



STATE HEALTH ASSESSMENT

TABLE OF CONTENTS

ACKNOWLEDGMENTS	3
LETTER FROM THE DIRECTOR	4
EXECUTIVE SUMMARY	6
INTRODUCTION	12
Healthy Illinois 2021 Components	13
State Health Assessment Purpose	14
Participants	14
Healthy Illinois 2021 Vision of Success	15
APPROACH AND METHODS	16
Core Assessment Framework	17
Building on Existing Work	19
Identify Preliminary Priorities	20
Stakeholder Engagement	20
Selection of Indicators	22
FINDINGS	24
Core Assessment Results	26
Who We Are	30
Social Determinants of Health	31
Access to Quality Care	35
Behavioral Health	38
Maternal and Child Health	41
Chronic Disease	45
CONCLUSION	48
APPENDICES	
Appendix A: Planning Council Member List	53
Appendix B: Local Health Department IPLAN Priority Summary	54
Appendix C: Stakeholder Engagement Organizational Participation Results	55
Appendix D: Core Indicator Summary	60

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Listings of the Planning Council Members and organizations that participated in feedback sessions are included in Appendices A and C.

LETTER FROM THE DIRECTOR

DEAR ILLINOIS STAKEHOLDERS:

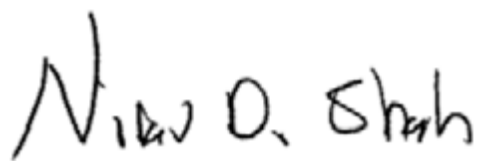
Thank you for your interest in the Healthy Illinois 2021 initiative. On behalf of the Department of Public Health, I'm excited to present the Illinois State Health Assessment. This document describes the statewide assessment process, a part of Healthy Illinois 2021, undertaken by the Illinois Department of Public Health over the last year.

Healthy Illinois 2021 represents three statewide initiatives all working to improve the health of Illinois residents. At the Department of Public Health, we recognize the need to assess the health states of residents in Illinois, and establish health improvement implementation strategies that address health issues and health disparities. Through the State Health Assessment, we have identified key health priorities for the public health system in Illinois. Based on this information, we will develop approaches and strategies that will lead to health improvement in these priority areas. The strategies will be documented in the State Health Improvement Plan, a companion document to this one that will be released in the spring of 2016. Healthy Illinois 2021 also includes the State Innovation Model initiative, which is focused on developing a strong health care system that will make health care better for people in Illinois.

The Healthy Illinois 2021 State Health Assessment was made possible through the collaborative and coordinated effort of many individuals and organizations across the State of Illinois. The project was led by the Illinois Department of Public Health (IDPH), the Illinois Governor's Office, and the University of Illinois at Chicago School of Public Health MidAmerica Center for Public Health Practice.

The Healthy Illinois 2021 Planning Council, whose members were integral to the development and production of the State Health Assessment, guided this process and met multiple times during 2015. I'm grateful for their work and commitment. Organizational partners also provided important feedback, and I thank them for their valuable contributions.

Addressing the health issues highlighted in this document will take the work of all of our public health system partners. I look forward to continuing this process toward health improvement with you.

A handwritten signature in black ink that reads "Nirav D. Shah". The signature is written in a cursive, flowing style.

Nirav D. Shah, MD, JD

Director, Illinois Department of Public Health

EXECUTIVE SUMMARY

The mission of the public health system is to lead health improvement and strive for health equity. As a means to address this mission in the state of Illinois, a coordinated process, Healthy Illinois 2021, is composed of three statewide initiatives — the State Health Assessment (SHA), the State Health Improvement Plan (SHIP), and the State Innovation Model (SIM) — that together work to coordinate and align plans, processes, and resources to lead health improvement and health equity.

Executive Summary continued »



A state health assessment is a systematic approach to fulfilling this mission by collecting, analyzing, and using data to educate and mobilize communities, develop priorities, garner resources, and plan actions to improve the public's health. This document represents the State Health Assessment (SHA), a process led by the Illinois Department of Public Health, the Illinois Governor's Office, and the University of Illinois at Chicago School of Public Health MidAmerica Center for Public Health Practice. Findings from this process, referred to as Healthy Illinois 2021, are presented in this report including selected statewide health priorities and summary data for a set of health indicators that highlight the key health issues in the state.

Healthy Illinois 2021 was guided by a Planning Council made up of state agencies, community-based organizations, associations, public health departments, health and hospital systems, insurance companies, and other entities. The Planning Council provided guidance and expertise in the selection of health priorities based on collective understanding of the current state of health in Illinois. The Planning Council also identified strengths, opportunities, and barriers to health improvement, which was foundational information for developing implementation plans to drive health improvement around these specific health priorities. Strategies and activities for improving health will be described in the State Health Improvement Plan (SHIP), a companion document to the SHA.

Approach

The approach taken to develop the SHA includes components designed to (a) apply a sound framework for conducting the assessment; (b) build on existing work; (c) identify a preliminary, flexible set of priorities; and (d) engage stakeholders in the assessment and final prioritization process. This approach was carried out through the use of four core assessments developed as part of the Mobilizing for Action through Planning and Partnerships (MAPP) process by the National Association of County and City Health Officials and modified for these purposes:

- Health Priorities and Status Assessment
- Community Themes and Strengths
- Public Health System Assessment
- Forces of Change

SUMMARY OF CORE ASSESSMENT AND CONTRIBUTORS			
Health Priorities and Status Assessment	Community Themes and Strengths	Public Health System Assessment	Forces of Change
- Health Status Indicators - Illinois Project for Local Assessment of Needs (IPLANs) - Community Health Needs Assessments (CHNAs) - State Agency Review - Focus Groups - Organizational Presentations	- State Agency Review - Focus Groups - Organizational Presentations	- Stakeholder Survey - State Agency Review	- State Agency Review - Focus Groups - Organizational Presentations

Fundamental to the assessment approach was a health status indicator selection process which identified key measures that highlight the current state of health in Illinois. In order to continuously monitor the state of health in Illinois a discrete set of indicators was selected by the Illinois Department of Public Health in collaboration with the University of Illinois at Chicago School of Public Health. The indicators presented in this document are a key subset of those indicators, shown by race and ethnicity, geography, and trend wherever possible. Presentation of data for the complete set of selected indicators is available in the companion document: Healthy Illinois 2021 Health Data: Core Indicators.

Findings

The health priorities selected through Healthy Illinois 2021 included Behavioral Health, Chronic Disease, and Maternal and Child Health, utilizing approaches that address Social Determinants of Health and Access to Quality Care as implementation requirements to address health improvement in these areas. These priorities were overwhelmingly supported through the community engagement process.

Results based on the four core assessments are summarized below.

What is the health status of our state?

The health status of Illinois was assessed using these data collection strategies:

- Reviewing local health department (N=100), not-for-profit hospitals (N=120) community health needs assessment data, and critical care hospitals (N=28) community health needs assessment data, state agency plans (N=35), and a preliminary presentation of existing health data.
- Vetting early identified health trends through focus groups and organizational presentations.
- Undertaking data production of selected key indicators.

Health Priority Findings:

- Across hundreds of plans and review with 400 focus group and organizational representatives, access to quality care, social determinants of health, behavioral health, maternal and child health, and chronic disease were found to be the top health issues in the state of Illinois.

Health Status Findings:

Identifying disparities in the health status indicator data collected was a key goal for this process. Racial/ethnic disparities were seen for the vast majority of the 33 core indicators for which data on race and ethnicity were available. The disparities between non-Hispanic blacks and non-Hispanic whites were the most pronounced, but disparities between Hispanics and non-Hispanic whites were also evident.

- For 17 of the 33 indicators, rates of adverse health effects were 2 or more times higher in non-Hispanic blacks than in non-Hispanic whites.
- For 7 of the 33 indicators, rates of adverse health effects were 2 or more times higher in Hispanics than in non-Hispanic whites.

The largest disparity between non-Hispanic blacks and non-Hispanic whites was for homicide rates, and the disparity between Hispanics and non-Hispanic whites is also large for this indicator of community safety. Moreover, the percentages of non-Hispanic black and Hispanic parents who reported that their children were living in unsafe neighborhoods were 3.5 and 3.9 times higher than the percentages reported by non-Hispanic whites, respectively.

Racial/ethnic disparities were relatively small for some indicators, including physical activity in adults, poor mental health in adults, and cancer. Small disparities do not diminish the importance of indicators, but may inform the strategies chosen to address them.

Disparities were also considered in relation to national benchmarks. For 20 of the 24 core indicators with relevant national benchmarks, one group in Illinois had met the benchmark while other groups had not.

- Non-Hispanic whites had met benchmarks for 18 of these 20 indicators; in stark contrast, non-Hispanic blacks had not met the benchmark for 17 of them, and Hispanics had not met benchmarks for 14.
- For cancer and suicide, the patterns of disparity were different. Hispanics had met the benchmark for cancer while both non-Hispanic whites and non-Hispanic blacks had not. For suicide, non-Hispanic whites had the highest rates and were the only group that had not met the benchmark.
- For childhood obesity, adult smoking, and smoking among pregnant women, racial/ethnic disparities were present, and the benchmarks had not been met by non-Hispanic blacks, Hispanics, or non-Hispanic whites.

What are the assets related to health improvement in Illinois?

The Healthy Illinois 2021 Planning Council identified statewide assets in four areas: services, innovation, state as a change driver, and partnership. Services included efforts to ensure that assistance is provided

in appropriate settings, the service delivery system, and efforts encouraging healthy lifestyles. Innovation included the ability to utilize evidence-based best practices and the commitment the state has made to innovation in health care and new delivery models. As a change driver, the state plays the role of convener and payer, and has shown a willingness to work together with different agencies and sectors. Partnerships referred to the strong relationships that exist between stakeholders and the state that benefit Illinois residents for the good.

These areas were vetted through focus groups and presentations, and strong alignment emerged around partnerships and services being strengths of the state as well as regional or local strengths. In the focus groups, technology, policy, and the workforce emerged as strengths.

What are the opportunities and barriers related to health improvement in Illinois?

The Planning Council also identified opportunities around health improvement. Five key areas were identified as opportunities: partnerships, prevention, data, leveraging resources, and innovation. For example, partnerships refers to the opportunity to expand partnerships with community-based organizations or linking clinical health and prevention to behavioral health. Data includes expanding the technological infrastructure and data collection that can help forecast needs at a state level. Prevention refers to the opportunity to expand preventive activities across the state. Leveraging resources includes leveraging previous planning processes around various health issues as well as seeking creative approaches to fiscal and programmatic challenges. Innovation includes the opportunity to standardize care coordination, incentivize the use of best practices, and encourage innovative delivery systems.

As part of the stakeholder engagement process, survey participants found that leveraging resources and prevention are the biggest statewide opportunities. From a local perspective, data sharing and use and engagement, such as increasing cross-sector coordination and coalition building, were the biggest areas for improvement. Barriers to health improvement identified by the Planning Council included resources, health literacy, coordination and collaboration, and workforce shortages. Health literacy refers to barriers for consumers navigating the health system. There is a lack of coordination and collaboration between sectors and agencies, and workforce development is a challenge.

As part of the stakeholder engagement process, survey participants found that leveraging resources and prevention are the biggest statewide opportunities.

Survey participants found that resources and coordination and collaboration are the biggest statewide barriers, meaning that improvements in these areas are needed. From a local perspective, programs and services, access to providers, provider education, and other issues around providers were the biggest barriers.

The process of summarizing Illinois indicator data has pointed to ways in which the data infrastructure and data analysis in Illinois can be improved to facilitate a statewide system of data sharing, use, and monitoring. To build and enhance capacity will require articulating a comprehensive vision for data utilization and includes a commitment to supporting analytic work that can inform program and policy.

How is the public health system performing in Illinois?

The Illinois Department of Public Health conducted a survey of stakeholders to assess satisfaction with the state public health system. The survey sought feedback both specifically about the Illinois Department of Public Health and, more broadly, the public health system overall on the delivery of the Ten Essential Public Health Services.¹ Survey results were analyzed by UIC SPH to identify those public health essential services that were above or below performance and capacity, representing possible strengths and limitations in the public health system.

The results suggest that the public health system is stronger in monitoring health, diagnosing and investigating, informing, educating and empowering, enforcing laws, and assuring a competent workforce. The results also suggest that the public health system is weaker in mobilizing community partnerships, developing policies and plans, linking to and providing care, evaluating, and conducting research.

Conclusion

Using the data from the SHA, the Planning Council and organizational partners moved into three Action Teams for each of the health issue priorities (Behavioral Health, Maternal and Child Health, and Chronic Disease) to develop action-oriented implementation plans, which were used to develop the SHIP.

INTRODUCTION

The mission of the public health system is to lead health improvement and tackle health equity. Its core functions are to assess the needs, assets, and opportunities related to the health of the public to facilitate and assure programming and policy strategies that drive health improvement.

Introduction continued »



In partial fulfillment of its mission and under Illinois state statute 20 ILCS 5/5-565,² the Illinois Department of Public Health (IDPH) is designated to lead an effort to create a unified strategy for improving the state's public health system. With other public agencies influencing the health of Illinoisans and a number of non-governmental partners contributing, IDPH led an effort that engaged a panel of experts and community stakeholders in a comprehensive planning process that recognized and built upon other statewide and local health improvement efforts across the state. The process worked to coordinate and align plans, processes, and resources to facilitate health improvement and achieve health equity. In the end, this process united three major statewide initiatives into what would become Healthy Illinois 2021.

Healthy Illinois 2021 Components

Healthy Illinois 2021 is composed of three statewide initiatives that together work to coordinate and align plans, processes, and resources to lead health improvement and health equity.

- **Illinois State Health Assessment**

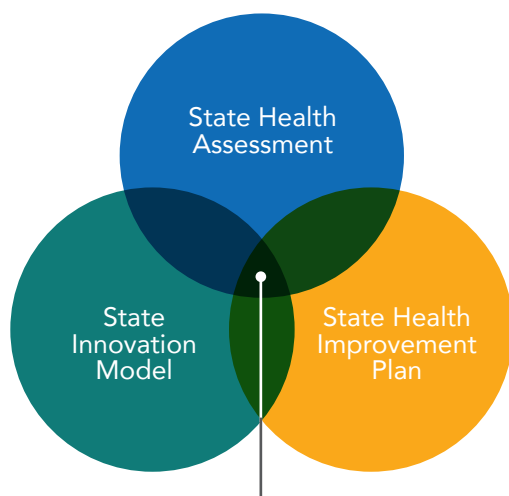
The State Health Assessment (SHA) is a systematic approach to accessing, analyzing, and using data to educate and mobilize communities, develop priorities, garner resources, and plan actions to improve the public's health.

- **Illinois State Health Improvement Plan**

The State Health Improvement Plan (SHIP) is a five-year systematic plan to address issues identified in the SHA. Based on the SHA, the SHIP describes how the state health department and the communities it serves can work together to improve the health of the population. The SHIP also represents the Plan for Population Health.

- **Illinois State Innovation Model**

The State Innovation Model (SIM) considers multi-payer health care payment and service delivery models that aim to improve health system performance, increase quality of care, and reduce costs.



Healthy Illinois 2021

State Health Assessment Purpose

This report presents the process and the findings of the SHA. The SHA serves as a basis for understanding the current state of health in Illinois, and provides valuable information regarding the needs and opportunities for health improvement. This process included the work of committed organizations, associations, research institutions, agencies, and many others to not only undertake a planning process, but begin that process with the end in mind: an actionable plan to improve health.

Participants

The Healthy Illinois 2021 Planning Council was appointed by Governor Rauner to serve as the guiding entity for the Healthy Illinois 2021 initiative (Appendix A). Planning Council members represent organizations from numerous sectors including transportation, education, health care, environment, and social service. Organizations include state agencies, community-based organizations, associations, public health departments, health and hospital systems, insurance companies, and other entities, which constitute the public health system in Illinois. As a statewide body, the Planning Council is convened by the Governor's Office and IDPH. The MidAmerica Center for Public Health Practice at the University of Illinois at Chicago School of Public Health facilitated the effort.

The Planning Council held six full-membership meetings between June and December of 2015 to assess the current state of health in Illinois. Each meeting represented a review and discussion of assessment data to obtain further validation of key themes emerging on emerging public health systems infrastructure and health priority issues. Planning Council meeting materials are located at http://www.healthycommunities.illinois.gov/planning_council.htm.

While the Planning Council guided the plan's development, numerous other entities participated through a series of focus groups, presentational meetings, and webinars. More than 400 individuals and agencies were engaged and made contributions throughout the planning process.

