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Suburban Cook County
Community Health Assessment and Plan





COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

Cook County Department of Public Health

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WePLAN 2015

Suburban Cook County

Community Health Assessment and Plan

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I. EXECUTIVE SUMMARY

The Cook County Department of Public Health (CCDPH) has completed its community health planning process, WePLAN 2015, and incorporated the community health assessment and improvement plan into its organization-wide strategic plan.[1] The WePLAN 2015 planning process and final report fulfills the requirements of the Illinois Joint Committee on Rules for certification for local public health departments by the Illinois Department of Public Health.[2] This document summarizes the WePLAN 2015 process undertaken June 2010 – December 2010 by CCDPH and the 50 member Community Planning Committee. Building upon accomplishments from WePLAN 2010, and with new findings from the community health assessment conducted Summer/Fall 2010, the community health improvement plan addresses four strategic health issues:

- Chronic Disease, focusing on cardiovascular disease prevention;
- Violence Prevention, focusing on reducing youth violence;
- Sexual Health Improvement in Youth, focusing on reducing youth sexually transmitted infections and teen pregnancy; and
- Access to Healthcare Services, focusing on increasing access to primary care.

These four strategic health issues and the findings of WePLAN 2015 will become the basis for the implementation of a Cook County strategic health plan, which is one of the main initiatives of the CCDPH 2015 Strategic Plan.

CCDPH serves a large and complex jurisdiction in suburban Cook County with 125 municipalities, 30 townships, more than 1000 schools, and some of the wealthiest and poorest populations in the country. The agency is also one of six certified health departments in Cook County and is a part of the third largest public health care delivery systems in the country. Over the past decade, CCDPH's population has become increasingly diverse, with an influx of new immigrants and increasingly poor as low income populations migrate to the suburbs, from Chicago.

Planning offers an opportunity to examine how to strategically address the issues facing our jurisdiction in a coordinated way that reduces duplication and optimizes prevention efforts for all, especially the most vulnerable. With the implementation in July 2010 of the Cook County Health and Hospitals System (CCHHS) Strategic Plan: Vision 2015, CCDPH began providing leadership with a population approach to optimize health across the entire health system, while also embarking on its own organization-wide strategic planning process in August 2010. It was fortuitous that the 5-year cycle of WePLAN began again at this same time, providing CCDPH with a vehicle for active community participation in assessment and planning. WePLAN 2015 will support both the strategic health plan initiative set forth in the CCDPH 2015 Strategic Plan, as well as fulfill requirements for national accreditation established by the Public Health Accreditation Board.[3]

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[1] See document, *"CCDPH 2015 Strategic Plan Final Report, April 2011"*.
[2] Illinois Joint Committee on Rules for certification for local public health departments by the Illinois Department of Public Health. <http://www.ilga.gov/commission/jcar/admincode/077/07700600sections.html>. 4 May 2011.
[3] Public Health Accreditation Board, <http://www.phaboard.org/.> 5 May 2011.

The WePLAN 2015 planning process attempted to 1) gain community input into the complex health and health related issues facing suburban Cook County residents; 2) build partnerships to maximize efforts and resources in addressing the leading challenges to a healthy population; 3) identify ways to increase coordination throughout the entire county including CCHHS and other public health jurisdictions within Cook County; and 4) develop actionable strategies for improving health that the public health system can accomplish.

There are two major components to this document: The Community Health Assessment and the Community Health Plan. The Community Health Assessment presents the results of four assessments:

1) Community Themes and Strengths Assessment – provides community members' perceptions of leading health issues and community needs. Major findings include concerns with certain health problems (mental health, cancers, diabetes and aging issues), economic problems (unemployment, lack of ability to pay for health insurance and medicine), and the lack of social services in local communities. Community assets include opportunities to improve local communities, and an overall sense that their communities are good places to live. A common theme of disparity was identified, primarily related to access to services and the impact of economic opportunity.

