true incidence of unintended pregnancy in the US, the following indicator looks at births occurring among unmarried mothers as a proxy measure for pregnancies that are not intended (knowing that this is not always the case).

More than one-half (52.6%) of 2007-2009 City of Chicago births were to unwed mothers.

- Higher than the regional percentage.
- Higher than the percentage reported statewide.
- Higher than that found nationally.

Births to Unwed Mothers

(Percentage of Live Births, 2007-2009)

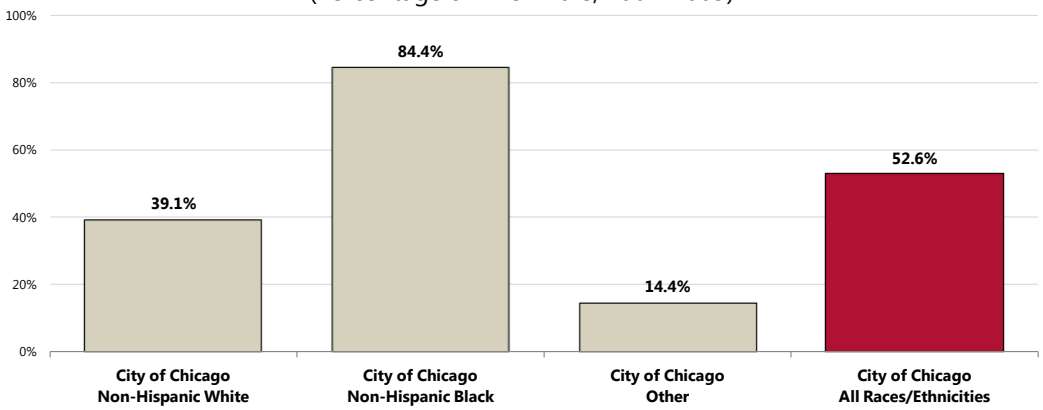


Sources: • Illinois Department of Public Health.
• Centers for Disease Control and Prevention, National Vital Statistics System.
Note: • Numbers are a percentage of all live births within each population.

- Note the high prevalence (84.4%) of births to unwed mothers in the City's Black population.

Births to Unwed Mothers

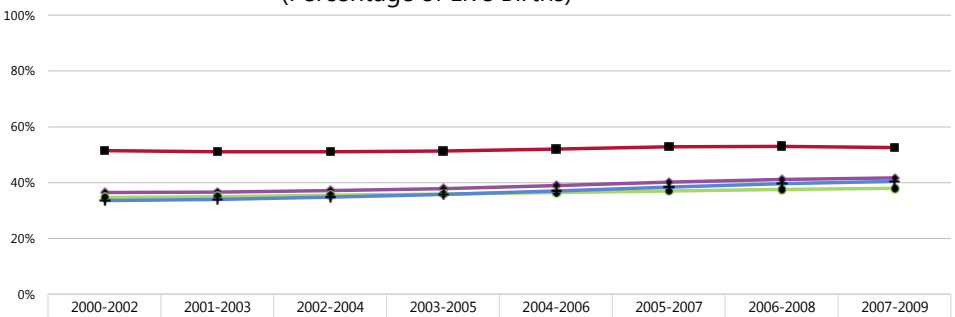
(Percentage of Live Births, 2007-2009)



Sources: • Illinois Department of Public Health.
Note: • Numbers are a percentage of all live births within each population.

The percentage of births to unwed mothers in the City of Chicago has increased slightly over the past decade; regional, state and national percentages have increased as well.

Births to Unwed Mothers
(Percentage of Live Births)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
City of Chicago	51.5%	51.1%	51.1%	51.3%	52.0%	52.8%	53.0%	52.6%
MCHC Region	36.5%	36.6%	37.1%	37.8%	38.9%	40.1%	41.2%	41.6%
Illinois	34.7%	35.0%	35.5%	35.9%	36.4%	37.1%	37.6%	38.0%
United States	33.6%	34.0%	34.8%	35.8%	37.1%	38.4%	39.6%	40.4%

Sources: • Illinois Department of Public Health
• Centers for Disease Control and Prevention, National Vital Statistics System.
Note: • Numbers are a percentage of all live births within each population.

Births to Teen Mothers

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

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

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

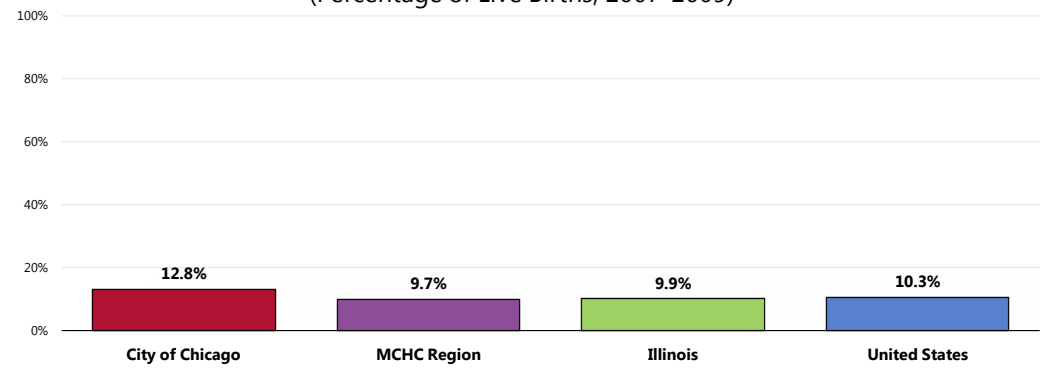
– Healthy People 2020 (www.healthypeople.gov)

12.8% of 2007-2009 City of Chicago births were to teenage mothers (under age 20).

- Worse than the regional proportion.
- Worse than the Illinois proportion.
- Worse than the national proportion.

Births to Teen Mothers (Under Age 20)

(Percentage of Live Births, 2007-2009)

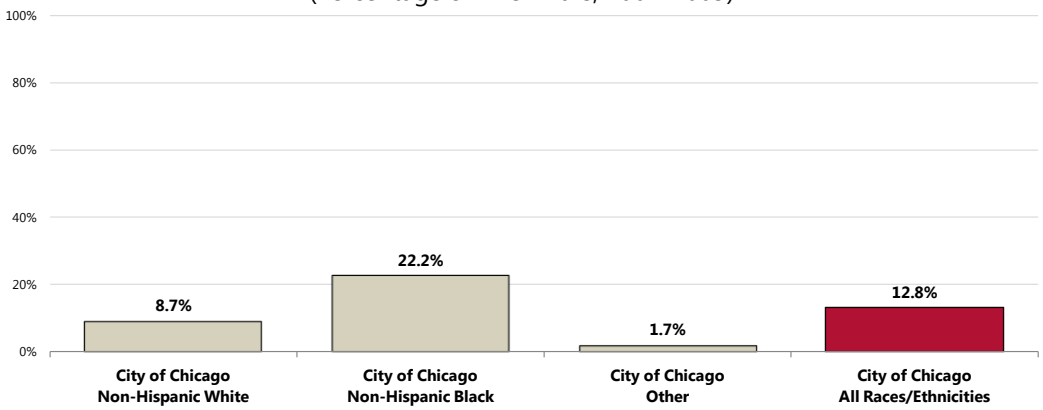


Sources: • Illinois Department of Public Health.
• Centers for Disease Control and Prevention, National Vital Statistics System.
Note: • Numbers are a percentage of all live births within each population.

Teen births are notably more prevalent among Blacks in the City of Chicago.

Births to Teen Mothers

(Percentage of Live Births, 2007-2009)

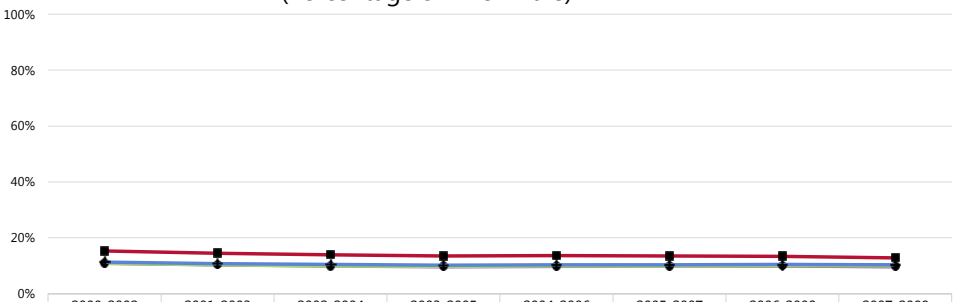


Sources: • Illinois Department of Public Health.
Note: • Numbers are a percentage of all live births within each population.

The percentage of births to teen mothers decreased over the past decade.

Births to Teen Mothers

(Percentage of Live Births)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
City of Chicago	15.3%	14.4%	13.9%	13.5%	13.6%	13.5%	13.4%	12.8%
MCHC Region	10.9%	10.3%	9.9%	9.7%	9.8%	9.9%	9.9%	9.7%
Illinois	10.9%	10.3%	10.0%	9.8%	9.9%	9.9%	10.0%	9.9%
United States	11.3%	10.8%	10.4%	10.2%	10.3%	10.3%	10.4%	10.3%

Sources:
- Illinois Department of Public Health
- Centers for Disease Control and Prevention, National Vital Statistics System.

Note:
- Numbers are a percentage of all live births within each population.

MODIFIABLE HEALTH RISKS

Actual Causes Of Death

A 1999 study (an update to a landmark 1993 study), estimated that as many as 40% of premature deaths in the United States are attributed to behavioral factors. This study found that behavior patterns represent the single-most prominent domain of influence over health prospects in the United States. The daily choices we make with respect to diet, physical activity, and sex; the substance abuse and addictions to which we fall prey; our approach to safety; and our coping strategies in confronting stress are all important determinants of health.

The most prominent contributors to mortality in the United States in 2000 were tobacco (an estimated 435,000 deaths), diet and activity patterns (400,000), alcohol (85,000), microbial agents (75,000), toxic agents (55,000), motor vehicles (43,000), firearms (29,000), sexual behavior (20,000), and illicit use of drugs (17,000). Socioeconomic status and access to medical care are also important contributors, but difficult to quantify independent of the other factors cited. Because the studies reviewed used different approaches to derive estimates, the stated numbers should be viewed as first approximations.

These analyses show that smoking remains the leading cause of mortality. However, poor diet and physical inactivity may soon overtake tobacco as the leading cause of death. These findings, along with escalating healthcare costs and aging population, argue persuasively that the need to establish a more preventive orientation in the US healthcare and public health systems has become more urgent.

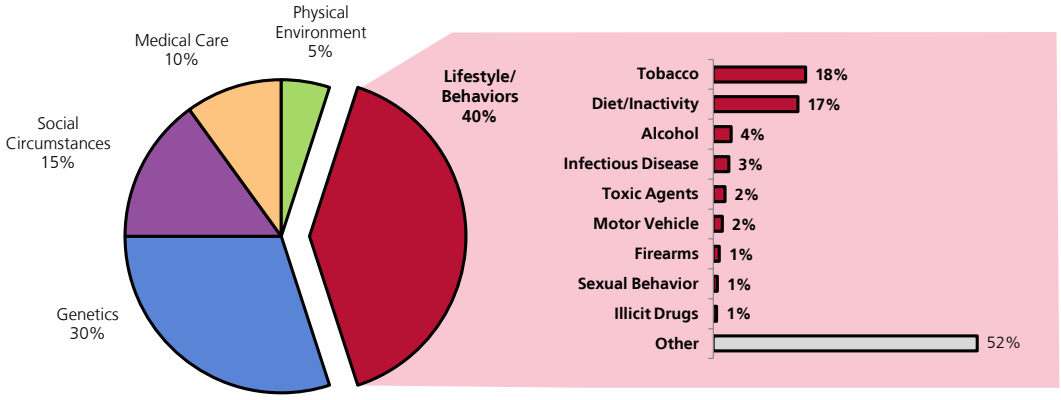
– Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, Phd, MSc; Julie L. Gerberding, MD, MPH. "Actual Causes of Death in the United States." JAMA, 291(2004):1238-1245.

While causes of death are typically described as the diseases or injuries immediately precipitating the end of life, a few important studies have shown that the actual causes of premature death (reflecting underlying risk factors) are often preventable.

Leading Causes of Death	Underlying Risk Factors (Actual Causes of Death)	
Cardiovascular disease	Tobacco use Elevated serum cholesterol High blood pressure	Obesity Diabetes Sedentary lifestyle
Cancer	Tobacco use Improper diet	Alcohol Occupational/environmental exposures
Cerebrovascular disease	High blood pressure Tobacco use	Elevated serum cholesterol
Accidental injuries	Safety belt noncompliance Alcohol/substance abuse Reckless driving	Occupational hazards Stress/fatigue
Chronic lung disease	Tobacco use	Occupational/environmental exposures

Source: National Center for Health Statistics/US Department of Health and Human Services, Health United States: 1987. DHHS Pub. No. (PHS) 88–1232.

Factors Contributing to Premature Deaths in the United States



Sources: "The Case For More Active Policy Attention to Health Promotion"; (McGinnis, Williams-Russo, Knickman) Health Affairs, Vol. 21, No. 2, March/April 2002. "Actual Causes of Death in the United States"; (Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, Phd, MSc; Julie L. Gerberding, MD, MPH) JAMA, 291(2000):1238-1245.

Nutrition

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

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

Americans with a healthful diet:

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

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

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

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

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

Social factors thought to influence diet include:

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

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

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

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

– Healthy People 2020 (www.healthypeople.gov)

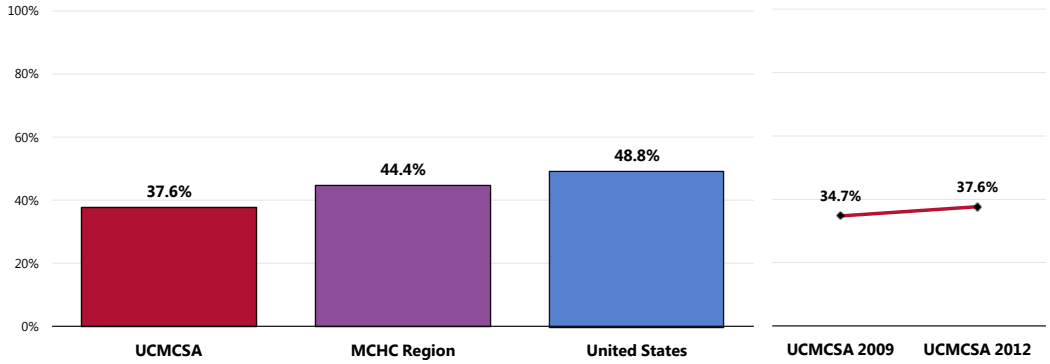
Daily Recommendation of Fruits/Vegetables

To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

A total of 37.6% of UCMC Service Area adults report eating five or more servings of fruits and/or vegetables per day.

- Less favorable than is found in the MCHC Region.
- Less favorable than national findings.
- Fruit/vegetable consumption has not changed significantly since 2009.

Consume Five or More Servings of Fruits/Vegetables Per Day



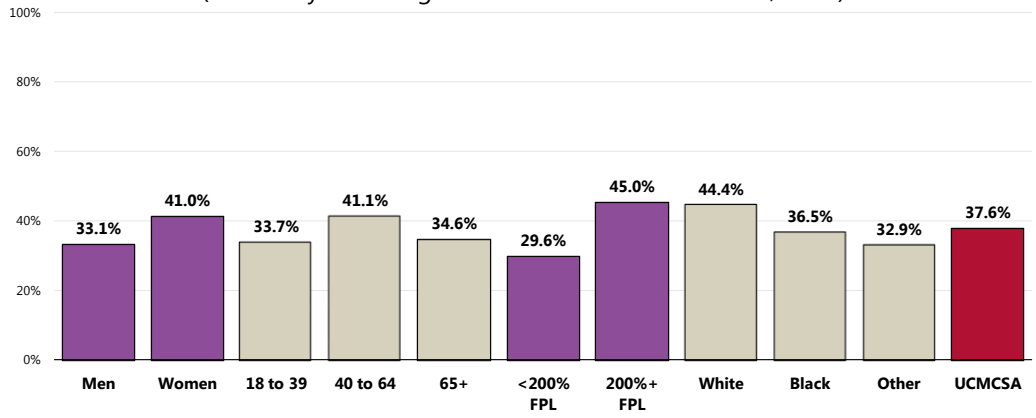
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 178]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- For this issue, respondents were asked to recall their food intake on the previous day.

- Those in the lower income group are less likely to get the recommended servings of daily fruits/vegetables.

Consume Five or More Servings of Fruits/Vegetables Per Day

(University of Chicago Medical Center Service Area, 2012)

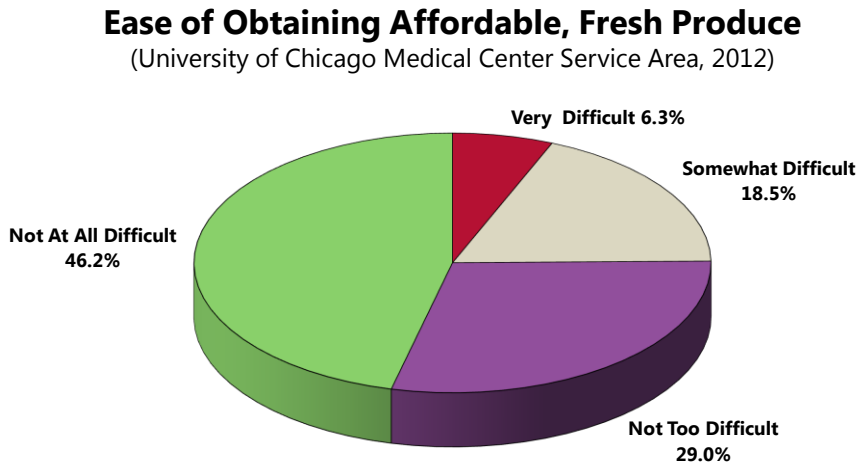


Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 178]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.
- For this issue, respondents were asked to recall their food intake on the previous day.

Ease of Obtaining Affordable, Fresh Produce

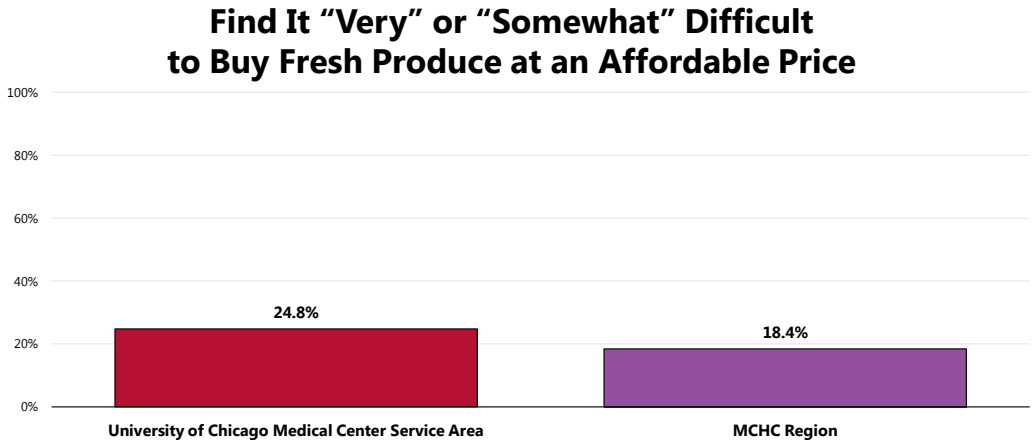
Three in four (75.2%) UCMC Service Area adults report that it is "not too difficult" or "not at all difficult" to obtain affordable, fresh produce in the community.



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 109]
Notes: • Asked of all respondents.

On the other hand, 24.8% of survey respondents consider it to be "very" or "somewhat" difficult to obtain affordable, fresh produce locally.

- Less favorable than the regional prevalence.

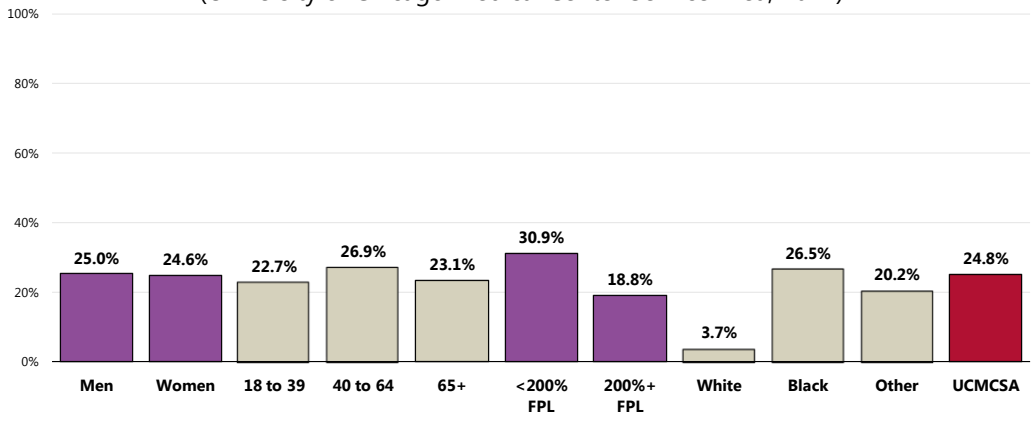


Sources: • 2012 PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 109]
Notes: • Asked of all respondents.

Difficulty is statistically high among adults with lower incomes and Blacks.

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

(University of Chicago Medical Center Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 109]

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

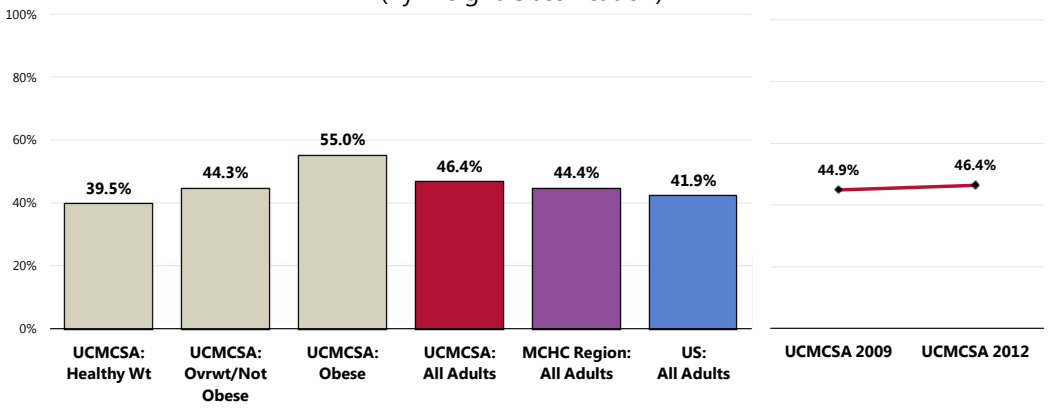
Health Advice About Diet & Nutrition

A total of 46.4% of survey respondents acknowledge that a physician counseled them about diet and nutrition in the past year.

- Similar to the MCHC Region figure.
- Similar to national findings.
- Statistically unchanged since 2009.
- Note: Among obese respondents, 55.0% report receiving diet/nutrition advice (meaning that nearly one-half did not).

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

(By Weight Classification)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 18]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Physical Activity

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

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

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

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

Among children ages 4 to 12, the following factors have a positive association with physical activity:

- Gender (boys)
- Belief in ability to be active (self-efficacy)
- Parental support

Among adolescents ages 13 to 18, the following factors have a positive association with physical activity:

- Parental education
- Gender (boys)
- Personal goals
- Physical education/school sports
- Belief in ability to be active (self-efficacy)
- Support of friends and family

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

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

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

– Healthy People 2020 (www.healthypeople.gov)

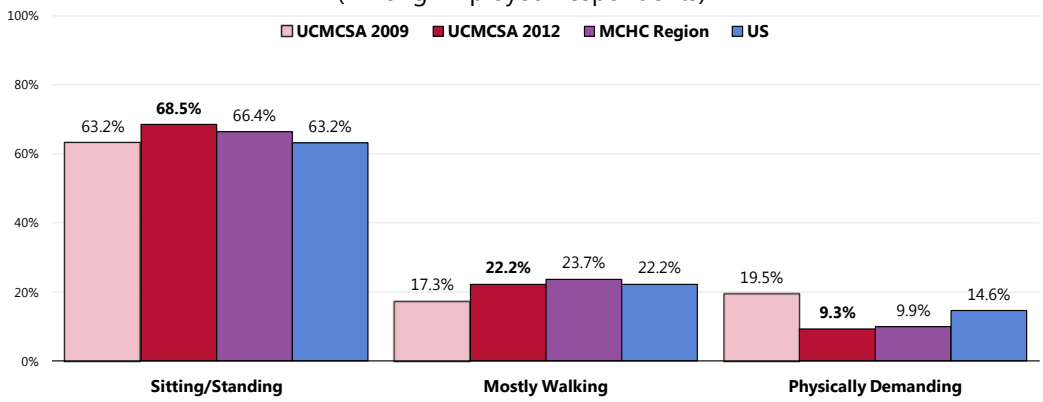
Level of Activity at Work

A majority of employed respondents reports low levels of physical activity at work.