Planning Council Representation



Healthy Illinois 2021 Vision of Success

Healthy Illinois 2021 represents a coordinated, aligned approach to lead health improvement and tackle health equity. With a five-year timeline, the Healthy Illinois 2021 Planning Council agreed that success of the overall initiative would lead to overall improvements in the public health system infrastructure, alongside improvements in specific health priorities that would benefit all Illinois residents. The Planning Council established broad infrastructure goals as an operational vision of success. Healthy Illinois 2021 will result in:

- Aligned and coordinated clinical and primary prevention strategies;
- Patients and community residents that are viewed holistically;
- Effective data systems and infrastructure;
- Aligned quality measures;
- Innovation that occurs through use of evidence-based strategies and best practices;
- Consumer education improvements;
- Maximized current workers and cultivated new workers within the public health system; and
- Community-oriented, asset-based decision making.

Planning Council meeting materials are located at
http://www.healthycommunities.illinois.gov/planning_council.htm.

APPROACH AND METHODS

The approach taken to develop the Illinois State Health Assessment reflects a convergence of four distinct but integrated components designed to (a) apply a sound framework for conducting the assessment; (b) build on existing work; (c) identify a preliminary, flexible set of priorities early in the process; and (d) engage stakeholders in the assessment and final prioritization process.

Approach and Methods continued »



CORE ASSESSMENT FRAMEWORK

At the core of this effort were four distinct assessment approaches adapted from a participatory community health improvement strategic planning process, Mobilizing for Action through Planning and Partnerships (MAPP),³ which has been used by hundreds of state and local health departments across the country. The MAPP framework was adapted to this state health improvement process in three ways:

- Focused on engaged organizations as representatives of communities;
- Reviewed existing community plans as part of the assessment process; and
- Focused on organization- or system-level issues.

The MAPP framework helps participants apply strategic thinking to prioritize public health issues and identify resources to address them using an interactive process that can improve the efficiency, effectiveness, and the performance of public health systems. The findings of the four assessments converge to point to key issues that must be addressed to strengthen the public health system. A brief description of the assessment and corresponding tools used to address these assessments is below.

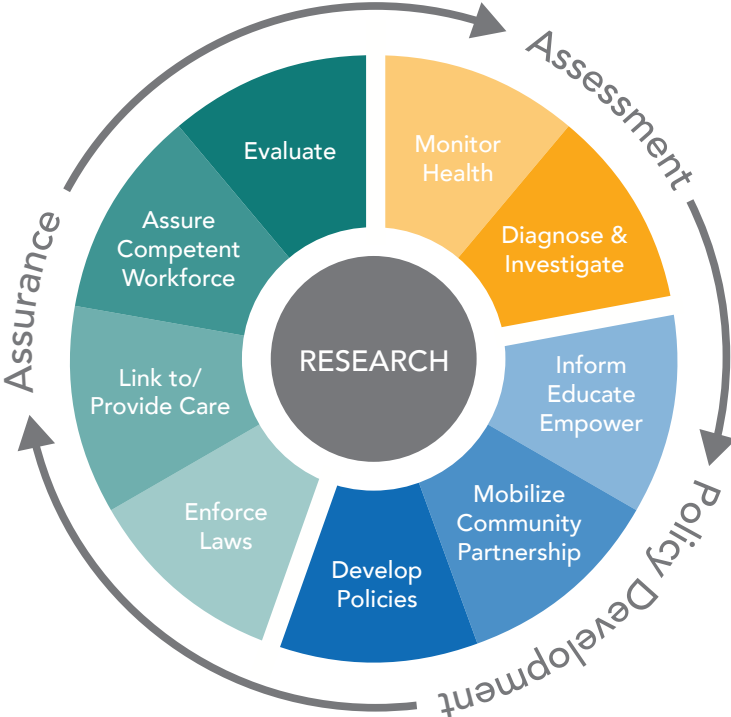
Health Priority and Status Assessment » This assessment asks the questions “How healthy are our residents?” and “What does the health status of our state look like?” As a first step for this assessment, local health department plans and community health assessments were analyzed to understand health priorities already identified by other organizations in the public health system. In addition, summarization of secondary data was carried out to produce a snapshot of the current state of health, highlighting specific health priorities in Illinois. The information presented was culled from reports and documents that provided health status indicators and was intended to provide an initial picture of the current state of health. This was built upon through the indicator selection process described later in this document and data presented through the indicator set. The UIC SPH team then focused on the data and generated descriptive analysis.

Community Themes and Strengths » This qualitative assessment considers the input of a broad range of stakeholders to obtain feedback about perceived quality of life and statewide assets and challenges. Community themes and strengths were gathered through focus groups, a review of existing health and strategic plans, and organizational presentations.

Public Health System Assessment » The system assessment explores the performance of not only the state public health department but also, more broadly, the public health system in carrying out the Ten Essential Public Health Services,⁴ which are public health activities for communities to undertake and serve as the framework for the National Public Health Performance Standards. The Illinois Department of Public Health (IDPH), with support from UIC SPH, led the 2015 Public Health Stakeholder Satisfaction Survey that inquired about IDPH staff and partner perceptions of the public health system’s performance and capacity.

Forces of Change Assessment » The forces of change assessment addresses the question “What is occurring or might occur that affects the health of our state?” This is done by identifying external forces such as legislation, technology, demographic shifts, and other impending changes that affect the context in which communities and the public health system operate. This information was collected from Planning Council members as well as through focus groups and organizational presentations.

Overall Summary » Primary and secondary data were used in the core MAPP assessment framework, adapted for a state process. The following table illustrates how the data collected came together to meet the core assessments. Data collection processes are described in the following section. Data collected, analyzed, produced, and/or reviewed are presented throughout the rest of this document.



SUMMARY OF CORE ASSESSMENT AND CONTRIBUTORS			
Health Priorities and Status Assessment	Community Themes and Strengths	Public Health System Assessment	Forces of Change
- Health Status Indicators - IPLANs - CHNAs - State Agency Review - Focus Groups - Organizational Presentations	- State Agency Review - Focus Groups - Organizational Presentations	- Stakeholder Survey - State Agency Review	- State Agency Review - Focus Groups - Organizational Presentations

BUILDING ON EXISTING WORK

A tremendous amount of assessment and planning is done in the state. From the start of this process, every effort was made to recognize the meaningful work occurring in localities throughout Illinois as well as in state agencies. The goals of these efforts were to consider existing health priorities, identify challenges and opportunities, and avoid duplicative efforts in assessment. Toward this end, the facilitators reviewed several documents identified below, and organized the findings of this review into the framework of the four core assessments. As a starting point, this work was done prior to any other assessments to provide a basic understanding of the current state of affairs of the public health system in Illinois.

- **Local Health Department Assessments (IPLANs)**

The Illinois Project for Local Assessment of Needs (IPLAN) is a required assessment process that every certified local health department must complete every five years as a condition of certification. The process calls for the engagement of community partners and the identification of health improvement priorities. As part of the State Health Assessment process, 100 county IPLANs were reviewed by IDPH to identify the priorities that emerged most frequently.⁵ This review process had not been done before and yielded a high-level perspective of local priorities that was easily compared across the state. This showed strong commonality and alignment between local priorities (Appendix B).

The IPLAN review found that the majority of the top ten priorities for local health departments were chronic diseases. Mental health and maternal and child health were among the top ten priorities as well.

- **Hospital Assessments (CHNAs)**

Under the Affordable Care Act, not-for-profit and critical care hospitals conduct Community Health Needs Assessments (CHNAs). The completed CHNAs from 148 Illinois hospitals were reviewed to identify the most frequently identified priorities.

As with the IPLAN review, a consolidated group of priorities emerged from the CHNA review. These included access to health care, mental health, obesity, substance abuse, diabetes, and cardiovascular disease.

- **State Agency Report Review**

In addition to IDPH, several state agencies conduct activities that influence the health of Illinois residents. A scan of these agency websites was conducted to identify reports and additional data that might inform the assessment process. In an effort to evaluate statewide assets, barriers, and opportunities for health improvement, 35 state agency strategic plans, operating plans, and needs assessments were reviewed.

The state agency report review found several areas of consistency related to statewide strengths, opportunities, and barriers. For example, state agencies make an effort to ensure that services are provided in appropriate settings whether services are for individuals with disabilities, children, justice-involved youth, or older adults. Additionally, a common theme for improvement was that data and technology systems could be more effective in allowing partners to share and use information.

IDENTIFYING PRELIMINARY PRIORITIES

Following the review of the more than 200 existing documents including the IPLANs, CHNAs, and state agency reports, findings were summarized and presented to Planning Council members for initial prioritization. Priorities emerging from this processes included:

- Social Determinants of Health
- Access to Quality Care
- Behavioral Health
- Maternal and Child Health
- Chronic Disease

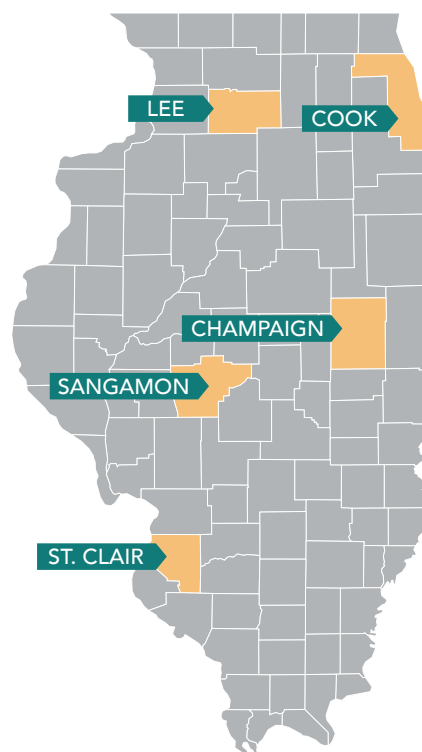
STAKEHOLDER ENGAGEMENT

Another key component of the State Health Assessment was the engagement of a broad range of stakeholders. As with the review of existing documents described above, stakeholder input was considered within the context of the four core assessments. Three steps were taken to obtain feedback from communities and other stakeholders. A summary of the results may be found in Appendix C.

Focus Groups » Eleven focus groups were conducted in five counties representing different regions of the state: Cook County, Lee County, Champaign County, St. Clair County, and Sangamon County. Each session was scheduled for two hours and included no more than 15 participants. Almost one hundred participants represented their organizations.

The session format included a basic overview of the Healthy Illinois 2021 project (including the SHA, SHIP, and SIM), as well as the purpose and objectives for the focus groups. The majority of the presentation focused on providing an early snapshot of the current state of health and understanding the initial priority areas recommended by the Planning Council. The discussion questions were geared toward reflecting on the presentation and then thinking about health improvement in participants' communities. Discussion questions included:

- Is there anything surprising in the current thinking around the major health issues in Illinois?
- What health issue(s) would you add as being a priority in Illinois, if any? Why?
- What health issue(s) would you subtract from being a priority in Illinois? Why?



- How do these health issues align with your organization's work?
- How are the health issues being experienced by the people you serve?
- How are communities working together in your region to address these issues?
- In what ways have you been successful working on these health issues?
- What can be improved?
- What needs to be done to address gaps that is not currently being done?

Transcripts were created from each focus group session, and content was reviewed and categorized based on the above questions. They were subsequently coded for key themes shared between focus groups at the same location and ultimately across all locations. Additional health priorities suggested by focus group participants were categorized into a broader "health issues" or "system strategies" category. The remaining information was presented as a strength, barrier, or opportunity for health improvement.

Organizational Presentations » Presentations for stakeholder organizations were held throughout September and October 2015. Sessions were held as in-person meetings/presentations and webinars. In total, eleven sessions were held with over three hundred people participating.

The format of these sessions included a basic overview of the Healthy Illinois 2021 project, as well as the purpose and objectives for feedback. As with the focus groups, the majority of the presentation focused on presenting a snapshot of the current state of health and understanding the early priority areas recommended by the Planning Council. Additionally, when time allowed, information was presented on the perceived statewide assets, barriers, and opportunities for health improvement.

Feedback was solicited during the presentations as well as via a survey tool after the session. Survey questions sought to identify:

- Feedback on preliminary priorities
- Suggestions for additional priorities
- Successful health improvement work conducted by respondent organizations
- Perceived statewide assets, barriers, and opportunities

Everyone who attended a presentation was invited to participate in the feedback survey, and fifty-six surveys were completed.

In-Depth Planning Council Member Interviews: Interviews were conducted with Planning Council members to elicit their thoughts on existing assets, barriers, and opportunities. This information collection strategy used one-on-one phone calls with Planning Council members as an opportunity to share specific and detailed feedback. Calls were conducted in advance of the Planning Council meeting in which assets, barriers, and opportunities were discussed. Information from the interviews was shared at the meeting as a starting point for discussion and to present early information. All Planning Council members were invited to participate.

2015 Public Health Stakeholder Satisfaction Survey » IDPH conducted a survey of stakeholders to assess satisfaction with the state public health system. The intent of the 2015 Public Health Stakeholder Satisfaction Survey was to obtain feedback from a broad spectrum of the public health community to identify areas for system improvements, strengthen state and local partnerships, and assure that a strong system is in place for effective responses to day-to-day public health issues and emergencies. The survey sought feedback both specifically about IDPH and, more broadly, the public health system on the delivery of the Ten Essential Public Health Services. The 2015 Public Health Stakeholder Satisfaction Survey was disseminated electronically to 5,873 community partners and all IDPH staff, which included approximately 1,200 employees. A total of 502 surveys were completed. Survey results were analyzed by UIC SPH to identify public health services that were above or below performance and capacity, representing possible strengths and limitations in the public health system.

SELECTION OF INDICATORS

The current state of health in Illinois is described using health data collected by IDPH. In order to monitor and annually assess and report on the state of health in Illinois to the public, a discrete set of indicators was selected. This indicator selection process also required agreement on how the data would be accessed, organized, and analyzed. This process serves as the foundation for periodic examination of a set of indicators in order to monitor the extent of progress being made on improving the health of Illinois citizens.

The indicator selection process began with a list of more than one hundred potential indicators culled from the Healthy People 2020 indicator set, already established indicators within IDPH, and other sources. UIC SPH and IDPH worked collaboratively to arrive at a set of 48 indicators that would be reported specific to this process (Appendix D).

A data template was developed by the UIC SPH data team to provide a consistent framework for data reporting by IDPH. The template specified a standard set of categories for racial/ethnic groups and for geographic regions, specified several alternative sets of categories for age, and called for as many years of trend data as feasible by the racial/ethnic categories when possible. Also, when possible, the template linked each indicator to relevant benchmark data from either Healthy People 2020 or other sources. The IDPH data team provided data for the indicators to the UIC SPH data team, who then completed indicator calculations; generated tables, graphs, and maps for presentation; and provided narrative description and interpretation of the findings.

FINDINGS

The purpose of the State Health Assessment is to highlight primary and secondary data that convey the current state of health in Illinois. From these data, the pressing health issues faced by the state emerge as priorities.

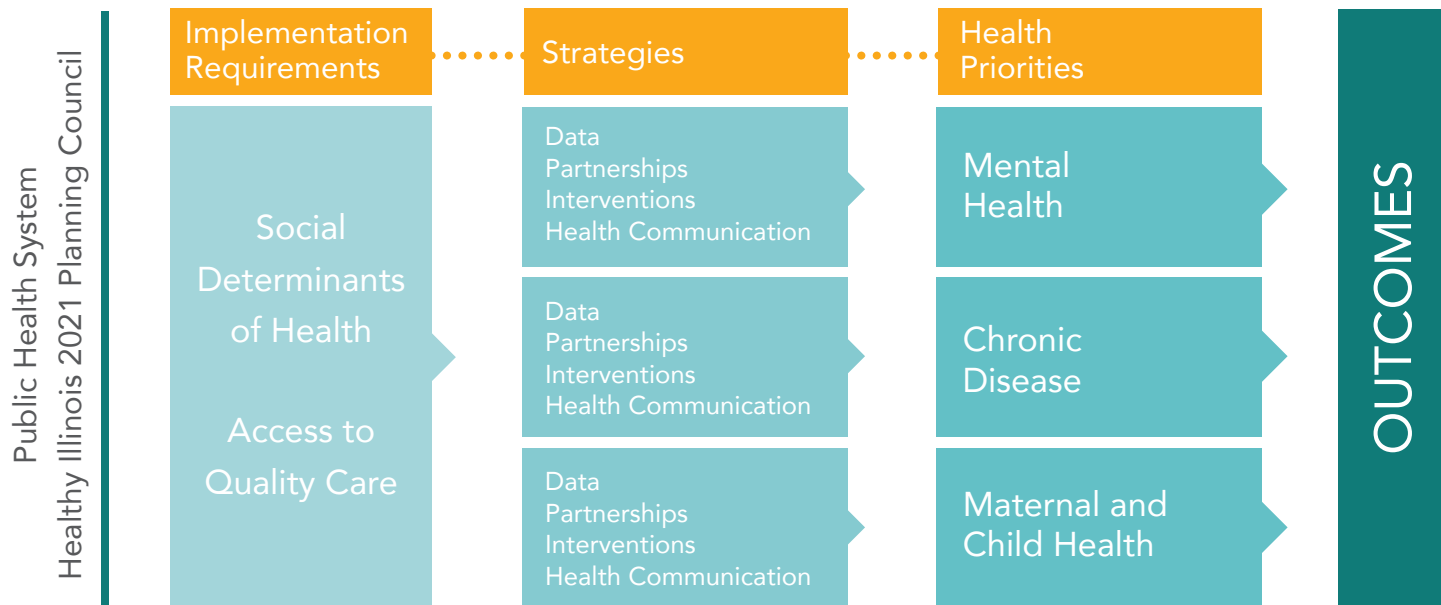
Findings continued »

Priority areas were identified through the four core assessments, the review of existing work, and the stakeholder engagement processes. The first topic speaks to broad societal challenges, while the second speaks to health care system challenges. The last three topics listed below represent health status domains to be addressed by the public health system through the State Health Improvement Plan (SHIP).