2) Community Health Status Assessment - assesses the health status of the population through an examination of a variety of population and health indicators. Health status improvements include a decrease in coronary artery disease mortality by 20%; cerebrovascular (stroke) mortality decrease by 18%; and an 8% decrease in teen birth rates among 15-19 year olds. Declines in health status include increased Chlamydia rates (56%) among 15-19 year olds and a twenty-six percent increase in gonorrhea for the same age group. Racial/ethnic disparities persisted or worsened with respect to coronary artery disease mortality (increase by 6%), stroke mortality (no change), diabetes-related mortality, and homicide for African-Americans. The teen birth rate for Hispanics and African-Americans continued to outpace Whites (10 times and 7 times, respectively).

3) Local Public Health System Performance Assessment - identifies strengths and gaps in the performance of system partners that have a role in assuring the public's health in relation to national model standards. The Community Planning Committee found the local public health system in moderate to significant compliance providing the 10 Essential Services for public health in suburban Cook County. Services rated as significantly provided by the public health system include: monitoring health status; diagnosing and investigating health problems and health hazards in the community; developing policies and plans that support individual and community health efforts; enforcing laws and regulations that protect health and ensure safety; and assuring a competent public and personal health care workforce. Gaps were found in informing, educating and empowering individuals and communities about health issues; mobilizing community partnerships to identify and solve health problems; linking people to needed personal health services and assuring the provision of healthcare when otherwise unavailable; evaluating effectiveness, accessibility, and quality of personal and population-based health services; and researching for new insights and innovative solutions to health problems. Participants reported cultural and language barriers, lack of timely funding and resources, lack of coordination between public health system partners and lack of community engagement as weakening the ranking of the provision of the 10 Essential Services by the public health system partners.

4) Forces of Change Assessment - considers some of the key forces that may impact the region's health now and in the next five years. The forces identified include health care reform; lack of insurance and lack of healthcare; economic crisis; social inequity; and increasing immigrant and undocumented populations.

After reviewing and discussing these data, the Community Planning Committee reached consensus on the four areas on which to focus health improvement efforts. The strategies selected to address these priorities include health promotion focused on prevention; capacity building through health education; making communities more livable through policy and environmental change; promoting advocacy and public support for public health issues; and improving access through coordination and network development. The overarching principles of equity, prevention and collaboration guide the strategies to implement the community health plan.

Planning is vital, especially during difficult economic times. As resources decrease and community needs increase, it is imperative to explore opportunities for efficiency and effectiveness, leverage current resources, develop shared plans when resources may become available, and craft a common pathway to achieve success. The WePlan 2015 process has resulted in a plan to guide the Cook County Department of Public Health in its population based efforts over the next five years, aligned with the overall CCDPH 2015 Strategic Plan.

II. INTRODUCTION

The Cook County Department of Public Health (CCDPH) has completed its community health planning process, WePLAN 2015, and incorporated the community health assessment and improvement plan into its organization-wide strategic plan.[4] This document summarizes the WePLAN 2015 process undertaken June 2010 – December 2010 by CCDPH and the 50 member Community Planning Committee.

WePLAN 2015 continues the 5 year cycle for jurisdiction-wide community health planning first established in 1994. The planning process and resulting document fulfills the requirements of the Illinois Administrative Code for certification for local public health departments by the Illinois Department of Public Health (IDPH). Specifically, "the process shall involve community participation in the identification of community health problems, priority-setting, and completion of the community health needs assessment and community health plan."[5]

CCDPH serves a large and complex jurisdiction in suburban Cook County with 125 municipalities, 30 townships, more than 1000 schools, and some of the wealthiest and poorest populations in the country. The agency is also one of six certified health departments in Cook County and is a part of the third largest public health care delivery systems in the country. Over the past decade, CCDPH's population has become increasingly diverse, with an influx of new immigrants and increasingly poor as low income populations migrate to the suburbs, from Chicago.

CCDPH now considers the WePLAN process not only a mandate, but an important component of public health practice in suburban Cook County (SCC). Planning offers an opportunity to examine how to strategically address the issues facing our jurisdiction in a coordinated way that reduces duplication and optimizes prevention efforts for all, especially the most vulnerable. With the implementation in July 2010 of the Cook County Health and Hospitals System (CCHHS) Strategic Plan: Vision 2015, CCDPH began providing leadership with a population approach to optimize health across the entire health system, while also embarking on its own organization-wide strategic planning process in August 2010. It was fortuitous that the 5-year cycle of WePLAN began again at this same time, providing CCDPH with a vehicle for active community participation in assessment and planning.