- A total of 68.5% of employed respondents report that their job entails mostly sitting or standing, which is similar to the US figure and the MCHC percentage.
- 22.2% report that their job entails mostly walking (similar to that reported nationally and regionally).
- 9.3% report that their work is physically demanding, which is comparable to the regional findings, but lower than the US findings.
- Reports of physically demanding work decreased significantly between 2009 and 2012.

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

Primary Level of Physical Activity At Work
(Among Employed Respondents)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 110]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

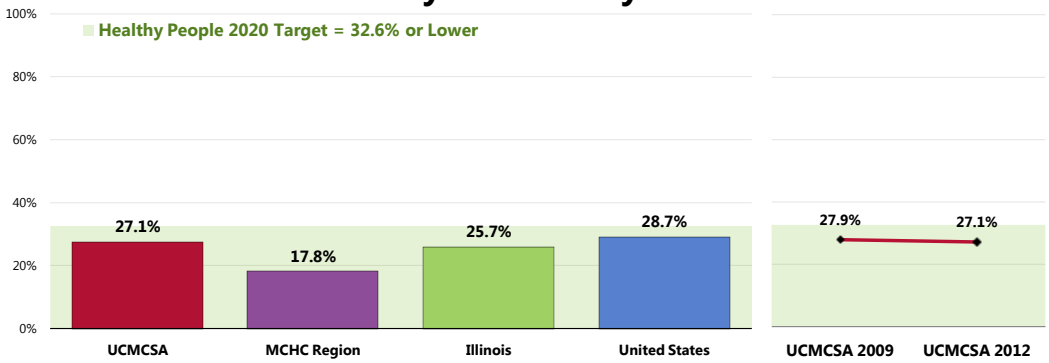
Notes:
- Asked of those respondents who are employed for wages.

Leisure-Time Physical Activity

A total of 27.1% of UCMC Service Area adults report no leisure-time physical activity in the past month.

- Less favorable than in the overall MCHC Region.
- Similar to statewide findings.
- Similar to national findings.
- Satisfies the Healthy People 2020 target (32.6% or lower).
- Statistically unchanged since 2009.

No Leisure-Time Physical Activity in the Past Month



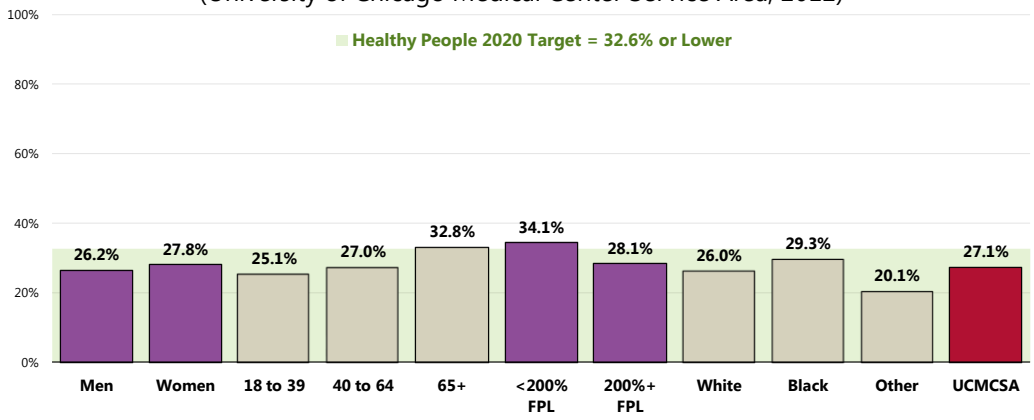
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 111]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-1]

Notes:
- Asked of all respondents.

Lack of leisure-time physical activity is similar across demographic groups.

No Leisure-Time Physical Activity in the Past Month

(University of Chicago Medical Center Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 111]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-1]

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

Activity Levels

Adults (age 18–64) should do 2 hours and 30 minutes a week of moderate-intensity, or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity aerobic physical activity, or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. Aerobic activity should be performed in episodes of at least 10 minutes, preferably spread throughout the week.

Additional health benefits are provided by increasing to 5 hours (300 minutes) a week of moderate-intensity aerobic physical activity, or 2 hours and 30 minutes a week of vigorous-intensity physical activity, or an equivalent combination of both.

Older adults (age 65 and older) should follow the adult guidelines. If this is not possible due to limiting chronic conditions, older adults should be as physically active as their abilities allow. They should avoid inactivity. Older adults should do exercises that maintain or improve balance if they are at risk of falling.

For all individuals, some activity is better than none. Physical activity is safe for almost everyone, and the health benefits of physical activity far outweigh the risks.

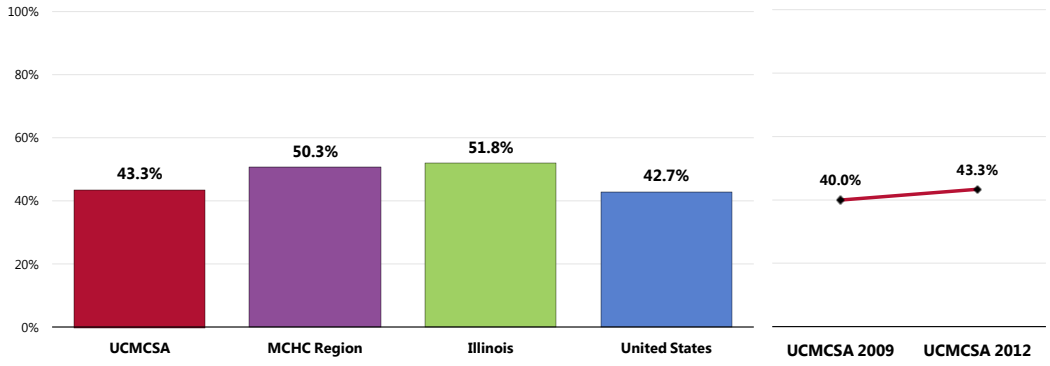
– 2008 Physical Activity Guidelines for Americans, U.S. Department of Health and Human Services. www.health.gov/PAGuidelines

Recommended Levels of Physical Activity

A total of 43.3% of UCMC Service Area adults participate in regular, sustained moderate or vigorous physical activity (meeting physical activity recommendations).

- Less favorable than regional findings.
- Less favorable than statewide findings.
- Comparable to national findings.
- Statistically unchanged since 2009.

Meets Physical Activity Recommendations



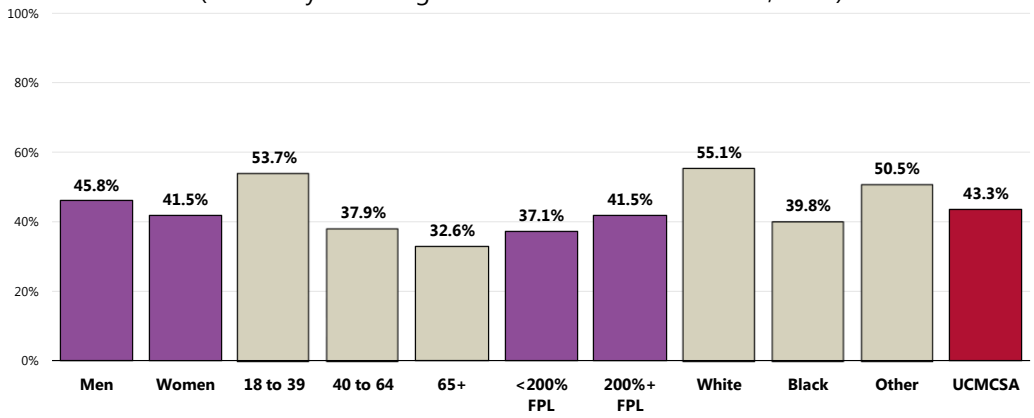
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 181]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Illinois data.

Notes:
- Asked of all respondents.
- In this case the term "meets physical activity recommendations" refers to participation in moderate physical activity (exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate) at least 5 times a week for 30 minutes at a time, and/or vigorous physical activity (activities that cause heavy sweating or large increases in breathing or heart rate) at least 3 times a week for 20 minutes at a time.

Those less likely to meet physical activity requirements include:

- Those age 40+ (note the negative correlation with age).
- Blacks.

Meets Physical Activity Recommendations
(University of Chicago Medical Center Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 181]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.
• In this case the term "meets physical activity recommendations" refers to participation in moderate physical activity (exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate) at least 5 times a week for 30 minutes at a time, and/or vigorous physical activity (activities that cause heavy sweating or large increases in breathing or heart rate) at least 3 times a week for 20 minutes at a time.

Moderate & Vigorous Physical Activity

The individual indicators of moderate and vigorous physical activity are shown here.

In the past month:

A total of 26.6% of adults participated in moderate physical activity (5 times a week, 30 minutes at a time).

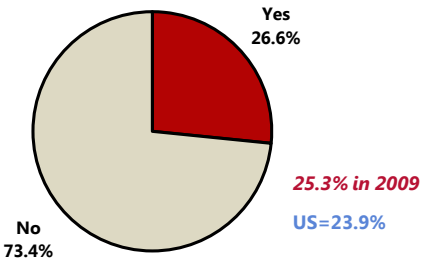
- Similar to MCHC Region findings.
- Similar to the national level.
- Similar to the 2009 findings.

A total of 33.5% participated in vigorous physical activity (3 times a week, 20 minutes at a time).

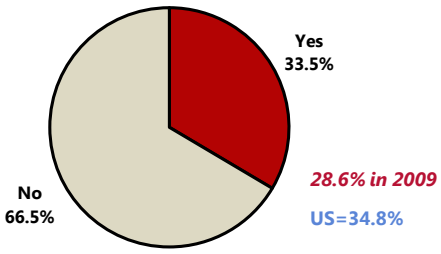
- Less favorable than the regional percentage.
- Similar to the statewide figure.
- Similar to the nationwide figure.
- Unchanged since 2009.

Moderate & Vigorous Physical Activity

(University of Chicago Medical Center Service Area, 2012)



Moderate Physical Activity



Vigorous Physical Activity

Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 183-184]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

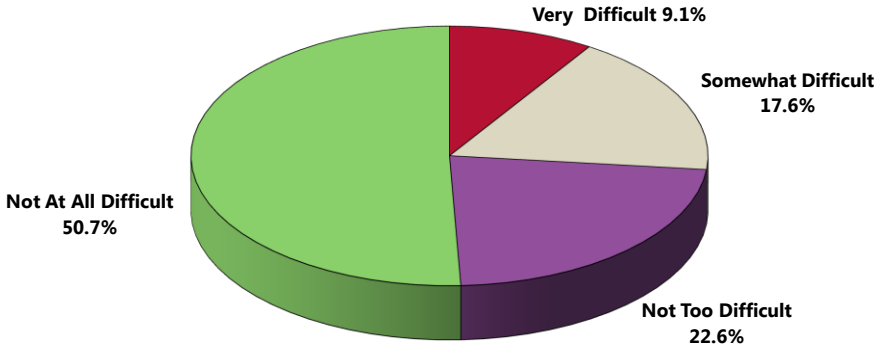
Notes:
- Asked of all respondents.
- Moderate Physical Activity: Takes part in exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate at least 5 times per week for at least 30 minutes per time.
- Vigorous Physical Activity: Takes part in activities that cause heavy sweating or large increases in breathing or heart rate at least 3 times per week for at least 20 minutes per time.

Ease of Accessing Exercise Facilities

A total of 73.3% of UCMC Service Area adults report that it is "not too difficult" or "not at all difficult" to access safe and affordable fitness facilities in the community.

Ease of Access to Safe and Affordable Fitness Facilities

(University of Chicago Medical Center Service Area, 2012)

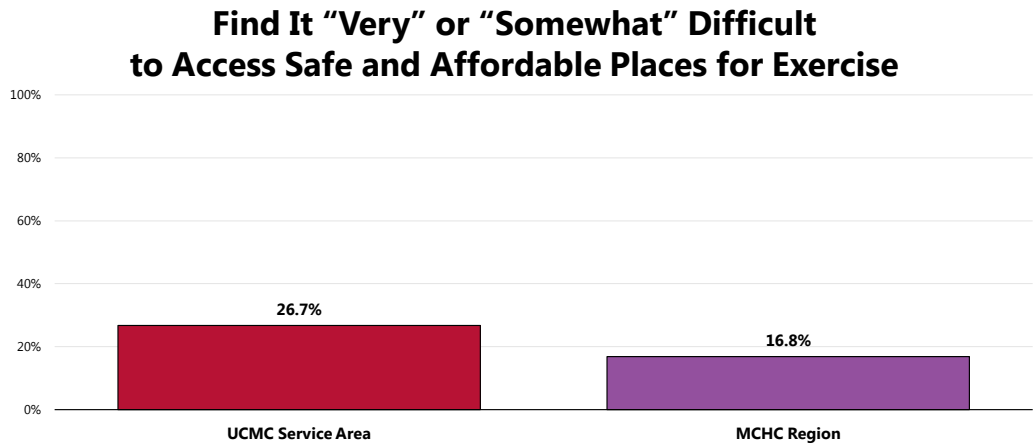


Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 114]

Notes:
- Asked of all respondents.

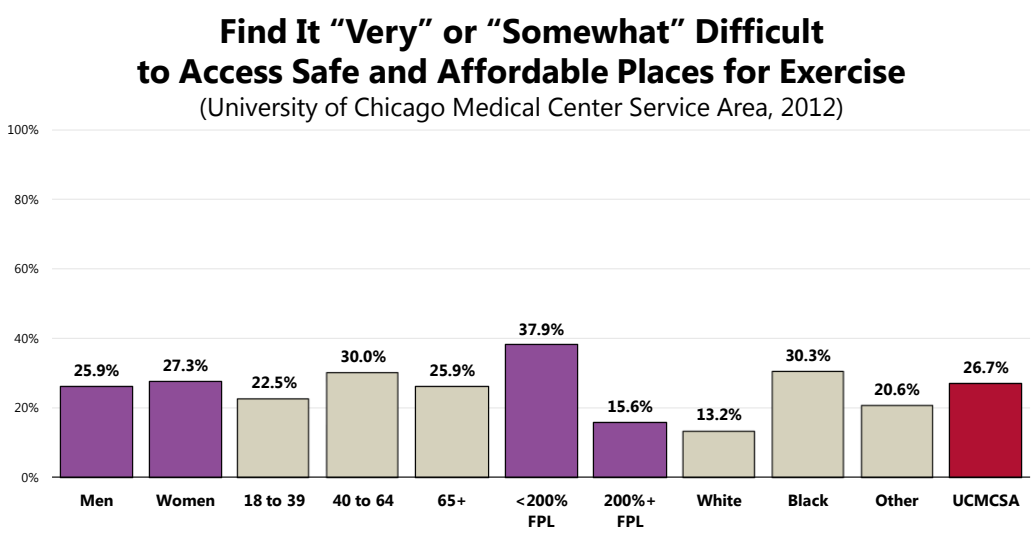
On the other hand, 26.7% of survey respondents consider it to be "very" or "somewhat" difficult to access safe and affordable exercise facilities locally.

- Less favorable than the regional percentage.



Sources: • 2012 PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 114]
Notes: • Asked of all respondents.
• Examples include a park, gym, YMCA or recreation center.

- Difficulty is statistically high among lower-income residents and Blacks.



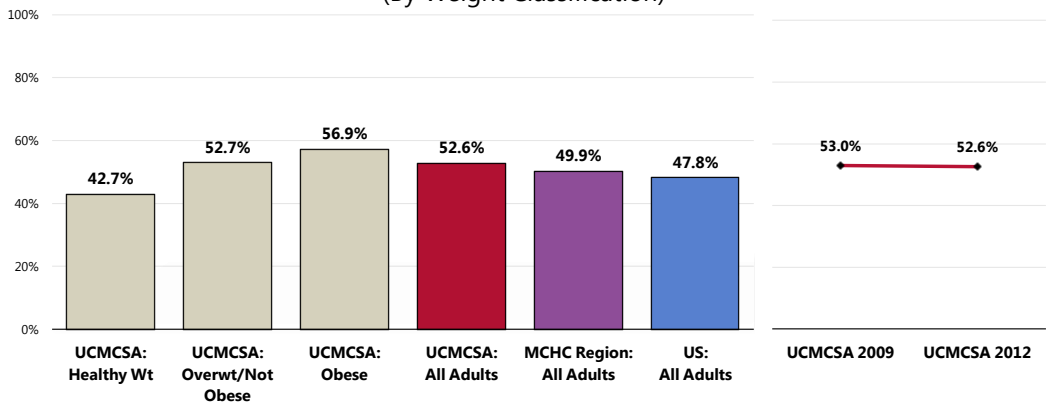
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 114]
Notes: • Asked of all respondents.
• Examples include a park, gym, YMCA or recreation center.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Health Advice About Physical Activity & Exercise

A total of 52.6% of UCMC Service Area adults report that their physician has asked about or given advice to them about physical activity in the past year.

- Comparable to the MCHC Region percentage.
- Comparable to the national average.
- Statistically similar to the 2009 survey findings.
- Note: 56.9% of obese UCMC Service Area respondents say that they have talked with their doctor about physical activity/exercise in the past year.

Have Received Advice About Exercise in the Past Year From a Physician, Nurse, or Other Health Professional
(By Weight Classification)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 19]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Children's Screen Time

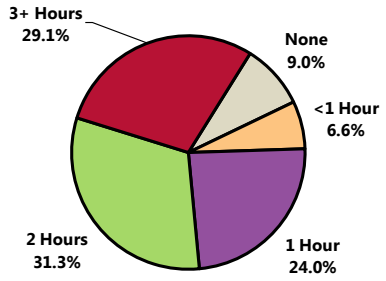
Television Watching & Other Screen Time

Among children aged 5 through 17, 29.1% are reported to watch three or more hours of television per day; 25.9% are reported to spend three or more hours on other types of screen time for entertainment (video games, Internet, etc.).

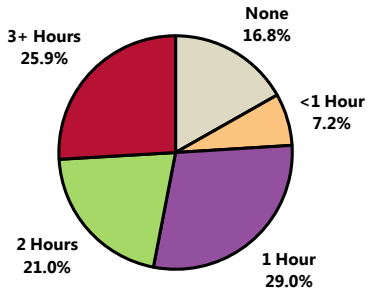
- The percentage of children viewing 3+ hours of **television** daily is higher than regional findings and similar to national findings.
- The percentage of children with 3+ hours of screen time (**other** than television) is similar to the MCHC Region prevalence but less favorable than found nationally.

Children's Screen Time

(Among Parents of Children Ages 5-17; University of Chicago Medical Center Service Area, 2012)



Hours per Day of Television



Hours per Day of Other Screen Time
(i.e., video games, computer/Internet entertainment)

Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 148-149, 185-186]
Notes: • Asked of respondents with a child aged 5 to 17 in the household.

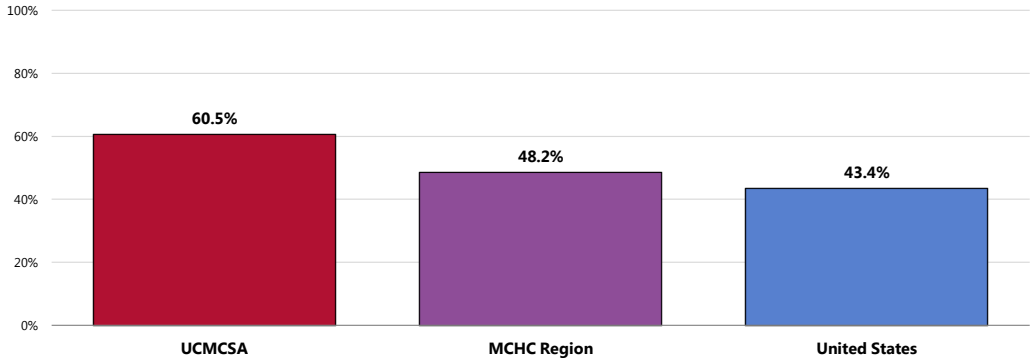
Total Screen Time

When combined, 60.5% of UCMC Service Area children aged 5 to 17 spend three or more hours on screen time (whether television or computer, Internet, video games, etc.) per day.

- Less favorable than the MCHC Region figure.
- Less favorable than found nationally.

Children With Three or More Hours per School Day of Total Screen Time [TV, Computer, Video Games, Etc. for Entertainment]

(Among Parents of Children 5-17)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 187]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents with children 5-17 at home.
• For this issue, respondents with children who are not in school were asked about "weekdays," while parents of children in school were asked about typical "school days."
• "Three or more hours" includes reported screen time of 180 minutes or more per day.

Related Focus Group Findings: Physical Activity

South Chicago group participants expressed concern about the **low levels of physical activity** in the community. Space for physical activity is not always available. Fitness centers are inaccessible due to **cost** and outdoor physical activity options may be limited due to **safety concerns**. A participant sums up concerns surrounding nutrition and physical activity:

> *"We live in a food desert. The mom and pop stores that are available in the area continue to push unhealthy foods, even though we're campaigning to try to change those things. Also there's not affordable health and wellness centers they can go to; when I say that, I'm talking about fitness centers where they can go to classes, where they can feel safe and comfortable when they go to the store (a) and then (b) to work out. If they wanted to go to the park are they going to feel safe and comfortable going to the park? " — South Chicago Key Informant*

South Chicago **youth** have additional barriers to accessing physical activity, with cost becoming a major obstacle as most sports or recreation activities have an associated fee. The park districts have a limited number of slots for summer programs, but getting a space is challenging. One participant recalls her experiences with the system:

> *"Many of the staff in my program have young children in school. They go to Chicago public schools. Every summer they enroll their children in the park district for summer program. It's almost like the lottery in terms of how you access it. They sit by their computer to be online and hopefully be one in a million that will get accepted for the slot. But they still have to pay a considerable amount of money for … it fills up within a matter of hours after they announce that this is the one day that you can go online and register your child for summer camp. It is a huge hurdle." — South Chicago Key Informant*

Weight Status

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

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

– Healthy People 2020 (www.healthypeople.gov)

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

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

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

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.

Adult Weight Status

Healthy Weight

"Healthy weight "means neither underweight, nor overweight (BMI = 18.5-24.9).

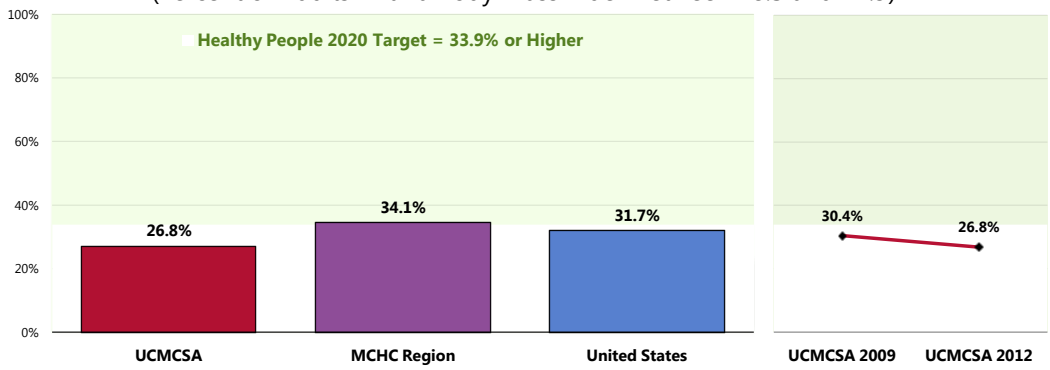
Based on self-reported heights and weights, 26.8% of UCMC Service Area adults are at a healthy weight.

- Less favorable than regional findings.
- Similar to national findings.
- Fails to satisfy the Healthy People 2020 target (33.9% or higher).

- Similar to the 2009 findings.

Healthy Weight

(Percent of Adults With a Body Mass Index Between 18.5 and 24.9)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 189]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Based on reported heights and weights, asked of all respondents.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-8]
- The definition of healthy weight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), between 18.5 and 24.9.

Overweight Status

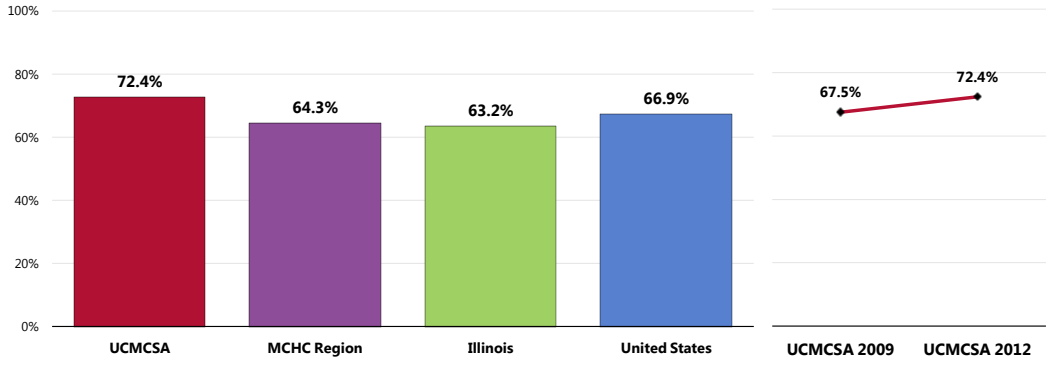
Here, "overweight" includes those respondents with a BMI value ≥25.