- Social Determinants of Health
- Access to Quality Care
- Behavioral Health
- Maternal and Child Health
- Chronic Disease

These issues resonated tremendously across the state during the stakeholder engagement process, and they were overwhelmingly supported during feedback sessions. Given that the process convened diverse segments of the Illinois public health system for their input on what the priorities of the state should be, varying perspectives were raised. However, there was consensus around the request to further define each priority so that the priorities could be effectively addressed in action planning.

Through a prioritization process with the Healthy Illinois 2021 Planning Council, the five areas prioritized included Behavioral Health, Chronic Disease, and Maternal and Child Health, utilizing approaches that address Social Determinants of Health and Access to Quality Care as implementation requirements for health improvement in these areas. These priorities, described in the following pages, serve as the basis for the SHIP. Relevant health status indicators are also included to further describe the state of health around these priority areas.



CORE ASSESSMENT RESULTS

The stakeholder engagement activities and core assessments produced data related to statewide strengths, barriers, and opportunities. The state agency assessment, public health system assessment, and key stakeholder interviews were shared with the Planning Council and discussed. Early strengths, opportunities, and barriers were shared with local stakeholders for further refinement.

STRENGTHS

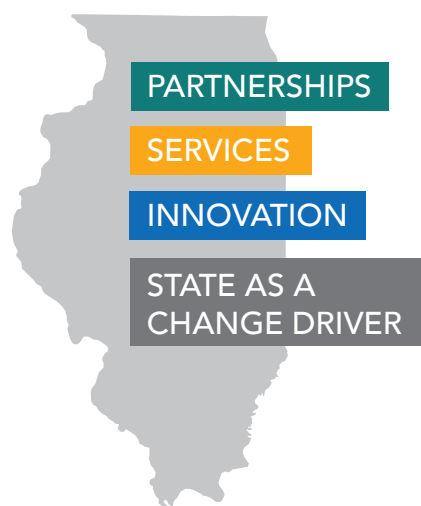
State Agency Reports

The agency needs assessment found that the strengths of the state include efforts to ensure that services are provided in appropriate settings; service delivery throughout the state that is largely grant-based, meaning that funding and decision making is concentrated at the local level to respond to community-level needs; statewide coverage for service delivery; agency efforts encouraging healthy lifestyles by promoting programs related to walkability, physical activity, and healthy food choices; programmatic efforts directed toward vulnerable populations; and efforts to utilize evidence-based best practices.

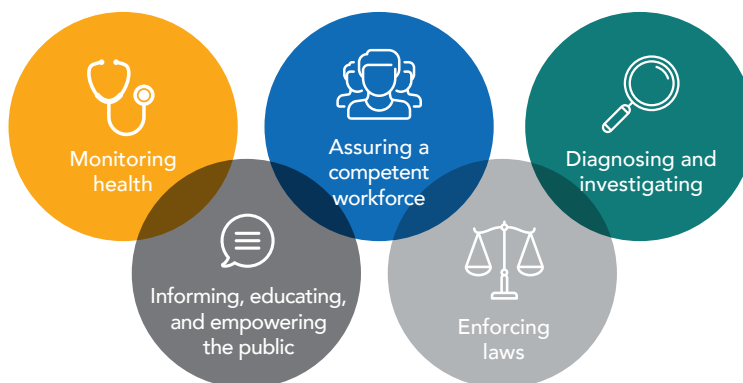
Interviews with Planning Council Members

Interviews indicated that the infrastructure of the state is strong. There is a commitment from the state to advance innovation in health care. State agencies play a key role in collaboration as a convener. The state is also the largest payer for health care, making its role at the table instrumental. Planning Council members noted that provider groups have strong relationships and partnerships across the state. Additionally, they highlighted that strategic plans are currently in place, and there has been work toward implementing such plans.

Statewide Strengths



Public Health System Functions with Higher Performance and Capacity



Stakeholder Engagement Process

Regional and local strengths were highlighted through the stakeholder engagement process. Many organizations saw their strengths as the programs and services they provided. Additionally, the partnerships and collaborations they are involved in are seen as assets to health improvement. This collaborative philosophy was echoed by participants. One noted: "It does seem that when you can bring a group of folks together and address an issue collectively you certainly have a greater bang for your buck in most cases."

OPPORTUNITIES

State Agency Reports

The agency needs assessment found that opportunities for health improvement in the state include the ability to address needs in the health care workforce to expand capacity, establish new health care worker roles, promote jobs and education, and expand on health care career pathway opportunities.

Illinois can also bolster wrap-around services for consumers, for example, ensuring health care access, transportation, and after-school programs. Rehabilitation services and vocational programs for justice-involved youth can be increased and expanded to address youth needs. Efforts such as asset-based mapping, joint goal setting, and increased communication would benefit health improvement efforts.

Given the information provided, the Planning Council found five key areas for opportunity in the state:



Interviews with Planning Council Members

Planning Council member interviews revealed that statewide opportunities included further establishing infrastructure for statewide clinical and population health data sharing needs. The state could do more as a convener and funder. There are also opportunities for standardizing care coordination, increasing access to mental health services, improving prevention activities, and strengthening population health and clinical care integration.

Stakeholder Engagement Process

Participants in focus groups and organizational presentations also considered the regional and local opportunities for health improvement. Key categories included leveraging resources, focusing on prevention, engaging communities, and doing more with data. Improvement around the data infrastructure was also seen as a necessity at the local level. For example, participants shared that access needs to be improved so that data are "more easily accessible, more timely, more current, because it's very difficult to show outcome when you don't have consistent data that's growing at the same rate."

BARRIERS

State Agency Reports

The agency needs assessment found that key barriers included state-based funding and the accessibility of statewide providers covered by public and private insurance, as well as poverty affecting Illinois residents across the life course and the need for data and technology systems to be more effective. Further, additional barriers such as gaps in health and health care coverage, especially for certain treatments, and a lack of a common definition of quality in health and health care delivery were noted.

Interviews with Planning Council Members

Interviews indicated that barriers included the state budget and funding situation, lack of investment in information technology infrastructure, inadequate access to mental health services in specific areas of the state, and siloed organizational structures resulting in lack of communication and coordination. Through Planning Council discussions and the presentation of data collected in the assessment and interviews, four top barriers were identified: resources, workforce shortages, insufficient coordination and collaboration, and lack of health literacy.

Stakeholder Engagement Process

An additional key barrier identified in focus groups and presentations was the current data infrastructure in Illinois, including surveillance, monitoring, and data sharing. While this is also an opportunity, it represents a current barrier to tracking and monitoring health in the state. The focus groups also considered barriers at the regional and local levels, and those that were identified included resources, coordination and collaboration across the state, access to resources regarding programs and services, and providers. Access to providers and provider networks in rural areas was a key challenge raised. One participant shared an example based on experience, saying, “Even though there are already incentives for providers to come to extreme rural areas like I’m from, you still have trouble getting them to those areas sometimes. One of our general surgeons just retired. We’re trying to build our surgery department and trying to get a surgeon to come to that area, and unless they want to go for the incentive of getting their student loans paid off we’re kind of sunk.”

Statewide Barriers



Public Health System Functions with Lower Performance and Capacity



HOW DID PRIORITIES EMERGE?

Several steps in the planning process were necessary in order to identify health priorities for the state. Building on existing work was the first component in this process. This included reviewing local health department priorities, Community Health Needs Assessments (CHNAs) conducted by hospitals, and state agency annual reports and strategic plans.

Priority Analysis

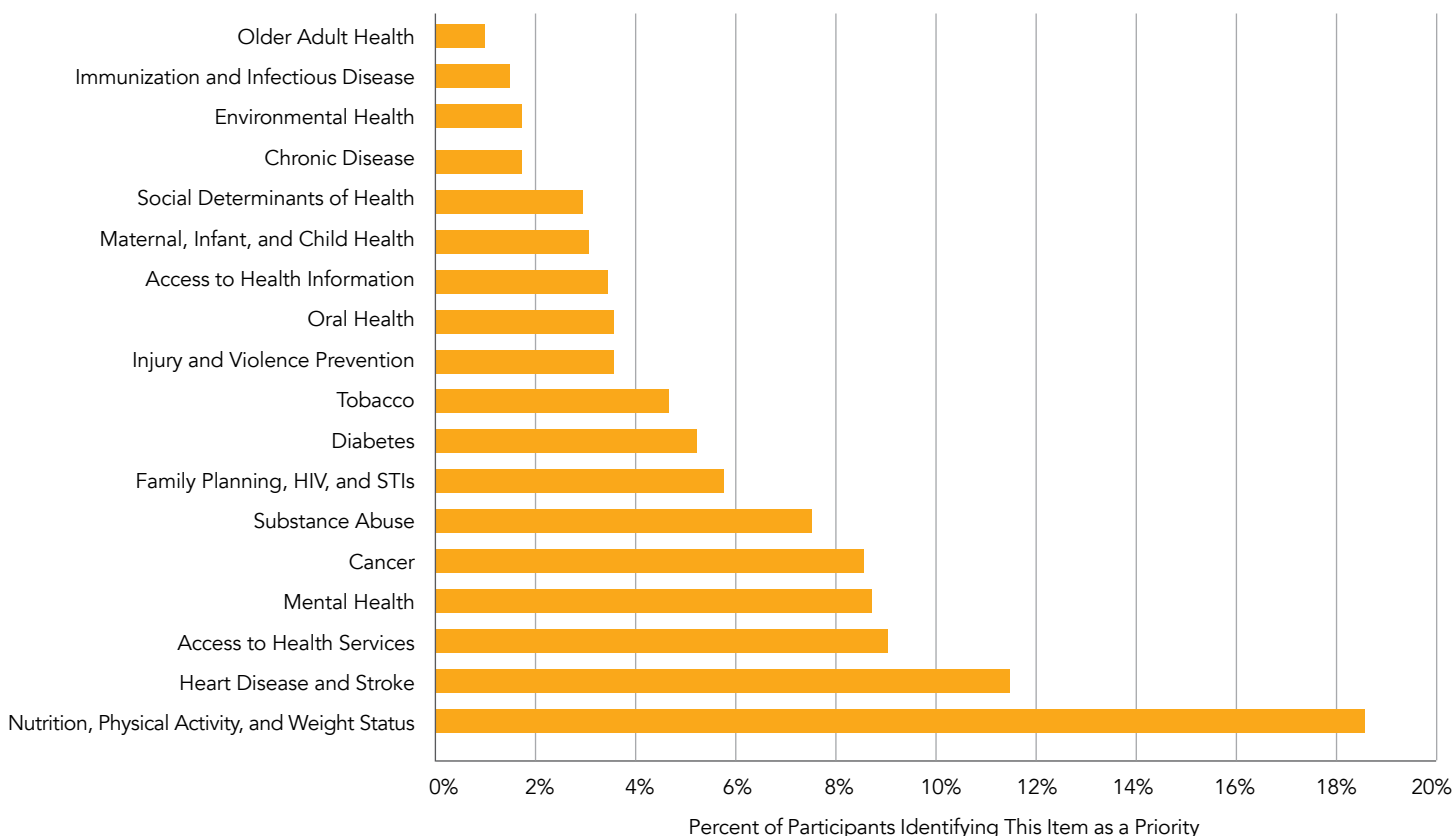
The analysis of the local health department priorities and CHNAs showed that local health improvement priorities are consistent throughout the state. The bar chart below shows the distribution of priorities for local health departments.⁶

Planning Council Input

The Healthy Illinois 2021 Planning Council was presented with the data from local needs assessment processes, as well as initial health status information. Planning Council members established an initial list of health priorities that was then narrowed down to include social determinants of health, access to quality care, behavioral health, chronic disease, and maternal and child health.

Stakeholder Engagement

This information was then vetted locally and regionally through focus groups and organizational presentations. There was overwhelming support for the health priorities suggested; none were rejected as areas the state should focus on.



A review of transcripts from the focus group sessions provided rich detail around how health issues are being experienced throughout Illinois and the efforts organizations are making to address key issues. Over 100 pages of transcripts and notes were reviewed, and the themes were categorized and tallied in order to identify examples and overarching themes. How health priorities are defined was the biggest issue with the early priorities. Participants requested that more detail on each priority area be available to better understand the areas. Of the additional priorities mentioned, about 35% of them could fall under a broader category of behavioral health, access to quality care, chronic disease, social determinants of health, or maternal health. Most of the additional priorities were strategies or target populations, as opposed to health issues. A few members of focus groups raised three additional and unique health issues: oral health, respiratory issues, and infectious disease.

Finalizing Priorities

The feedback provided in focus group and organizational presentation sessions was then reported back to the Planning Council for final prioritization. After a facilitated discussion using standardized prioritization tools (e.g., prioritization matrix and dotmocracy, also know as idea rating sheets or sticker dot voting), the Planning Council voted to select Behavioral Health, Chronic Disease, and Maternal and Child Health as the statewide health priorities. The group also came to consensus that access to quality care and social determinants of health should serve as implementation requirements for addressing these health priorities.

WHO WE ARE

In 2014, Illinois was home to nearly 13 million people, making it the fifth most populous state in the nation. Between 2000 and 2010, the total population of Illinois increased by 3.3%. Chicago is the third largest city in the nation with approximately 2.7 million residents. Two-thirds of Illinois residents live in the northeastern region of the state.

Illinois has a diverse population. While 63% of the population is white, close to 15% is non-Hispanic black, close to 17% is Hispanic, and a little over 5% is Asian/Pacific Islander. About 14% of the Illinois population is foreign born.

Almost a quarter of Illinois residents are children under 18 years old, while approximately 1 in 7 of the state's residents are 65 and older. A majority of Illinois residents (ages 25 and older) have at least a high school education.

Close to two million people living in Illinois were living in poverty in 2014.

Select Sociodemographic Characteristics, Illinois, 2014

Source: IDPH, Center for Health Statistics*

	NUMBER	PERCENT
Illinois Overall	12,880,580	100.0
Race/Ethnicity		
Non-Hispanic Black	1,885,164	14.6
Non-Hispanic White	8,115,541	63.0
Hispanic	2,152,974	16.7
Asian/Pacific Islander	701,675	5.4
American Indian/Alaskan Native	25,226	0.2
Foreign-Born	1,786,926	13.9
Age		
< 18	2,988,474	23.2
18-44	4,712,911	36.6
45-64	3,390,662	26.3
65-84	1,532,481	11.9
85+	256,062	2.0
Geographic Region		
Central Illinois	426,349	3.3
Northeastern Illinois	8,687,508	67.5
Northwestern Illinois	1,251,758	9.7
Southern Illinois	972,440	7.6
Southwestern Illinois	756,311	5.9
Western Illinois	786,214	6.1
At Least High School Education, Among Ages 25 and Over	7,427,358	87.3
Below the Federal Poverty Line	1,772,333	14.1
*U.S. Census Bureau Population Estimates		

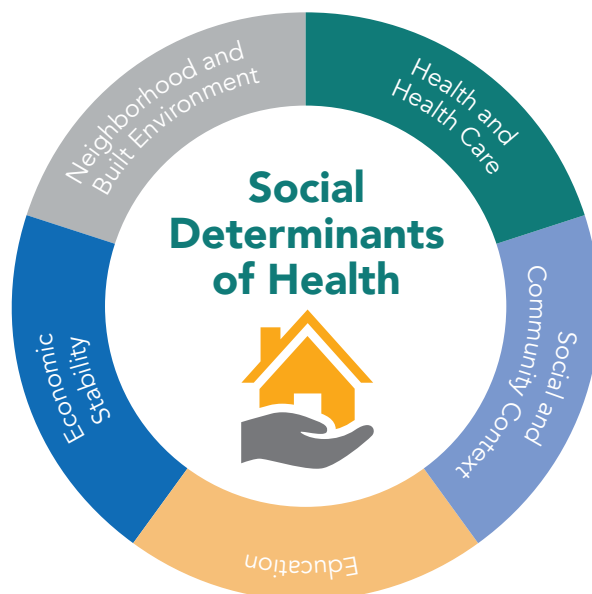
SOCIAL DETERMINANTS OF HEALTH

Definition

The World Health Organization defines social determinants of health as “the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.”⁷

For the purposes of Illinois’ State Health Assessment and improvement plan, social determinants of health are considered implementation requirements for addressing health improvement. These factors are described here to better understand what contributes to the health of Illinois residents.