III. PROCESS

WePLAN 2015 was led by a five member planning committee representing CCDPH's Prevention Services and Medical Units. A fifty member Community Planning Committee, comprised of a diverse cross section of sectors from throughout the CCDPH region, including local government, health, business, academia, social services, faith-based and public safety, participated

[4] See document, *"CCDPH 2015 Strategic Plan Final Report, April 2011"*.

[5] Illinois Joint Committee on Rules for certification for local public health departments by the Illinois Department of Public Health. <http://www.ilga.gov/commission/jcar/admincode/077/07700600sections.html>. 4 May 2011.

and helped guide and craft the components of the assessment and plan. The planning process was designed to 1) gain community input into the complex health and health related issues facing suburban Cook County residents; 2) build partnerships to maximize effort and resources in addressing the leading challenges to a healthy population; 3) identify ways to increase coordination throughout the entire county including CCHHS and other public health jurisdictions within Cook County; and 4) develop actionable strategies for improving health that the public health system can accomplish.

CCDPH used a nationally recognized model, recognized as state-of-the-art in public health planning, called MAPP – Mobilizing for Action through Planning and Partnership.[6] The MAPP process led to the development of the two major components of WePLAN 2015: the Community Health Assessment and the Community Health Plan. At the start of the WePLAN 2015 process, the Community Planning Committee reviewed the priorities and accomplishments of WePLAN 2010. In WePLAN 2010, the Community Health Plan prioritized chronic disease, specifically diabetes and obesity, youth violence prevention and access to care. CCDPH aligned fiscal and staff resources to two of the priorities (youth violence and chronic disease prevention) and additional grant funding was received to address issues related to access to primary care. Task forces were created around the three priorities and met on a quarterly basis to increase awareness and coordination on these issues. Among the achievements related to the WePLAN 2010 priorities was: a $16 million federal grant to address obesity and chronic diseases, development of a resource directory for violence prevention and referral resources and a report summarizing the experiences of patient navigators accessing healthcare for their uninsured and underinsured clients.

For WePLAN 2015, CCDPH adapted its planning process with an emphasis on two key issues: a focus on implementation by the agency and its partners from the outset and promotion of a public health system approach to address key strategic issues. The resulting WePLAN 2015 planning process used technology including webinars for selected data presentations and keypad voting to streamline data gathering of the planning process, allow more time for discussion and build consensus toward action. This approach led to fewer in-person meetings and increased participant interaction. As a result, the Community Planning Committee's work developed into a clear conceptual model to address the selected health priorities, and an approach that potentially could be applied to nearly any public health improvement priority.

The WePLAN 2015 Community Planning Committee met during two webinars and four in-person meetings and examined a range of aspects of the SCC's public health system. The meetings involved the following activities:

- Development of a bold and inspirational vision statement;
- Review of issues, assets and needs as identified by survey data from community members;
- A review of health status, disparities and trends in SCC health indicator data including demographic and socioeconomic data, infectious disease, chronic diseases, maternal and child health indicators, injury and violence data and measures of selected health risk factors;

[6] Mobilizing for Action through Planning and Partnership, National Association of City and County Health Officials, <http://www.naccho.org/topics/infrastructure/mapp/framework/index.cfm>. 5 May 2011.

- An examination of key informant data on the local public health system's performance in relation to national standards followed by facilitated discussion and rating;
- Presentation and discussion on emerging forces, trends, threats and opportunities in the public health system at the local, state and national levels;
- Identification and prioritization of three (3) community health priorities on which to develop plans to improve the community's health status; and
- Consensus on a broad conceptual model, with fours strategic approaches that could be tailored to each health priority.

The final meeting focused entirely on action planning – suggesting interventions and activities to address the priorities within the proposed framework. In addition, the Community Planning Committee encouraged the development of a Community Heath Advisory Committee (CHAC) to foster ongoing coordination, assure community input and guidance into the implementation of WePLAN 2015.