More than 7 in 10 UCMC Service Area adults (72.4%) are overweight.

- Less favorable than the MCHC Region prevalence.
- Less favorable than the Illinois prevalence.
- Less favorable than the US overweight prevalence.
- Statistically unchanged since 2009.

Prevalence of Total Overweight

(Percent of Overweight or/Obese Adults; Body Mass Index of 25.0 or Higher)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 189]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.

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

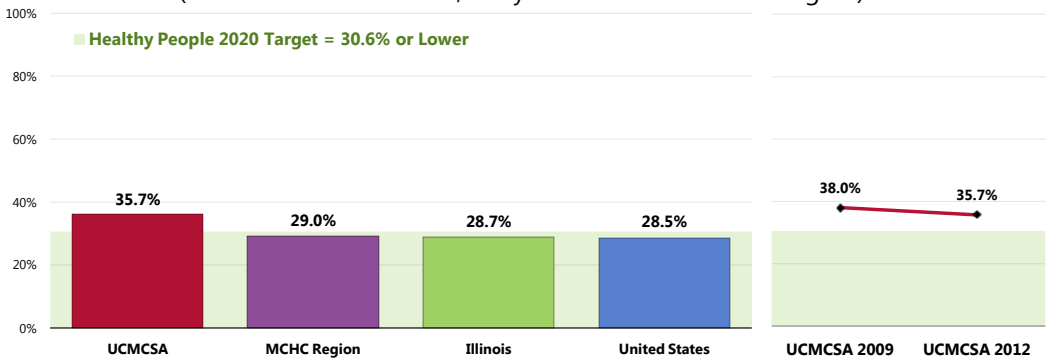
"Obese" (also included in overweight prevalence discussed previously) includes respondents with a BMI value ≥30.

Further, 35.7% of UCMC Service Area adults are obese.

- Less favorable than the MCHC Region findings.
- Less favorable than Illinois findings.
- Less favorable than the US findings.
- Fails to meet the Healthy People 2020 target (30.6% or lower).
- The rate of obesity is statistically unchanged since 2009.

Prevalence of Obesity

(Percent of Obese Adults; Body Mass Index of 30.0 or Higher)



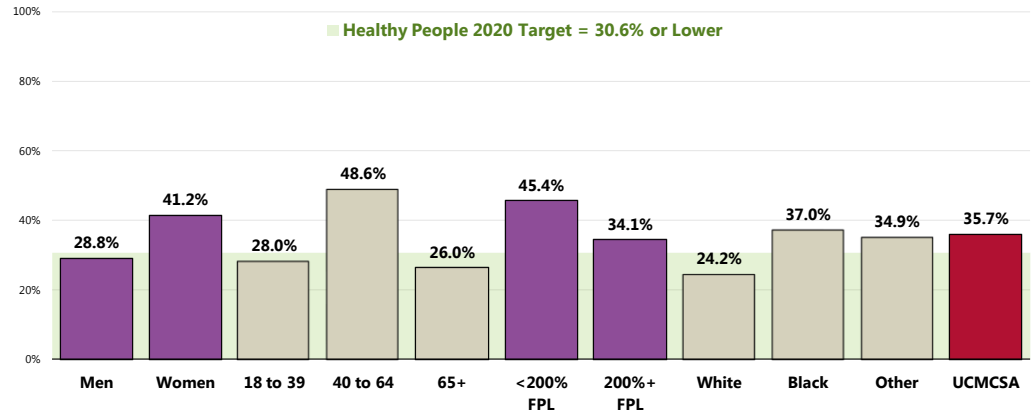
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 189]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-9]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.

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.

- Obesity is notably more prevalence among women, adults aged 40 to 64, and respondents with lower incomes.

Prevalence of Obesity

(Percent of Obese Adults; BMI of 30.0 or Higher; UCMC Service Area, 2012)



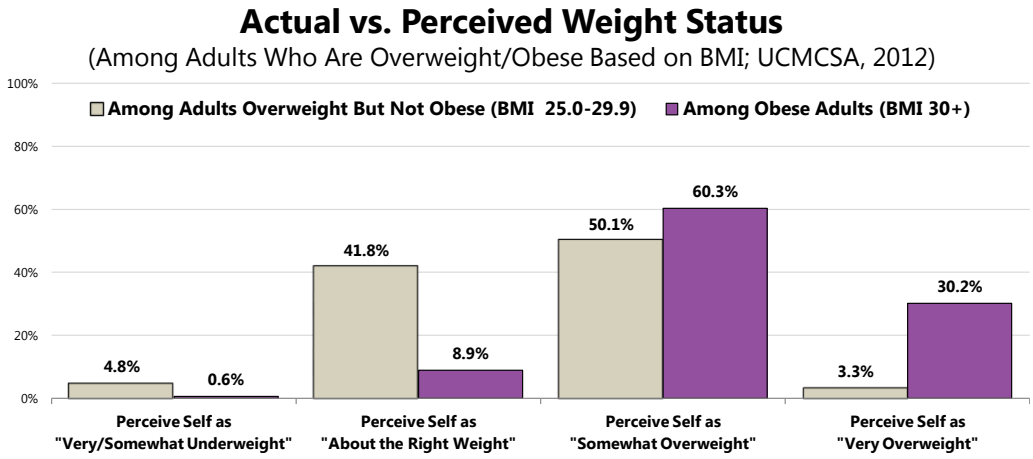
Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 189]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-9]

Notes:
- Based on reported heights and weights, asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.
- 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.

Actual vs. Perceived Body Weight

A total of 8.9% of obese adults and 41.8% of overweight (but not obese) adults feel that their current weight is "about right."

- 50.1% of overweight (but not obese) adults see themselves as "somewhat overweight."
- 30.2% of obese adults see themselves as "very overweight."



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 119]
Notes: • BMI is based on reported heights and weights, asked of all respondents.
• The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

Relationship of Overweight With Other Health Issues

The correlation between overweight and various health issues cannot be disputed.

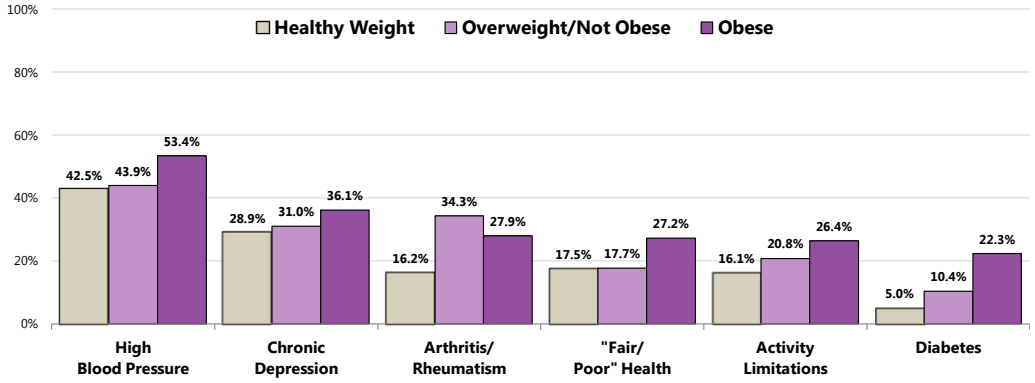
Obese (and often overweight) adults are more likely to report a number of adverse health conditions.

Among these are:

- Hypertension (high blood pressure).
- Chronic depression.
- Arthritis/rheumatism.
- "Fair" or "poor" physical health.
- Activity limitations.
- Diabetes.

Relationship of Overweight With Other Health Issues

(By Weight Classification; University of Chicago Medical Center Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 5, 28, 47, 121, 125, 152]
Notes: • Based on reported heights and weights, asked of all respondents.

Weight Management

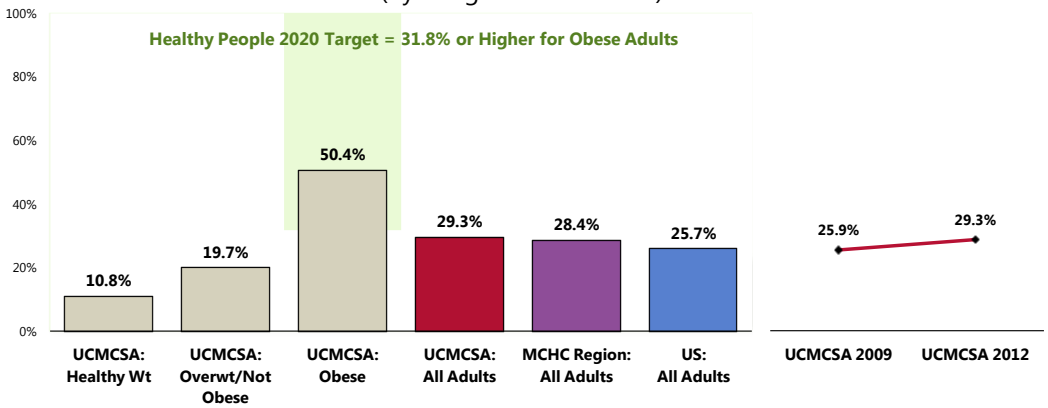
Health Advice

A total of 29.3% of adults have been given advice about their weight by a doctor, nurse or other health professional in the past year.

- Similar to regional findings.
- Similar to national findings.
- Similar to findings of the 2009 study.
- Note that 50.4% of <u>obese</u> adults have been given advice about their weight by a health professional in the past year (while one-half has not).
  - This meets the Healthy People 2020 target of 31.8% or higher.

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

(By Weight Classification)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 118, 191-192]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-6.2]
Notes: • Asked of all respondents.

Weight Control

Individuals who are at a healthy weight are less likely to:

- Develop chronic disease risk factors, such as high blood pressure and dyslipidemia.
- Develop chronic diseases, such as type 2 diabetes, heart disease, osteoarthritis, and some cancers.
- Experience complications during pregnancy.
- Die at an earlier age.

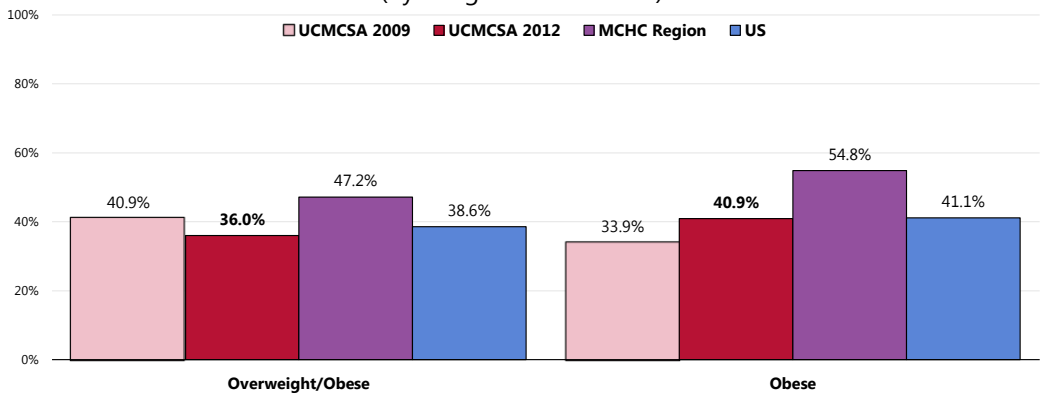
All Americans should avoid unhealthy weight gain, and those whose weight is too high may also need to lose weight.

– Healthy People 2020 (www.healthypeople.gov)

A total of 36.0% of UCMC Service Area adults who are overweight say that they are both modifying their diet and increasing their physical activity to try to lose weight.

- Lower than the MCHC Region findings.
- Similar to national findings.
- Statistically similar to that reported among overweight adults in 2009.
- Note: 40.9% of <u>obese</u> UCMC Service Area adults report that they are trying to lose weight through a combination of diet and exercise, which is similar to what is found nationally, higher than what was reported in UCMC Service Area in 2009, and lower than currently reported in the MCHC Region.

Trying to Lose Weight by Both Modifying Diet and Increasing Physical Activity
(By Weight Classification)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 190]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Based on reported heights and weights, asked of all respondents.

Childhood Overweight & Obesity

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

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

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

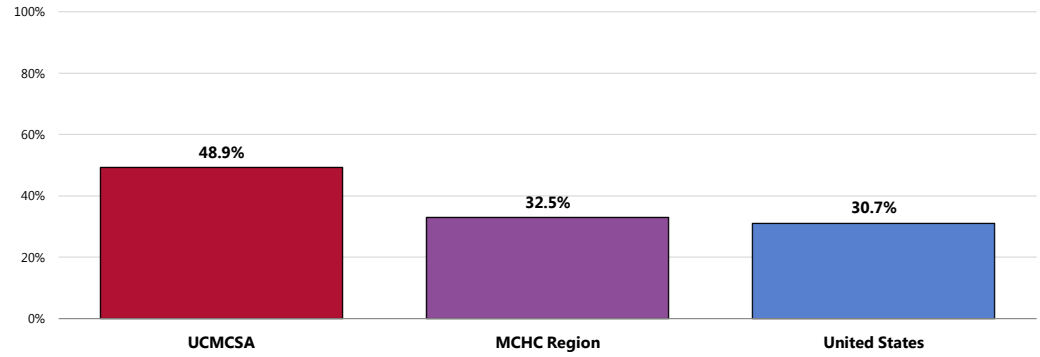
– Centers for Disease Control and Prevention.

Based on the heights/weights reported by surveyed parents, 48.9% of UCMC Service Area children age 5 to 17 are overweight or obese (≥85th percentile).

- Less favorable than MCHC Region findings.
- Less favorable than found nationally.

Child Total Overweight Prevalence

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

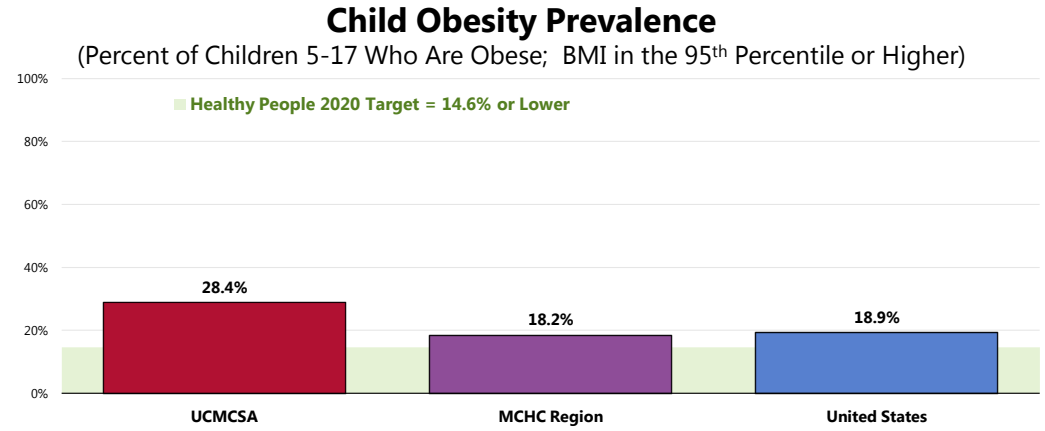


Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 193]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents with children age 5-17 at home.
- Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

Further, 28.4% of UCMC Service Area children age 5 to 17 are obese (≥95th percentile).

- Considerably higher than the MCHC Region prevalence.
- Comparable to the national percentage.
- Fails to satisfy the Healthy People 2020 target (14.6% or lower for children age 2-19).



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 193]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-10.4]

Notes:
- Asked of all respondents with children age 5-17 at home.
- Obesity among children is determined by children's Body Mass Index status equal to or above the 95th percentile of US growth charts by gender and age.

Related Focus Group Findings: Obesity & Nutrition

Many focus group participants discussed nutrition, with the overriding themes including:

- Nutritional education
- Low levels of physical activity
  - Cost
  - Safety
- Youth
- Poor eating habits
  - Food deserts
  - Fast food is less expensive
- Basic needs are not being met

Focus group attendees believe that many residents within Cook County cannot meet their own **basic needs**. The environment in which these individuals live does not support their ability to make healthy choices, like eating nutritious foods or participating in physical activity.

> *"I think we call too many things 'lifestyle' that really are 'environment.' I'm not talking about belching smokestacks although that's one piece of it but if you're living in a high crime neighborhood, how can I blame you for not getting out and exercising or not getting your kids out and exercising; it doesn't seem very productive. If you're living in a food desert -- I have students in West Garfield all the time and they are astonished by how few food choices there are for people to take advantage of in that neighborhood that are affordable, that are fresh." — Cook County Key Informant*

Attendees stressed the importance of meeting people where they live, work and play in order to make the most impact. In addition, agencies must recognize the hardships which residents face daily, as one participant explains:

> *"I think the problem is also small rewards. Like everybody knows pretty much that smoking isn't good for you, but a cigarette is a reward and it's within people's reach, more or less. And food is a reward, God knows, and it's within people's reach. And so you have to think small because if you think big you aren't going to meet these people where they really live. I serve a low income population and probably most of them are below the poverty line…So I can hardly begrudge them a cigarette or food if they're obese because that's it. They aren't going to go on vacation." — Cook County Key Informant*

Many residents living in South Chicago possess **poor eating habits** and many areas of the community are considered to be "food deserts" because there are no local grocery stores. Convenient stores are abundant in the community, but these stores do not offer inexpensive "healthy foods."

South Chicago focus group attendees agree that **nutritional education** should occur regularly, as many residents do not know how to cook healthy meals. KLEO, a local non-profit, offers a food pantry for residents and provides cooking classes. KLEO advertises these popular services through their website, flyers and via word-of-mouth. A participant describes the efforts:

> *"We bring out a chef that shows them how to cook the food that they're about to receive and so now these individuals leave; they've been screened, they've gotten free food, now they have a recipe when they get home they can cook with it." — South Chicago Key Informant*

Substance Abuse

In 2005, an estimated 22 million Americans struggled with a drug or alcohol problem. Almost 95% of people with substance use problems are considered unaware of their problem. Of those who recognize their problem, 273,000 have made an unsuccessful effort to obtain treatment. These estimates highlight the importance of increasing prevention efforts and improving access to treatment for substance abuse and co-occurring disorders.

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include:

- Teenage pregnancy
- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Other sexually transmitted diseases (STDs)
- Domestic violence
- Child abuse
- Motor vehicle crashes
- Physical fights
- Crime
- Homicide
- Suicide

The field has made progress in addressing substance abuse, particularly among youth. According to data from the national Institute of Drug Abuse (NIDA) Monitoring the Future (MTF) survey, which is an ongoing study of the behaviors and values of America's youth between 2004 and 2009, a drop in drug use (including amphetamines, methamphetamine, cocaine, hallucinogens, and LSD) was reported among students in 8th, 10th, and 12th grades. Note that, despite a decreasing trend in marijuana use which began in the mid-1990s, the trend has stalled in recent years among these youth. Use of alcohol among students in these three grades also decreased during this time.

Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. Social attitudes and political and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues. In addition to the considerable health implications, substance abuse has been a flash-point in the criminal justice system and a major focal point in discussions about social values: people argue over whether substance abuse is a disease with genetic and biological foundations or a matter of personal choice.

Advances in research have led to the development of evidence-based strategies to effectively address substance abuse. Improvements in brain-imaging technologies and the development of medications that assist in treatment have gradually shifted the research community's perspective on substance abuse. There is now a deeper understanding of substance abuse as a disorder that develops in adolescence and, for some individuals, will develop into a chronic illness that will require lifelong monitoring and care.

Improved evaluation of community-level prevention has enhanced researchers' understanding of environmental and social factors that contribute to the initiation and abuse of alcohol and illicit drugs, leading to a more sophisticated understanding of how to implement evidence-based strategies in specific social and cultural settings.

A stronger emphasis on evaluation has expanded evidence-based practices for drug and alcohol treatment. Improvements have focused on the development of better clinical interventions through research and increasing the skills and qualifications of treatment providers.

– Healthy People 2020 (www.healthypeople.gov)

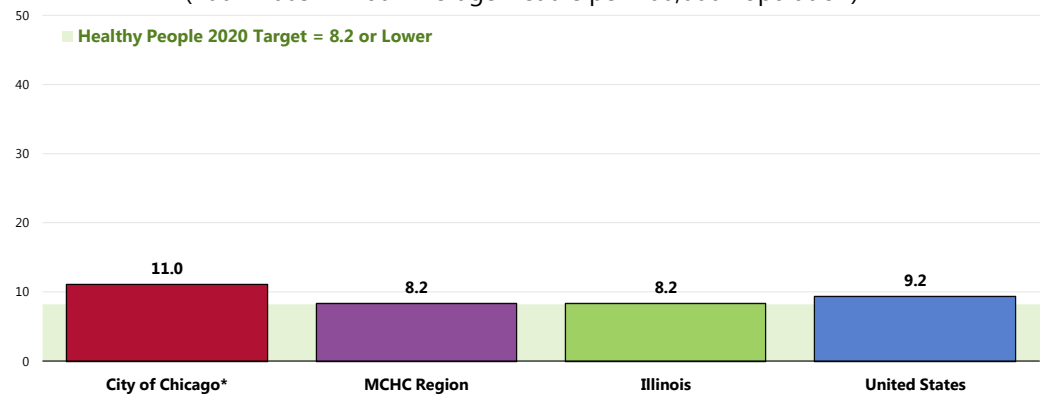
Age-Adjusted Cirrhosis/Liver Disease Deaths

Between 2006 and 2008, the City of Chicago reported an annual average age-adjusted cirrhosis/liver disease mortality rate of 11.0 deaths per 100,000 population.

- Higher than the regional rate.
- Higher than the statewide rate.
- Higher than the national rate.
- Fails to satisfy the Healthy People 2020 target (8.2 or lower).

Cirrhosis/Liver Disease: Age-Adjusted Mortality

(2007-2009 Annual Average Deaths per 100,000 Population)



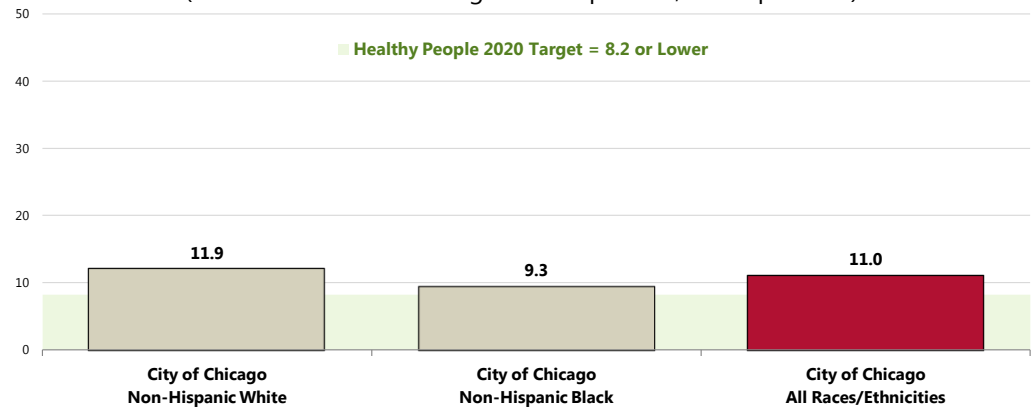
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-11]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- *City of Chicago rate represents 2006-2008 data.

The City's cirrhosis mortality rate appears to be higher among Whites than Blacks.

Cirrhosis/Liver Disease: Age-Adjusted Mortality by Race

(2006-2008 Annual Average Deaths per 100,000 Population)



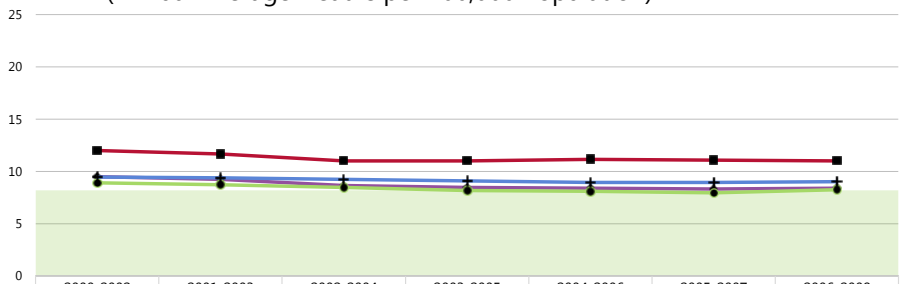
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-11]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.

- The mortality rate decreased slightly over the past decade, echoing the regional, state and national trends.

