



**Cook County Department of Public Health  
Quarterly Report  
to the  
Cook County Board  
in their capacity as  
the Board of Health of Cook County**

**June 8, 2016**

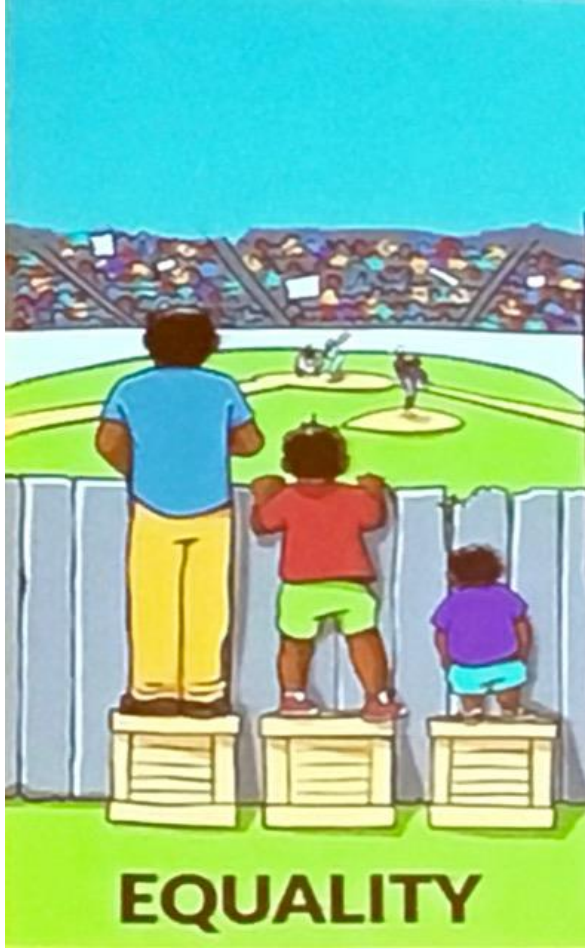


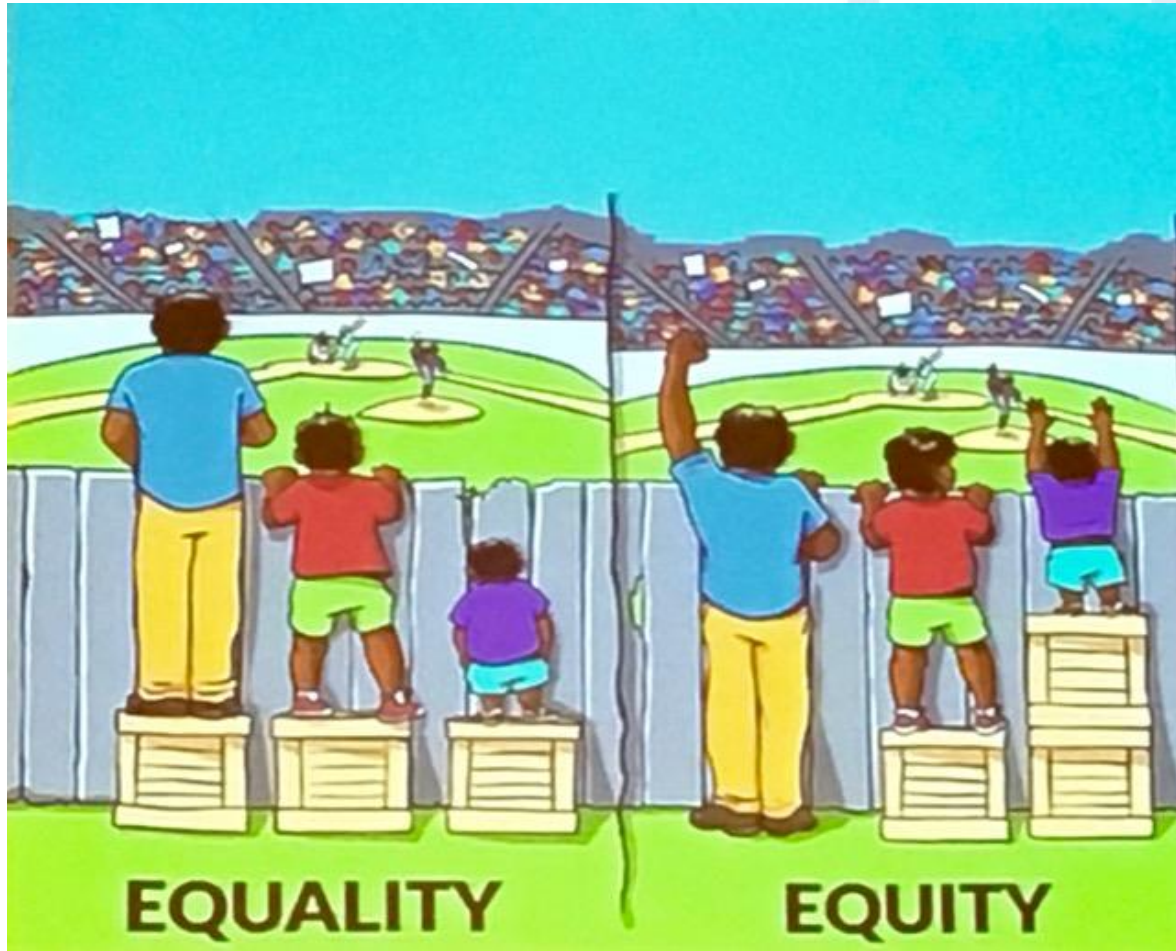
**COOK COUNTY HEALTH  
& HOSPITALS SYSTEM**  
**CC+HHS**

# Outline

- Conceptual Framework
- Terms
- Historical Perspective
- Data
- Recommendations





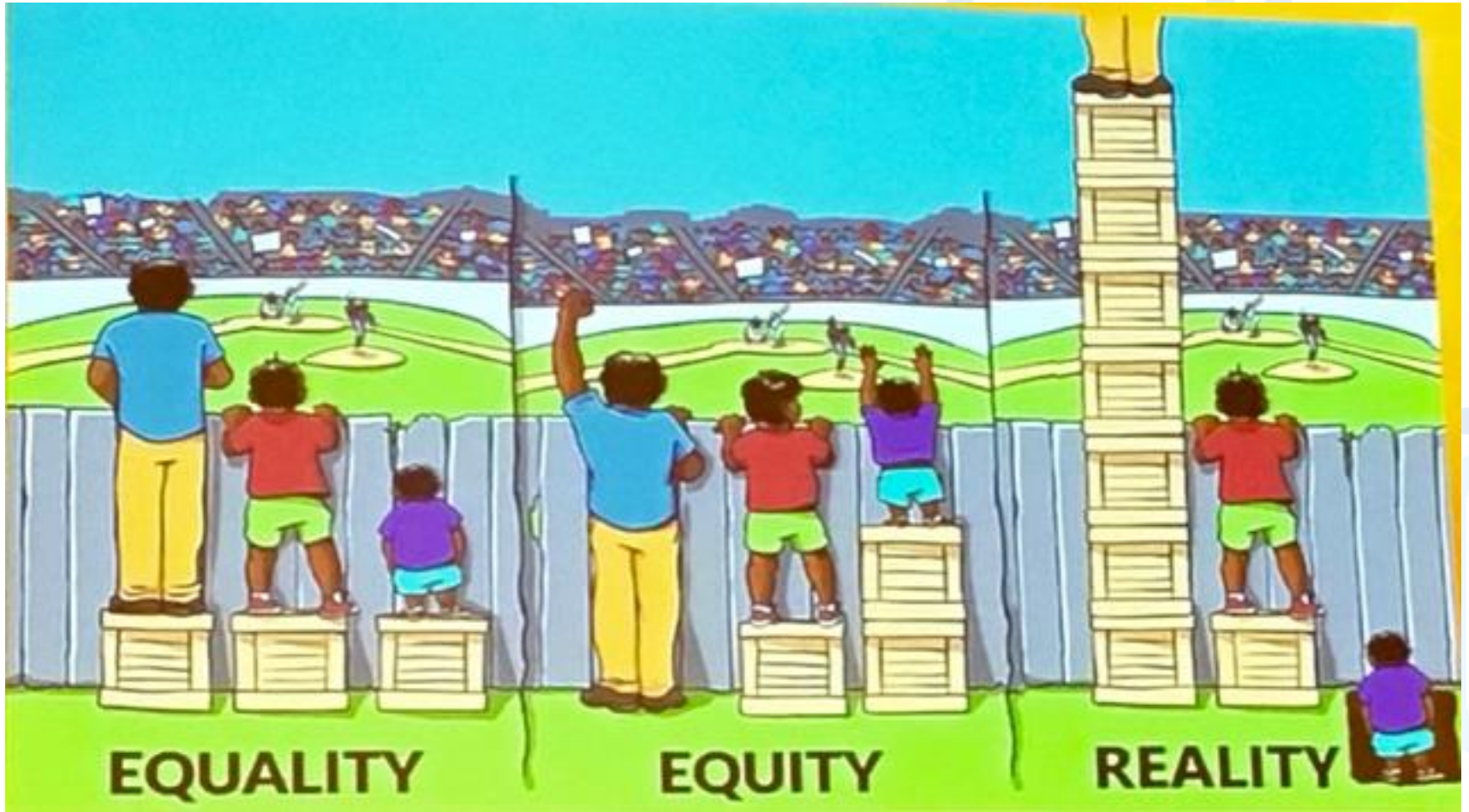


**EQUALITY**

**EQUITY**



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**CCHHS**



# CCDPH Mission Statement\*

To optimize health and **achieve health equity** for all people and communities of Cook County through our leadership and collaboration, focusing on health promotion and prevention, while advocating for and assuring the natural environmental and social conditions necessary to advance physical, mental and social well-being

\*Adopted, as required, during CCDPH PHAB accreditation process



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# National Movement for Health Equity

- Healthcare should be “equitable, (that is) providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.”

*Source: Institute of Medicine (US). Committee on Quality of Health Care in America. (2001). Crossing the quality chasm: A new health system for the 21st century. National Academy Press.*

- “Many sources – including health systems, healthcare providers, patients, and utilization managers – may contribute to racial and ethnic disparities in healthcare.”

*Source: Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2003). Institute of Medicine, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Unequal treatment: confronting racial and ethnic disparities in health care.*



# National Movement for Health Equity

- Centers for Disease Control (CDC)
  - Convened 99 leaders “Strengthening the Capacity of Public Health Departments to Advance Health Equity”
- National Association of City and County Health Officials (NACCHO)
  - Annual meeting focus on health equity – summer 2016
  - Swannie Jett - Confront inequity
- American Public Health Association (APHA)
  - President Camara Jones—Race and Racism
- Association of State and Territorial Health Officials (ASTHO)
  - Pres Ed Ehlinger—Triple Aim for Health Equity
- National Collaborative for Health Equity
  - Learning community of 20 teams