The information provides a more complete picture of the health of Illinoisans, but will also be used in the action planning process to identify strategies that can improve behavioral health, chronic disease, and maternal and child health in Illinois.



Core Assessments

Information obtained from the focus groups and organizational presentations showed that addressing social determinants of health is an underlying tenet of health improvement work regionally and locally. For example, according to one participant, organizations are “looking at addressing all of these [issues], but through the social determinants of health. So our mission is really to eliminate barriers towards accessing health care through working with social service organizations.”

Focus group participants agreed that, as one participant stated, “if you look at the social determinants of health as well, addressing those would affect all the other things on the list. As we’re talking about access to primary care, that can have a lot to do with transportation for people in cities but also often time in rural areas of the state; people can’t get to where the care is, due to transportation, where the clinics are located, poverty, etc. Access to good nutrition can also be hard if you don’t have access to transportation or are in poverty-stricken areas.”

A barrier identified through the Community Themes and Strengths assessment was that minority and vulnerable populations in Illinois experience greater poverty, underinsurance, unemployment, and food insecurity. Poverty in general is a concern for improving the health status of Illinois residents. This is reinforced by findings from the Forces of Change assessment that highlight the lack of funding for community-based organizations that provide services to this population.

Health Status Indicators

A number of indicators are related to social determinants of health. Issues such as economic stability, education, the environment, and social and community context have an impact on health and well-being. Key indicators from these areas are presented below.

Economic Stability

In 2014, close to two million Illinois residents were living in poverty, with the highest rate of poverty in southern Illinois. However, mirroring the overall distribution of where people live in the state, most of the people in poverty live in the northeast region. Although Illinois residents of all races experience poverty, there is still a racial/ethnic disparity, where non-whites experience higher rates of poverty throughout the state.

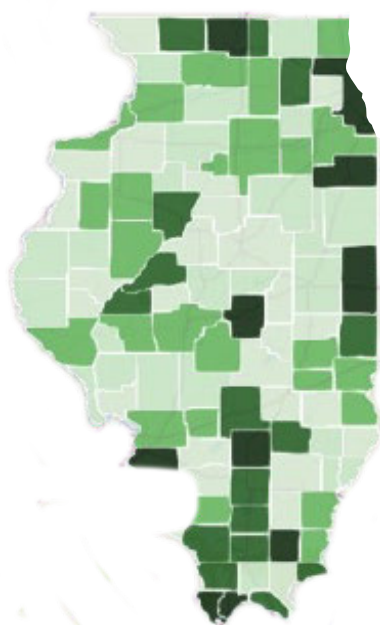
To assess poverty more comprehensively, approaches such as concentrated disadvantage and county well-being can be applied. These approaches seek to capture the complex circumstances in which people live. The “Concentrated Disadvantage” map below compiles indicators such as percentage of people living in poverty, unemployment rate, percentage of households receiving public assistance, households that are female-headed, and percentage of individuals that are under 18 years old. The “County Well-Being” map focuses on the percentage of individuals living in poverty, as well as unemployment rate, percentage of teen births, and high school graduation rates.

In Illinois, the northeast region, which includes Chicago and its suburbs, and the southern region have the largest income inequality in the state according to the Gini index, which measures household income inequality. Gini index scores range from 0 (total income equality) to 1 (total inequality). The northeast region of Illinois has a score of 0.474 on the Gini index, and the southern region is measured at 0.453.

Education

The high school graduation rates vary slightly across the state, ranging from a low of 86.2% to a high of 90.3%, with the lowest rates in the northeast and south regions.

Concentrated Disadvantage



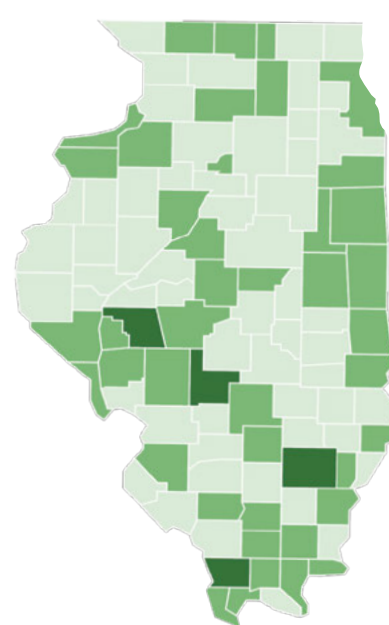
Level of Disadvantage (compared to state average)
Highest High Med-High Low-Med Low

Source: IDPH, Office of Women's Health and Family Services

Concentrated Disadvantage is a summary index created from five variables in the 2008-2012 American Community Survey and 2010 Census files, as recommended by the Association of Maternal and Child Health Programs (AMCHP) Life Course Indicator Set: http://www.amchp.org/programsandtopics/data-assessment/LifeCourseIndicatorDocuments/LC-06_ConcentratedDisad_Final-4-24-2014.pdf

The 10 most disadvantaged counties (darkest green) are: Winnebago, Cook, Kankakee, Vermilion, Macon, Marion, St. Clair, Saline, Alexander, and Pulaski.

County Well-Being



Status
Normal Watch List Warning List

Source: Terpstra, A., Clary, J., & Rynell, A. (2015, January). Poor by comparison: Report on Illinois poverty. Chicago: Social IMPACT Research Center at Heartland Alliance. <https://www.heartlandalliance.org/research/annual-poverty-report/>

42 Illinois counties are on the well-being “watch list” (darker green), and 4 are on the well-being “warning list” (darkest green): Montgomery, Morgan, Union, and Wayne.

Environment

One indicator explored was the level of daily fine particulate matter in the state. The eastern part of Illinois, from north to south, has the highest level of fine particulate matter pollution, meaning that the air quality in this area is decreased. According to the United States Environmental Protection Agency, "health studies have shown a significant association between exposure to fine particles and premature death from heart or lung disease. Fine particles can aggravate heart and lung diseases and have been linked to effects such as: cardiovascular symptoms; cardiac arrhythmias; heart attacks; respiratory symptoms; asthma attacks; and bronchitis."⁸

The housing available to Illinoisans is another indicator of the context in which people live. For example, the age of housing across the state, which aligns with lead levels among children who have been tested, is one measure. Compared to other areas of Illinois, the western region has a higher percentage of older housing as well as a higher percentage of high lead levels among children who were tested in 2014.

Social and Community Context

Lack of community safety is another social determinant of health. Like many other social determinants, it has been shown to be associated with both physical and mental health outcomes throughout the course of an individual's life.

In Illinois overall, close to 1 in 6 children were reported by a parent or guardian as living in an unsafe community. For both non-Hispanic black and Hispanic children, approximately 1 in 4 were reported as living in an unsafe community.

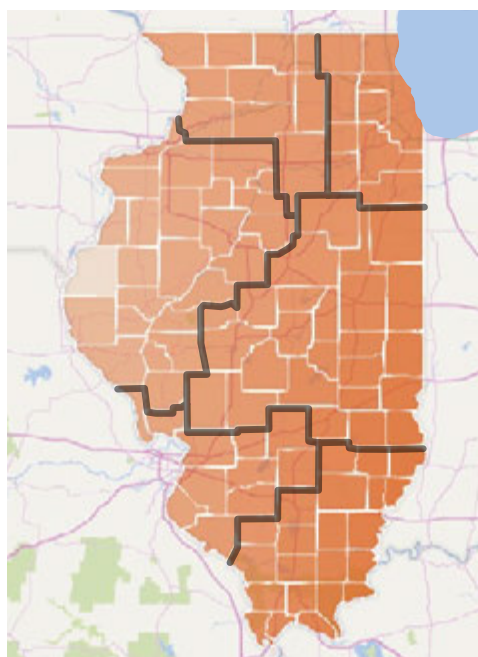
Homicide and mortality due to motor vehicle accidents reflect a combination of factors. In 2014, 768 Illinoisans were victims of homicide and 984 Illinoisans died in motor vehicle accidents. Even after adjusting for age, non-Hispanic blacks were far more often the victims of homicide compared to other racial/ethnic

Daily Fine Particulate Matter, Avg Daily Measure, by County

Micrograms per cubic meter, 2011

U.S. EPA PM 2.5 Standard: 12.0

Illinois Overall: 12.6



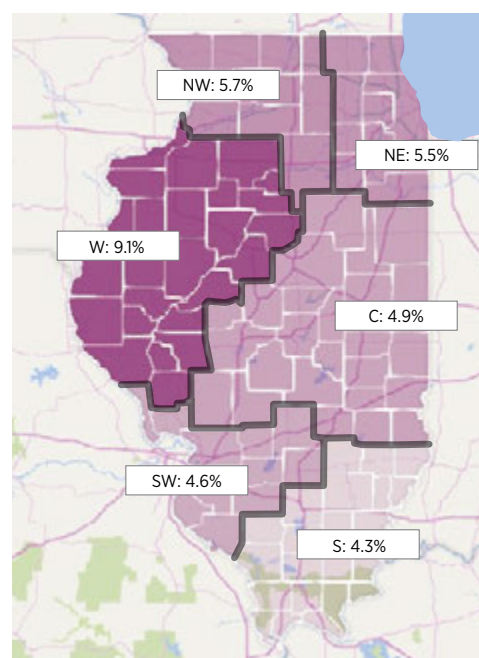
Less Particulate More Particulate

Source: U.S. Environmental Protection Agency

Percent Blood Lead ≥ 5 $\mu\text{g}/\text{dl}$ of Illinois Children Tested

72 Months and Younger,

by Region, 2014



Lower Higher

Source: IDPH, Center for Health Statistics and Division of Vital Records

<http://www.cdc.gov/nceh/lead/data/state/ildata.htm>

groups, and their age-adjusted rate was more than five times that of the Healthy People 2020 benchmark. In contrast, there was very little racial/ethnic disparity in the rate of death due to motor vehicle accidents, and in fact the age-adjusted rates in Illinois were all better than the Healthy People 2020 benchmark.

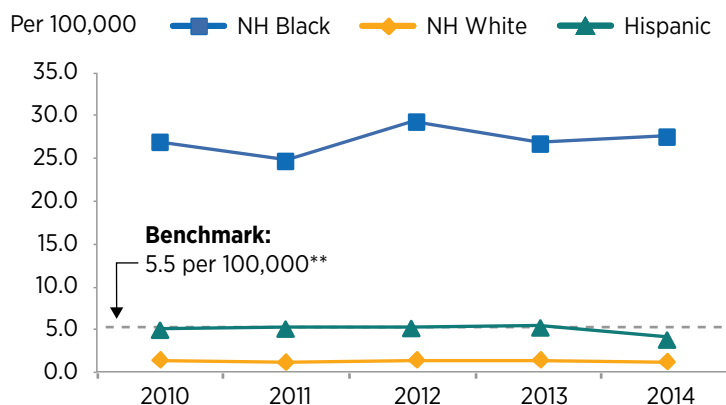
Homicide rates were also highest among men and among young adults. The motor vehicle death rate was similarly higher among men, but the age pattern was different, with a high rate among young adults and the highest rate among the elderly.

The trend data for homicide show the persistence of the disparity between non-Hispanic blacks and other racial/ethnic groups. The trends in motor vehicle deaths were more variable, but all groups were below the benchmark throughout 2010-2014.

Age-Adjusted Homicide Rate

per 100,000 Population
by Year and Race/Ethnicity, 2010-2014*

Source: IDPH, Center for Health Statistics and Division of Vital Records



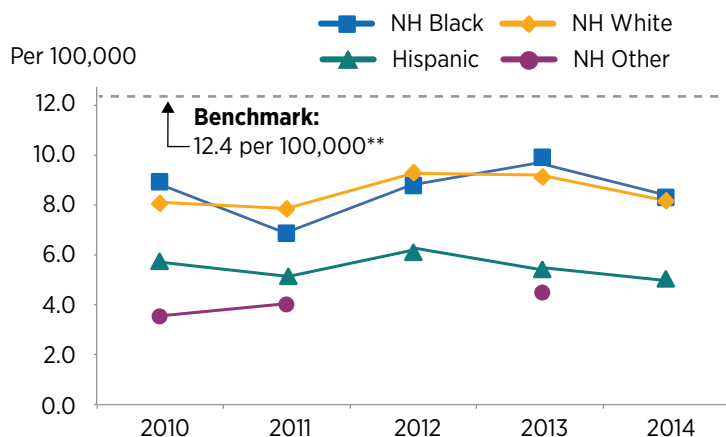
*2014 data are provisional.

**Healthy People 2020 IVP-29, Reduce homicides; based on age-adjusted rates.

Age-Adjusted Motor Vehicle Mortality Rate

per 100,000 Population
by Year and Race/Ethnicity, 2010-2014*

Source: IDPH, Center for Health Statistics and Division of Vital Records



*2014 data are provisional.

**Healthy People 2020 IVP-13.1, Reduce motor vehicle crash-related deaths; based on age-adjusted rates.

ACCESS TO QUALITY CARE

According to the Institute of Medicine, access to health care means “the timely use of personal health services to achieve the best health outcomes.”⁹ Attaining good access to care requires 1) Gaining entry into the health care system, 2) getting access to sites of care where patients can receive needed services, and 3) finding providers who meet the needs of individual patients and with whom patients can develop a relationship based on mutual communication and trust. Access and quality are both critical components of the health care system. Access to quality care is viewed as foundational for achieving health improvement in Illinois.

The Affordable Care Act and Access to Quality Care

During the first two years of open enrollment under the Affordable Care Act (ACA), just under 1 million Illinois residents gained health insurance coverage either through the Illinois Health Insurance Marketplace (approximately 344,222) or the expanded Medicaid program (622,673). Almost 600,000 remain eligible for Marketplace coverage. Over 100,000 of the uninsured Marketplace-eligible individuals reside in 10 geographic areas of the state (known as Public Use Microdata Areas), with the largest pockets of uninsured living in Cook and Champaign Counties.

While improved access to care is significant, the ACA also holds promise for efforts to address other priorities identified through the State Health Assessment, including health inequities.

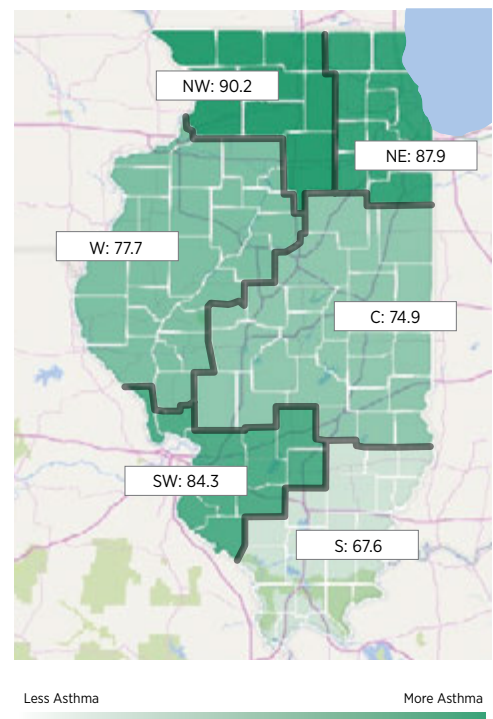
- The ACA contains language to provide preventive services and comprehensive treatment for mental health that is equivalent to that provided for physical health.
- Several provisions, including the mandatory inclusion of maternity care coverage, are designed to address coverage gaps and inequities in women’s health insurance.
- The ACA aims to prevent and reduce chronic diseases both through provisions for preventive care and through the Public Health and Prevention Fund, which provides grants to states and other entities.

