



Health Outcome Disparities

Semi-Annual Report

Item# 23-0555

Addressing Health Disparities through the
Building Healthier Communities Initiative – COVID-19

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Cook County DEPT of
Public Health



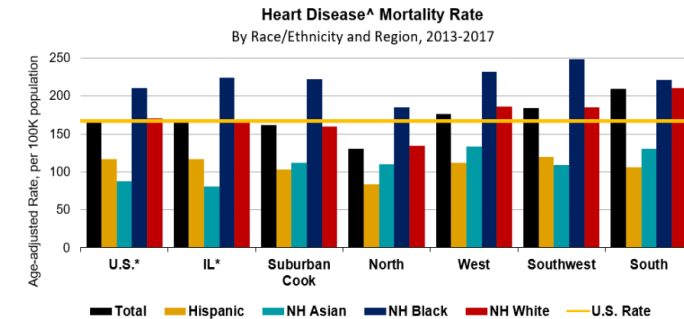
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Community Challenge: Chronic Disease and Mental Health Disparities Persist

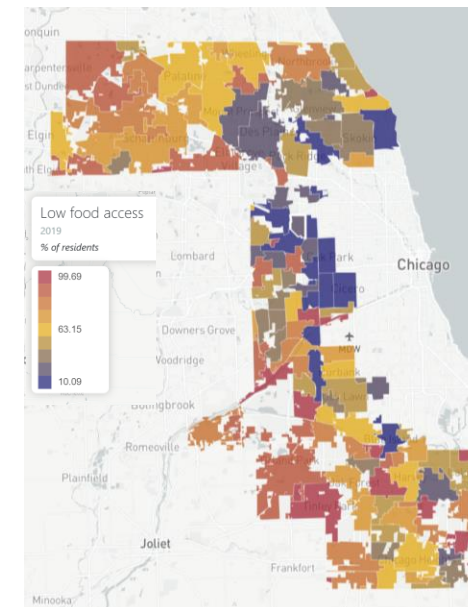
Status:



- Heart disease continues to be the leading cause of death and disability in suburban Cook, with the highest rates among Non-Hispanic Black residents
- Contributing to this burden is food insecurity, with south and west Cook municipalities sharing the greatest burden of low food access
- Placeholder for mental health data*



Heart Disease Mortality Rate by Race & Ethnicity and Region, 5 year moving average, Target: 167.1 deaths per 100,000 (U.S. Rate 2013-2017)
Heart Disease Mortality ICD-10 Codes: I00-I09, I11, I13, I20-I51.
Data Source: IDPH Death File, 2013-2017



Map of Low Food Access in Suburban Cook, Cook County Health
Atlas, <https://cookcountyhealthatlas.org/>