IV. ASSESSMENT FINDINGS

1. Community Health Assessment

The Community Health Assessment presents the results of four assessments: 1) the Community Themes and Strengths Assessment (CTSA) gauged community members' perceptions of leading health issues and community needs; 2) the Community Health Status Assessment (CHSA) assessed the health status of the population through an examination of a variety of population and health indicators; 3) the Local Public Health System Performance Assessment (LPHSPA) identified strengths and gaps in the performance of system partners that have a role in assuring the public's health in relation to national model standards; and 4) the Forces of Change Assessment (FOCA) considered some of the key forces that impacts the region's health now and in the next five years.

Community Themes and Strengths Assessment

This assessment involved collecting information via in-person and online surveys. The survey asked residents about their perceptions of major community problems, strengths and issues related to the health and well-being of their community. Completed surveys were received from a total of 354 respondents. These data were compared where possible to a randomized 1200 household survey conducted by the Metropolitan Chicago Healthcare Council. We recognize that the small number of surveys collected by CCDPH is not representative of the entire region, but the purpose of this assessment is not to measure trends. Its main strength is that it presents a community voice in this process. Its goal is to draw attention to broad areas of concern and also to identify community expectations and desires, providing a context for the other assessments, and for use in defining both priorities and plans.

While overall community respondents indicated their communities were good places to live, one-third of respondents stated their community was not healthy. The respondents expressed concern with certain health problems including mental health, cancers, diabetes and issues associated with the aging process – loss of sight/hearing, arthritis, etc. One key community asset identified was the opportunity to participate in making their communities better. However, the economy and lack of economic opportunity, including availability of jobs, were major concerns repeated by residents. In addition, the lack of social services in local communities was a reported concern. Community

respondents also identified low crime rates, safe neighborhoods and access to healthcare as leading elements needed to make a community a healthy place to live – characteristics that all communities should share, recognizing that some do not.

While respondents felt that access to healthcare was an important component of a healthy community, barriers to healthcare were evident. Among the most important barriers to care indicated by the community were lack of insurance, lack of ability to pay for healthcare services and lack of ability to pay for medicines/prescriptions, factors that impact low income residents and impact the heath communities with fewer resources. Not surprisingly, lower income respondents were more likely to report that their health was not good, or fair at best.

From the survey data, the Community Planning Committee recognized a common theme of disparity, primarily related to access to services and the impact of economic opportunity. These were evident in the responses related to access to primary care, concerns about mental health and chronic diseases, and in the variations in access seen by socioeconomic status. For example, while most respondents indicated that they had access to healthy food, nearly 1 in 6 did not, raising questions about whether this was an acceptable standard in a suburban areas in one of our country's largest cities. The need for more equitable distribution of social and community services was also identified by the Committee, recognizing the importance of improved systems and better coordination as a means of addressing this issue.

Community Health Status Assessment

From a comprehensive review of births, disease morbidity, mortality and risk factors, the following key findings were reported.

Improvements in health status were seen in these indicators:

- Coronary heart disease mortality decreased by 20% from 145.6/100,000 in 2000-2002 to 166.0/100,000 in 2005-2007. In 2006, the coronary heart disease mortality rate for the U.S. was (135.0/100,000). The HP2010 for this disease was 166/100,000.

- Cerebrovascular (stroke) mortality decreased by 18% from 55.4/100,000 to 45.5/100,000 between 2000-2002 and 2005-2007. In 2006 the U.S. rate for cerebrovascular disease mortality was 43.6/100,000. With a cerebrovascular mortality rate of 52.1/100,000 in 2005-2007, the South District was the only region in SCC to not meet the HP2010 goal of 48/100,000 for this disease.

- Teen birth rates among 15-19 year olds decreased by 8% from 35.8 births per 1,000 females age 15-19 years to 32.9 birth per 1,000 females age 15-19 years between 2000-2002 and 2005-2007. In 2006, the U.S. teen birth rate was 44.3 births per 1,000 females age 15-19 years.