Core Assessments

The changing health care environment informed the Planning Council discussion around access to quality care. The ACA is playing a large role in increasing access to care across the state, both through private insurance and through the publicly funded Medicaid program. Although access is increasing, many Planning Council members were concerned about the quality of services provided. Issues raised during the Community Themes and Strengths and Forces of Change discussions included the distribution of primary and specialty care providers across the state, the standard of care across the state, navigating the health care system to find quality providers, and ensuring consumers can receive the services they need at a price they can afford.

Rate of Emergency Department Discharges, Pediatric Asthma

Per 10,000 Children, by Region, 2014
Illinois Overall: 85.4



Source: IDPH, Division of Patient Safety and Quality

Access to care is also a concern for local health departments; 9% of the health priorities identified through IPLANs were related to access to health care services.

Health Status Indicators

Childhood asthma, type 2 diabetes, and hypertension are often referred to as “ambulatory care sensitive conditions,” since in a health care system with adequate and equal access to care these conditions can be managed in a primary care setting.

In 2014, non-Hispanic blacks had much higher rates of emergency department use for pediatric asthma, type 2 diabetes, and hypertension compared to other Illinoisans.

There also appears to be some geographic disparity in the use of the emergency department for pediatric asthma, type 2 diabetes, and hypertension. In 2014, northern Illinois and southwestern Illinois had the highest rates of emergency department use for pediatric asthma compared to other areas of the state. In contrast, the northeastern part of the state, including Chicago, had lower rates of emergency department use for type 2 diabetes and hypertension, with the remainder of the state having higher rates of emergency department use for these two conditions.

Overall, in 2011, Illinois had more primary care physicians per capita than the United States had overall, which would ideally translate into better access to basic health care and reduce the need for use of emergency care. The rate of primary care physicians varies by county in Illinois, but there is no clear pattern that corresponds to the geographic differences in use of the emergency department for pediatric asthma, type 2 diabetes, and hypertension.

Access to primary care can be measured using the concept of a “medical home,” which is a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.¹⁰ The American Academy of Pediatrics has championed development of methods for measuring this concept for children. In 2011, 2 in 5 Illinois children did **not** have a medical home; more than half of non-Hispanic black children in Illinois did **not** have a medical home.

Prenatal care is another measure of whether a health care system has adequate and equal access to basic health care services. One measure of access to prenatal care is the extent to which

Rate of Emergency Department Discharges for Type II Diabetes, per 10,000 Adults

Illinois Overall and by Race/Ethnicity, 2014*

Source: IDPH, Division of Patient Safety and Quality

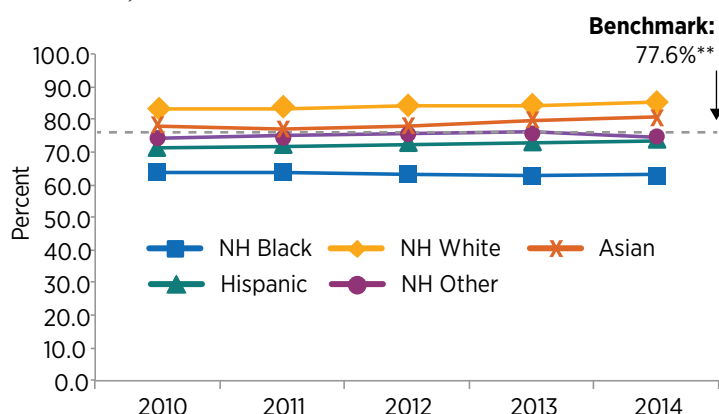
Illinois Overall	288.0	(286.9-289.0)**
Non-Hispanic Black	601.5	(597.4-605.5)
Non-Hispanic White	224.0	(222.8-225.1)
Hispanic	283.6	(280.8-286.3)
Non-Hispanic Other	296.0	(291.8-300.3)

*Denominator is the mean 2012-2014 data, from Claritas.
 **(95% confidence intervals)

Percent of Pregnant Women with Adequate Prenatal Care

by Year and Race/Ethnicity, 2010-2014*

Source: IDPH, Center for Health Statistics and Division of Vital Records



*2014 data are provisional.

**Healthy People 2020 MICH-10.2, Increase the proportion of pregnant women who receive early and adequate prenatal care—entry by month 4 and number of visits corresponding to recommendations of the American College of Obstetricians and Gynecologists.

pregnant women begin receiving care early in pregnancy. In 2014, approximately 4 in 5 pregnant women in Illinois started prenatal care in the first trimester of pregnancy, but only two-thirds of non-Hispanic black women had received early care.

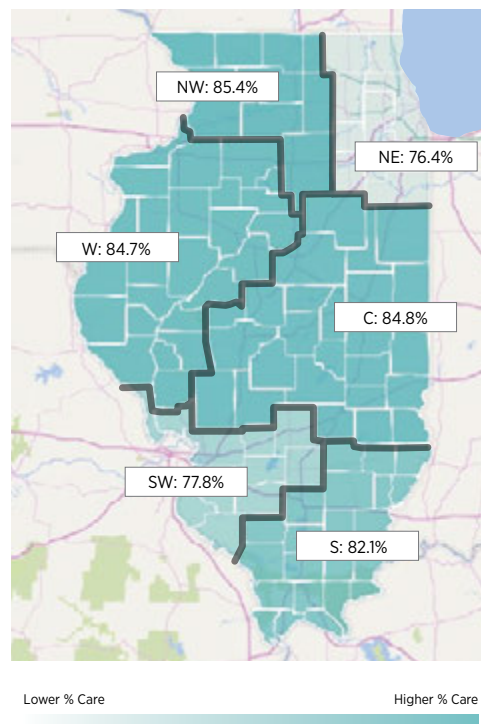
A more comprehensive measure of prenatal care combines early entry with whether pregnant women receive the recommended number of visits once they are in care. The percentages of Illinois pregnant women who received adequate prenatal care overall mirror those for early entry alone. In addition, receiving prenatal care increased with age, and younger pregnant women were well below the Healthy People 2020 benchmark.

Of note, the trend data show no improvement in adequacy of prenatal care since 2010, and the racial/ethnic disparity persists and may be increasing over this time period. The southern and southwestern regions of the state as well as the northeastern region, which includes Chicago, had lower percentages of pregnant women who had obtained adequate prenatal care.

Adequate Prenatal Care

Benchmark: 77.6%

Illinois Overall: 78.3%



Source: IDPH, Center for Health Statistics and Division of Vital Records

BEHAVIORAL HEALTH

Definition

There is currently no known consensus definition for behavioral health. For the purposes of this assessment, behavioral health includes the emotions, behaviors, and biology relating to mental health, including one's ability to function in everyday life and one's concept of self. This can also encompass anything that contributes to mental wellness, including substances and their abuse, behavior, habits, and other external forces.

Mental health is described by the World Health Organization (WHO) "as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. The positive dimension of mental health is stressed in WHO's definition of health as contained in its constitution: 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.'"¹¹

Core Assessments

Mental and behavioral health was raised as a health issue during the qualitative and quantitative analyses conducted for the State Health Assessment. As one stakeholder noted, "mental health drives your chronic diseases because if you can't take care of yourself you're not going to get out of bed, you're not going to go to work, you're not going to care for your babies. It just rolls and if they're sad and depressed, and you try and get them on medication, it's taboo..."

Additionally, almost half of the not-for-profit hospitals identified mental health as a priority concern. Moreover, a review of the IPLANs across county health departments for top priority areas found that of the top health issues identified, mental health was 9% of the priority health topics and substance abuse was 7% of the priority health topics.

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

» WHO definition of health

Further, the Community Themes and Strengths assessment identified limited access to behavioral health services in specific areas of the state as a barrier, while it also highlighted opportunities to increase access to services. As noted by a participant in the focus groups, "it's not only having the providers who are able to properly diagnose those conditions and prescribe the right medications for that person, but it's also having an individual who can walk the journey with them."

Consistent with these findings was the Public Health System Assessment, which found that the public health system could improve its performance in assuring and linking people to care, which would include behavioral health services.

A concern emerging from the Forces of Change assessment was identifying new resources and alternative strategies for addressing behavioral health.

Health Status Indicators

Adverse childhood experiences (ACEs) have been shown to have an impact on both physical and behavioral health outcomes. Overall, approximately 1 in 8 Illinois adults reported experiencing 4 or more ACEs. While small disparities exist, reporting of ACEs is similar across race/ethnicity, gender, age, and geography.

Self-reports on adults experiencing poor mental health more than 7 days a month can be one means of determining adult mental health status in a population. The question "...how many days during the past 30 days was your mental health not good?" was asked on the 2014 Illinois Behavioral Risk Factor Surveillance System (BRFSS) survey. Unlike many other indicators, the racial and ethnic disparities in how Illinois adults reported experiencing poor mental health for more than one week in a month were relatively small. Overall, 14.8% percent of all Illinois adults reported experiencing poor mental health for more than one week in a month. For non-Hispanic blacks and non-Hispanic whites, the percentages were 17.3% and 14.7% respectively. The percentage for Hispanics was 15.5%.

Also unlike many other indicators, reports of poor mental health for more than one week in a month occurred more frequently in women than in men, and more frequently in young adults, with decreasing frequency in older age groups.

In 2014, 1 of 5 young adults in Illinois ages 18-24 reported experiencing poor mental health for more than one week in a month. In contrast, according to this measure, 1 in 10 adults 65 and older reported poor mental health.

Also in 2014, more than 1,300 Illinoisans committed suicide. Suicide in Illinois showed a different pattern across racial/ethnic groups and is also different than for other indicators, with non-Hispanic whites having a rate worse than the Healthy People 2020 objective and more than

Percent of Adults Reporting Poor Mental Health More than 7 Days in a Month*

Illinois Overall and by Race/Ethnicity, 2014

Source: IDPH, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS)

Benchmark	-
Illinois Overall	14.8 (15.2-18.2)**
Non-Hispanic Black	17.3 (13.6-21.8)
Non-Hispanic White	14.7 (13.2-16.4)
Hispanic	15.5 (11.8-20.1)

* "... how many days during the past 30 days was your mental health not good?"
 ** (95% confidence intervals)

Age-Adjusted Suicide Rate per 100,000 Population

Illinois Overall and by Race/Ethnicity, 2014*

Source: IDPH, Center for Health Statistics and Division of Vital Records

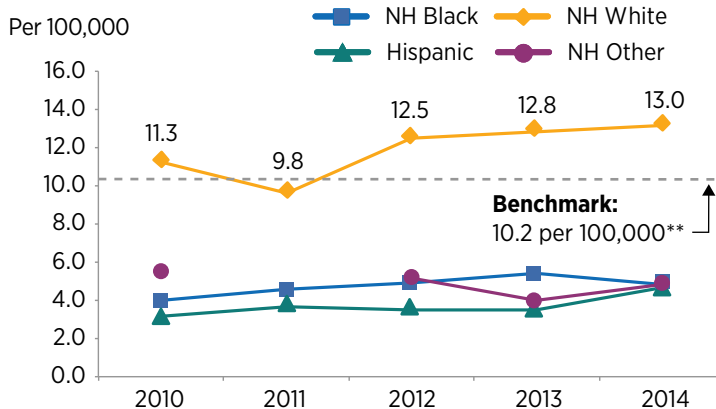
Benchmark**	10.2
Illinois Overall	10.2 (9.6-10.8)†
Non-Hispanic Black	4.9 (3.9-6.0)
Non-Hispanic White	13.0 (12.2-13.8)
Hispanic	5.2 (4.2-6.1)
Non-Hispanic Other	4.8 (3.4-6.7)

*2014 data are provisional.
 **Healthy People 2020 MHMD-1, Reduce the suicide rate; based on age-adjusted rates.
 † (95% confidence intervals)

Age-Adjusted Suicide Rate per 100,000 Population

by Year and Race/Ethnicity, 2010-2014*

Source: IDPH, Center for Health Statistics and Division of Vital Records



*2014 data are provisional.

**Healthy People 2020 MHMD-1, Reduce the suicide rate; based on age-adjusted rates.

twice as high as the rates in other groups whose rates were already below the national objective.

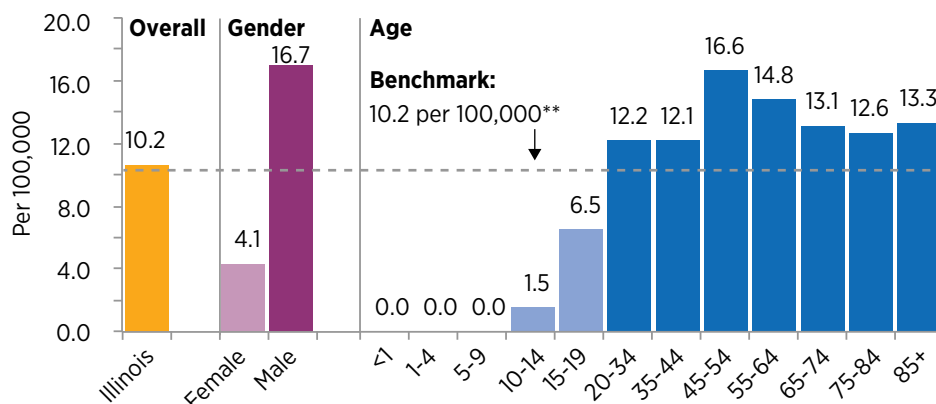
In addition, in 2014, men had a suicide rate four times that of women in Illinois, with women at a rate of 4.1 per 100,000 and men at 16.7 per 100,000. The suicide rates among adults were similar across age groups, although those ages 45-54 had the highest rate at 16.6 per 100,000; comparatively, the second highest rate was among those ages 55-64 at 14.8 per 100,000. Young adults aged 20-34 had a rate of 12.2 per 100,000.

The trend data for 2010-2014 in Illinois suggest that suicide rates after age adjustment may be increasing over time, particularly among non-Hispanic whites, the group that also had the highest rates over the five-year period.

Suicide Rate per 100,000 Population

Illinois Overall and by Gender (Age Adjusted) and Age, 2014*

Source: IDPH, Center for Health Statistics and Division of Vital Records



*2014 data are provisional.

**Healthy People 2020 MHMD-1, Reduce the suicide rate; based on age-adjusted rates.

MATERNAL AND CHILD HEALTH

Definition

Maternal and Child Health focuses on six population health domains: 1) women/maternal health; 2) perinatal/infant health; 3) child health; 4) children with special health care needs; 5) adolescent health; and 6) cross-cutting or life course. Work in this area seeks to improve access to health care and the delivery of quality public health services to women and children.

Core Assessments

Maternal and Child Health was identified as a preliminary priority by the Planning Council and subsequently reinforced through the stakeholder engagement process across the state. During the community engagement process, it became evident that organizations are already working on maternal and child health issues through the services they provide and the populations they serve. Focus group participants noted the need, in the words of one participant, "to coordinate with [agencies] and make sure sound public health policies are in sync with Medicaid, WIC, and SNAP." It was also suggested that community-based approaches should be assessed and used to address maternal mortality.

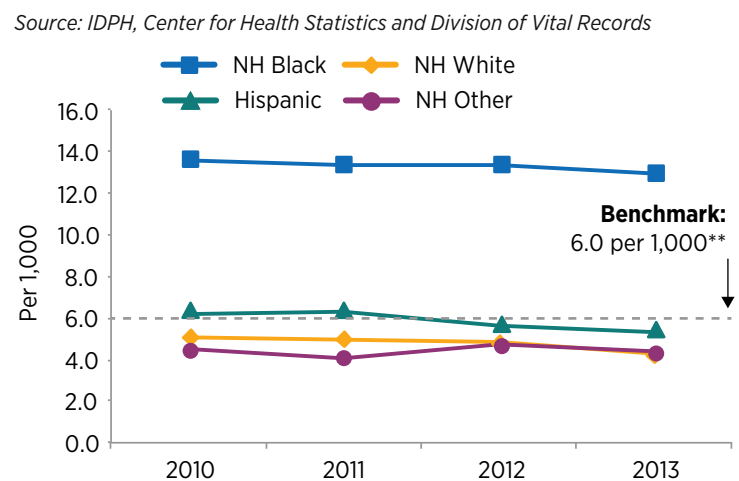
Examples of assets related to maternal and child health identified through the community engagement process included prenatal programs, free-standing birth centers, the Collaborative Improvement and Innovation Network (CoIIN) to Reduce Infant Mortality, and recommendations from the Early Learning Council and Healthy Start programs. Additionally, maternal, child, and infant health was in the top ten health priorities of local health departments, making up 3% of the priorities raised.