# Classical Public Health Model

## HEALTH FACTORS

### Population Characteristics

- Demographic Characteristics
- Social Determinants of Health

### Risk and Resiliency Factors

- Health Behaviors
- Physical Environment

### Health Care Services & Systems

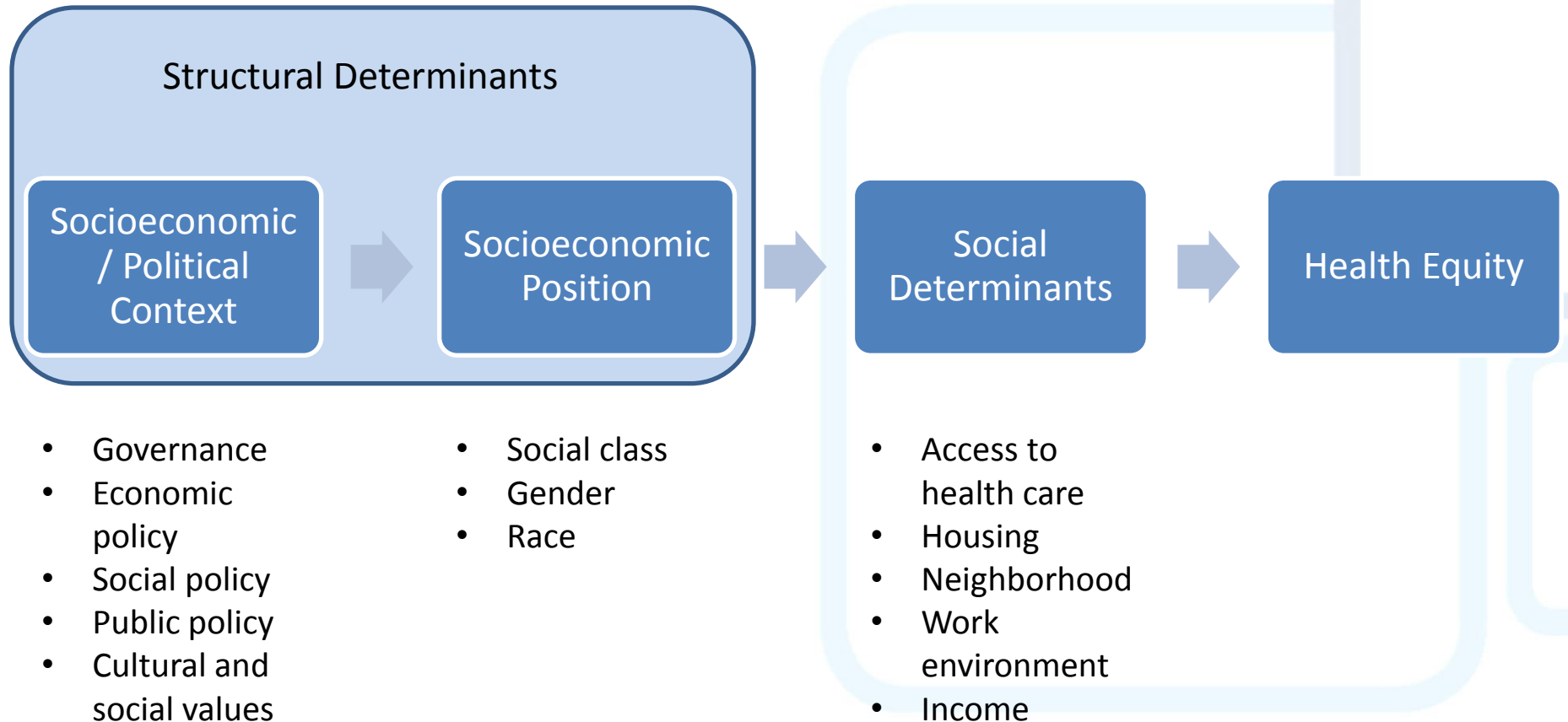
- Access to Care
- Quality of Care
- Use of Preventive Services

## HEALTH OUTCOMES

### Health Outcomes

- Mothers and Infants
- Leading Causes of Death
- Infectious Diseases
- Cancer
- Chronic Conditions
- Injury and Violence
- Mental and Behavioral Health
- Summary Measures of Health

# Health Equity Framework



*Modified from Solar, O., & Irwin, A. (2007). A conceptual framework for action on the social determinants of health.*



# Structural Determinants of Health

- “...structural mechanisms are those that generate stratification and social class divisions in the society and that define individual socioeconomic position within hierarchies of power, prestige and access to resources.”

*Source: Solar, O., & Irwin, A. (2007). A conceptual framework for action on the social determinants of health.*



# Social Determinants of Health

- The economic and social conditions that influence the health of individuals, communities, and jurisdictions as a whole.
  - Availability of food
  - Affordable housing
  - Quality education
  - Job security
  - Social connection and safety
  - Living wage
  - Access to transportation

*Source: Raphael, D. (2009). Social determinants of health: Canadian perspectives. Canadian Scholars' Press.*



# Health Disparity

- A disproportionate difference in health between groups.

This term **does not** address the chain of events that produce it.