Cirrhosis/Liver Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2020	8.2	8.2	8.2	8.2	8.2	8.2	8.2
City of Chicago	12.0	11.7	11.0	11.0	11.2	11.1	11.0
MCHC Region	9.5	9.2	8.7	8.5	8.4	8.3	8.4
Illinois	8.9	8.7	8.5	8.2	8.1	8.0	8.2
United States	9.5	9.4	9.2	9.1	8.9	9.0	9.0

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-11]

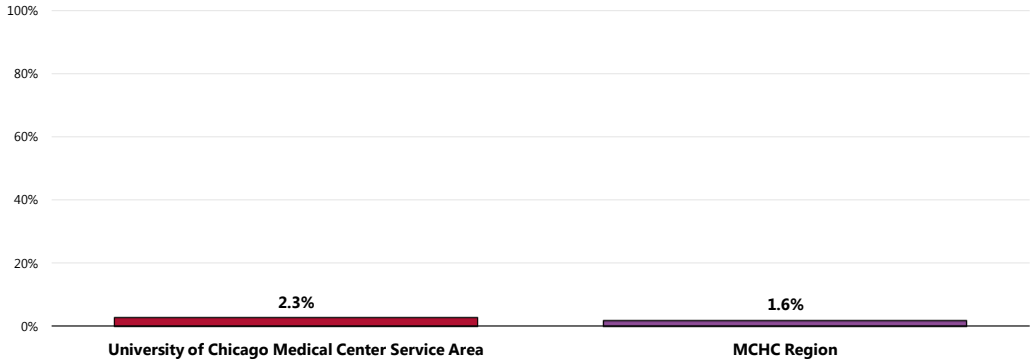
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

Prevalence of Liver Disease

According to survey results, 2.3% of UCMC Service Area adults suffer from liver disease.

- Similar to the regional percentage.

Prevalence of Liver Disease



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 38]

Notes:
- Reflects the total sample of respondents.

High-Risk Alcohol Use

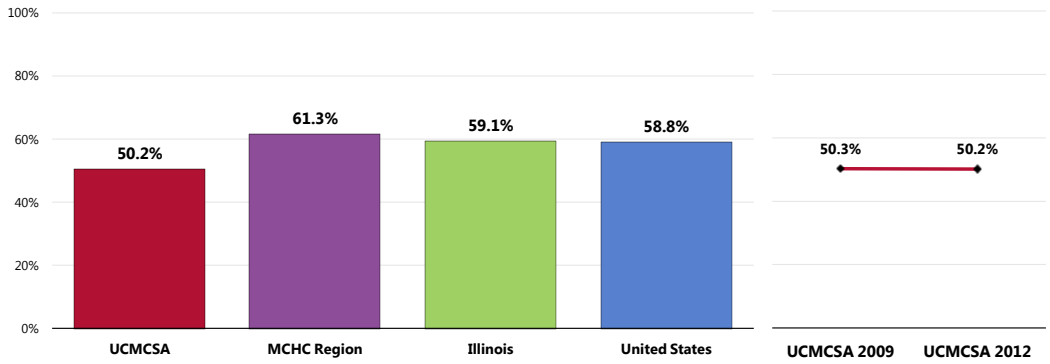
Current Drinking

"Current drinkers" include survey respondents who had at least one drink of alcohol in the month preceding the interview. For the purposes of this study, a "drink" is considered one can or bottle of beer, one glass of wine, one can or bottle of wine cooler, one cocktail, or one shot of liquor.

One-half (50.2%) of area adults had at least one drink of alcohol in the past month (current drinkers).

- Better than the regional proportion.
- Better than the statewide proportion.
- Better than the national proportion.
- Unchanged over time.

Current Drinkers



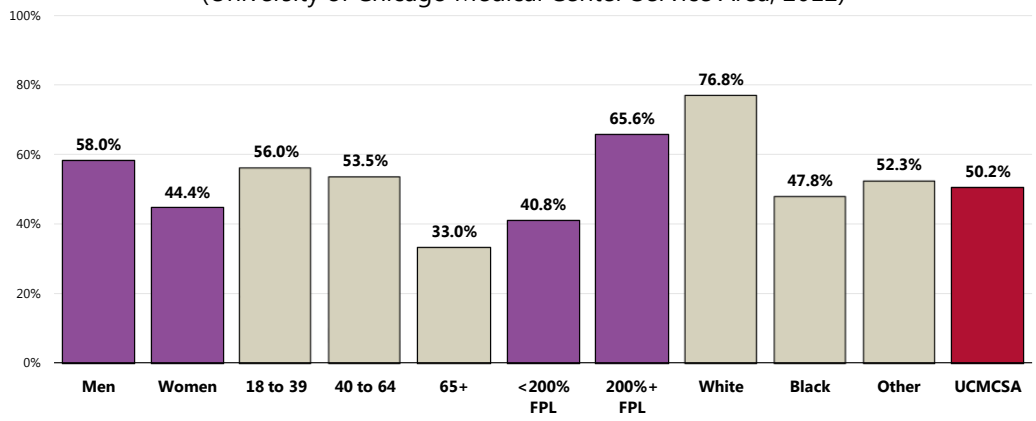
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 198]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Current drinkers had at least one alcoholic drink in the past month.

Current drinking is more prevalent among men, adults under age 65, those in the higher income category, and Whites.

Current Drinkers

(University of Chicago Medical Center Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 198]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.
- Current drinkers had at least one alcoholic drink in the past month.

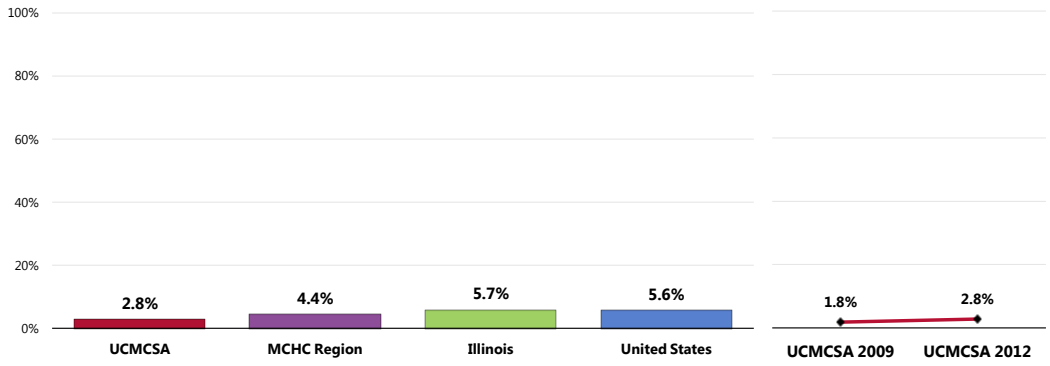
A total of 2.8% of area adults averaged two or more drinks of alcohol per day in the past month (chronic drinkers).

- Similar to the regional proportion.
- More favorable than the statewide proportion.
- More favorable than the national proportion.
- Unchanged from 2009.

RELATED ISSUE: See also *Stress* in the **Mental Health & Mental Disorders** section of this report.

"Chronic drinkers" include survey respondents reporting 60 or more drinks of alcohol in the month preceding the interview.

Chronic Drinkers



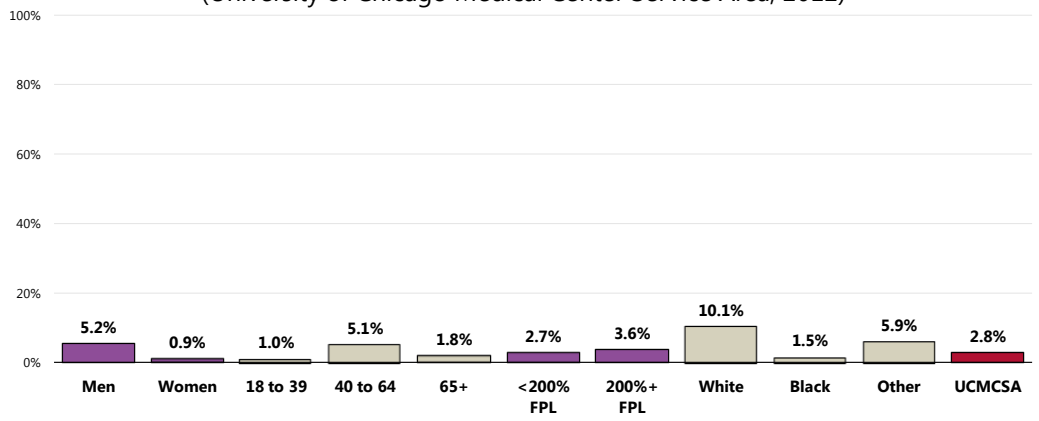
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 199]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Chronic drinkers are defined as having 60+ alcoholic drinks in the past month.
- *The state definition for chronic drinkers is males consuming 2+ drinks per day and females consuming 1+ drink per day.

Chronic drinking is more prevalent among men, those between ages 40 and 64, Whites and "Other" adults.

Chronic Drinkers

(University of Chicago Medical Center Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 199]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.
- Chronic drinkers are defined as those having 60+ alcoholic drinks in the past month.

Binge Drinking

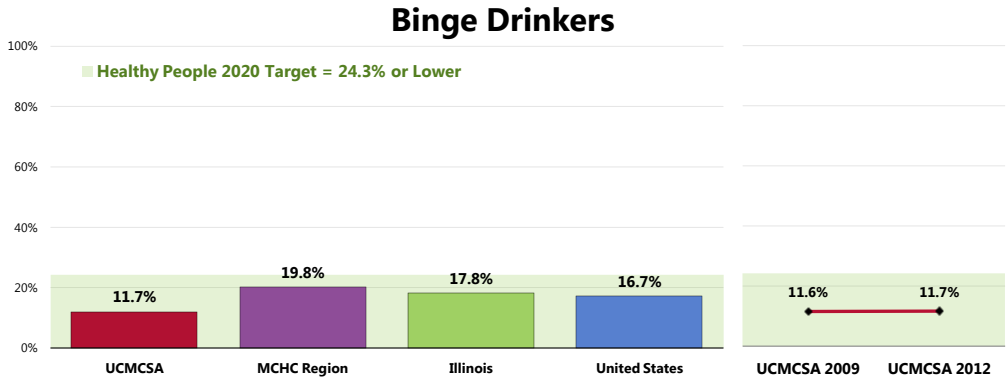
"Binge drinkers" include:

1) MEN who report drinking 5 or more alcoholic drinks on any single occasion during the past month; and

2) WOMEN who report drinking 4 or more alcoholic drinks on any single occasion during the past month.

A total of 11.7% of UCMC Service Area adults are binge drinkers.

- More favorable than the MCHC Region findings.
- More favorable than Illinois findings.
- More favorable than national findings.
- Satisfies the Healthy People 2020 target (24.3% or lower).
- Nearly identical to the 2009 percentage.

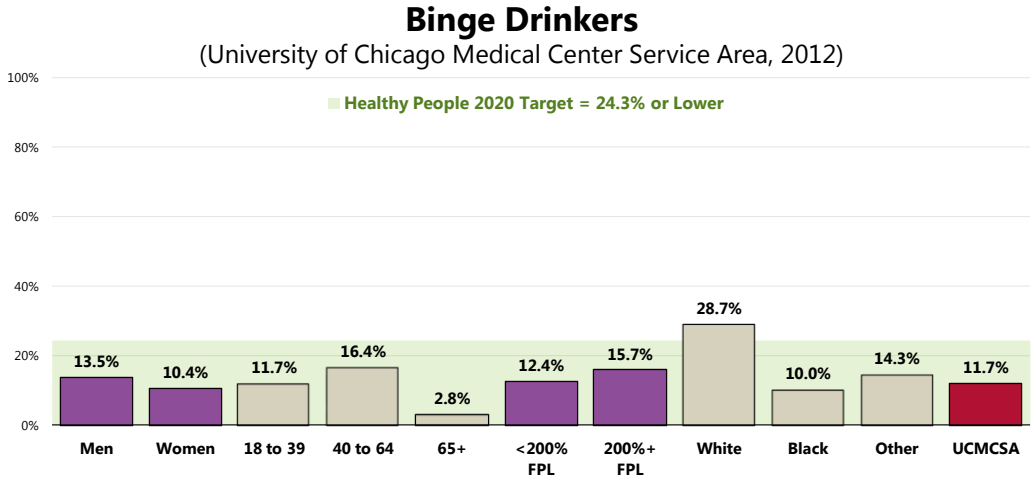


Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 200]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-14.3]

Notes:
- Asked of all respondents.
- Binge drinkers are defined as men having 5+ alcoholic drinks on any one occasion or women consuming 4+ drinks on any one occasion.

Binge drinking is <u>more</u> prevalent among:

- Respondents between ages 40 and 64.
- Whites.



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 200]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-14.3]

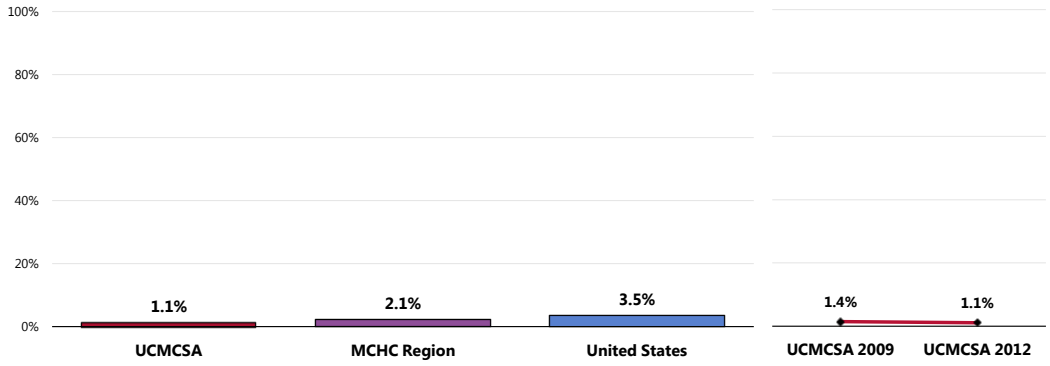
Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.
- Binge drinkers are defined as men having 5+ alcoholic drinks on any one occasion or women consuming 4+ drinks on any one occasion

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 the actual incidence of drinking and driving in the community is likely higher.

A total of 1.1% of UCMC Service Area adults acknowledge having driven a vehicle in the past month after they had perhaps too much to drink.

- Comparable to MCHC Region findings.
- Well below the national findings.
- The drinking and driving prevalence has not changed over time.

Have Driven in the Past Month After Perhaps Having Too Much to Drink

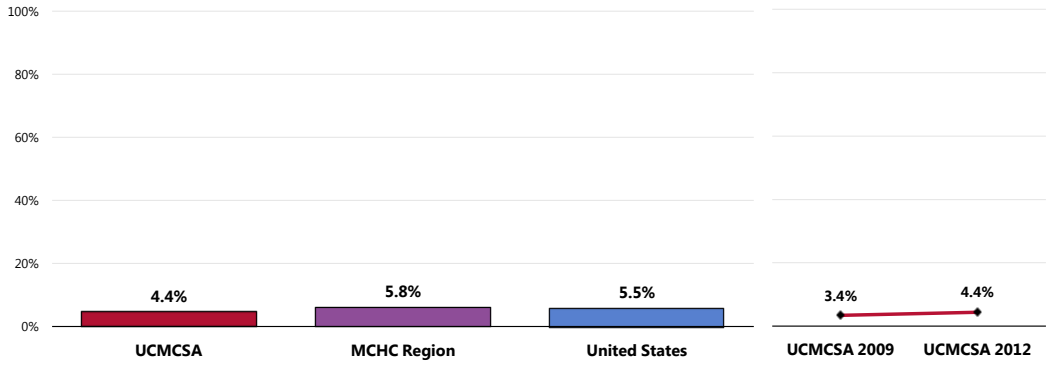


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 75]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

A total of 4.4% of UCMC Service Area adults acknowledge either drinking and driving or riding with a drunk driver in the past month.

- Comparable to regional findings.
- Comparable to the national findings.
- Statically unchanged since the 2009 UCMC Service Area study.

Have Driven Drunk OR Ridden With a Driver in the Past Month Who Had Too Much to Drink



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 201]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

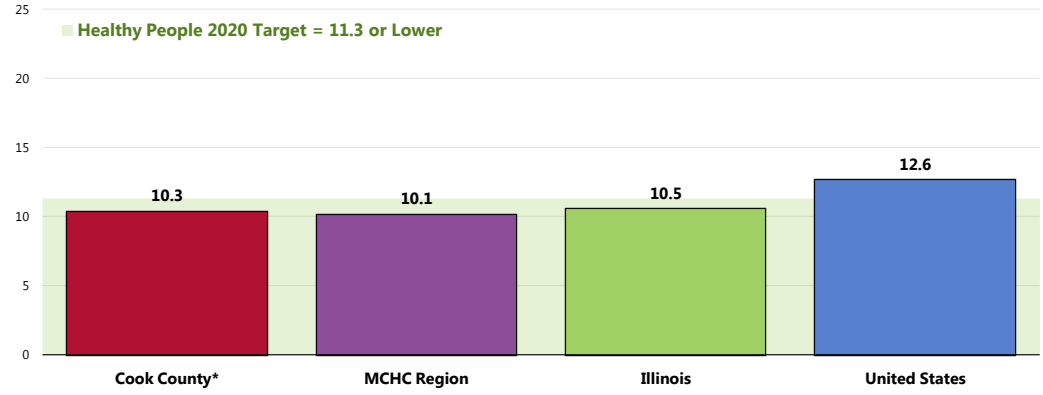
Age-Adjusted Drug-Induced Deaths

Between 2007 and 2009, there was an annual average age-adjusted drug-induced mortality rate of 10.3 deaths per 100,000 population in Cook County.

- Similar to the regional rate.
- Similar to the statewide rate.
- Better than the national rate.
- Satisfies the Healthy People 2020 target (11.3 or lower).

Drug-Induced Deaths: Age-Adjusted Mortality

(2007-2009 Annual Average Deaths per 100,000 Population)



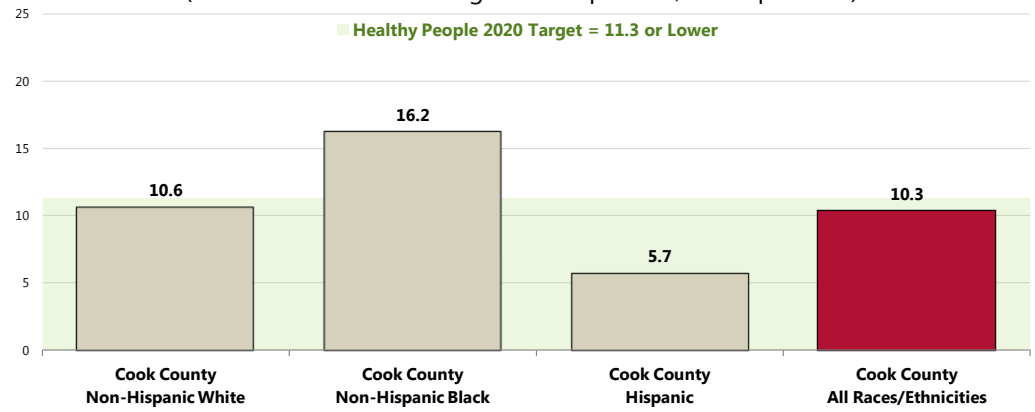
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-12]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- Local, state and national data are simple three-year averages.
- *City of Chicago data unavailable; Cook County data is used here.

The drug-induced mortality rate appears to be higher among the county's Black population when compared with Whites and Hispanics.

Drug-Induced Deaths: Age-Adjusted Mortality by Race

(2007-2009 Annual Average Deaths per 100,000 Population)



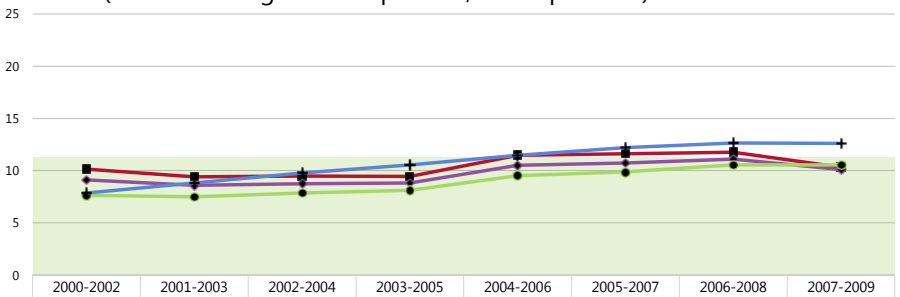
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-12]

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

- The drug-induced mortality rate has fluctuated in Cook County over the past decade, but the general trend is upward. Statewide and nationwide, rates have clearly increased.

Drug-Induced Deaths: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
Healthy People 2020	11.3	11.3	11.3	11.3	11.3	11.3	11.3	11.3
Cook County	10.1	9.4	9.5	9.4	11.5	11.6	11.8	10.3
MCHC	9.1	8.6	8.7	8.8	10.5	10.7	11.1	10.1
Illinois	7.6	7.5	7.9	8.1	9.5	9.9	10.5	10.5
United States	7.9	8.8	9.8	10.5	11.5	12.2	12.6	12.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-12]

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

Illicit Drug Use

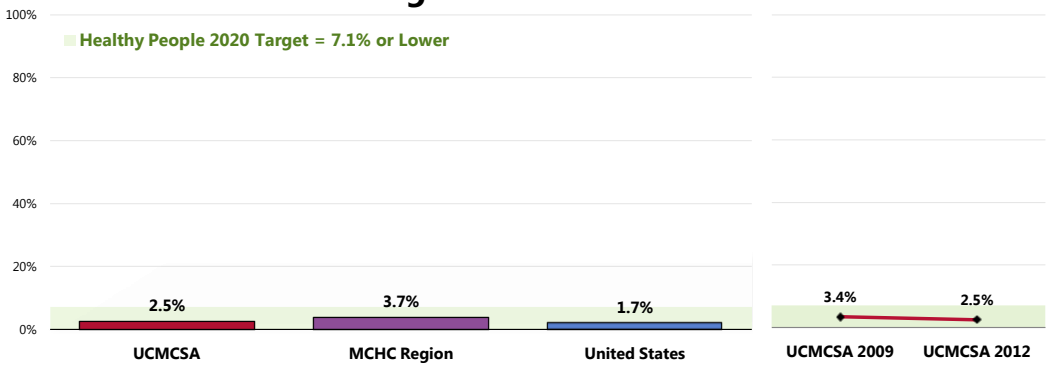
A total of 2.5% of area adults acknowledge using an illicit drug in the past month.

- Similar to the proportion found in the MCHC Region.
- Similar to the proportion found nationally.
- Easily satisfies the Healthy People 2020 target of 7.1% or lower.
- Similar to the 2009 findings.

For the purposes of this survey, "illicit drug use" includes use of illegal substances or of prescription drugs taken without a physician's order.

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

Illicit Drug Use in the Past Month



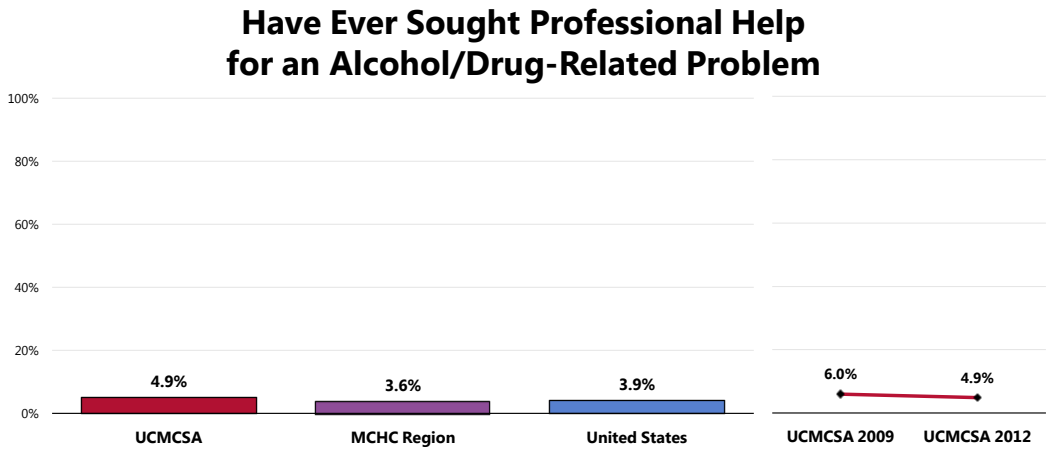
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 77]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-13.3]

Notes:
- Asked of all respondents.

Alcohol & Drug Treatment

A total of 4.9% of UCMC Service Area adults report that they have sought professional help for an alcohol or drug problem at some point in their lives.

- Similar to MCHC Region findings.
- Similar to national findings.
- Unchanged over time.



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 78]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Related Focus Group Findings: Substance Abuse

Focus group participants are concerned with substance abuse in the community, with discussion focused on:

- Prevalence of substance abuse
- Self-medication
- Stigma
- Limited treatment facilities

A number of Cook County focus group participants express concern with the **prevalence of substance abuse** in the community, especially prescription drug abuse and use of heroin. Members agree that not enough prevention occurs in the community and that education on substance abuse needs to begin early. There are several substance abuse treatment facilities which anyone can enter regardless of insurance status, but the current **stigma** attached to substance abuse affects local agencies' ability to make an impact on the community:

> *"If you're not insured or have poor economic mobility, you have very good programs like Gateway and Haymarket. Those programs do a very good job. Resurrection has good outreach certainly for mental health in particular. But there is still a problem, a bias and a lack of education as to brain diseases, the whole spectrum." — Cook County Key Informant*

South Chicago attendees also expressed concern about the **prevalence of substance abuse** in the community, especially alcohol abuse. In addition, there are a limited number of treatment providers/facilities for individuals with substance abuse problems in the South Chicago area. Several non-profit organizations refer residents to Jordan House, which provides substance abuse treatment; however, Jordan House only provides services to insured or Medicaid patients, so access is a major obstacle for those without insurance.