Health Status Indicators

Health status indicators particularly pertinent to maternal and child health are used here to show the current state of health for mothers and children in Illinois. Infant mortality (infant death) is used

Infant Mortality* Rate per 1,000 Live Births, 2010-2013

by Year and Race and Ethnicity



*Death in the first year of life.

**Healthy People 2020 MICH-1.3, Reduce the rate of all infant deaths (within 1 year).

Child Mortality* Rate from All Causes per 100,000 Children Ages 1-19

Illinois Overall and by Race/Ethnicity, 2014*

Source: IDPH, Center for Health Statistics and Division of Vital Records

Benchmark**	-
Illinois Overall	23.3 (21.6-25.0) [†]
Non-Hispanic Black	47.5 (41.6-53.3)
Non-Hispanic White	19.6 (17.5-21.7)
Hispanic	16.8 (13.9-19.7)
Non-Hispanic Other	13.9 (8.4-19.5)

*2014 data are provisional.

**Healthy People 2020 MCH-3.1, 3.2, Reduce the rate of deaths among children aged 1-4 years, 5-9 years. MICH-4.1, 4.2, Reduce the rate of adolescent and young adult deaths, 10-14, 15-19.

[†](95% confidence intervals)

all over the world as a marker for the health of a society overall, while child mortality is also a worldwide measure of health.

In 2014, the infant mortality rates for non-Hispanic whites, Hispanics, and non-Hispanic Illinois infants were better than the national objective, but the rate for non-Hispanic black infants was approximately 3 times higher, far worse than the national objective.

The threefold disparity in infant deaths between non-Hispanic blacks and all other racial/ethnic groups is persistent over time. In addition, the trend data for all racial/ethnic groups shows very little change from 2010 to 2013.

The child mortality rates for Illinois children ages 1-4, 5-9, 10-14, and 15-19 are better in 2014 than the national age-specific objectives. Looking at race/ethnicity, however, the rate for non-Hispanic black children is more than twice as high as that for all other children.

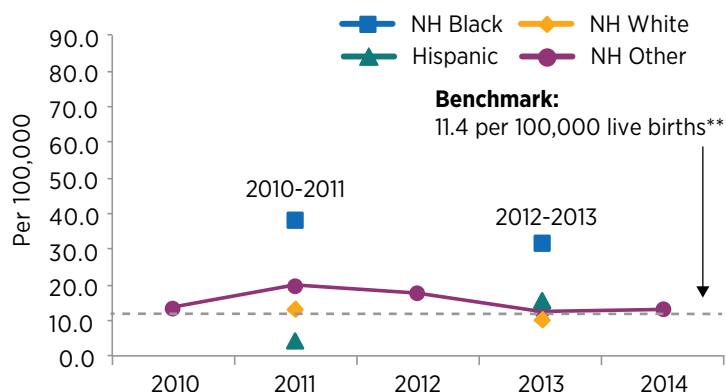
Although the child mortality rates in Illinois were better than the Healthy People 2020 objective, the pattern over time looks similar to that for infant mortality, with the same persistent disparity between non-Hispanic blacks and all other racial/ethnic groups and little change in the rates from 2010 to 2013.

Maternal mortality is very rare, but like infant mortality, it is monitored worldwide as an indicator that reflects broadly on the overall health of a society. Historically, maternal deaths resulting directly from medical complications of pregnancy have been monitored, but it is becoming more typical to also document all deaths to women occurring within one year following pregnancy. In 2013, 19 Illinois women died from causes related to pregnancy itself, and a total of 54 Illinois women died within one year of giving birth from all causes combined.

Maternal Mortality Rate A Deaths to Women Directly Related to Pregnancy per 100,000 Live Births, 2010-2014*

Overall by Year and 2-Year Combined for Race/Ethnicity

Source: IDPH, Center for Health Statistics and Division of Vital Records



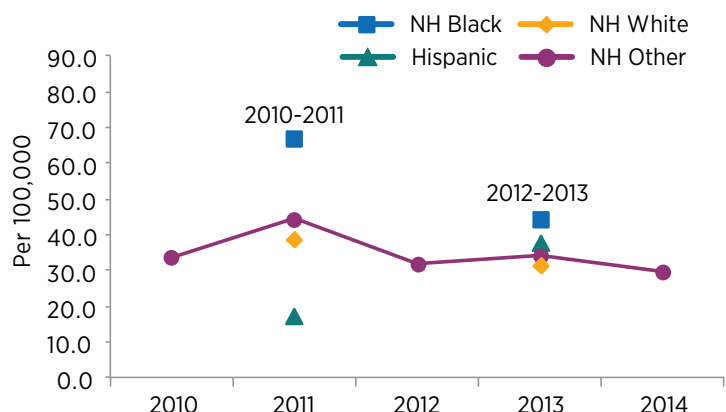
* 2014 data are provisional.

Healthy People 2020 MICH-5, Reduce the rate of maternal mortality—number of female deaths due to **obstetric causes within 42 days of pregnancy.

Maternal Mortality Rate B Deaths to Women within One Year of Pregnancy per 100,000 Live Births, 2010-2014*

Overall by Year and 2-Year Combined for Race/Ethnicity

Source: IDPH, Center for Health Statistics and Division of Vital Records



* 2014 data are provisional.

There is no benchmark; these deaths include deaths directly related to pregnancy both before and after 42 days, and other deaths indirectly related to pregnancy.

There was a large disparity between non-Hispanic blacks and non-Hispanic whites, and also between Hispanics and non-Hispanic whites, with respect to maternal death due to medical causes related to pregnancy itself. Only the rate for non-Hispanic whites meets the Healthy People 2020 benchmark. The disparities also exist, though to a lesser extent, when any cause of death within one year of pregnancy is considered. Because maternal mortality is so rare, annual data are displayed only for Illinois overall. In order to gain more reliability in the estimates by race/ethnicity, data have been combined for two 2-year periods—2010-2011 and 2012-2013.

The trend for Illinois overall for maternal deaths from medical causes related to pregnancy shows that the Healthy People 2020 benchmark was not met during this time period. With two years of data combined, the persistent disparity between non-Hispanic blacks and non-Hispanic whites is evident. When deaths from all causes to women within one year of pregnancy are considered, the racial/ethnic disparities are also present. Note that for the broader definition of maternal mortality, causes include issues such as homicide, suicide, and motor vehicle accidents. It is important to understand whether women are more or less vulnerable to experiencing these nonclinical causes in the year following pregnancy than they would be otherwise.

While there appears to have been an increase in maternal deaths (on both measures) in 2011, with rates decreasing since then, this may be random fluctuation due to very small numbers.

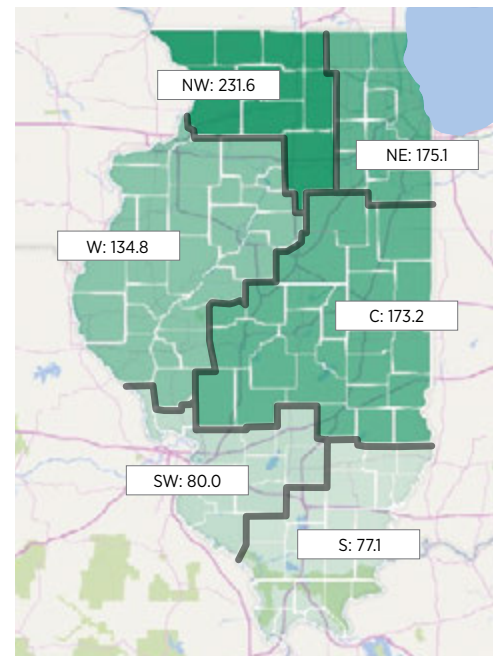
Pregnant women with severe maternal morbidity are women who have potentially life-threatening conditions related to their pregnancy.

Non-Hispanic black women have a higher rate of severe maternal morbidity compared to other racial/ethnic groups, but only non-Hispanic white women in Illinois are meeting the Healthy People 2020 benchmark. There is no improvement in the rate of severe maternal mortality from 2010 to 2014, either in the rates themselves or in the racial/ethnic disparities. There is variation in rates of severe maternal morbidity across Illinois that may be related to access to care or quality of care.

Overall in Illinois in 2013, approximately one in twelve infants was born at low birthweight, which puts these infants at risk of death as well as other health problems if they survive.

As with many maternal and child health indicators, both younger and older women are at highest risk of delivering a low-birthweight infant.

**Rate of Severe Maternal Morbidity*
per 10,000 Delivery Hospitalizations,
by Region, 2014**
Benchmark: 129.0**
Illinois Overall: 167.8



Less Morbidity → More Morbidity

Source: IDPH, Division of Patient Safety and Quality

*Severe maternal morbidity is defined using an algorithm identifying pregnant women with any of 25 markers of potentially life-threatening obstetric diagnoses and procedures. Callaghan WM, et al. Identification of severe maternal morbidity during delivery hospitalizations, United States, 1991-2003. *Am J Obstet Gynecol* 2008; 199:133. e1-8.

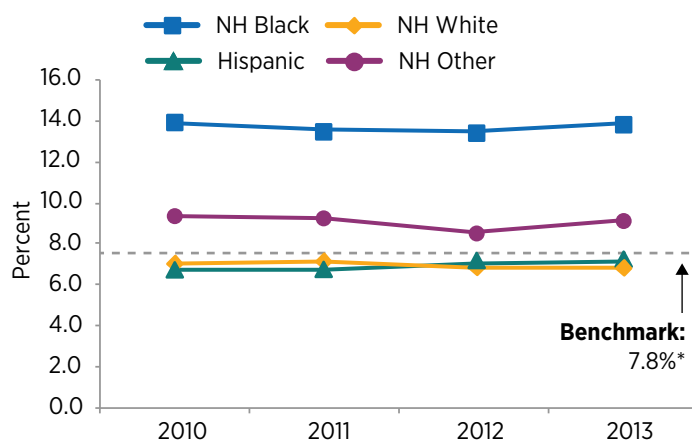
**National estimate from analysis of the 2008-2009 Nationwide Inpatient Sample. Callaghan WM, et al. Severe maternal morbidity among delivery and postpartum hospitalizations in the United States, *Am J Obstet Gynecol* 2012;120:1029-36.

While non-Hispanic white and Hispanic women were meeting the Healthy People 2020 objective in 2013, non-Hispanic black and non-Hispanic other women are not. Almost one in seven non-Hispanic black pregnant women delivered a low-birthweight infant in 2013. From 2010 to 2013, there was little change in the rates of low birthweight, and the racial/ethnic disparity also remained the same.

Percent of Live Births Born at Low Birthweight*

by Year and Race/Ethnicity, 2010-2013

Source: IDPH, Center for Health Statistics and Division of Vital Records



*Low birthweight is weight less than 2500 grams.

**Healthy People 2020 MICH-8.1, Reduce low birthweight.

CHRONIC DISEASE

Definition

Chronic disease is a long-lasting condition that can be controlled but not cured. Chronic disease affects the population worldwide and, as described by the Centers for Disease Control and Prevention (CDC), is the leading cause of death and disability in the United States. At a national level, chronic diseases are responsible for 7 of 10 deaths each year, equaling 1.7 million deaths. Additionally, treating people with chronic diseases accounts for 86% of our nation's health care costs. The CDC includes heart disease, stroke, cancer, diabetes, obesity, and arthritis as some of the most common and costly chronic disease conditions.

Core Assessments

Chronic disease is a health issue prioritized by local health departments as well as hospitals. Of the 511 priorities raised by 120 not-for-profit hospitals, 152 related to chronic disease or chronic disease risk factors. Additionally, the review of IPLANs across local health departments found that half of the top ten priorities related to chronic disease.

The Community Themes and Strengths assessment identified encouraging healthy lifestyles and promoting programs related to walkability, physical activity, and healthy food choices as strengths of the state. Focus group participants indicated that organizations provide services around chronic disease as part of their missions. An example of a statewide success raised in the focus groups was the state of Illinois being smoke-free. A participant shared that "you don't realize until you're in another state that has smoke, how much you're thinking I'm glad that passed and we live in a state with [a smoke-free ban]. When we fought that it was huge. Think how much resistance we had. To me that is one of the biggest accomplishments we've had as a state in the last 10 years."

Percent of All Adults Reporting No Physical Activity in the Last 30 Days*

Illinois Overall and by Race/Ethnicity, 2014

Source: IDPH, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS)

Benchmark**	25.3
Illinois Overall	24.0 (22.5-25.6) [†]
Non-Hispanic Black	29.8 (25.1-35.0)
Non-Hispanic White	22.2 (20.5-23.9)
Hispanic	28.9 (23.8-34.5)
**"During the past month, did you participate in any physical activities?"	
**U.S. Overall from BRFSS, 2013	
†(95% confidence intervals)	

Percent of Children 6-17 Reported as Not Engaging in Vigorous Physical Activity*

Illinois Overall and by Race/Ethnicity, 2011

Source: Child and Adolescent Health Measurement Initiative, Data Resource Center National Survey of Children's Health (NSCH)

Benchmark**	9.1
Illinois Overall	8.0 (8.6-9.7) [†]
Non-Hispanic Black	7.6 (2.6-12.7)
Non-Hispanic White	5.1 (3.0-7.2)
Hispanic	13.4 (7.0-19.9)
Non-Hispanic Other	11.8 (2.6-21.0)
**"How many days during the past week did [child name] exercise, play a sport, or participate in physical activity for at least 20 minutes that made [him/her] sweat and breathe hard?"	
**U.S. Overall from NSCH, 2011/12	
†(95% confidence intervals)	

Percent of All Adults Reporting Smoking*

Illinois Overall and by Race/Ethnicity, 2014

Source: IDPH, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS)

Benchmark**	12.0
Illinois Overall	16.7 (15.2-18.2) [†]
Non-Hispanic Black	25.2 (20.3-30.9)
Non-Hispanic White	16.5 (14.8-18.2)
Hispanic	12.9 (9.6-17.1)
*Current smoker	
**Healthy People 2020 TU-1.1, Reduce cigarette smoking by adults.	
†(95% confidence intervals)	

Consistent with these findings was the Public Health System Assessment, which found that the public health system is strong in monitoring health and enforcing laws.

A key finding from the Forces of Change assessment noted that there is opportunity to increase prevention activities in the state. This relates to addressing risk factors for chronic disease.

Health Status Indicators

Chronic Disease Risk Factors

Physical activity is recognized as an approach for preventing chronic disease and disability. Around a quarter of adults in Illinois reported engaging in no physical activity. Among children, the percentages are lower, but every child should be engaging in at least some vigorous physical exercise.

Smoking is perhaps the most well-established risk factor for a wide array of health outcomes. Overall, 1 in 6 adults in Illinois reported being current smokers in 2014, and 1 in 4 non-Hispanic black adults reported smoking. Among pregnant women, smoking rates are lower as might be expected, but still approximately 10% of pregnant women report smoking.

Obesity is both a risk factor for chronic disease and an outcome in and of itself, and it occurs across the lifespan. In adulthood, almost 1 in 3 Illinoisans were obese, with obesity defined according to the consensus cut point on the Body Mass Index (30 or greater BMI). Approximately 2 of 5 non-Hispanic black adults were in this category. There were only slight differences in obesity by gender and age.

Approximately 1 in 5 children in Illinois were obese, with closer to 1 in 3 non-Hispanic black children in Illinois being in this category. (Obesity in children is affected by a series of factors including physical education opportunities, quality of meals served within schools, recess policies, etc.)