Declines in health status were seen for these indicators:

- Chlamydia incidence rate increased 56% among ages 15-19 years from 1,168.1/100,000 to 1,825.0/100,000 between 2000-2002 to 2006-2008.
- Gonorrhea incidence rate rose 26% for youth ages 15-19 from 447.9/100,000 in 2000-2002 to 575.4/100,001,168.1 in 2006-2008.

Racial/ethnic disparities persisted or worsened for these indicators:

- Coronary heart disease mortality rate increased for African Americans in CCDPH from 237.2/100,000 to 251.7/100,000 between 2000-2002 and 2005-2007. At the same time the mortality rates for this disease decreased among Whites from 180.7/100,000 to 140.3/100,000. The African American mortality rate for this disease was almost 1.8 times higher than the White rate. The HP2010 goal of for this disease was 166.0/100,000.

- Diabetes-related mortality rate for African Americans increased 14% from 120.8/100,000 to 136.8/100,000 between 2000-2002 and 2005-2007. In 2005-2007, the diabetes mortality rate for African Americans was nearly 2.5 times higher than the rate among Whites (55.2/100,000). The overall U.S. rate was 75.5/100,000).

- Homicide rate among African Americans increased 12.8% from 23.3/100,000 to 26.3/100,000. The homicide rate for African Americans in SCC (25.5/100,000) was higher than the U.S. rate (21.6/100,000) and 4 times higher than the HP 2010 goal of 6.0/100,000.

- Teen birth rate among Hispanics in SCC (85.6/1,000) was almost 10 times greater than the teen birth rate among Whites (8.6/1,000) in 2005-2007. The teen birth rate among African Americans (69.1/1000) was more than seven times greater than the White rate.

While the Community Planning Committee found some positive improvement for the overall population of SCC, racial/ethnic inequities are apparent. Due mainly to medical advances and the decline in smoking[7], the cardiovascular disease (CVD) mortality rate has declined both in SCC and nationally. Despite this decline, coronary heart disease and stroke are still the leading causes of death in SCC, responsible for 33% of all deaths in 2005-2007.

The Community Planning Committee noted the increase in poverty in SCC, and a decrease in income of white men and women with previously high income. Additionally, obesity and smoking, the leading causes of CVD, are higher among the poor, less educated, and minorities.[8] The Community Planning Committee observed that many of the major health issues were preventable, and could be addressed through changes in all populations having access to resources before they get sick. This further emphasized the need for coordination and system-wide strategies to promote health equity in SCC.

Local Public Health System Assessment

The Local Public Health System Performance Assessment (LPHSPA) evaluates the strengths and gaps of the system's ability to perform its duties, as outlined by the 10 Essential Services (ES). The Community Planning Committee found the local public health system in moderate to significant compliance providing the 10 Essential Services in suburban Cook County (rating of 50 %.) All of

[7] National Heart, Lung and Blood Institute. (1998) Morbidity & mortality: 1998 chartbook on cardiovascular, lung, and blood diseases. Rockville, Maryland: US Department of Health and Human Services, National Institutes of Health.

[8] Wing, S., M. Casper, H.A. Tyroler. (1988). Geographic and Socioeconomic Variation in the Onset of Decline of Ischemic Heart Disease Mortality in the United States. Am J. Public Health 78:923-926.

the ES were assessed as being provided at a moderate level of activity or higher (5/10 rated significant activity; 5/10 rated moderate activity).

Essential Services rated as significantly provided by the public health system include:

- # 1- Monitor health status to identify community health problems;
- #2 - Diagnose and investigate health problems and health hazards in the community;
- #5 - Develop policies and plans that support individual and community health efforts;
- #6 - Enforce laws and regulations that protect health and ensure safety; and
- #8 - Assure a competent public and personal health care workforce.

Gaps in services were identified as follows:

- #3 -Inform, educate and empower individuals and communities about health issues;
- #4 - Mobilize community partnerships to identify and solve health problems;
- #7 - Link people to needed personal health services and assure the provision of healthcare when otherwise unavailable;
- #9 - Evaluate effectiveness, accessibility, and quality of personal and population-based health services; and
- #10 - Research for new insights and innovative solutions to health problems.

Participants reported cultural and language barriers, lack of timely funding and resources, lack of coordination between public health system partners and lack of community engagement as significant problems in the provision of the ES by the public health system partners.