> *"We partner with a group called Jordan House. And what they do is they'll come out and do substance abuse counseling. But you have to have insurance. So that's the only that they get the help is if they have a Medical Card." — South Chicago Key Informant*

Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. Each year, approximately 443,000 Americans die from tobacco-related illnesses. For every person who dies from tobacco use, 20 more people suffer with at least one serious tobacco-related illness. In addition, tobacco use costs the US $193 billion annually in direct medical expenses and lost productivity.

Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General's report on tobacco was released in 1964.

Tobacco use causes:

- Cancer
- Heart disease
- Lung diseases (including emphysema, bronchitis, and chronic airway obstruction)
- Premature birth, low birth weight, stillbirth, and infant death

There is no risk-free level of exposure to secondhand smoke. Secondhand smoke causes heart disease and lung cancer in adults and a number of health problems in infants and children, including: severe asthma attacks; respiratory infections; ear infections; and sudden infant death syndrome (SIDS).

Smokeless tobacco causes a number of serious oral health problems, including cancer of the mouth and gums, periodontitis, and tooth loss. Cigar use causes cancer of the larynx, mouth, esophagus, and lung.

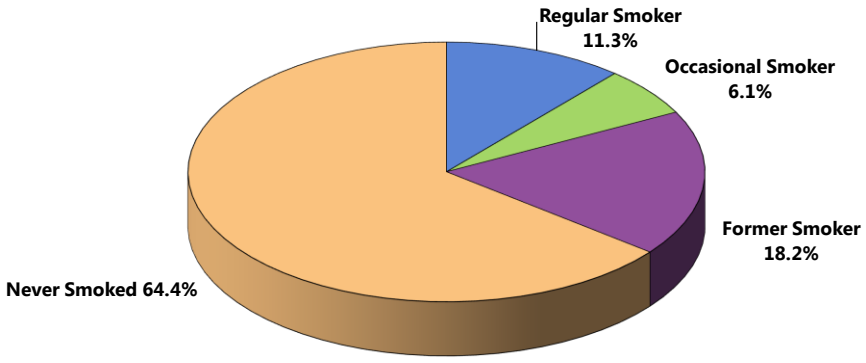
– Healthy People 2020 (www.healthypeople.gov)

Cigarette Smoking

Cigarette Smoking Prevalence

A total of 17.4% of UCMC Service Area adults currently smoke cigarettes, either regularly (11.3% every day) or occasionally (6.1% on some days).

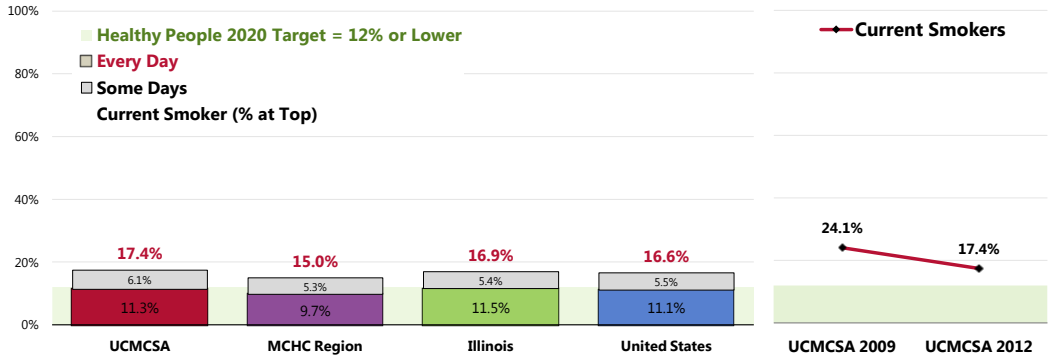
Cigarette Smoking Prevalence
(University of Chicago Medical Center Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 194]
Notes: • Asked of all respondents.

- Similar to regional findings.
- Similar to statewide findings.
- Similar to national findings.
- Fails to meet the Healthy People 2020 target (12% or lower).
- The current smoking percentage is statistically unchanged since 2009.

Current Smokers



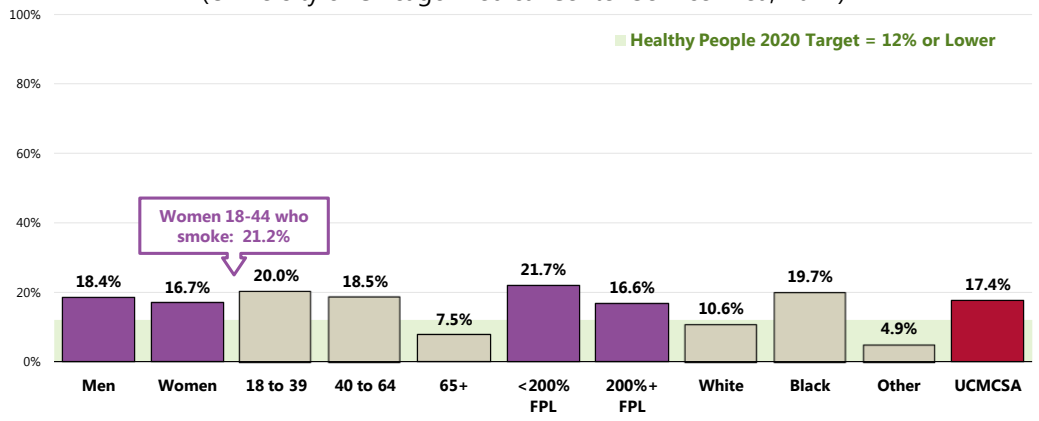
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 194]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.1]

Notes:
- Asked of all respondents.
- Includes regular and occasional smokers (everyday and some days).

- Smoking is more prevalence among adults under 65.
- Note also that 21.2% of women of child-bearing age (ages 18 to 44) currently smoke. This is notable given that tobacco use increases the risk of infertility, as well as the risks for miscarriage, stillbirth and low birthweight for women who smoke during pregnancy.

Current Smokers

(University of Chicago Medical Center Service Area, 2012)



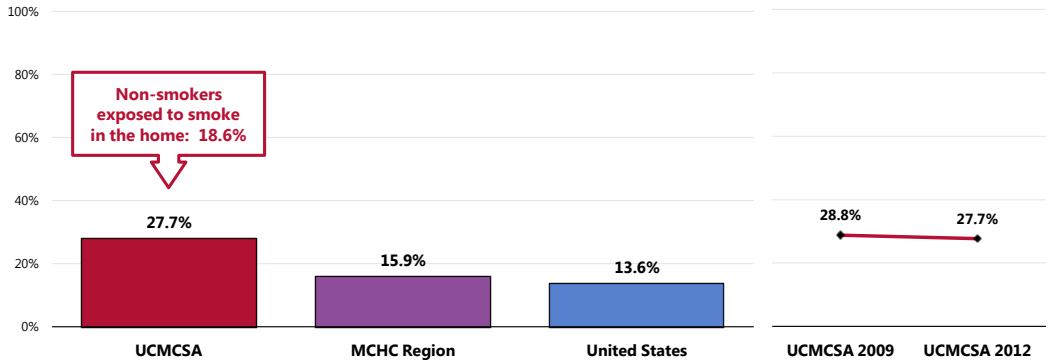
Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 194-195]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.1]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.
- Includes regular and occasion smokers (everyday and some days).

A total of 27.7% of UCMC Service Area adults (including smokers and non-smokers) report that a member of their household has smoked cigarettes in the home an average of 4+ times per week over the past month.

- Less favorable than regional findings.
- Less favorable than national findings.
- Statistically similar to the 2009 findings.
- Note that 18.6% of UCMC Service Area non-smokers are exposed to cigarette smoke at home, which is less favorable than regional and national findings.

Member of Household Smokes at Home



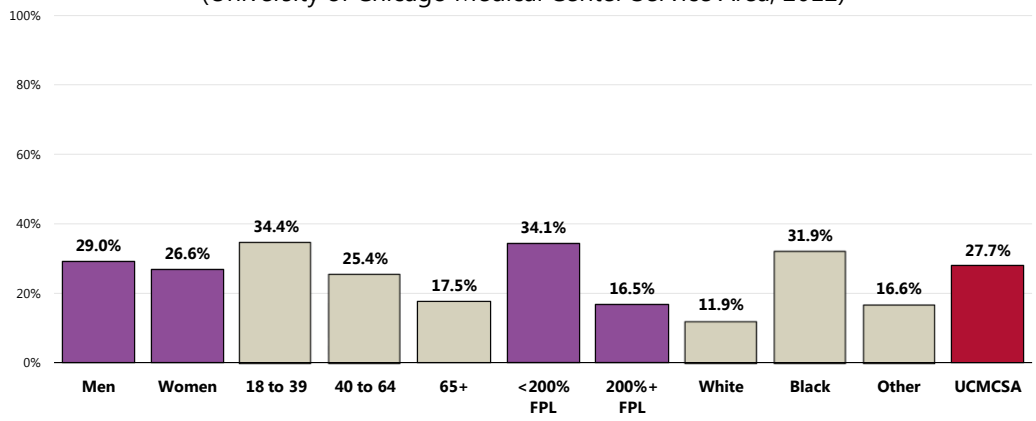
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 69, 196]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

- Exposure to cigarette smoke in the home is notably higher among adults under age 40, those with lower incomes and Blacks.

Member of Household Smokes At Home

(University of Chicago Medical Center Service Area, 2012)

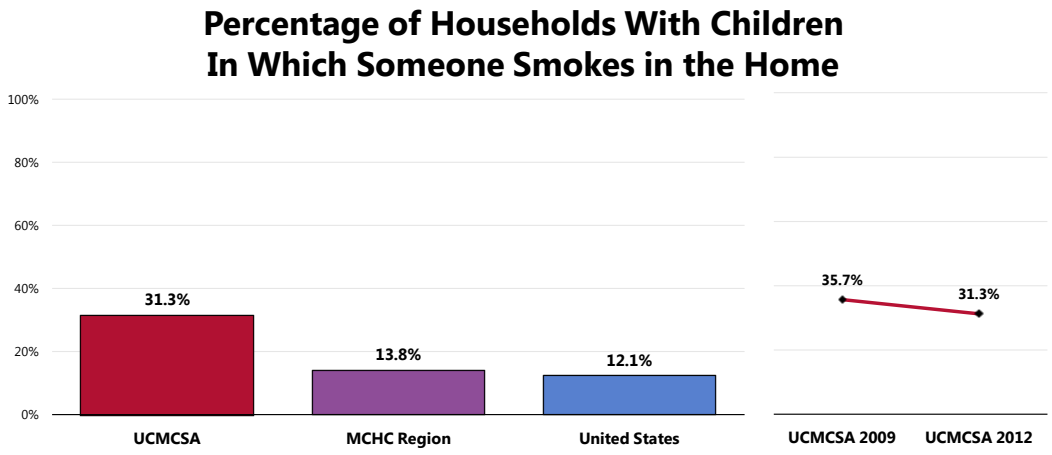


Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 69]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Among households with children, 31.3% have someone who smokes cigarettes in the home.

- Less favorable than MCHC Region findings.
- Less favorable than national findings.
- Statistically unchanged over time.



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 197]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Smoking Cessation

Preventing tobacco use and helping tobacco users quit can improve the health and quality of life for Americans of all ages. People who stop smoking greatly reduce their risk of disease and premature death. Benefits are greater for people who stop at earlier ages, but quitting tobacco use is beneficial at any age.

Many factors influence tobacco use, disease, and mortality. Risk factors include race/ethnicity, age, education, and socioeconomic status. Significant disparities in tobacco use exist geographically; such disparities typically result from differences among states in smoke-free protections, tobacco prices, and program funding for tobacco prevention.

– Healthy People 2020 (www.healthypeople.gov)

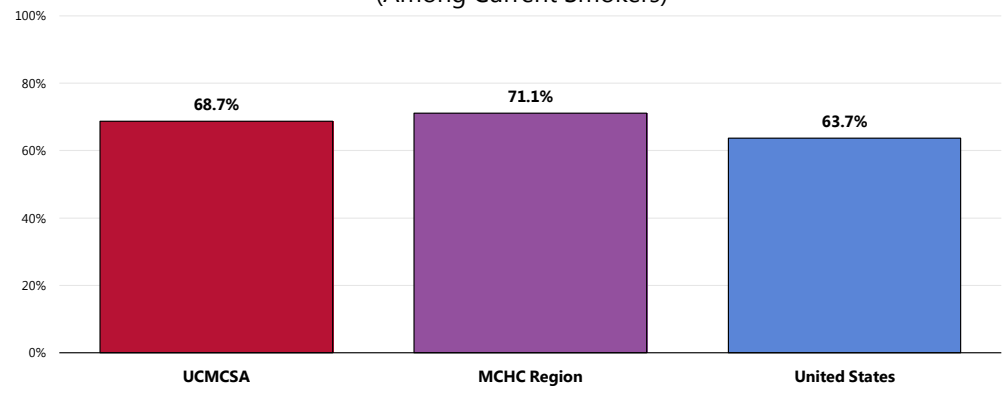
Health Advice About Smoking Cessation

A total of 68.7% of smokers say that a doctor, nurse or other health professional has recommended in the past year that they quit smoking.

- Comparable to the regional percentage.
- Comparable to the national percentage.

Advised by a Healthcare Professional in the Past Year to Quit Smoking

(Among Current Smokers)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 68]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all current smokers.

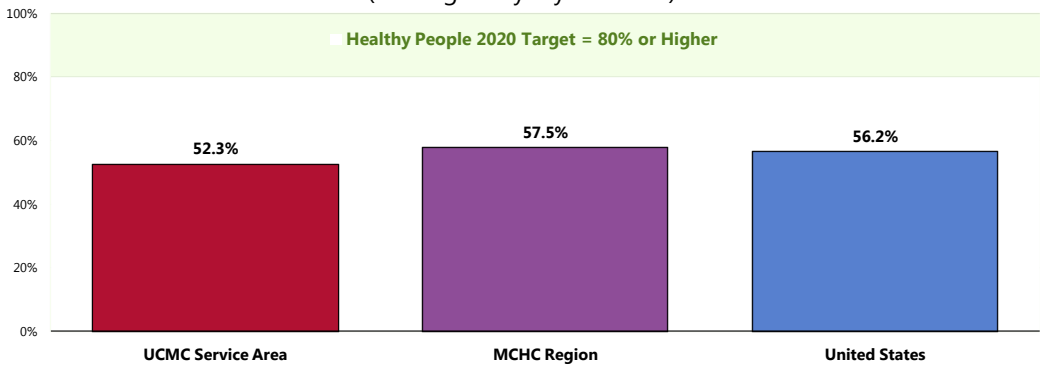
Smoking Cessation Attempts

One-half (52.3%) of regular smokers went without smoking for one day or longer in the past year because they were trying to quit smoking.

- Similar to the MCHC Region percentage.
- Similar to the national percentage.
- Fails to satisfy the Healthy People 2020 target (80% or higher).

Have Stopped Smoking for One Day or Longer in the Past Year in an Attempt to Quit Smoking

(Among Everyday Smokers)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 67]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-4.1]

Notes:
- Asked of respondents who smoke cigarettes every day.

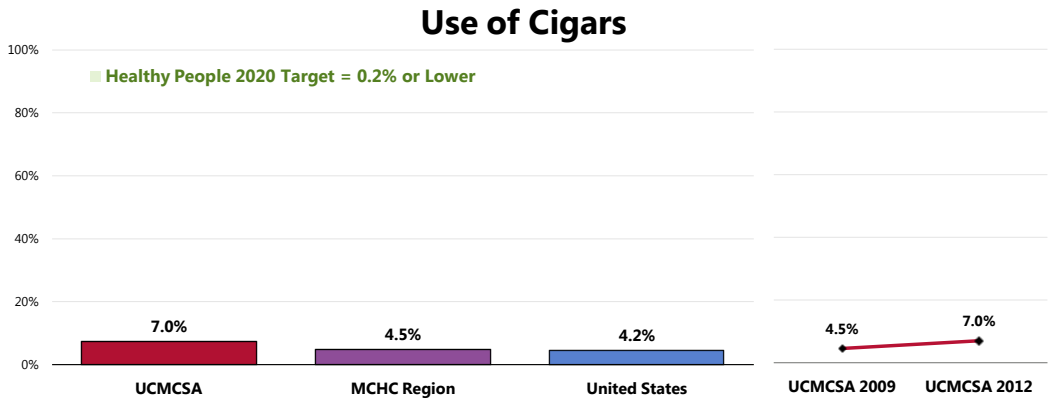
Other Tobacco Use

Cigars

A total of 7.0% of Service Area adults smoke cigars every day or on some days.

- Similar to the MCHC Region findings.
- Higher than the national percentage.
- Fails to satisfy the Healthy People 2020 target (0.2% or lower).
- Statistically unchanged since 2009.

Examples of smokeless tobacco include chewing tobacco, snuff, or "snus."



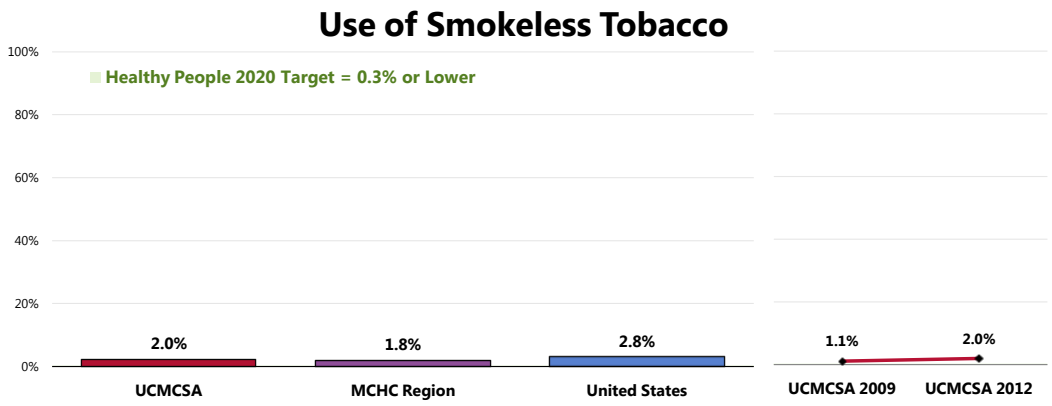
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 71]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.3]

Notes:
- Asked of all respondents.

Smokeless Tobacco

A total of 2.0% of UCMC Service Area adults use some type of smokeless tobacco every day or on some days.

- Comparable to the MCHC Region findings.
- Comparable to the national percentage.
- Fails to satisfy the Healthy People 2020 target (0.3% or lower).
- Comparable to the 2009 findings.



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 70]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.2]

Notes:
- Asked of all respondents.
- Smokeless tobacco includes chewing tobacco or snuff.

Related Focus Group Findings: Tobacco

Many South Chicago participants are concerned with tobacco use in the community, focusing on these issues:

- Youth
- Cigarette markets
- Minority residents
- Stress

South Chicago focus group participants feel that cigarette smoking is a concern, especially for **youth** in their community. Attendees believe that the non-smoking ordinance has lowered overall smoking levels, but they still see youth smoking in the neighborhoods or on their way to school.

Group members also expressed concern about illegal **cigarette markets** evident in the community. The cost of cigarettes now exceeds $10 dollars, so some smokers in the community participate in the purchasing of illegal cigarettes at cigarette markets, where cigarettes are sold individually:

> *"They do it in the open (sell cigarettes). Open street market. We have farmer's markets and cigarette markets." — South Chicago Key Informant*

ACCESS TO HEALTH SERVICES

Health Insurance Coverage

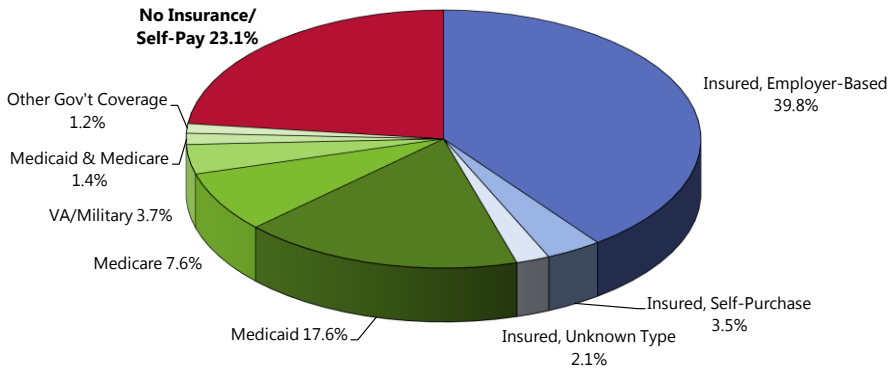
Type of Healthcare Coverage

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

A total of 45.4% of UCMC Service Area adults age 18 to 64 report having healthcare coverage through private insurance. Another 31.5% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, military benefits).

Healthcare Insurance Coverage

(Among Adults 18-64; University of Chicago Medical Center Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 202]
Notes: • Reflects respondents age 18 to 64.

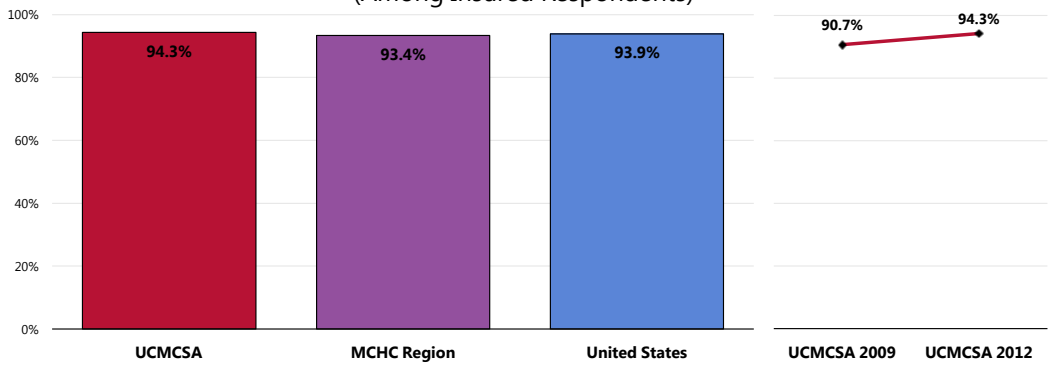
Prescription Drug Coverage

94.3% of insured adults have prescription coverage as part of their insurance plan.

- Similar to the MCHC Region prevalence.
- Similar to the national prevalence.
- Statistically unchanged since 2009.

Health Insurance Covers Prescriptions at Least in Part

(Among Insured Respondents)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 93]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents with healthcare insurance coverage.

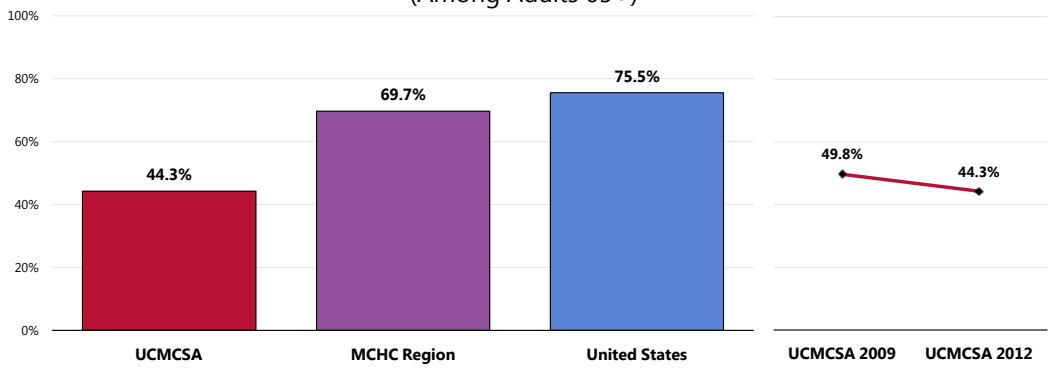
Supplemental Coverage

Among Medicare recipients, 44.3% have additional, supplemental healthcare coverage.

- Less favorable than found in the MCHC Region.
- Much lower than reported among Medicare recipients nationwide.
- Statistically similar to the proportion reported in 2009.

Have Supplemental Coverage in Addition to Medicare

(Among Adults 65+)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 92]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of respondents age 65+.