Percent of Obesity Among Children Ages 10-17*

Illinois Overall and by Race/Ethnicity, 2011

Source: Child and Adolescent Health Measurement Initiative, Data Resource Center National Survey of Children's Health (NSCH)

Benchmark**	14.5
Illinois Overall	19.3 (15.4-23.1)[†]
Non-Hispanic Black	28.5 (18.1-39.0)
Non-Hispanic White	16.3 (11.5-21.1)
Hispanic	21.4 (11.5-31.3)
Non-Hispanic Other	8.8 (2.1-15.5)

*Based on 95th percentile of Body Mass Index (BMI) for age.
 **Healthy People 2020 NWS-10.4, Reduce the proportion of children and adolescents aged 2 to 19 years who are considered obese. Target: 14.5, based on BMI 95th percentile.
 †(95% confidence intervals)

Percent of Obesity Among Adults*

Illinois Overall and by Race/Ethnicity, 2014

Source: IDPH, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS)

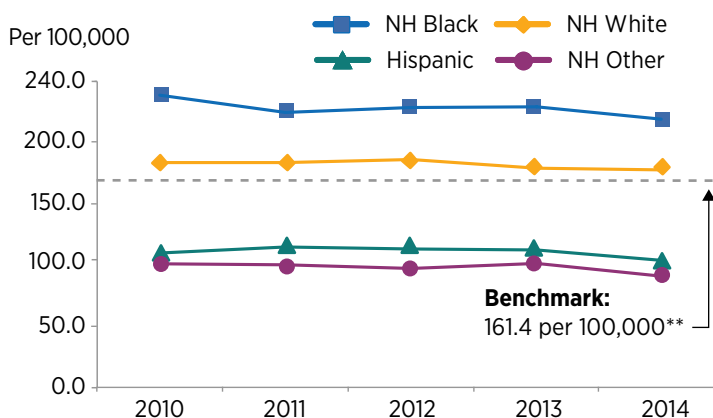
Benchmark**	30.5
Illinois Overall	29.5 (27.8-31.2)[†]
Non-Hispanic Black	42.5 (37.1-48.1)
Non-Hispanic White	27.6 (25.7-29.5)
Hispanic	34.7 (25.7-29.5)

*Body Mass Index (BMI) of 30 or more.
 **Healthy People 2020 NWS-9, Reduce the proportion of adults who are obese. The benchmark is based on age-adjusted rates so is not directly comparable to the data as shown.
 †(95% confidence intervals)

Age-Adjusted Cancer Rate per 100,000 Population

by Year and Race/Ethnicity, 2010-2014*

Source: IDPH, Center for Health Statistics and Division of Vital Records



*2014 data are provisional.

**Healthy People 2020 C-1, Reduce the overall cancer death rate; based on age-adjusted rates.

Chronic Disease Mortality

Similar to national data, the two leading causes of death in Illinois are heart disease and cancer. Heart disease and cancer each account for approximately 24,000 deaths in Illinois each year. The subset of deaths due to ischemic heart disease accounts for approximately 13,000 deaths in Illinois annually.

After adjusting for age, the mortality rates for ischemic heart disease and for cancer were each close to the corresponding Healthy People 2020 objectives. Non-Hispanic blacks in Illinois, however, had rates that are worse than the benchmark for each cause of death. Hispanics had lower mortality rates for both heart disease and cancer compared to either non-Hispanic blacks or non-Hispanic whites.

As would be expected, there is a strong age gradient with both heart disease and cancer. In addition, men have higher age-adjusted rates than do women for both causes of death. From a prevention perspective, monitoring the mortality rates for these causes among persons in early and middle adulthood may be important. In 2014, 2,755 Illinois residents or approximately 20% of those dying from ischemic heart disease were ages 20-64, while close to 7,000 Illinois residents or almost 30% of those dying from cancer were in this age group.

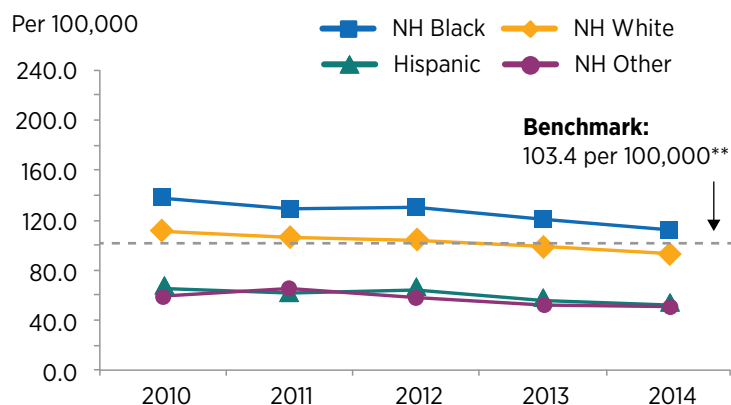
The age-adjusted trend data for both heart disease and cancer mortality show a persistent racial/ethnic disparity over time. For heart disease mortality, rates appear to be improving over time, with non-Hispanic whites reaching the benchmark by 2014 and non-Hispanic blacks getting close. For cancer mortality, while rates also appear to be slightly improving over time, both non-Hispanic blacks and non-Hispanic whites have rates higher than the benchmark.

The percentage of Illinois adults who reported having diabetes is similar to the percentage of adults who report diabetes nationally, at 10.2% and 9.7% respectively. A higher percentage of both non-Hispanic blacks (14.0%) and Hispanics (12.7%) report having diabetes, compared to non-Hispanic whites (9.1%).

Age-Adjusted Heart Disease Mortality Rate per 100,000 Population

by Year and Race/Ethnicity, 2010-2014*

Source: IDPH, Center for Health Statistics and Division of Vital Records



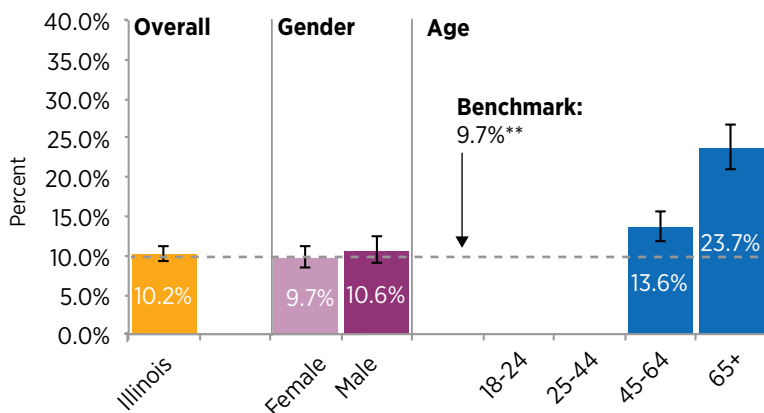
*2014 data are provisional.

**Healthy People 2020 HDS-2, Reduce coronary heart disease deaths; based on age-adjusted rates.

Percent of Adults Reporting Diabetes*

Illinois Overall and by Gender and Age, 2014

Source: IDPH, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS)



*"Have you ever been told by a doctor that you have diabetes?"

**U.S. Overall from BRFSS 2013.

Note: Error bars represent 95% confidence intervals

CONCLUSION



Through this process the state has identified the areas of the focus for the State Health Improvement Plan. The Illinois health priorities are:

- Behavioral Health
- Chronic Disease
- Maternal and Child Health

These three areas will be addressed utilizing approaches that include Social Determinants of Health and Access to Quality Care as implementation requirements to improve health.

The State Health Assessment also represents a comprehensive process to assess Illinois' strengths, opportunities, and barriers to health improvement as well as the status of health in the state.

Highlights include the following key statements:

Social Determinants of Health

- Non-Hispanic whites had met benchmarks for 18 of 20 indicators where disparity data were available.
- In stark contrast, non-Hispanic blacks had not met benchmarks for 17 of 20 indicators, and Hispanics had not met benchmarks for 14.
- The largest disparity between non-Hispanic blacks and non-Hispanic whites was for homicide rates, and even after adjusting for age, the rate among non-Hispanic blacks was an alarming 5 times higher than the national benchmark.
- The percentages of non-Hispanic black and Hispanic parents who reported that their children were living in unsafe neighborhoods were 3.5 and 3.9 times higher, respectively, than the percentage of non-Hispanic whites reporting children living in unsafe neighborhoods.

Access to Quality Care

- Almost 600,000 individuals in Illinois remain eligible for Marketplace coverage but have not enrolled in health insurance. Over 100,000 of uninsured Marketplace-eligible individuals reside in 10 geographic areas of the state, with the largest pockets of uninsured living in Cook and Champaign Counties.

- In 2011, 2 in 5 Illinois children did not have a medical home; more than half of non-Hispanic black children in Illinois did not have a medical home.

Chronic Disease

- In adulthood, almost 1 in 3 Illinoisans were obese, with obesity defined according to the consensus cut point on the Body Mass Index (BMI). Approximately 2 of 5 non-Hispanic black adults were in this category.
- Approximately 1 in 5 children in Illinois were obese, with closer to 1 in 3 non-Hispanic black children in Illinois being in this category.
- One in six adults in Illinois reported being current smokers in 2014, which does not meet the Healthy People 2020 benchmark for this indicator. One in four non-Hispanic black adults reported smoking.
- Among pregnant women, smoking rates are lower as might be expected, but still approximately 10% of pregnant women report smoking.

Behavioral Health

- Nearly 15% of adults in Illinois experience more than one week of poor mental health in a month. The percentage was similar across racial/ethnic groups.

Maternal and Child Health

- Approximately 4 in 5 pregnant women in Illinois started prenatal care in the first trimester of pregnancy, but only two-thirds of non-Hispanic black women had access to early care.

The findings of this State Health Assessment provide a clear direction for the Healthy Illinois 2021 Planning Council. In order to drive toward action, attention must focus on both the health status priorities of behavioral health, maternal and child health, and chronic disease, and the core underlying influences of access to quality care and social determinants of health. The charge is to improve overall health status and reduce disparities.

Action Teams for each priority area have now been established. These teams will focus on developing objectives to improve health around behavioral health, chronic disease, and maternal and child health as well as identifying the necessary steps and activities to achieve these objectives. Efforts will also be made to complete a scan of resources, review health indicator data, assess best practices related to data collection and monitoring, and recommend policy, systems, and environmental strategies to help achieve ongoing health status monitoring.

These activities will be described in the State Health Improvement Plan.

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APPENDICES

APPENDIX A

Planning Council Members

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Department of Insurance
Anne Melissa Dowling / C.J. Metcalf (designee)

Department of Public Health
Nirav D. Shah / Bill Dart (designee)

Department of Transportation
Karen Shoup

Environmental Protection Agency
Thomas Hornshaw

Get Covered Illinois
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Health Information Exchange Authority
Diego Estrella / Krysta Heaney (designee)

Illinois African American Family Commission
Michael Holmes

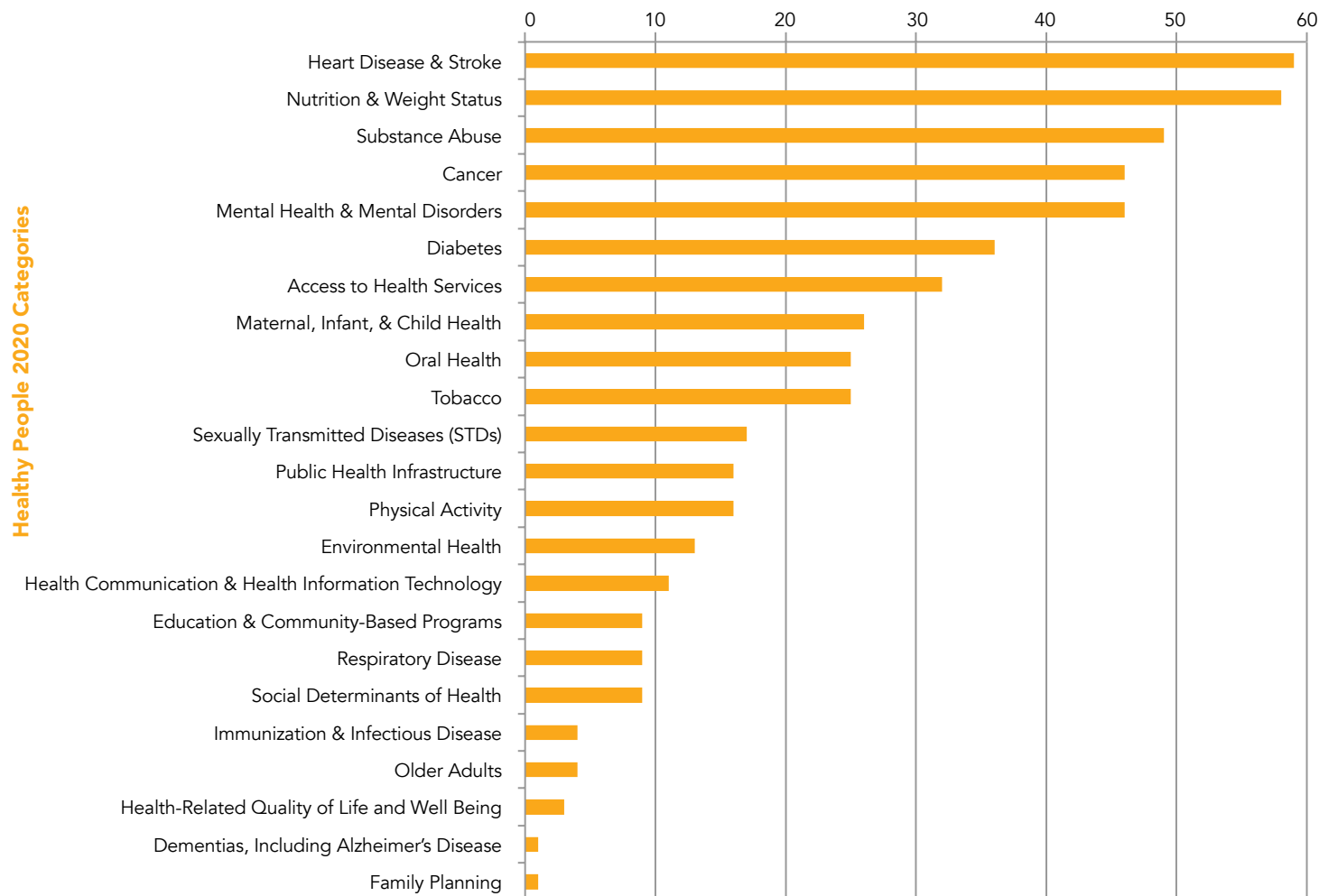
Illinois Latino Family Commission
Layla Suleiman Gonzalez, PhD, JD

State Board of Education
Jessica H. Gerdes, RN

State Board of Health
Javette C. Orgain, MD

APPENDIX B: LOCAL HEALTH DEPARTMENT IPLAN PRIORITY SUMMARY

Healthy People 2020 Health Issues Identified by Local Health Departments



APPENDIX C: STAKEHOLDER ENGAGEMENT ORGANIZATIONAL PARTICIPATION RESULTS

Background

In order to engage stakeholders and communities in assessing the current state of health in Illinois, feedback sessions were held in July, August, September, and October of 2015. These feedback sessions, including focus groups and presentations to organizations, confirmed that the initial health priorities identified by the Healthy Illinois 2021 Planning Council resonated with stakeholders. This process also allowed for specific, detailed input from organizations across the state.

Participants helped validate health issues, identified gaps, and prioritized identified health issues through examples and dialogue. Stakeholders were also asked to identify assets, opportunities, and barriers to health improvement at the local level, and provided examples of current efforts that address identified health issues. Participants represented organizations including health departments, hospital and health systems, non-profit organizations, academic institutions, health insurance plans, government entities, and associations.

The proposed health priorities included social determinants of health, access to quality care, mental health, maternal and child health, and chronic disease. Overall, there was overwhelming validation that these health issues are priorities at the local level. As a participant noted, “We really need to address all of those things. Is it easy? No. Do we have the dollars to do it all? No. Can we go out there and create jobs and try and address a lot of these social determinants? No. But I think together we can do more than each of us individually can do.”

Focus Groups

Eleven focus groups were conducted in five counties across Illinois representing main regions within the state: Cook, Lee, Champaign, St. Clair, and Sangamon. Each session was scheduled for two hours and included no more than 15 participants. In total, 94 participants represented their organizations in the focus groups.

Each focus group was conducted in the same format, and each session included a basic overview of the Healthy Illinois 2021 initiative. The purpose and objectives for the focus group were also shared:

- Highlight high-level commonalities and examples of best practices for health improvement;
- Communicate what’s being done in the process in order to increase awareness and provide an opportunity to contribute; and
- Establish a common agenda for health improvement using local and regional strengths.

Each session began with a presentation that provided an early snapshot of the current state of health in Illinois and introduced the initial priority areas recommended by the Planning Council. After the presentation, questions were asked that allowed participants to reflect on the information and think about health improvement in participants’ communities. Discussion questions included:

- Is there anything surprising about the major health issues in Illinois?
- What health issue(s) would you add as being a priority in Illinois, if any? Why?

- What health issue(s) would you subtract from being a priority in Illinois? Why?
- How do these health issues align with your organization's work?
- How are the health issues being experienced by the people you serve?
- How are communities working together in your region to address these issues?
- In what ways have you been successful working on these health issues?
- What can be improved?
- What needs to be done to address gaps that is not currently being done?

A note taker and audio recording documented each focus group session. Notes were compared to the audio recording of the focus groups, resulting in the creation of transcripts from each focus group session. The content of each focus group was reviewed and categorized based on the questions asked.

The next phase of analysis included coding for overarching themes between focus groups at the same location for sessions where two separate focus groups occurred at the same time. From a health priority perspective, key themes were categorized from a grouping process involving over 38 topics.