The LPHSPA was also used to gauge CCDPH organizational capacity to perform the 10 Essential Services. This assessment was conducted with Senior Managers at CCDPH. There was consensus between the Community Planning Committee's and the CCDPH Senior Program Staff's ranking of the ES for both service provision and priority for the public health system. Diagnose and Investigate Health Problems and Health Hazards in the Community (#2) and Enforce Laws and Regulations that Protect Health and Ensure Safety (#6) were both rated the highest in current provision of the service (4/5) and in priority for the public health system (9/10).

Forces of Change Assessment

The FOCA assessment, conducted with the Community Planning Committee, described trends, factors and events, and the likely impact of these forces on the community's health or the public health system. Responses were further categorized as threats or opportunities. Five major categories were identified and appear below with one participant quote summarizing the forces:

- Health Care Reform - *As healthcare reform unfolds, we have an opportunity to contribute to the development of a newly structured healthcare system with a focus on prevention and a stronger public health system.*
- Lack of insurance and lack of healthcare - C*onsequences of loss of health insurance include delayed diagnosis, decreased opportunities for effective treatment options at a later stage of diagnosis, greater likelihood of spread of communicable disease and health apathy.*
- Economic crisis – *The economic downturn has and will continue to impact the health of our community.*
- Social inequity – *Black, Hispanic and low income communities are plagued by multi-level systemic problems including lack of education, limited goods and services, limited quality jobs, poor transportation.*

- Increasing immigrant and undocumented populations - *Increasing number of poor immigrants in need of services, leading to an increased need for interpreters and translators.*

The WePLAN Planning Committee concurred with the areas of concern identified in the FOCA. Forces such as political instability, shortage of primary care providers and dentists, adequate funding and resources continue to threaten access to healthcare services. The Committee supported the opportunity offered in healthcare reform, but recognized that it will still not provide health coverage for all of the uninsured or the undocumented. Health Information Exchange was also seen as an opportunity to both improve access to population health data that can be used to support population based prevention efforts and as a means of improving continuity of care.

V. COMMUNITY HEALTH PLAN

After reviewing and discussing these data, the Community Planning Committee reached consensus and four areas on which to focus health improvement efforts:

- Chronic Disease Prevention with an emphasis on cardiovascular disease prevention;
- Sexual Health Improvement in Youth, focusing on reducing youth sexually transmitted infections and teen pregnancy; and
- Violence Prevention, focusing on reducing youth violence;
- Access to Healthcare Services, focusing on increasing access to primary care.

With these priority areas, the Community Planning Committee identified operating principles of equity, prevention and collaboration to guide the strategies to implement the community health plan. The strategies selected to address these priorities include health promotion and health education; policy and advocacy to change and support prevention efforts; and coordination to assure efficiency and effectiveness. A Community Health Plan was developed with measureable objectives, practice and evidence-based interventions, and preliminary implementation steps, noting potential resources and barriers for CCDPH and its system partners, as they work together to implement this plan over the next five years. The WePLAN 2015 priorities and findings will also be incorporated into the CCDPH 2015 Strategic Plan, and will be further reviewed and improved as CCDPH implements a strategic health plan for Cook County.

Priority Health Indicators and Potential Interventions:

a. Chronic Disease: Cardiovascular Disease Prevention

Because cardiovascular disease is responsible for 33% of all deaths in SCC, and a majority of these deaths were preventable, the Community Planning Committee continued to prioritize CVD as a major health concern. Coronary heart disease was responsible for more than half of CVD deaths in SCC and stroke was responsible for 17% of CVD deaths. Although the mortality rate for coronary heart disease in SCC has declined 30% from 2000 to 2007, CVD still remains the leading cause of death for all groups, regardless of race/ethnicity or gender. While the stroke mortality rate for SCC (45.2/100,000) is below the HP 2010 goal of 48.0/100,000, stroke is still the leading cause of adult disability.