Lack of Health Insurance Coverage

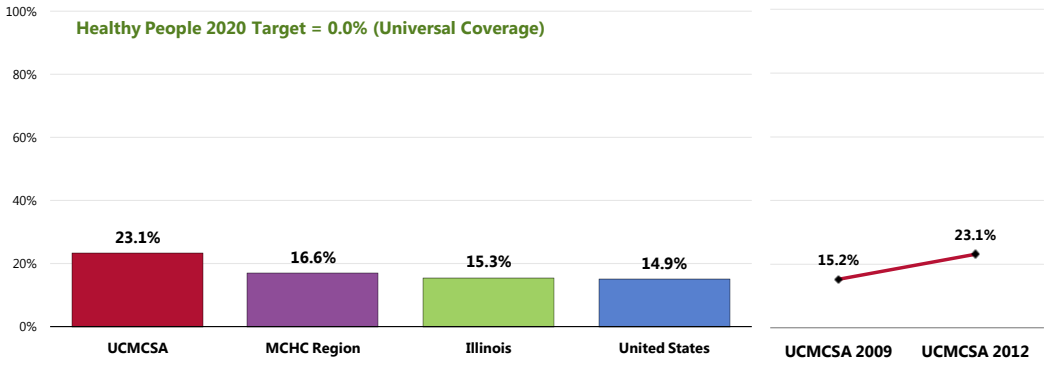
Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

Among adults age 18 to 64, 23.1% report having no insurance coverage for healthcare expenses.

- Less favorable than the MCHC Region findings.
- Less favorable than the state findings.
- Less favorable than the national findings.
- The Healthy People 2020 target is universal coverage (0% uninsured).
- Higher than the 2009 findings.

Lack of Healthcare Insurance Coverage

(Among Adults 18-64)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 202]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-1]

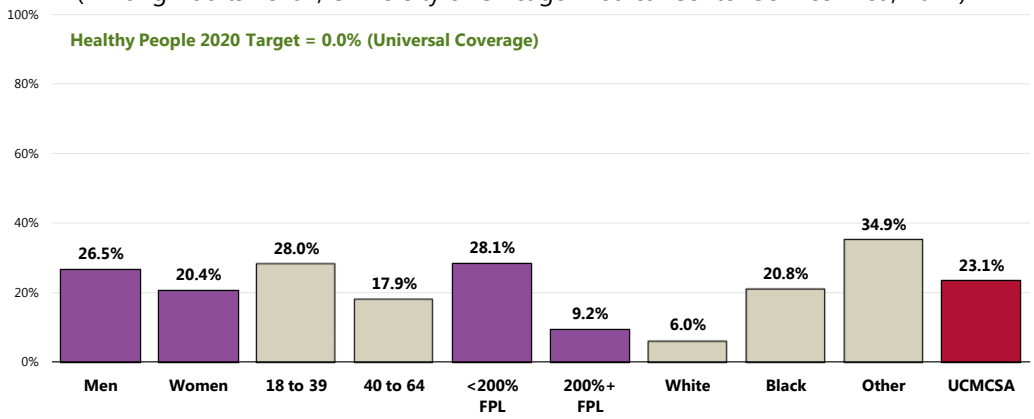
Notes:
- Asked of all respondents under the age of 65.

The following population segments are more likely to be without healthcare insurance coverage:

- Young adults (under 40).
- Residents living at lower incomes.
- "Other" races.

Lack of Healthcare Insurance Coverage

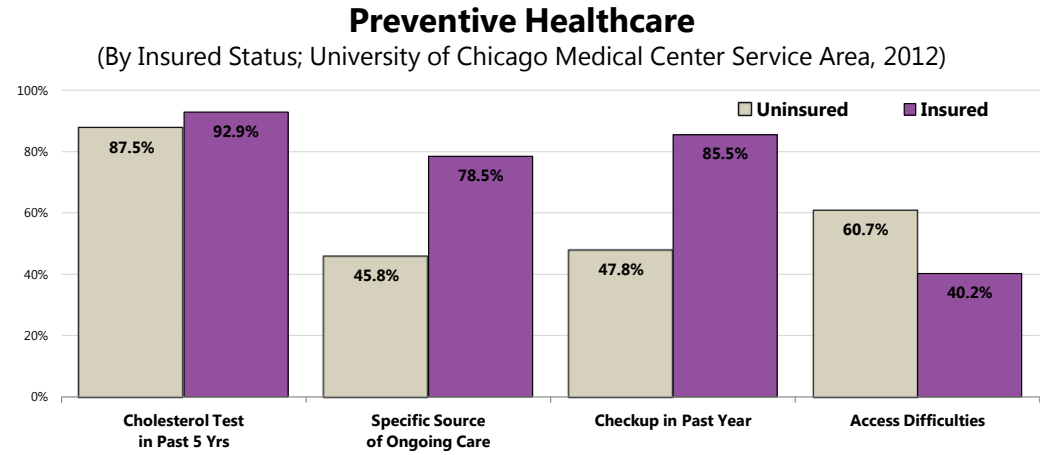
(Among Adults 18-64; University of Chicago Medical Center Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 202]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-1]

Notes:
- Asked of all respondents under the age of 65.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

- As might be expected, uninsured adults in UCMC Service Area are less likely to receive routine care and preventive health screenings, and are more likely to have experienced difficulties accessing healthcare.

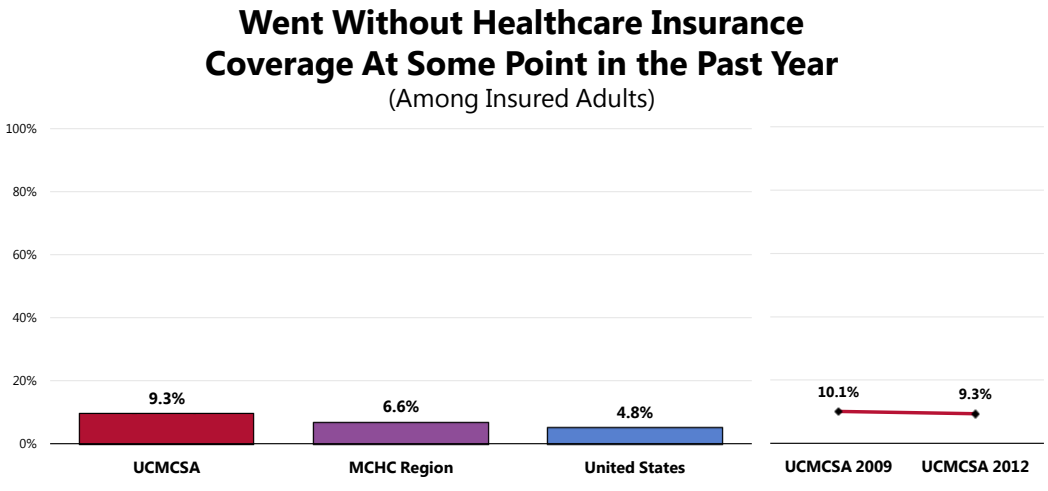


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 17, 53, 56, 203, 206]
Notes: • Asked of all respondents.

Recent Lack of Coverage (Insurance Instability)

Among currently insured adults in UCMC Service Area, 9.3% report that they were without healthcare coverage at some point in the past year.

- Comparable to the MCHC Region findings.
- Less favorable than the US findings.
- Statistically unchanged from 2009.



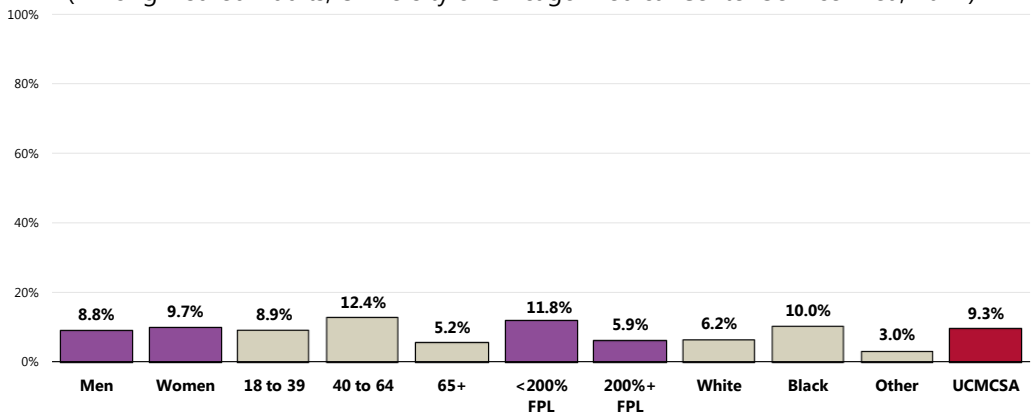
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 94]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all insured respondents.

Among insured adults, the following segments are more likely to have gone without healthcare insurance coverage at some point in the past year:

- Respondents between ages 40 and 64.
- Blacks.

Went Without Healthcare Insurance Coverage At Some Point in the Past Year

(Among Insured Adults; University of Chicago Medical Center Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 94]

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

Difficulties Accessing Healthcare

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It impacts: overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy.

Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires three distinct steps: 1) Gaining entry into the health care system; 2) Accessing a health care location where needed services are provided; and 3) Finding a health care provider with whom the patient can communicate and trust.

– Healthy People 2020 (www.healthypeople.gov)

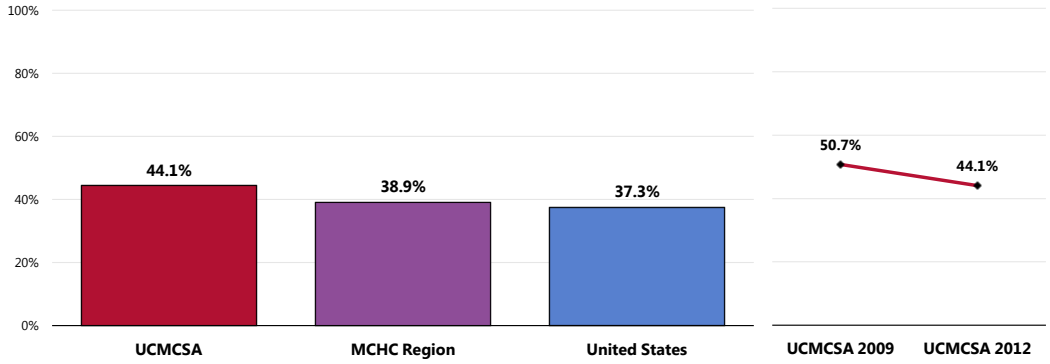
Difficulties Accessing Services

This indicator reflects the percentage of the total population experiencing problems accessing healthcare in the past year, regardless of whether they needed or sought care.

A total of 44.1% of UCMC Service Area adults report some type of difficulty or delay in obtaining healthcare services in the past year.

- Higher than the MCHC Region findings.
- Higher than national findings.
- Similar to the percentage reported in 2009.

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



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 206]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

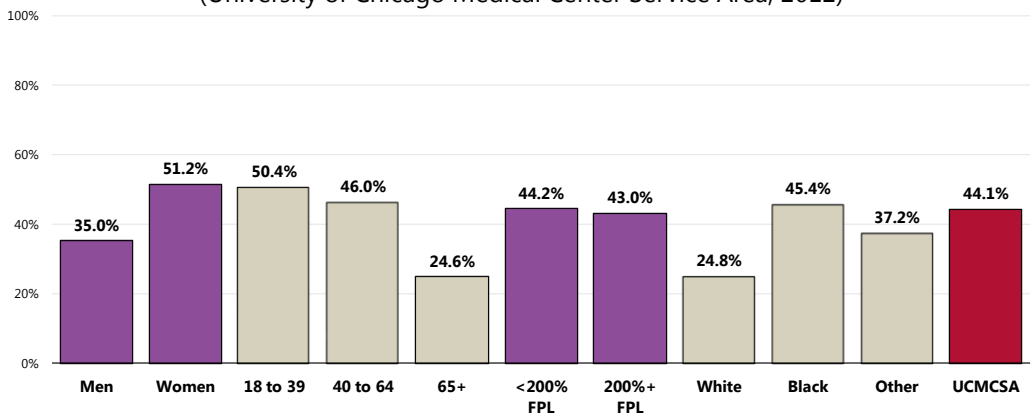
Notes:
- Asked of all respondents.
- Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.

Note that the following demographic groups more often report difficulties accessing healthcare services:

- Women.
- Adults under the age of 65.
- Blacks.

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

(University of Chicago Medical Center Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 206]

Notes:
- Asked of all respondents.
- Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Barriers to Healthcare Access

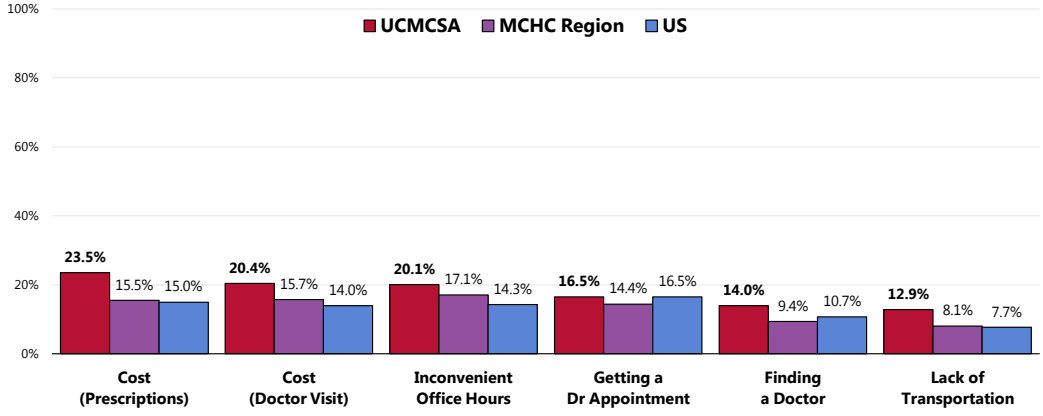
To better understand healthcare access barriers, survey participants were asked whether any of six types of barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

Again, these percentages reflect the total population, regardless of whether medical care was needed or sought.

Of the tested barriers, the cost of prescriptions impacted the greatest share of UCMC Service Area adults (23.5% say that cost prevented them from obtaining prescription medicine in the past year).

- Reports of the barriers associated with prescription costs, costs of physician visits, difficulty finding physicians, and transportation problems were higher among UCMC Service Area adults than adults across the MCHC Region.
- The proportion of UCMC Service Area adults impacted was statistically higher than was found nationwide for the barriers of inconvenient hours, prescription costs, costs associated with physician visits, and transportation problems.

Barriers to Access Have Prevented Medical Care in the Past Year



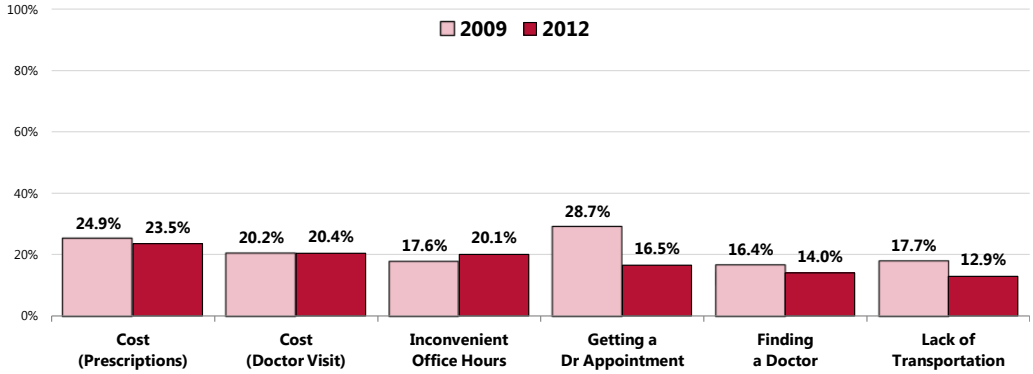
Sources:
- 2012 PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 7-12]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Compared to baseline 2009 data, the UCMC Service Area has seen a significant decrease with regard to the barrier of **difficulty getting an appointment**.

Trend in Barriers to Healthcare Access

(University of Chicago Medical Center Service Area, 2009-2012)

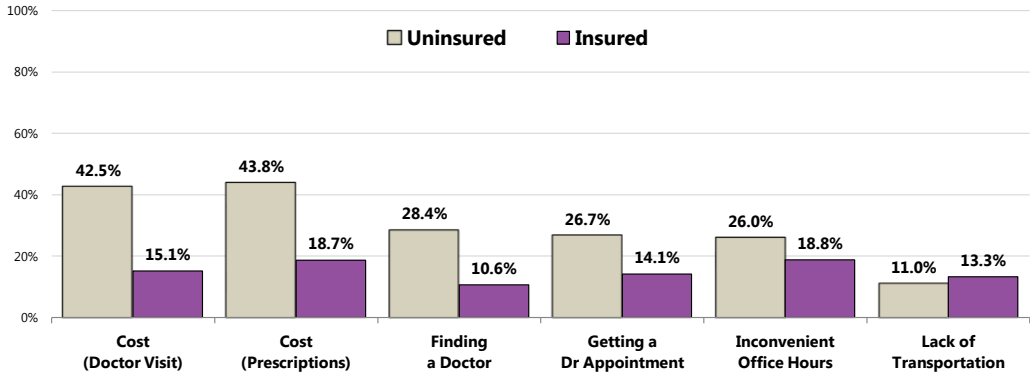


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 7-12]
Notes: • Asked of all respondents.

As might be expected, UCMC Service Area adults without health insurance are much more likely to report access barriers when compared to the insured population, particularly those related to cost. However, lack of transportation affected respondents regardless of insurance status.

Barriers to Healthcare Access

(By Insured Status, Adults 18+; University of Chicago Medical Center Service Area, 2012)



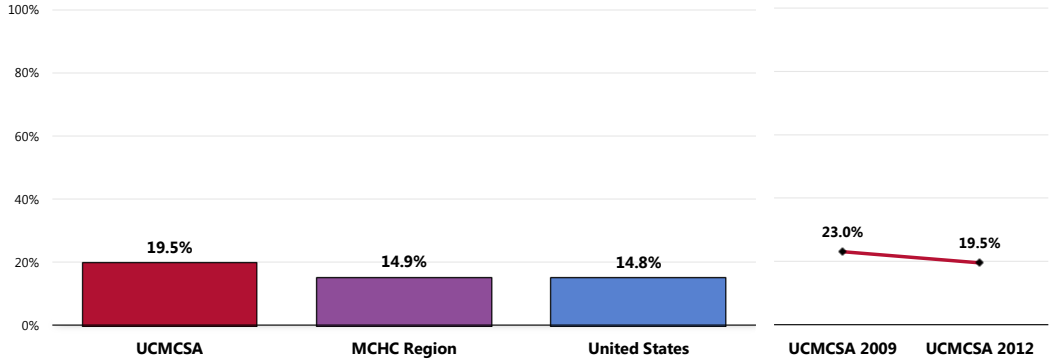
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 7-12]
Notes: • Asked of all respondents.

Prescriptions

Among all UCMC Service Area adults, 19.5% skipped or reduced medication doses in the past year in order to stretch a prescription and save money.

- Less favorable than regional findings.
- Less favorable than national findings.
- Statistically similar to 2009 findings.

Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money



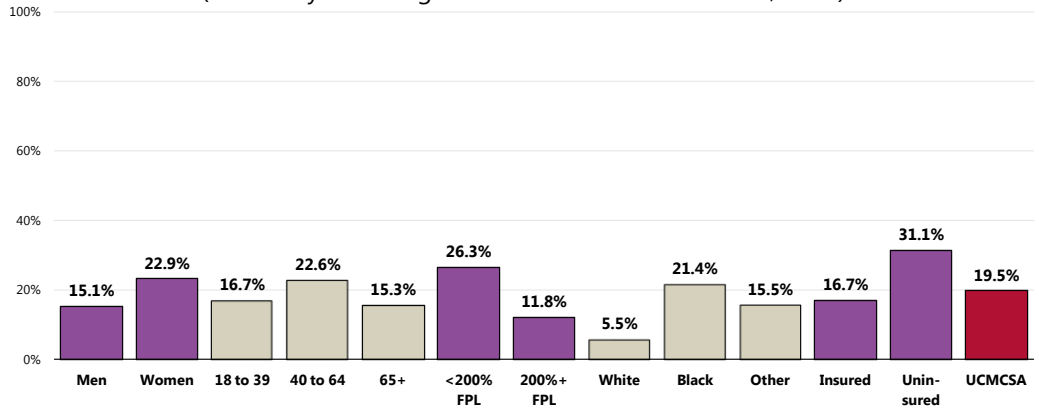
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 13]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Adults more likely to have skipped or reduced their prescription doses include:

- Women.
- Respondents with lower incomes.
- Blacks.
- Uninsured adults (note the 31.1% response).

Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money

(University of Chicago Medical Center Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 13]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Accessing Healthcare for Children

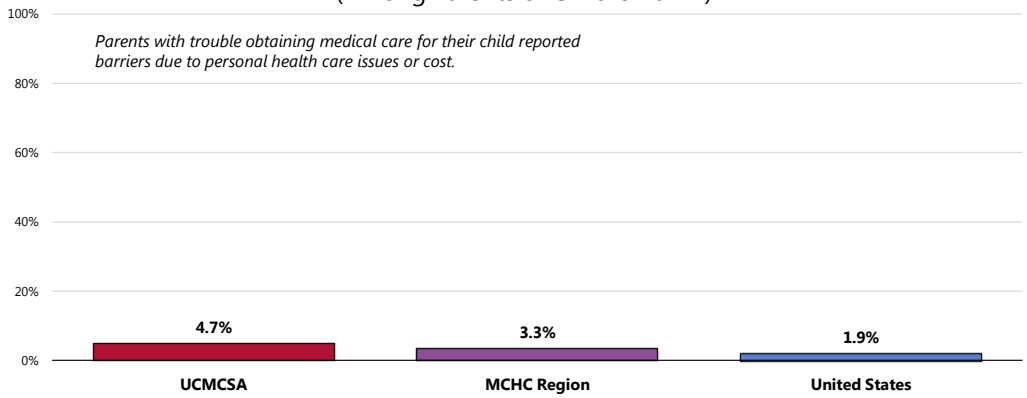
Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly-selected child in their household.

A total of 4.7% of parents say there was a time in the past year when they needed medical care for their child, but were unable to get it.

- Similar to MCHC Region findings.
- Similar to US findings.
- Statistically unchanged since 2009.

Had Trouble Obtaining Medical Care for Child in the Past Year

(Among Parents of Children 0-17)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 134-135]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents with children 0 to 17 in the household.

Parents experiencing difficulties cited **personal health care issues** or **costs** as the primary reason.

Related Focus Group Findings: Access to Healthcare

Many focus group participants are concerned about access to healthcare, with discussion focused on these themes:

- Barriers to accessing healthcare
  - Uninsured and under-insured
  - Cost
  - Medicaid reimbursement rates
  - Income- and insurance-dependent
  - Prescription medication cost
  - Transportation
    - PACE bus system
    - City trains

- Trauma centers
- Medical homes

Focus group participants agree that residents encounter several **barriers** when trying to **access healthcare services** in Cook County, and many disparities exist within the community (dependent upon geography). As one participant explains:

> *"Place plays a very large part in the disparity that we see between the healthy and those who aren't healthy. I'd like to suggest, and this isn't my idea, but that we actually talk about 'sick care' as what we now know as 'healthcare,' and that 'healthcare' we actually talk about 'prevention' and community programs that support a person with self-management." — Cook County Key Informant*

South Chicago group attendees agree that local residents encounter several **barriers** when trying to **access healthcare services**, and that access to healthcare is **income- and insurance-dependent**. There are several Federally Qualified Health Centers (including KOMED) which uninsured persons can access in South Chicago, but these clinics are understaffed and overwhelmed. The clinics can have lengthy wait times, so residents may need to take a whole day off work if they want to obtain care, which many residents cannot afford to do. One participant describes her recent experience:

> *"I got upstairs, there were a million people sitting in that waiting room. And I left. So if I'm leaving, think about all the other people that just see the amount of people that are in front of you and leave and not know what's wrong with them." — South Chicago Key Informant*

The **cost of prescription medication** can overburden families, *even those with insurance*. Many families in the South Chicago community live below the poverty line, so any cost can act as a deterrent to medication. Attendees worry that with the new state legislation effective July 1st 2012 (which limits the number of Medicaid-covered prescriptions), residents' health will continue to deteriorate.

Cook County focus group members report that many residents are **under-insured or uninsured**, creating additional barriers to accessing healthcare (especially specialty services). The under-insured population includes the working poor: those individuals who may qualify for employer insurance but the deductibles are too high or the monthly employee cost is too much, so they elect to go without.

> *"You have the people with lots of resources, insurance, then you have folks that don't have or they have public aid. But then you have those in the middle, the working poor, so I want to just bring that up, the difficulty with those populations whereas they have employment and maybe their place of employment even offers health insurance but they cannot afford to take that." — Cook County Key Informant*

Some residents may qualify for **Medicaid** or **public aid**, but finding a provider who accepts that insurance can prove difficult; group participants agree that the number of physicians who accept Medicaid has decreased in recent years, due to the low **reimbursement rate** and the opportunity for primary care physicians to receive higher returns in other states.

The **cost of prescription medication** can overburden families, *even those with insurance*. Many families in the South Chicago community live below the poverty line, so any cost can act as a deterrent to medication. Attendees worry that with the new state legislation effective July 1st 2012 (which limits the number of Medicaid-covered prescriptions), residents' health will continue to deteriorate.