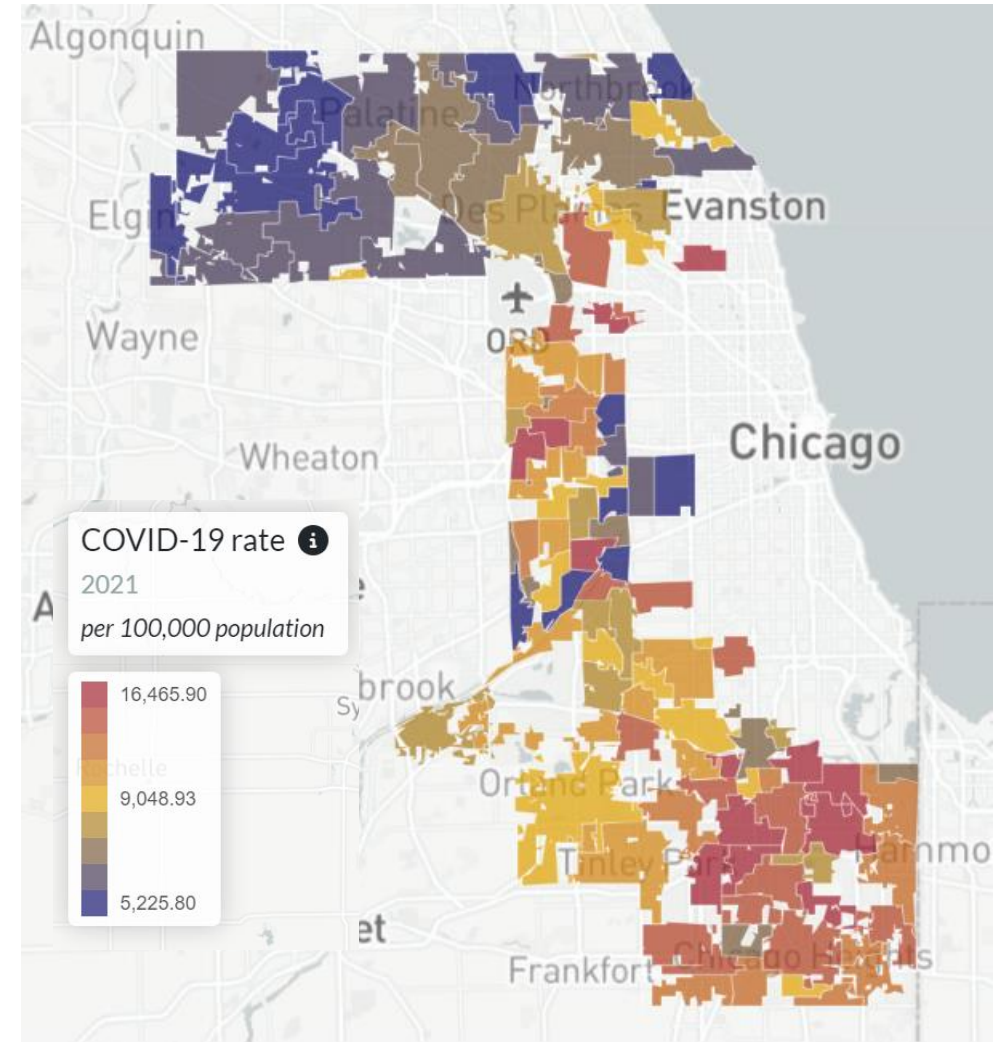
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Community Challenge: COVID-19 Disparities

- Case rates for people of color in SCC 4x-5x that of whites
- Blacks make up 22% of Cook County's population, but account for 28% of all COVID-19 related deaths
- Average age of death from COVID-19 for non-whites is seven years younger than whites
- COVID-19 highlighted existing health inequities, fragmented systems and limited availability and access to programs, services and resources



<https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0268317#:~:text=Principal%20findings%20showed%20that%3A%201,Minority%20ZCTA%20areas%20were%201.02>



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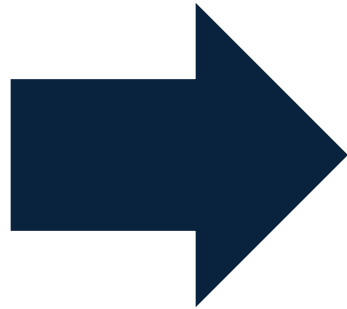
Building Healthier Communities

An overall community engagement strategy for racial and health equity

- Aims to share and build capacity of community-based organizations (CBOs) and other entities to advance community solutions for racial and health equity
- Supports CBOs and other entities in implementing evidence-informed programs and equitable policy, systems and environmental change strategies that make suburban Cook County a healthier place to live, work, learn & play
- Critical in reaching priority populations and building trust with communities for sustainable, transformative change
- Impact across the region is through collective efforts