WePLAN 2010 assisted CCDPH in aligning resources and creating a Chronic Disease Prevention Unit. This unit was able to secure two grants -- an ACHIEVE (Action Communities for Health, Innovation, and EnVironmental change) demonstration project funded by NACCHO that assisted five communities in assessing their capacity to implement systems changes to promote chronic disease prevention; and a $16 million Communities Putting Prevention to Work (CPPW) Centers for Disease Control and Prevention grant to support real policy, systems and environmental changes in communities related to address access to healthy foods, physical activity and obesity prevention. In 2010, model communities grants were awarded to suburban communities and community agencies through a Request for Proposal process. The grant also is working to develop a Cook County Chronic Disease Prevention Network and a web-based community capacity building center to provide resources for training and information for community partners on chronic disease prevention. In addition, tobacco prevention efforts continue to address the impact of tobacco dependence on chronic diseases.

To prevent or reduce cardiovascular disease mortality and morbidity, WePLAN 2015 proposes:

Strategies

- Develop and increase consistent use of health communications messaging related to cardiovascular disease prevention.
- Implement a social marketing campaign targeted at high risk groups for tobacco use.
- Implement opportunities for access to healthy food, especially in areas without adequate access to fresh foods.
- Implement local policies for access to safe places to play/exercise.
- Foster adoption of joint use agreements for use of existing community facilities as public locations for physical activity.
- Enact a comprehensive region-wide policy for smoke free housing, parks and public spaces.
- Advocate for state-wide support for chronic disease prevention programs.
- Develop multidisciplinary networks to address community based plans for chronic disease prevention interventions.
- Advocate for increased chronic disease morbidity and risk factor data to identify at risk populations.

b. Improve Sexual Health Status of Youth

Concerned with the increase in certain STIs, early and unprotected sexual activity and teen pregnancy, the Community Planning Committee prioritized prevention efforts to improve the sexual health status of youth. The WePLAN participants recognized that improving youth sexual health is closely associated with improving community factors such as factual science-based information, availability of community social and recreational services, as well as access to quality healthcare services.

With over 2,500 teen births in SCC in 2007 and an increase in sexually transmitted infections among youth, the WePLAN Steering Committee recognized the need to prioritize the health of our youth. For example, between 2000-2002 and 2006-2008, the rates for gonorrhea increased 26% and

Chlamydia increased 56% among youth (15-19 years) in CCDPH jurisdiction. Among high school students, 37% have had intercourse and 11% have had intercourse with 4 or more people. And among students who have had sexual intercourse during the past 3 months, 40% did not use a condom and 19% drank alcohol or used drugs before intercourse.

To reduce the rates of sexually transmitted infections and unintended pregnancies in youth, WePLAN 2015 proposes:

Strategies

- Increase awareness of the sexual health status of youth, the implications of early and unprotected sexual activity and the factors influencing youth sexual decisions.
- Advocate for policy change on the state and local levels to address implementation of sexual health education curriculum in schools.
- Assess the needs of youth in high risk communities to advocate for increased funding to provide opportunities for youth development.
- Increase coordination of youth health and social service providers to increase understanding of current community resources and to better meet the needs of youth.

c. Violence Prevention

Participants in WePLAN 2015 again acknowledged a healthy community as a safe community. Recognizing that violent acts threaten the quality of life and the mental well-being, residents were concerned that with the economic recession, the threat of violence in their communities and in their families could worsen.

Significant disparities by community, age and race/ethnicity exist. Homicide was responsible for one out of four deaths among youth ages 15-19 in SCC and resulted in an average of 46 years of potential life lost per death. The firearm-related mortality rate for SCC (7.1/100,000) was almost double the Healthy People 2010 goal of 3.6/100,000.

Among the prevention efforts to reduce the threat of violence conducted in the past few years are:

- Development of the WePLAN FOR ACTION Youth Violence Taskforce resource directory and youth leadership efforts.
- The CCDPH Violence Prevention Coordination Unit reaches out to the community's most impacted by violence with capacity-building and networking opportunities as well as data collection.
- CCDPH, Stroger Hospital Trauma and University of Illinois at Chicago are examining the trauma needs in South Cook County. The impetus for this study was the closing of the only trauma center in the far southern suburbs of Cook County in 2009.
- All clients attending CCDPH clinics were assessed for sexual coercion and unhealthy relationships.