Additionally, Cook County participants feel that the **cost** of healthcare and prescription medication can overburden families, *even those with insurance*.

> *"Well if you don't have the money when you go to see a doctor you don't know how much it's going to cost. Because unlike everything else in the world there could be a basic price given to you but lab tests, medicine, x-rays. So you really don't know. And that causes huge difficulty. Also the uninsured pay full price, unlike everybody else." — Cook County Key Informant*

There are several school-based clinics and federally qualified health centers (FQHCs) in the community which operate on a sliding fee schedule to provide services to uninsured residents. However, the clinics are overwhelmed, so residents face extensive wait times or wait lists. **Transportation** may also hinder access. The current public transit routes don't always travel past a clinic, so some residents do not have easy access to a clinic. As one participant describes:

> *"FQHCs and community health centers are in the areas but they're overwhelmed. Also if you can't get to a clinic then there's no point. In suburban Cook County distances are fairly --public transportation is fairly poor. So you combine those two things and you can't maybe get to a FQHC even though it's relatively near but it isn't on a major route, or you're not on a major route." — Cook County Key Informant*

Transportation also represents a major barrier to accessing healthcare services in the South Chicago communities. To easily maneuver the community, residents must have access to a personal vehicle, but parking is costly. A participant explains:

> *"When I went to Oak Park last week, I put a quarter in; it was 45 minutes to an hour for one quarter. You can run and go and conduct your business and handle everything that you need to handle for a quarter…But on the other side of town, the South side, one quarter in a lower economic neighborhood – one quarter was 15 minutes. The disparity doesn't make any sense at all." — South Chicago Key Informant*

South Chicago residents can utilize the **PACE bus system and city trains**, but hours of operation and limited routes hinder access. The train may be under repair for months at a time, further limiting the accessible transportation network. In addition, many transportation vendors who previously serviced the Medicaid/Medicare populations no longer operate in the community due to low reimbursement rates.

> *"Transportation access totally depends on where you live and where you're trying to go. They've cut back on the number of the buses; they've deleted a lot express routes. The train was down for four months. The red line which goes south will be closed for five months for repair – only on the South side." — South Chicago Key Informant*

South Chicago participants have concern about community members' lack of access to a local **trauma center**. Focus group attendees spoke at length about the need for a

trauma center due to the high levels of gun violence in the community. The closest trauma center is at least 30 minutes away and emergency rooms can go on "bypass" (diverting to other hospitals), making access more difficult. A participant explains his frustrations:

> *"I think the number one factor is there are no trauma centers on the South side of Chicago. And so when you look at when how many shootings that we have on the South side, and not to have a trauma center anywhere in the area that's being affected the most is just astonishing to me." — South Chicago Key Informant*

Participants also feel that the lack of a **medical home** negatively impacts residents. Overall, the population in South Chicago is transient, and residents often do not have a regular medical provider. Many agencies have begun to offer mobile clinics and health fairs to reach this population, but continuity of care and medical records do not follow these families, often resulting in duplicative services. In addition, participants worry about the actual amount of follow-through with recommendations provided from the medical staff. Attendees stress the need for mobile clinics to somehow allow for medical records to follow the patients, as one participant explains:

> *"One of the challenges with the mobile model, in terms of providing healthcare as it relates to children is the inconsistent nature of it…So that school-aged children, specifically, if the families only have the mobile resource, they tend to be over-immunized because the medical record doesn't follow them typically. So every year they're being re-serviced and duplicated efforts." — South Chicago Key Informant*

Primary Care Services

Improving health care services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. Having a primary care provider (PCP) as the usual source of care is especially important. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Having a usual PCP is associated with:

- Greater patient trust in the provider
- Good patient-provider communication
- Increased likelihood that patients will receive appropriate care

Improving health care services includes increasing access to and use of evidence-based preventive services. Clinical preventive services are services that: **prevent** illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention); or **detect** a disease at an earlier, and often more treatable, stage (secondary prevention).

– Healthy People 2020 (www.healthypeople.gov)

Specific Source of Ongoing Care

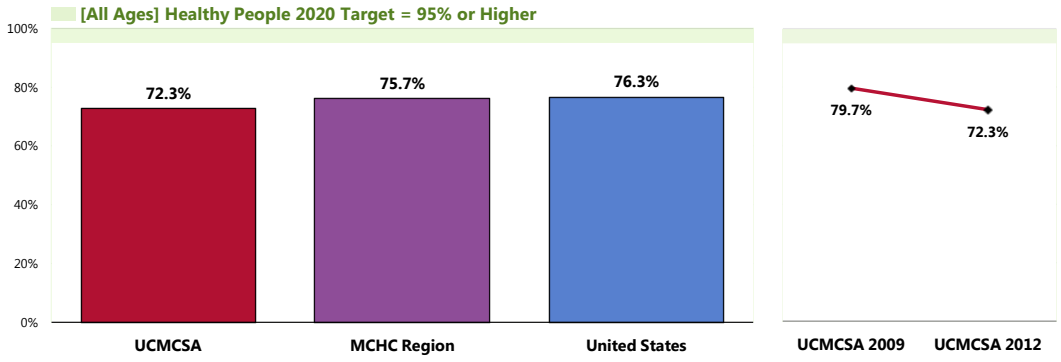
Having a specific source of ongoing care includes having a doctor's office, clinic, urgent care center, walk-in clinic, health center facility, hospital outpatient clinic, HMO or prepaid group, military/VA clinic, or some other kind of place to go if one is sick or needs advice about his or her health. This resource is also known as a "medical home."

A hospital emergency room is not considered a source of ongoing care in this instance.

A total of 72.3% of UCMC Service Area adults were determined to have a specific source of ongoing medical care (a "medical home").

- Similar to the MCHC Region findings.
- Similar to national findings.
- Fails to meet the Healthy People 2010 objective (95% or higher).
- A statistically significant decrease since 2009.

Have a Specific Source of Ongoing Medical Care



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 203]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-5.1]

Notes:
- Asked of all respondents.

When viewed by demographic characteristics, the following population segments are less likely to have a specific source of care:

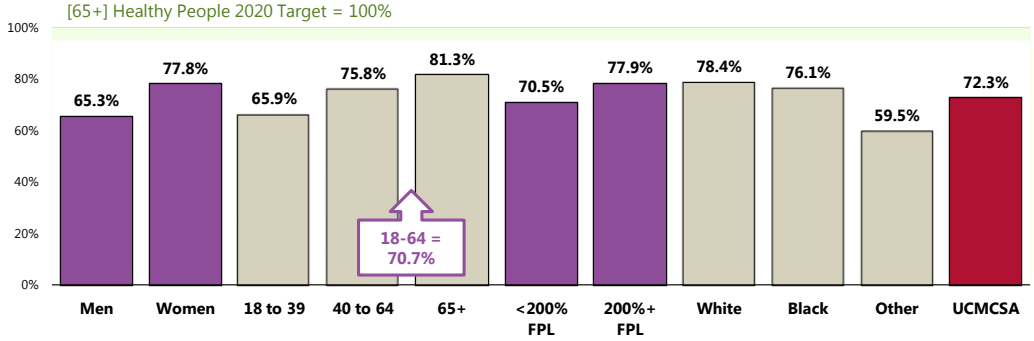
- Men.
- Adults under age 40.

- "Other" races.
- Among adults age 18-64, 70.7% have a specific source for ongoing medical care, similar to regional and national findings.
  - Fails to satisfy the Healthy People 2020 target for this age group (89.4% or higher).
- Among adults 65+, 81.3% have a specific source for care, which is similar to the percentage reported among seniors regionally and nationally.
  - Fails to satisfy the Healthy People 2020 target of 100% for seniors.

Have a Specific Source of Ongoing Medical Care

(University of Chicago Medical Center Service Area, 2012)

[All Ages] Healthy People 2020 Target = 95.0% or Higher
[18-64] Healthy People 2020 Target = 89.4% or Higher
[65+] Healthy People 2020 Target = 100%



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 203-205x]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objectives AHS-5.1, 5.3, 5.4]

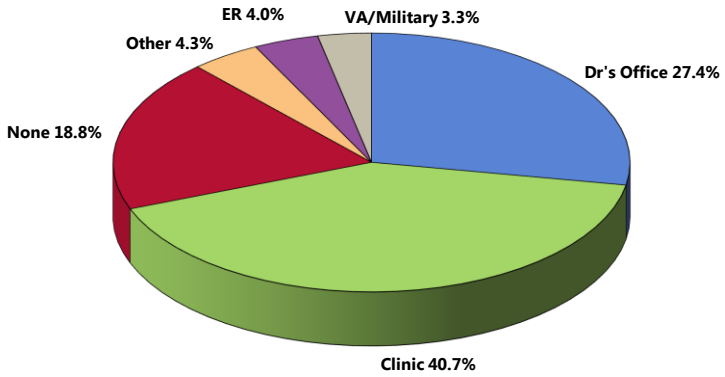
Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household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

Type of Place Used for Medical Care

When asked where they usually go if they are sick or need advice about their health, 40.7% indicated a clinic and 27.4% identified a particular doctor's office. Another 4.0% said they usually go to an ER and 3.3% use a VA or military facility.

Particular Place Utilized for Medical Care

(University of Chicago Medical Center Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 15-16]

Notes:
- Asked of all respondents.

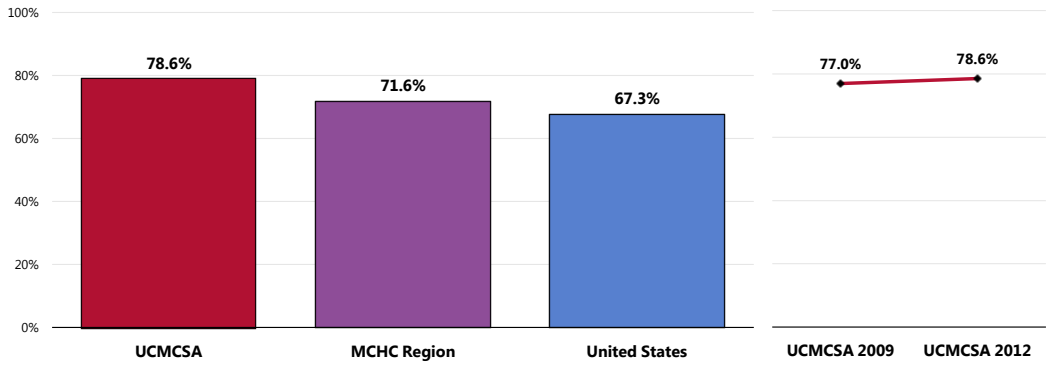
Utilization of Primary Care Services

Adults

Most (78.6%) area adults visited a physician for a routine checkup in the past year.

- Better than regional findings.
- Better than national findings.
- Statistically similar to 2009 findings.

Have Visited a Physician for a Checkup in the Past Year

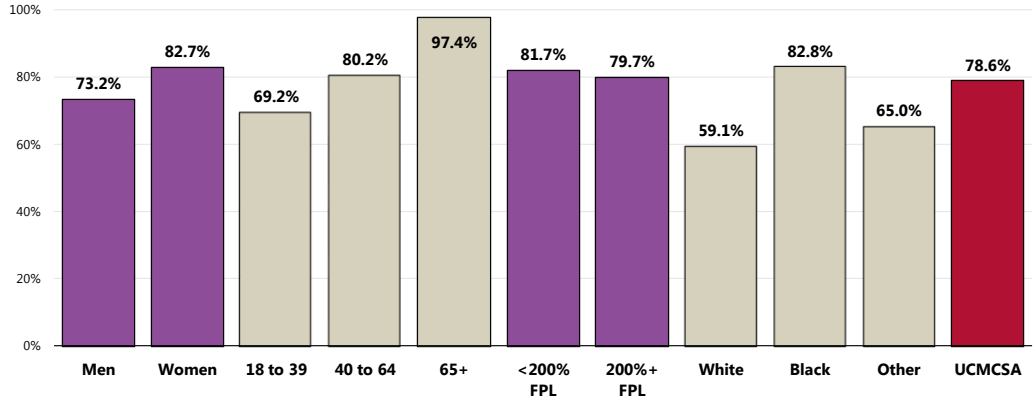


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 17]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

When viewed by demographic characteristics, the following population segments are <u>less likely</u> to have received routine care in the past year:

- Men.
- Adults under age 40.
- Whites and "Other" respondents.

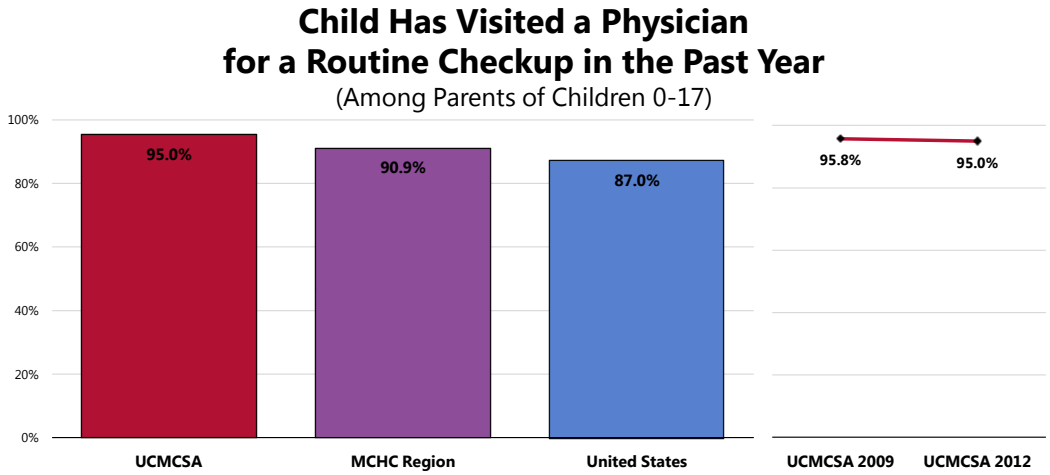
Have Visited a Physician for a Checkup in the Past Year
(University of Chicago Medical Center Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 17]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Among surveyed parents, 95.0% report that their child has had a routine checkup in the past year.

- Similar to MCHC Region findings.
- Better than national findings.
- Similar to the 2009 findings.



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 136]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

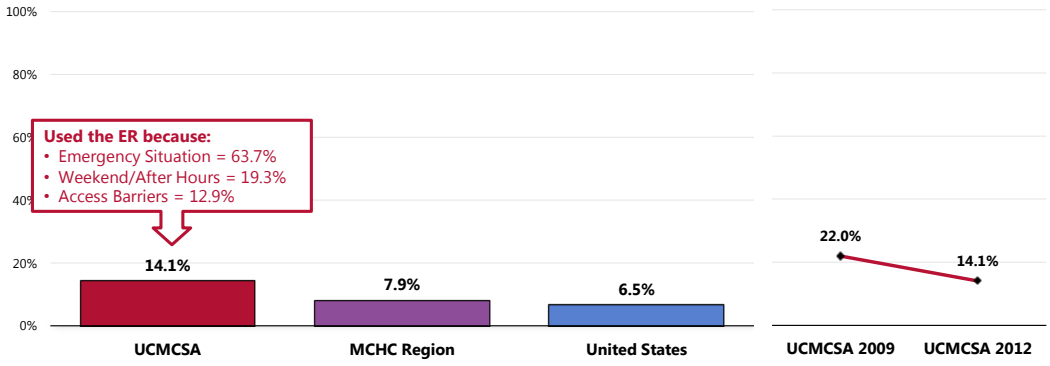
Notes:
- Asked of all respondents with children 0 to 17 in the household.

Emergency Room Utilization

A total of 14.1% of UCMC Service Area adults have gone to a hospital emergency room more than once in the past year for their own health.

- Higher than the MCHC Region findings.
- Higher than national findings.
- Considerably lower than was found in 2009.

Have Used a Hospital Emergency Room More Than Once in the Past Year



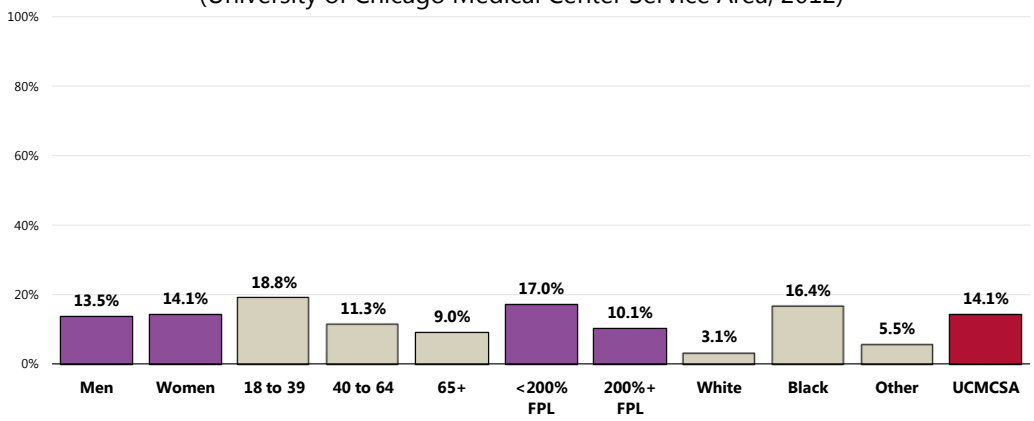
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 23-24]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Of those using a hospital ER, 63.7% say this was due to an **emergency or life-threatening situation** and 19.3% indicated that the visit was during **after-hours or on the weekend**. Another 12.9% cited some type of **access barrier** to primary care services.

- Black respondents were more likely to use an ER more than once.

Have Used a Hospital Emergency Room More Than Once in the Past Year

(University of Chicago Medical Center Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 23]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Oral Health

The health of the mouth and surrounding craniofacial (skull and face) structures is central to a person's overall health and well-being. Oral and craniofacial diseases and conditions include: dental caries (tooth decay); periodontal (gum) diseases; cleft lip and palate; oral and facial pain; and oral and pharyngeal (mouth and throat) cancers.

The significant improvement in the oral health of Americans over the past 50 years is a public health success story. Most of the gains are a result of effective prevention and treatment efforts. One major success is community water fluoridation, which now benefits about 7 out of 10 Americans who get water through public water systems. However, some Americans do not have access to preventive programs. People who have the least access to preventive services and dental treatment have greater rates of oral diseases. A person's ability to access oral healthcare is associated with factors such as education level, income, race, and ethnicity.

Oral health is essential to overall health. Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions. However, oral diseases, from cavities to oral cancer, cause pain and disability for many Americans. Good self-care, such as brushing with fluoride toothpaste, daily flossing, and professional treatment, is key to good oral health. Health behaviors that can lead to poor oral health include:

- Tobacco use
- Excessive alcohol use
- Poor dietary choices

Barriers that can limit a person's use of preventive interventions and treatments include:

- Limited access to and availability of dental services
- Lack of awareness of the need for care
- Cost
- Fear of dental procedures

There are also social determinants that affect oral health. In general, people with lower levels of education and income, and people from specific racial/ethnic groups, have higher rates of disease. People with disabilities and other health conditions, like diabetes, are more likely to have poor oral health.

Community water fluoridation and school-based dental sealant programs are 2 leading evidence-based interventions to prevent tooth decay.

Major improvements have occurred in the nation's oral health, but some challenges remain and new concerns have emerged. One important emerging oral health issue is the increase of tooth decay in preschool children. A recent CDC publication reported that, over the past decade, dental caries (tooth decay) in children ages 2 to 5 have increased.

Lack of access to dental care for all ages remains a public health challenge. This issue was highlighted in a 2008 Government Accountability Office (GAO) report that described difficulties in accessing dental care for low-income children. In addition, the Institute of Medicine (IOM) has convened an expert panel to evaluate factors that influence access to dental care.

Potential strategies to address these issues include:

- Implementing and evaluating activities that have an impact on health behavior.
- Promoting interventions to reduce tooth decay, such as dental sealants and fluoride use.
- Evaluating and improving methods of monitoring oral diseases and conditions.
- Increasing the capacity of State dental health programs to provide preventive oral health services.
- Increasing the number of community health centers with an oral health component.

– Healthy People 2020 (www.healthypeople.gov)

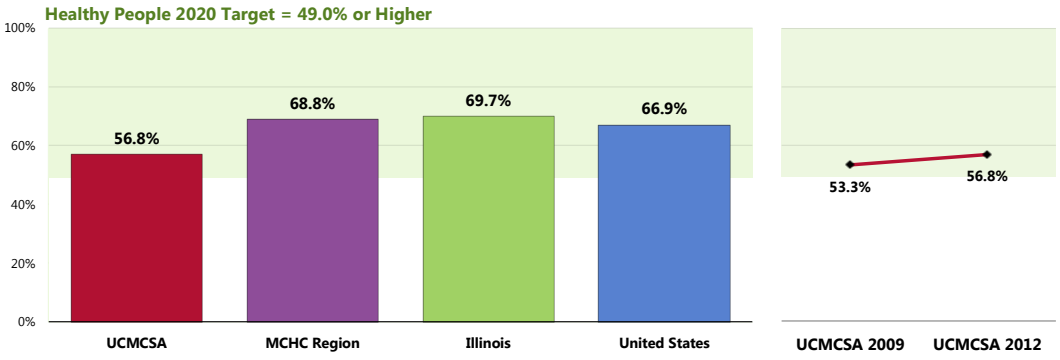
Dental Care

Adults

56.8% area adults visited a dentist or dental clinic (for any reason) in the past year.

- Lower than regional findings.
- Lower than statewide findings.
- Lower than national findings.
- Satisfies the Healthy People 2020 target (49% or higher).
- Statistically unchanged since 2009.

Have Visited a Dentist or Dental Clinic Within the Past Year



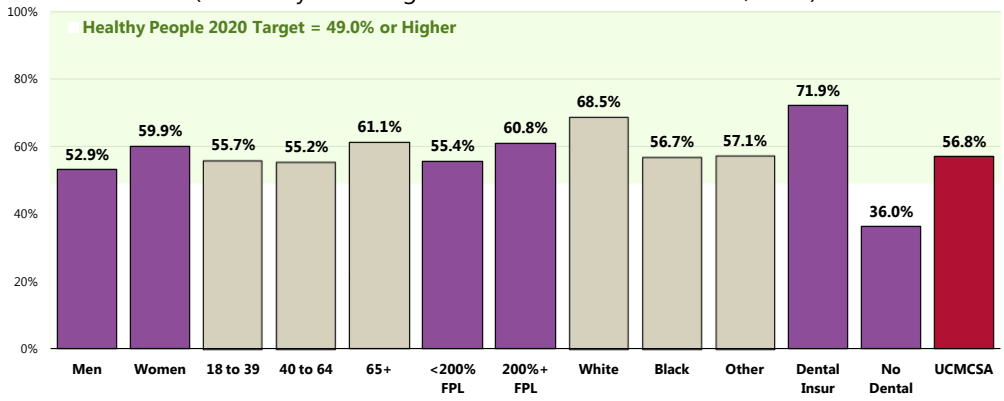
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 21]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.

Notes:
- Asked of all respondents.

As might be expected, persons without dental insurance report much lower utilization of oral health services than those with dental coverage.

Have Visited a Dentist or Dental Clinic Within the Past Year

(University of Chicago Medical Center Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]

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

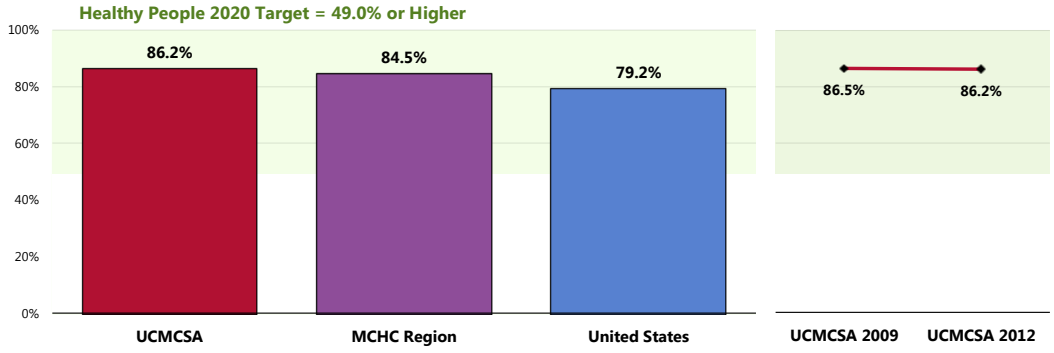
Children

A total of 86.2% of parents report that their child (age 2 to 17) has been to a dentist or dental clinic within the past year.

- Comparable to the regional findings.
- Comparable to national findings.
- Satisfies the Healthy People 2020 target (49% or higher).
- Children's dental care rates remained statistically unchanged since 2009.