Organizational Presentations

Presentations for stakeholder organizations were held between August and October 2015. Sessions were held as in-person presentations and webinars. In total, ten sessions were held with over 300 people participating.

The format of these sessions included a basic overview of the Healthy Illinois 2021 initiative, as well as the purpose and objectives for the feedback session. As with the focus groups, the majority of the presentation focused on presenting a snapshot of the current state of health and understanding the initial

priority areas recommended by the Planning Council. Additionally, when time allowed, information was presented on perceived statewide assets, barriers, and opportunities for health improvement.

Feedback was solicited using a survey tool completed in person after the session or online. In some cases, general feedback was also solicited during the presentation. Survey questions sought to identify:

- Feedback on initial priorities;
- Suggestions for additional priorities;
- Successful health improvement work conducted by respondent organizations; and
- Perceived statewide assets, barriers, and opportunities.

Fifty-six surveys from presentations were completed and reviewed. Results were then coded for overarching themes and incorporated with the focus group results for a comprehensive analysis of findings from the stakeholder engagement processes.

Findings: Focus Groups and Organizational Presentations

A review of transcripts from the focus group sessions provided rich detail into how health issues are being experienced throughout Illinois and the efforts organizations are making to address these issues. Over 100 pages of transcripts and notes were reviewed, and the themes were categorized and tallied in order to identify examples and overarching themes. Determining how health priorities were defined was among the biggest challenge with the early priorities, as many questions were raised regarding the meaning and breadth of the priorities. For example, questions included "Is there a specific chronic disease?" and "Where does obesity fit in? Is that chronic?" and "What formal definition is being used for social determinants of health?" Participants requested that more detail on each priority area be available to better understand the areas.

Of additional priorities mentioned, about 35% of them fell under a broader category of mental health, access to quality care, chronic disease, social determinants of health, or maternal and child health. Most of the additional priorities were strategies or target populations, as opposed to health issues (e.g., older adult health needs). A few members of focus groups raised three additional and unique health issues: oral health, respiratory issues, and infectious disease. Oral health was raised three times, and respiratory issues and infectious disease were raised only once across all focus groups.

Regional and local strengths were highlighted through the stakeholder engagement process. Many organizational representatives saw their strengths as the programs and services their organizations provided. Additionally, the partnerships and collaborations they reported being involved in were seen as assets to health improvement. This collaborative philosophy was echoed by one participant: “It does seem that when you can bring a group of folks together and address an issue collectively you certainly have a greater bang for your buck in most cases.”

Focus group and organizational presentation participants also considered regional and local opportunities for health improvement. Key categories included leveraging resources, focusing on prevention, engaging communities, and utilizing data more effectively. Improving the data infrastructure was seen as a necessity at the local level. For example, participants shared that access needs to be improved so data is “more easily accessible, more timely, more current, because it’s very difficult to show outcome when you don’t have consistent data that’s growing at the same rate.”

Key barriers identified in focus groups and presentations were the current data infrastructure in Illinois, including data sharing, surveillance, and monitoring. While this was also viewed as an opportunity, it represented a current barrier to tracking and monitoring health in the state. The focus

groups also considered barriers at the regional and local levels, and those that were identified included resources, coordination and collaboration across the state, access to program and service resources, and availability of providers. Specifically, access to providers and provider networks in rural areas was a key challenge raised. One participant shared an example based on experience, saying, “Even though there are already incentives for providers to come to extreme rural areas like I’m from, you still have trouble getting them to those areas sometimes. One of our general surgeons just retired. We’re trying to build our surgery department and trying to get a surgeon to come to that area, and unless they want to go for the incentive of getting their student loans paid off we’re kind of sunk.”

Conclusion

The stakeholder engagement process was a key step in producing the State Health Assessment and the State Health Improvement Plan, as the process provided a wealth of information. The feedback gathered from across the state showed agreement with the initial priorities: social determinants of health, access to quality care, behavioral health (expanded from mental health to also include substance use), and chronic disease, and maternal and child health.

It is clear from the findings that although there are barriers to health improvement, there are also many opportunities based on assets within the state, including partnerships. Specifically, local and regional partnerships are working together to effect change and improve health, and organizations show an unwavering commitment to do continue this work. Data availability, utilization, and monitoring are clearly issues in which focused time and energy is needed.

Organizations Represented by Participants in the Feedback Sessions

Abcor Health Care Inc.	Chicago Children's Center for Behavioral Health	Family Voices of Illinois
Access to Care	Chicago Department of Public Health	Fayette County Health Department
Advocate Health Care	Chicago Public Schools	FHN Family Counseling Center
Advocate Lutheran General Hospital	Chinese Mutual Aid Association	Grand Prairie Services
AFSCME Council 31	Cigna	GROW in Illinois
AgeSmart Community Resources	City of Evanston Health & Human Services Department	Harmony/WellCare
AIDS Foundation of Chicago	CJE SeniorLife	Harrisburg Medical Center
Align Resources, Inc.	Collinsville Faith in Action	Health & Medicine Policy Research Group
AME Church	Communities Organized to Win	Health Alliance Medical Plans
American Academy of Pediatrics, Illinois Chapter	Community Behavioral Healthcare Association of Illinois	Healthcare Alternative Assistance, Inc.
American Heart Association	Community Health Partnership of Illinois	Heartland Alliance for Human Needs and Human Rights
American Lung Association of Illinois	Consilink, LLC	Help at Home
Arab American Family Services	Consortium to Lower Obesity in Chicago Children (CLOCC)	Henry/Stark Co. Health Department
Asian Health Coalition	CPRD, UIUC	Housing Authority of Henry County
Asian Human Services	Crusader Community Health	HSBS St. Francis Hospital
AUA Foundation (<i>now known as the Urology Care Foundation</i>)	Cumberland County Health Department	HSBS St. Elizabeth's Hospital
Aunt Martha's	DeKalb County Health Department	HSBS St. Joseph's Hospital, Breese
Blue Cross Blue Shield of Illinois	Delta Dental of Illinois Foundation	IlliniCare Health
Beacon Health Options	Departments of Navy and Veteran Administration	Illinois Association of Free & Charitable Clinics
Call for Help, Inc.	Douglas County Health Department	Illinois Association of Medicaid Health Plans
Campaign for Better Health Care	DuPage County Health Department	Illinois Association of School Nurses
Caritas Family	Eagle View Community Health System	Illinois Children's Mental Health Partnership
Carle Hospital	East Side Health District	Illinois Collaboration on Youth
Cass County Health Department	Edgar County Public Health Department	Illinois Critical Access Hospital Network
Catholic Charities	Effingham County Health Department	Illinois Department of Corrections
Catholic Charities Northwest Senior Services	Egyptian Area Agency on Aging	Illinois Department of Financial and Professional Regulation's Center for Nursing
CCAR Industries	Elder Care Services of DeKalb County	Illinois Department of Human Services
Champaign County	EverThrive Illinois	Illinois Department of Public Health
Champaign County Health Care Consumers		Illinois Division of Mental Health
Champaign County Regional Planning Commission		
Champaign Urbana Public Health District		
Cherished Place Adult Day Services		

Appendix C: Stakeholder Engagement Organizational Participation Results, continued

Illinois Hospital Association	Midwest Dairy Council	Stellation Group, LLC
Illinois House of Representatives	Molina Healthcare	Stephenson County Health Department
Illinois Informatics Institute	Momentum Health Center	Sterling-Rock Falls Family YMCA
Illinois Partners for Human Service	Northside Action for Justice	Suburban Primary Health Care Council
Illinois Pharmacists Association	Northwestern Memorial Hospital	Tazewell County Health Department
Illinois Primary Health Care Association	Oral Health Forum	Touchette Regional Hospital
Illinois Public Health Association	OSF HealthCare	Total Resource Community Development Organization
Illinois State Alliance of YMCAs	Park Forest Health Department	UI Health
Illinois State Board of Education	Parkland College	University of Illinois at Chicago College of Nursing
Illinois State Dental Society	Planned Parenthood of Illinois	University of Illinois College of Medicine at Rockford
Illinois State Medical Society	Playworks	University of Illinois College of Medicine at Rockford, National Center for Rural Health Professions
Illinois State Medical Society	Presence Health	United Way of Decatur & Mid-Illinois
Illinois State University	Rockford Health Council	United Way of Metropolitan Chicago
Imagine Englewood If	Sakal Wellness Institute	UnityPoint Health - Trinity
Iroquois County Public Health Department	Salud Latina	University of Illinois Hospital
Jackson County Health Department	Sarah Bush Lincoln Health Center	University of Illinois at Chicago
Jersey Community Hospital	Self-employed individual	University of Illinois at Urbana-Champaign
Knox County Health Department	Senior Services Plus, Inc.	University of Illinois Cancer Center
LaSalle County Health Department	Sinai Health System	University of Illinois College of Veterinary Medicine
Libertyville High School	Sinnissippi Centers, Inc.	University of Illinois Extension, SNAP-Ed
Lifecare	Skokie Health Department	University of Illinois, Chicago Specialized Care for Children
Logan County Department of Public Health	South Suburban Mayors and Managers Association	Whiteside County Health Department
Louis' Groceries	Southern Illinois Healthcare	Will County Health Department
Loyola University Chicago, Marcella Niehoff School of Nursing	Southern Illinois Healthcare Foundation	Will-Grundy Medical Clinic
Lutheran Social Services of Illinois	Southern Illinois University Center for Rural Health and Social Service Development	YMCA of Rock River Valley
Lyons Township Mental Health Commission	Southern Illinois University School of Dental Medicine	YMCA of Southwest Illinois
MacNeal Hospital	Southern Illinois University School of Medicine	
Macoupin County Public Health Department	Southern Seven Health Department	
Madison County Health Department	Springfield YMCA	
March of Dimes	St. Clair County Health Department	
McDonough County Health Department	St. Clair County Transit District	
McKendree University	St. John Missionary Baptist Church	
McLean County Health Department	State of Illinois	

APPENDIX D: CORE INDICATOR SUMMARY

Forty-eight indicators were identified for the State Health Assessment and State Health Improvement Plan. The indicator set is not necessarily the “best” possible set nor is it comprehensive; it is not static and should be reconsidered annually.

Whenever possible and as appropriate, each indicator was examined by gender, race/ethnicity, age, geographic region, and over time. When race/ethnicity data were available, comparisons between non-Hispanic blacks and non-Hispanic whites, and between Hispanics and non-Hispanic whites, were made by computing disparity ratios.

SET OF 48 CORE INDICATORS USED IN THE 2015 STATE HEALTH ASSESSMENT AND STATE HEALTH IMPROVEMENT PLAN

1. Poverty	24. 4 or more adverse childhood experiences
2. Concentrated disadvantage	25. Poor mental health
3. County well-being	26. Suicide (age-adjusted)
4. Gini index of income inequality	27. Ischemic heart disease mortality (age-adjusted)
5. Daily fine particulate matter	28. Cancer mortality (age-adjusted)
6. Less than high school education	29. Diabetes prevalence, adult
7. Age of Housing	30. Obesity ages 10-17
8. Lead testing	31. Obesity prevalence, adult
9. Unsafe neighborhoods	32. Infant mortality, all causes
10. Homicide (age-adjusted)	33. Child mortality, all causes
11. Motor vehicle accident mortality (age-adjusted)	34. Maternal mortality from causes related to pregnancy
12. Emergency department discharges for pediatric asthma	35. Maternal mortality, any cause within 1 year of pregnancy
13. Emergency department discharges for type 2 diabetes, adults	36. Severe maternal morbidity
14. Emergency department discharges for hypertension, adults	37. Low birthweight
15. Children not having a medical home	38. Hospital-acquired infections: MRSA
16. Primary care physicians	39. Hospital-acquired infections: <i>Clostridium difficile</i>
17. Prenatal care in first trimester	40. HIV incidence
18. Women not receiving adequate prenatal care	41. Gonorrhea incidence
19. No physical activity in past 30 days, adult	42. Chlamydia incidence
20. Children not engaging in vigorous physical activity	43. MMR immunization, 19-35 months
21. Smoking, adults	44. Polio immunization, 19-35 months
22. Smoking during last 3 months of pregnancy	45. DTaP immunization, 19-35 months
23. Unsafe sleep practices	46. Tdap immunization, 13-17 years
	47. Meningitis immunization, 13-17 years
	48. HPV immunization, 13-17 years

Appendix D: Core Indicator Summary, continued

The following table shows that of the 48 core indicators, 24 had both race/ethnicity information and relevant benchmarks, while the remaining 24 did not. For the 24 with both pieces of information, the table lists indicators according to whether the benchmark had been met by all, some, or none of the three major race/ethnic groups.

48 CORE INDICATORS IN RELATION TO BENCHMARKS (FOR NON-HISPANIC BLACKS, NON-HISPANIC WHITES, AND HISPANICS)

All Racial/Ethnic Groups Meet the Benchmark	Some Racial/Ethnic Groups Meet a Benchmark While Others Do Not	No Racial/Ethnic Group Meets the Benchmark	No Overall Benchmark, No Race/Ethnicity Information, or No Benchmark At All
24 Indicators* with both Race/Ethnicity Information and a Benchmark Ordered according to the Magnitude of the Disparity Ratios			24 Indicators
1. Motor vehicle accident mortality (age-adjusted)	1. Homicide (age-adjusted) 2. HIV 3. Children living in unsafe neighborhoods 4. Infant mortality 5. Poverty 6. Pregnant women not receiving adequate prenatal care 7. Unsafe sleep practices 8. Pregnant women not entering prenatal care in 1st trimester 9. Severe maternal morbidity 10. Children not having a medical home 11. Low birthweight 12. Less than high school education 13. Children 6-17 having no vigorous physical activity 14. Maternal mortality from causes clinically related to pregnancy 15. Adult diabetes 16. Adult obesity 17. Adults with no exercise in past 30 days 18. Cancer mortality (age-adjusted) 19. Ischemic heart disease mortality (age-adjusted) 20. Suicide (age-adjusted)	1. Children 10-17 who are obese 2. Current smoker 3. Smoking during pregnancy	Benchmarks, but only age or gender-specific - Gonorrhea* - Child mortality* - Emergency department pediatric asthma discharges* Overall benchmarks, but no race/ethnicity data - MRSA - Cdiff - MMR 19-35 months - Polio 19-35 months - DTaP 19-35 months - Tdap 13-17 years - HPV 13-17 years - Meningitis 13-17 years - Lead testing - Primary Care Physicians No benchmarks - Chlamydia* - Emergency department discharges for type 2 diabetes* - Emergency department discharges for hypertension* - Adults with 4 or more adverse childhood experiences (ACEs)* - Maternal mortality: any cause within one year of pregnancy* - Adults with more than 7 poor mental health days in a month* - Fine particulate matter - Age of housing - Gini index of income inequality - Concentrated disadvantage - County well-being

* A total of 33 of the 48 core indicators had race/ethnicity information; 24 also had relevant benchmarks, 9 did not.

This next table lists 21 indicators for which non-Hispanic blacks had not met a benchmark, 17 for which Hispanics had not met a benchmark, and 5 for which non-Hispanic whites had not met a benchmark.

INDICATORS FOR WHICH A BENCHMARK IS **NOT** BEING MET BY RACE/ETHNICITY FOR THE 24 INDICATORS WITH BOTH RACE/ETHNICITY INFORMATION AND A RELEVANT BENCHMARK

Non-Hispanic Blacks (21 Indicators)	Hispanics (17 Indicators)	Non-Hispanic Whites (5 Indicators)
• Homicide • Ischemic heart disease mortality • Infant mortality • Low birthweight		
	• Children 6-17 having no vigorous physical activity	
		• Suicide
• Children 10-17 who are obese • Current smoker • Smoking during pregnancy	• Children 10-17 who are obese • Current smoker • Smoking during pregnancy	• Children 10-17 who are obese • Current smoker • Smoking during pregnancy
• HIV • Children living in unsafe neighborhoods • Poverty • Pregnant women not receiving adequate prenatal care • Unsafe sleep practices • Pregnant women not entering prenatal care in 1st trimester • Severe maternal morbidity • Children not having a medical home • Less than high school education • Maternal mortality from causes clinically related to pregnancy • Adult diabetes • Adult obesity • Adults with no exercise in past 30 days	• HIV • Children living in unsafe neighborhoods • Poverty • Pregnant women not receiving adequate prenatal care • Unsafe sleep practices • Pregnant women not entering prenatal care in 1st trimester • Severe maternal morbidity • Children not having a medical home • Less than high school education • Maternal mortality from causes clinically related to pregnancy • Adult diabetes • Adult obesity • Adults with no exercise in past 30 days	
• Cancer mortality		• Cancer mortality



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