To prevent or reduce personal, family and community violence especially in communities suffering from disproportionate rates of violent acts, WePLAN 2015 proposes:

Strategies

- In partnership with community stakeholders, develop a community assessment profile to survey community stability and protective factors.
- Advocate for stronger purchasing requirements for handguns.
- Increase collaborative and networking opportunities to address community resources and referral processes, leverage resources and advocate for support of early childhood programs and improved access to mental health and substance abuse treatment services.
- Conduct provider training on domestic violence and bullying.
- Develop and/or provide tool kits for schools, daycares, churches, youth activities on violence prevention.
- Develop a campaign to bring attention to family violence and the protective factors needed for prevention of violence.

d. Access to Healthcare Services

Access to comprehensive healthcare services remained a priority in our region as confirmed in the community assessments. Residents identified that paying for services and prescriptions, primarily because of no health insurance, remains a significant barrier to staying healthy. Unfortunately, the number of uninsured residents has increased mainly due to rising unemployment and the economic recession.

Over 16% of adults in SCC in 2009 have not had a routine check-up in the last two years and 13% did not have a regular primary care provider. In SCC, the diabetes-related hospitalization rate from 2008-2009 among African Americans was 2,243.7/100,000, which is more than 2.5 times the rate for Whites (846.6/100,000). Likewise, the uncontrolled hypertension hospitalization rate for SCC (115.1/100,000) is much lower than the rate for African Americans (392.3/100,000). The asthma hospitalization rate for children under the age of 5 was 128.8/100,000 for Whites, 258.0/100,000 for Hispanics and 608.1/100,000 for African Americans.

Among past efforts to understand and address the barriers to healthcare were:

- An Access to Care Task Force of the WePLAN for Action committee developed a report: *Access to Primary Care Resources for Un/Underinsured Residents in Suburban Cook County,* examining experiences of community patient navigators and identifying barriers for the un/underinsured. Regionally, Health & Medicine Policy Research Group in Chicago, assessed the status of the healthcare safety net in the Chicago Metropolitan Region and Center for Faith and Community Heath Transformation examined influences on primary care including health care reform;
- State and local partners worked to plan for Health Information Exchange (HIE). Planning grants to two regional partners – Metropolitan Chicago Healthcare Council and Health Care Consortium of Illinois were used to develop plans for an HIE structure in the Chicago region. An IDPH HIE workgroup examined the value and role of HIE in supporting population and public health.

To improve access to personal healthcare services, especially comprehensive primary care. WePLAN 2015 proposes:

Strategies

- Focus local/regional social marketing campaigns on the importance of preventive services, where to obtain them, and assure that they are culturally and linguistically appropriate.
- Foster the development of an online electronic clearinghouse of all available local specialty services that includes the ability to make referrals (in addition to CCHHS).
- Increase regional capacity to effectively implement the Patient Protection and Affordable Care Act of 2010 (Health Reform).
- Develop materials on return on investment of population-based public health.
- Advance universal health care access and coverage.
- Advocate for integration of comprehensive services within primary care.
- Foster the implementation of the CCHHS Strategic Plan, especially as it relates to expansion of ambulatory care services.
- Engage opportunities to implement evidence based models of community-oriented primary care.
- Complete an assessment of the Cook County Ambulatory Care capacity.
- Advocate for and participate in the development of a regional Health Information Exchange focused on both personal and population health.

Conclusion

Planning offers an opportunity to examine how to strategically address the issues facing our jurisdiction in a coordinated way that reduces duplication and optimizes prevention efforts for all, especially the most vulnerable. During difficult economic times, planning becomes even more important, as resources decrease and community needs increase.

With the implementation in July 2010 of the Cook County Health and Hospitals System (CCHHS) Strategic Plan: Vision 2015, CCDPH began providing leadership with a population approach to optimize health across the entire health system, while also embarking on its own organization-wide strategic planning process in August 2010. It was fortuitous that the 5-year cycle of WePLAN began again at this same time, providing CCDPH with a vehicle for active community participation in assessment and planning. WePLAN 2015 will support both the strategic health plan and national voluntary agency accreditation initiatives set forth in the CCDPH 2015 Strategic Plan.