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

(Among Parents of Children 2-17)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 137]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]

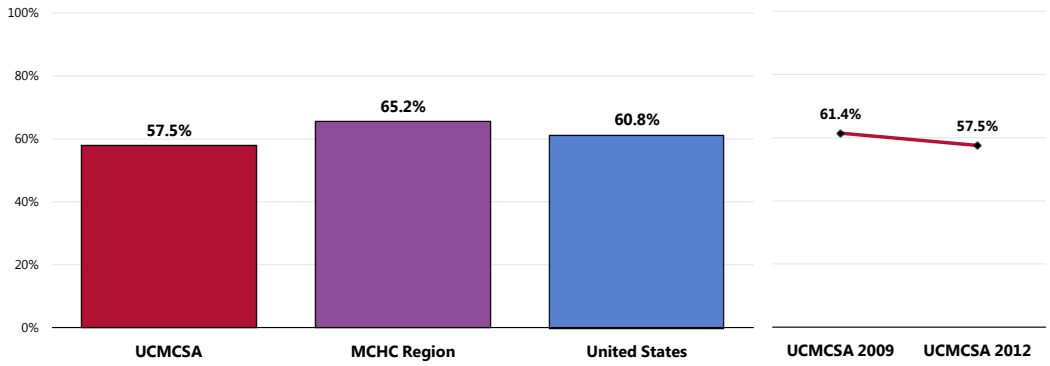
Notes:
- Asked of all respondents with children age 2 through 17.

Dental Insurance

Most UCMC Service Area adults (57.5%) have dental insurance that covers all or part of their dental care costs.

- Lower than is found in the MCHC Region.
- Similar to the national finding.
- Statistically unchanged since 2009.

Have Insurance Coverage That Pays All or Part of Dental Care Costs



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 22]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

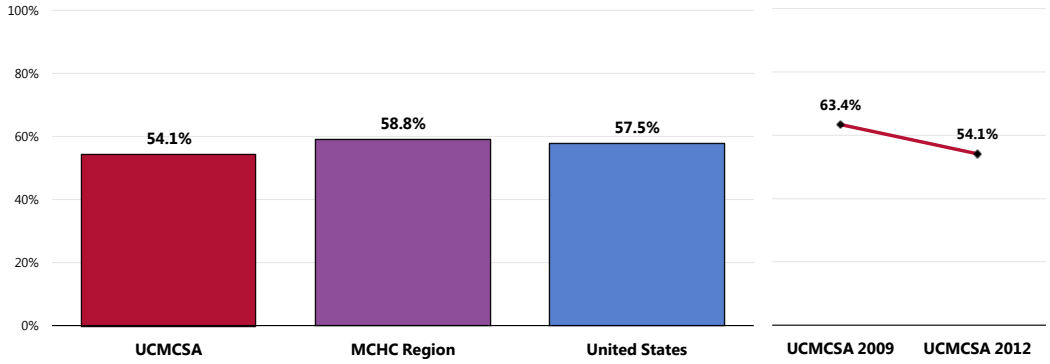
Vision Care

RELATED ISSUE:
See also *Vision & Hearing* in the **Deaths & Disease** section of this report.

A total of 54.1% of residents had an eye exam in the past two years during which their pupils were dilated.

- Comparable to regional findings.
- Comparable to national findings.
- Marks a significant decrease from 2009.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated



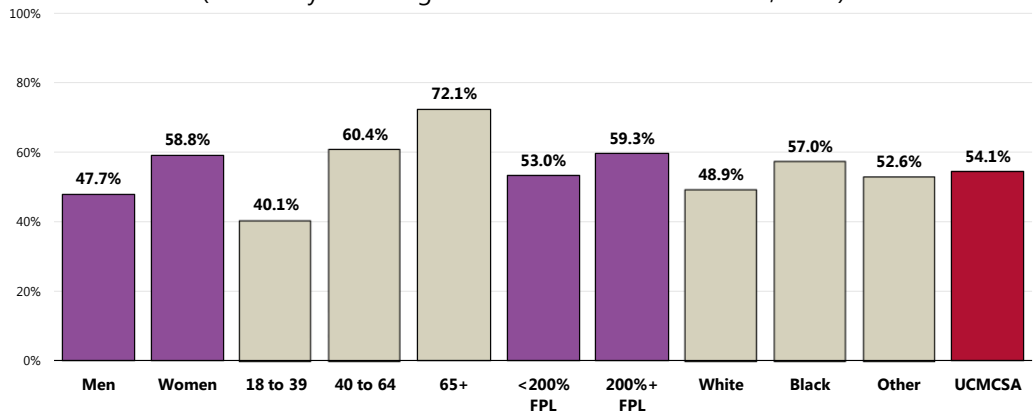
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 20]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Recent vision care is less often reported among men and young adults.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

(University of Chicago Medical Center Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]

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

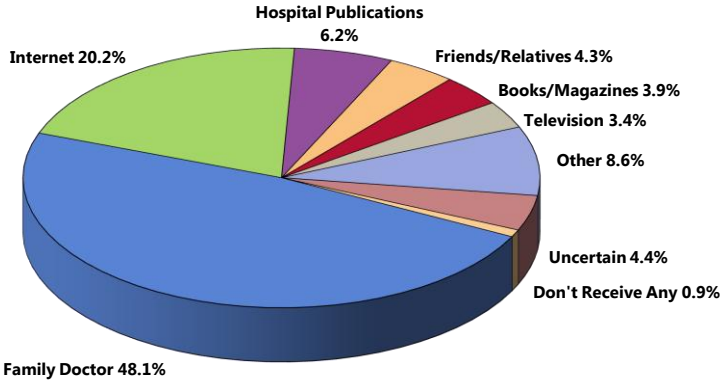
HEALTH EDUCATION & OUTREACH

Healthcare Information Sources

Family physicians and the Internet are residents' primary sources of healthcare information.

- 48.1% of UCMC Service Area adults cited their **family physician** as their primary source of healthcare information.
- The **Internet** received the second-highest response, with 20.2%.
  - Other sources mentioned include hospital publications (6.2%), friends and relatives (4.3%), books/magazines (3.9%), and television (3.4%).
- Just 0.9% of survey respondents say that they do not receive any healthcare information.

Primary Source of Healthcare Information
(University of Chicago Medical Center Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 127]
Notes: • Asked of all respondents.

Participation in Health Promotion Events

Educational and community-based programs play a key role in preventing disease and injury, improving health, and enhancing quality of life.

Health status and related-health behaviors are determined by influences at multiple levels: personal, organizational/institutional, environmental, and policy. Because significant and dynamic interrelationships exist among these different levels of health determinants, educational and community-based programs are most likely to succeed in improving health and wellness when they address influences at all levels and in a variety of environments/settings.

Education and community-based programs and strategies are designed to reach people outside of traditional healthcare settings. These settings may include schools, worksites, healthcare facilities, and/or communities.

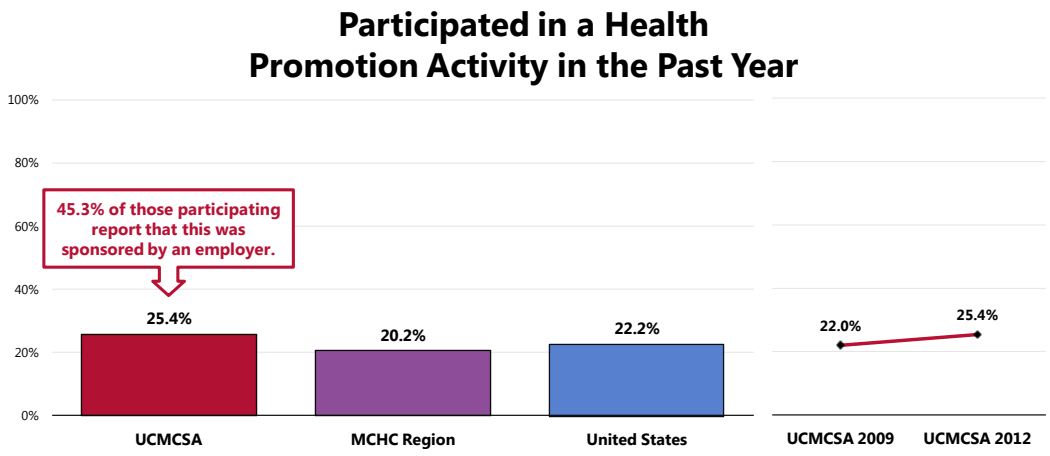
Using nontraditional settings can help encourage informal information sharing within communities through peer social interaction. Reaching out to people in different settings also allows for greater tailoring of health information and education.

Educational and community-based programs encourage and enhance health and wellness by educating communities on topics such as: chronic diseases; injury and violence prevention; mental illness/behavioral health; unintended pregnancy; oral health; tobacco use; substance abuse; nutrition; and obesity prevention.

– Healthy People 2020 (www.healthypeople.gov)

A total of 25.4% of UCMC Service Area adults participated in some type of organized health promotion activity in the past year, such as health fairs, health screenings, or seminars.

- More favorable than the MCHC Region prevalence.
- Similar to the national prevalence.
- Similar to the 2009 prevalence.
- Note that 45.3% of adults who participated in a health promotion activity in the past year indicate that it was sponsored by their employer.

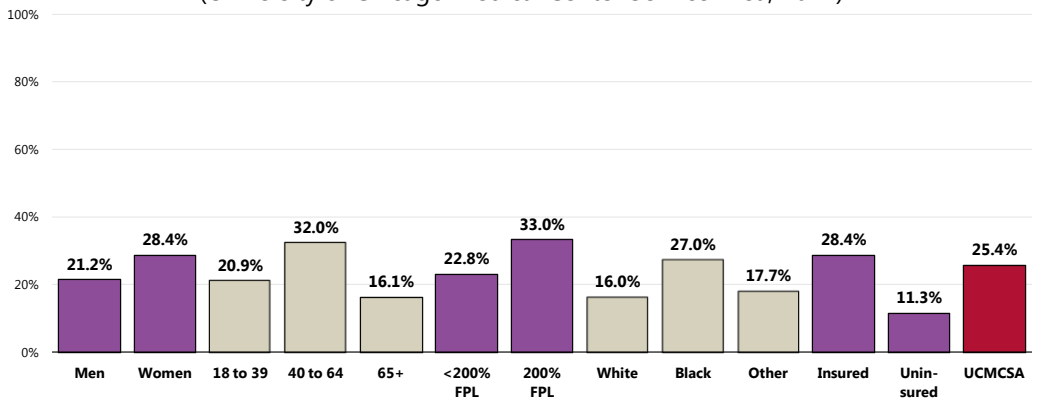


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 128-129]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

The following chart outlines participation by various demographic characteristics.

- Note that those under age 40 or age 65+, those with lower incomes, and the uninsured less often report participation in health promotion activities than their demographic counterparts.

Participated in a Health Promotion Activity in the Past Year
(University of Chicago Medical Center Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 128]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Related Focus Group Findings: Education

Many focus group participants discussed education and prevention needs for the community, with conversation delving into these issues:

- Prevention
- Health literacy
- Cultural competence
- Provide education where people live, work and play; Churches
- Employee wellness programs
- Radios and billboards

Focus group participants agree that health education represents an important factor in the equation of **prevention** and improving the overall health of community members. Attendees believe that Cook County residents suffer due to limited prevention programming and that prevention does not occur regularly because of minimal subsidies for those services. School-based clinics do their best to educate students, but funding is always a challenge:

> *"I'm going back to our school-based health centers and I think of all the wonderful work that our RNs do and that it's all prevention and education and keeping people out of the emergency departments. But nobody pays me for that. So you're constantly writing grants which are not sustainable and taking up time of mine where I could be doing something much more functional than continuing to write." — Cook County Key Informant*

Providing education where people live, work and play is critical to ensuring that education reaches the entire community. Agencies and providers must recognize the diverse cultures and ethnicities in the community and provide programming in multiple languages.

South Chicago focus group participants agree that health education is an important aspect of prevention and improving the overall health of community members. KLEO, a local non-profit, provides health fairs and food pantry days which also include health education for participants.

Overall, **health literacy levels** in Cook County remain low and urgently need to increase. Higher health literacy would help residents realize the importance of preventative healthcare, medication management and healthy eating. Health-literate residents would seek improved communication with their physicians.

South Chicago group attendees also consider local **health literacy** levels to be low and agree that they urgently need to increase. Currently, many residents do not realize that their choices impact their health, and that they are not predestined to have a certain health condition. One participant explains:

> *The community has a low health literacy. They may think that 'because mama had diabetes, I'm going to get diabetes.' They don't realize that's it's something that they can prevent. You know, 'I'm 50 years old and I made it this far, I've lived a really good life, I've lived a long life,' because some people don't know that they can live a longer life, you don't have to go through all these different illnesses, these chronic diseases that you have." — South Chicago Key Informant*

Cook County participants also feel strongly that **employee wellness programs** can positively impact workers. In addition to better engagement at work, many wellness programs increase overall health and quality of life.

> *"So now there's a push to encourage employers to continue with the health prevention programs and not to look for a return on the investment per se but look for -- these are all jargon -- return on engagement, that what happens is because you offer this prevention in general your employees will feel more engaged even if they don't take advantage of the prevention services." — Cook County Key Informant*

South Chicago focus group participants believe that both physicians and social service providers need to possess **cultural competence** in order to make an impact on an individual's health. Culturally-competent providers recognize the myriad ways in which culture affects a patient's attitude, and can tailor their message accordingly to each patient. Physicians must demonstrate high levels of cultural sensitivity, and community members must be willing to listen. The focus group participants stressed the importance of two-way communication between physician and patient. Here, one participant describes the responsibility which physicians possess:

> *"I would also add that the medical community shares some of the responsibility on that because I think often physicians are oriented to that frame of mind and that thought process that some people of color will not access services. And so they stop offering." — South Chicago Key Informant*

Having open-minded and culturally-competent providers is even more important in communities of color, as South Chicago participants believe that Blacks in general have feelings of mistrust toward medical professionals. Having **churches** and other types of organizations relaying health messages can have a strong impact on these community members. Additional types of media, like **radio and billboards**, need to reinforce health messages as well:

> *"To piggyback on the marketing piece – radio would be a really useful tool because often this community (African Americans) doesn't necessarily trust researchers and physicians from experiments that took place years ago." — South Chicago Key Informant*

LOCAL HEALTHCARE

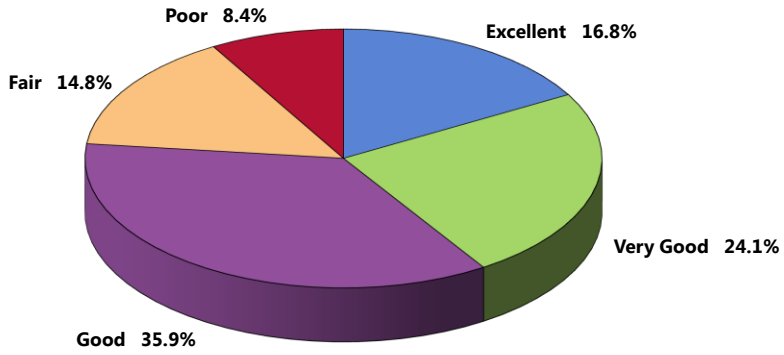
Perceptions of Local Healthcare Services

A total of 40.9% of UCMC Service Area adults rate the overall healthcare services available in their community as "excellent" or "very good."

- Another 35.9% gave "good" ratings.

Rating of Overall Healthcare Services Available in the Community

(University of Chicago Medical Center Service Area, 2012)

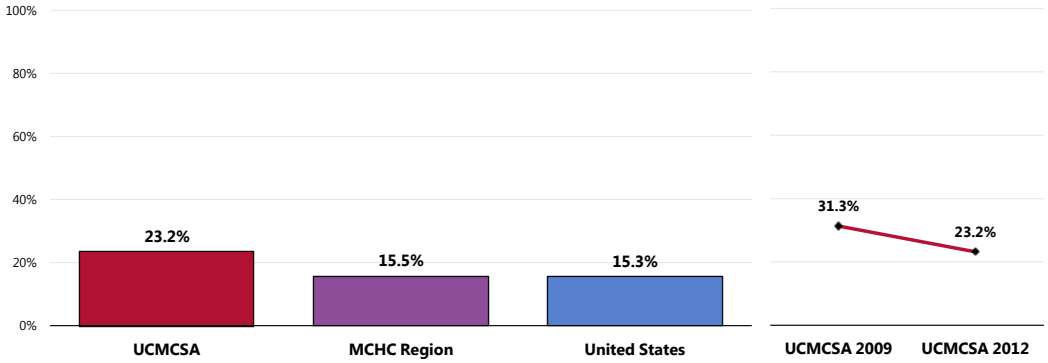


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
Notes: • Asked of all respondents.

However, 23.2% characterize local healthcare services as "fair" or "poor."

- Less favorable than found regionally.
- Less favorable than reported nationally.
- Represents an improvement since 2009.

Perceive Local Healthcare Services as "Fair/Poor"



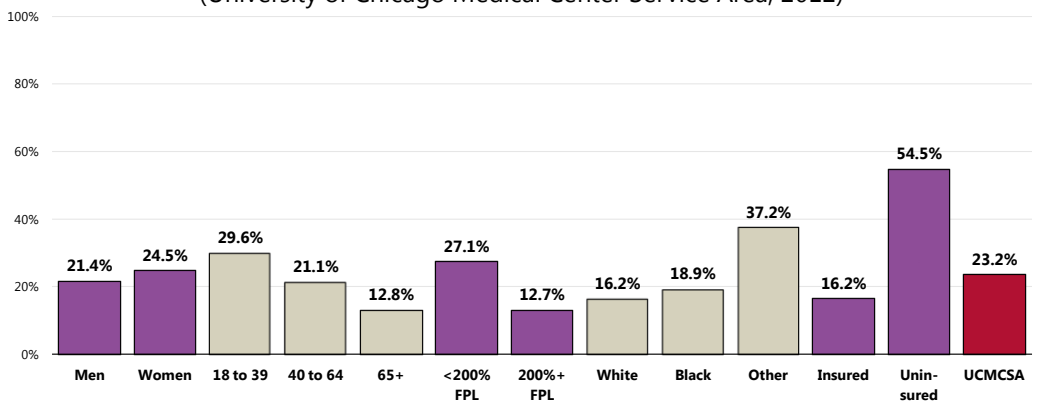
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 6]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

The following residents are more critical of local healthcare services:

- Adults under age 40 (negative correlation with age).
- Residents with lower incomes.
- "Other" races.
- Uninsured adults (note the 54.5% response).

Perceive Local Healthcare Services as "Fair/Poor"

(University of Chicago Medical Center Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "<200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Other Issues

Related Focus Group Findings: Collaboration

Participants spent time discussing the varying degrees of collaboration occurring in the community between non-profit organizations, schools, healthcare providers and hospitals. The issues surrounding collaboration were:

- Varying degrees of collaboration
- Operation in silos
- Complement vs. competition
- Resource guide
- Competition over-funding

Many of the focus group respondents feel there are **varying degrees of collaboration** in Cook County and collaboration is not the norm. Historically, organizations in Cook County have **operated in silos** and do not communicate (aside from non-profits). The status quo frustrates participants because they believe it is critical to connect primary care physicians with public health and for hospitals to coordinate care.

However, with the reduction in state funding and with grant applications pushing coordination, attendees note that some collaborative efforts have begun:

> *"I mean I think that recent events have tended to create more pressures, opportunities in some cases to look at ways to partner and work together to address issues where it used to be one organization that could do it. As those resources are being cut back they're looking for partners to kind of continue meeting that need that's out there even if they can't do it within their own organization." — Cook County Key Informant*

Participants also see a need for a **resource guide**, some type of clearinghouse or system where agencies and residents can locate information about the current resources available. Participants believe easy access to information and services will facilitate better access to care for the community members. One participant explains:

> *"I think a lot of it's we don't have the information at our fingertips and then it becomes a hassle to do it so we don't. In the last two years is when I finally found out about access clinics." — Cook County Key Informant*

Many of the South Chicago focus group respondents agree that collaboration does occur within the community, but that organizations have room for improvement; larger organizations need to spearhead collaborates and coordinate their efforts, as one participant explains:

> *"We can do a much better job of collaboration. Organizations like those larger, non-profits that are backed by big money backers. And those organizations can collaborate with smaller organizations that are doing a lot of good services." — South Chicago Key Informant*

Limited funding makes it more difficult for agencies to work together, although new grant applications request coordinated efforts. Currently, many agencies **compete for the same funding**. Focus group attendees have hope for future collaborative efforts similar to the University of Chicago's efforts:

> *"The University of Chicago's been reaching out to a lot of different people to work with them on various programs that they're trying to do within the community. So I know that if you look at that example, that's one example they've been reaching out to different, smaller, grass-root organizations to work with them. But there could be more." — South Chicago Key Informant*

Related Focus Group Findings: Senior Health

Many focus group participants discussed geriatric health issues, with primary concern over:

- A need for health advocates

Cook County focus group attendees believe that senior citizens experience unique health concerns, facing such barriers as hearing or vision difficulties. In general, physicians do not have extra time to explain procedures or prescriptions to them; therefore, many seniors leave the office without a complete understanding of their medications. Participants agree that having a **health advocate** for this population would assist in comprehension and treatment adherence. Further, long-term use of health advocates could potentially result in lower hospitalization rates.

> *"They have a little bit of a hearing problem and the providers speak fast like me and soft, so the seniors can't hear. Nothing is given to them in writing to follow up. There isn't a chance to meet with somebody perhaps less expensive than the physician's specialist provider to really go through the visit to say, 'What just happened here and what questions do you have?' or beforehand to say what questions you have when you want to go in. I despair for the people who don't have somebody to accompany them on every visit and help them." — Cook County Key Informant*

Related Focus Group Findings: Specialties

Many South Chicago focus group participants discussed difficulties accessing medical specialists in their community, with primary focus on:

- Limited number of specialists

Nearly all of the focus group participants feel the community has a **limited number of specialists available**. South Chicago respondents agree that specialists are needed in the following areas: psychiatry, dentistry, ophthalmology, rehabilitative services (both physical and speech), and wellness/fitness coaches. One participant describes:

> *"Wellness, you know. Myself as an example, I have a Blue Cross Blue Shield PPO and they always send me these discounts for fitness plans, part of their program. But when I click to link on where the closest one, it's a Life Time Gym at Orland Park. Well, that's about 25 miles south from where I live. Not quite something in my neighborhood." — South Chicago Key Informant*

APPENDIX

Public Health & Community Stakeholder Input

Focus groups held as part of this Community Health Needs Assessment incorporated input from 16 key informants (or community stakeholders), with special emphasis on persons who work with or have special knowledge about vulnerable populations in South Chicago and throughout Cook County, including low-income individuals, minority populations, those with chronic conditions, and other medically underserved residents. A list of these participants is provided below.

South Chicago

Wednesday, June 20th, Noon to 2:00 PM

Focus Group Participant	Title	Populations Served: Medically Underserved	Low-Income Residents	Minority Populations	Populations w/ Chronic Disease
Ms. Carol Muhammad	La Rabida Children's Hospital/CFC #10	X	X	X	X
Ms. Ramona James	Centers for New Horizon	X	X	X	X
Ms. Wendy Walker Williams	South East Chicago Commission	X	X	X	X
Mr. Torrey Barrett	KLEO Center	X	X	X	X

Cook County

Thursday, June 21st, Noon to 2:00 PM

Focus Group Participant	Organization	Populations Served: Medically Underserved	Low-Income Residents	Minority Populations	Populations w/ Chronic Disease
Ms. Valerie L. Webb	Cook County Department of Public Health, Oak Forest Hospital Campus	X	X	X	X
Dr. Daniel Angres	Resurrection Behavioral Health, Addiction Services, Professionals Program				X
Mr. Jack Kaplan	United Way of Metropolitan Chicago	X	X	X	X
Ms. Laura Leon	Campaign for Better Health Care	X	X	X	X
Ms. Lucy Mullen	Rush Oak Park Hospital	X	X	X	X
Dr. Marilyn Wideman	Rush University	X	X	X	X
Ms. Peggy Luce	Chicagoland Chamber of Commerce				X
Ms. Victoria Bigelow	Access to Care	X	X	X	X
Ms. Robyn L. Golden	Rush University Medical Center	X	X	X	X
Ms. Sherry E. Weingart	School of Public Health, University of Illinois at Chicago	X	X	X	X
Ms. Susan Knight	March of Dimes, Illinois Chapter	X	X	X	X
Dr. Susan M. Swider	Rush University	X	X	X	X

Further note that two of the participants have special knowledge of and expertise in public health, including:

Valerie Webb, MPH	
Position(s)	• Regional Health Officer at Cook County Department of Public Health (1991– Present)
Education	• Master of Public Health (MPH), Community Health Education at University of Illinois School of Public Health
Skills & Expertise	• Public Health, Community Health, Program Evaluation, Epidemiology, Health Education

Sherry E. Weingart	
Position(s)	• Clinical Assistant Professor, UIC School of Public Health, 2008 – Present (4 years) • Principal, Health Systems and Human Services Strategist, October 1997 – Present (15 years 2 months) • Past President, UIC SPH Alumni Association, June 2009 – 2010 (1 year) • Assistant Health Officer, Cook County Department of Public Health, 1983 – 1997 (14 years)
Education	• Master of Public Health (MPH), University of Illinois at Chicago-School of Public Health
Skills & Expertise	• Instructional design, e-learning, student advising, research, policy consultation, PH-Analysis, Strategy, Action, Performance (PH_ASAP)