Building Healthier Communities

Highlighted strategy to address disparities



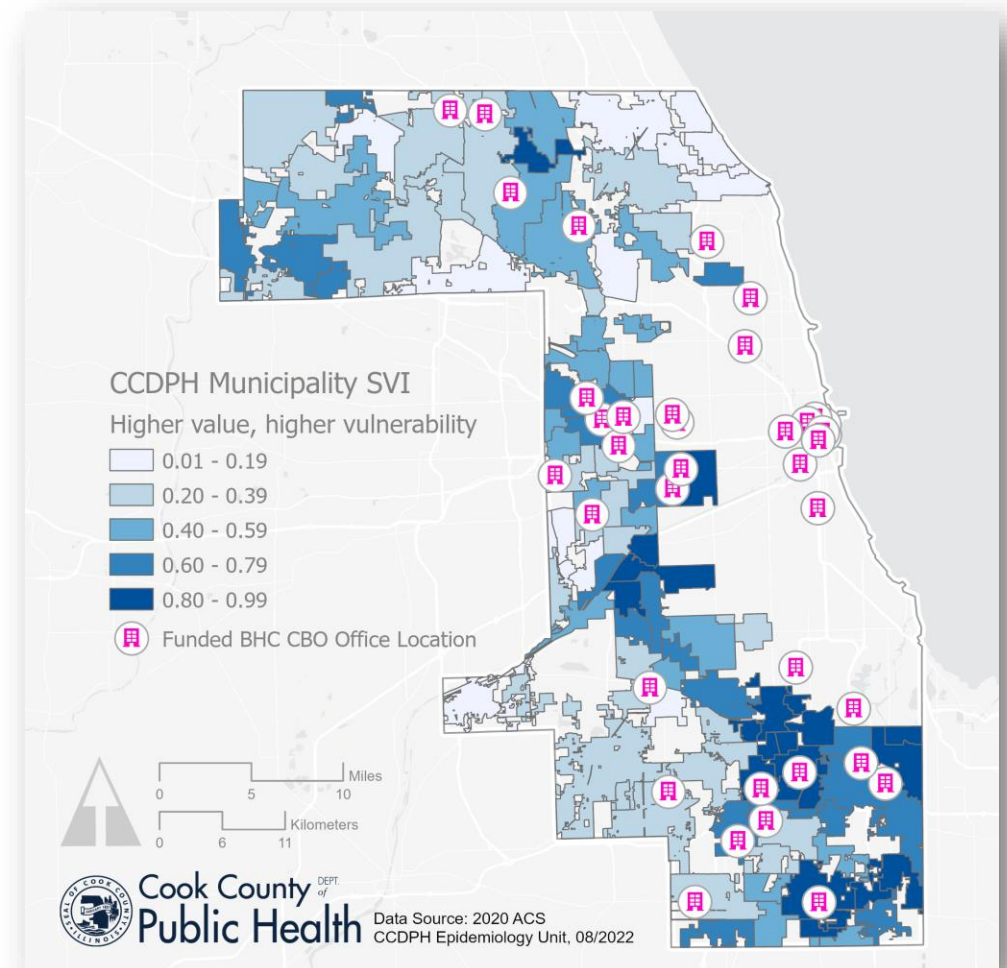
Strategic Priority/Pillar	CCDPH	CCH		Cook County
	WePLAN 2025	Strategic Plan	Change Institute	Policy Roadmap
Primary Care and Behavioral Health	✓			
Healthy Environments	✓			
Education & Economic Opportunities	✓			
Patient Safety				
Health Equity, Community Health		✓		
Workforce				
Fiscal Resiliency				
Patient Experience				
Performance Improvement				
Innovation & Transformation				
Cancer			✓	
Diabetes			✓	
Heart Disease			✓	
Neurologic Disease (e.g., stroke)			✓	
Healthy Communities				✓
Vital Communities				
Safe/Thriving Communities				
Sustainable Communities				
Smart Communities				
Open Communities				



Building Healthier Communities Reach

We are prioritizing across both geography and population groups.

- Use public health data (the Social Vulnerability Index) to direct resources, programs, and services
- This map shows our priority communities (high SVI) and where the BHC-funded organizations are located



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Progress: Addressing COVID-19 Disparities in disease and death

- More than 50,000 total COVID-19 related health messages distributed
- More than 21,000 people engaged to promote COVID-19 vaccination and testing
- 2,725 total COVID-19 vaccine doses given at 140 COVID-19 vaccination events held in 26 priority municipalities in West and South Cook
- More than 37,000 units of resources distributed including PPE (face masks, gloves, etc.), COVID-19 test kits, hand sanitizer, and other cleaning supplies



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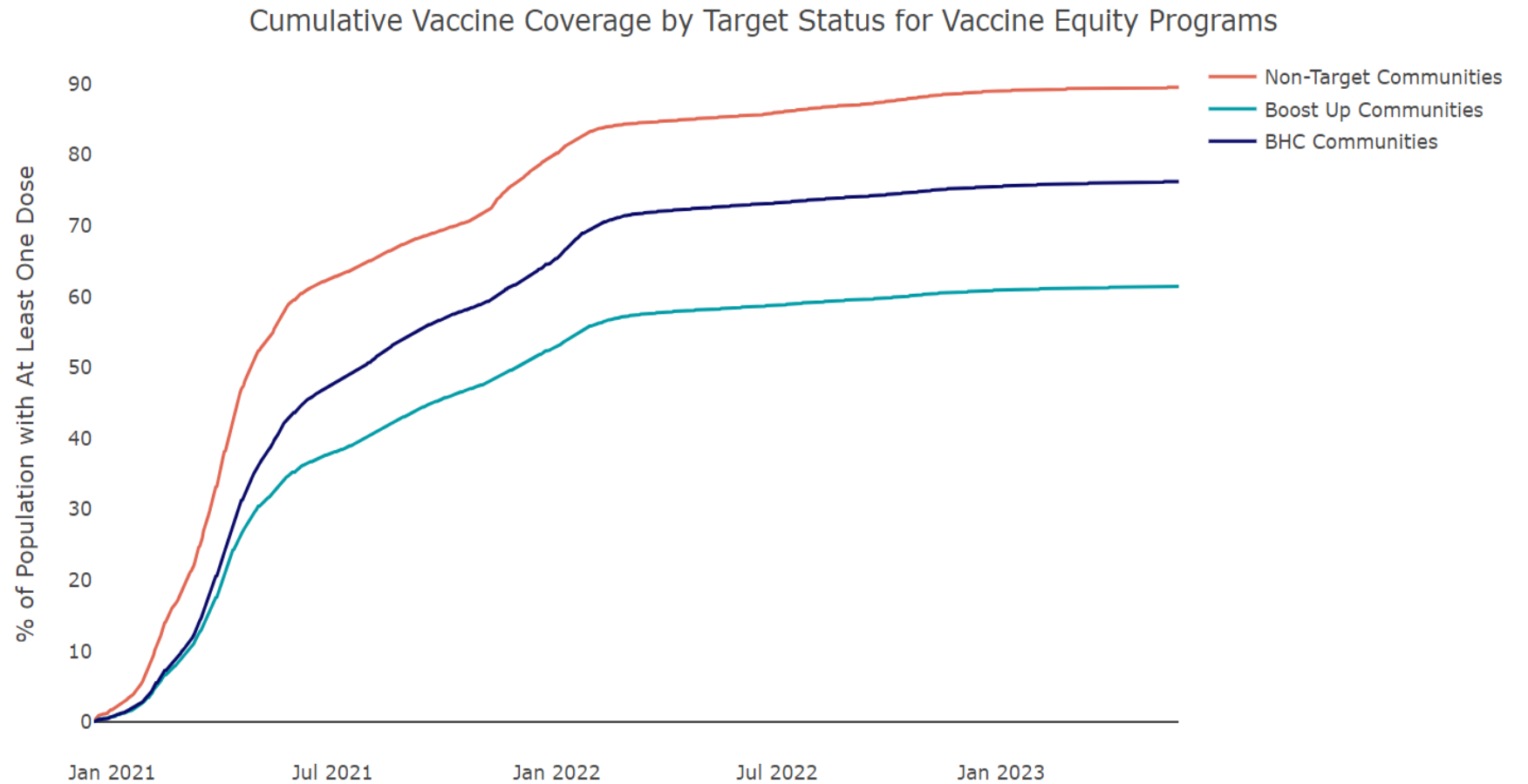
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BHC-funded CBOs distributing COVID-19 educational materials from CCDPH Boost Up Campaign in priority south suburban Cook municipalities

Progress: Vaccination

BHC communities and communities prioritized for media messages through the 'Boost Up' Campaign show increased

Percent with At Least One Dose



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Progress: Addressing Chronic Disease and Mental Health Disparities in Priority Communities

Increasing access to critical resources, programs, and services

Nearly 2,000 individuals connected to critical health and social resources and services by Community Health Workers and staff at funded community-based organizations

More than 288,000 meals served, distributed, or delivered to residents in priority communities

Referrals were made to:

- COVID testing and vaccination
- Clothing and household items
- Food services / federal nutrition programs
- Housing and shelter
- Government and legal
- Mental health and behavioral health services
- Physical healthcare/medical services
- Other health/medical/ social service



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Thank you



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