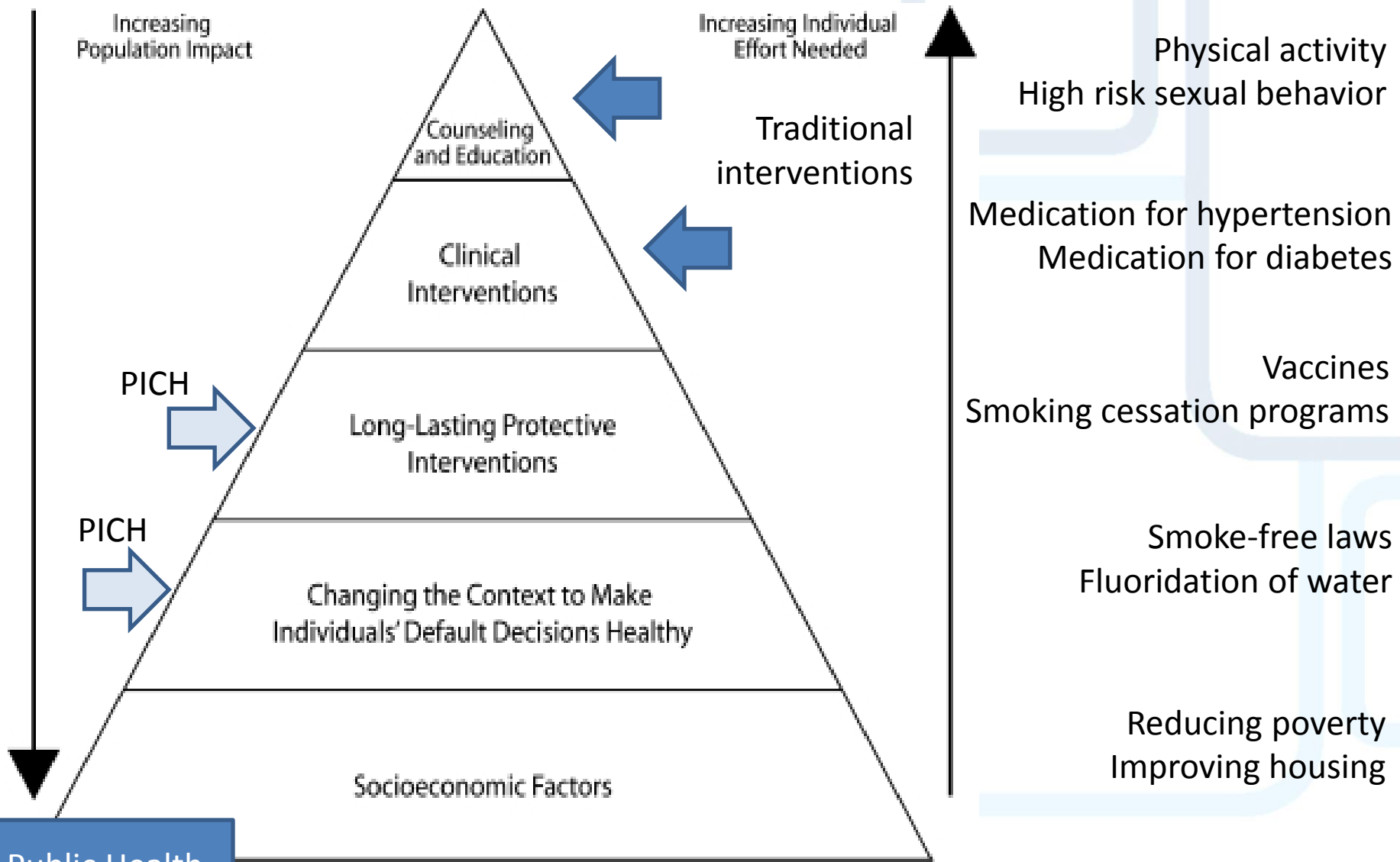


# Health Inequity

- “Differences in population health status and mortality rates that are systemic, patterned, unfair, unjust, and actionable, as opposed to random or caused by those who become ill.”

*Source: Whitehead, M. (1992). The concepts and principles of equity and health. International journal of health services, 22(3), 429-445.*





*Modified from Frieden, T. R. (2010). A framework for public health action: the health impact pyramid. American journal of public health, 100(4), 590-595.*



- “Demonstrating that a given disparity is plausibly avoidable and can be reduced by policies [is sufficient evidence for action...]”

*Source: Braveman, P. A., Kumanyika, S., Fielding, J., LaVeist, T., Borrell, L. N., Manderscheid, R., & Troutman, A. (2011). Health disparities and health equity: the issue is justice. American Journal of Public Health, 101(S1), S149-S155.*





# Why do we have Disparities?

- “It should be noted that adjusting for socioeconomic status almost always reduces, though seldom eliminates, the effects of race and ethnicity on the health care that a patient receives”

*Source: Swift, E. K. (Ed.). (2002). Guidance for the National Healthcare Disparities Report. National Academies Press.*



**We are supposed to!!**



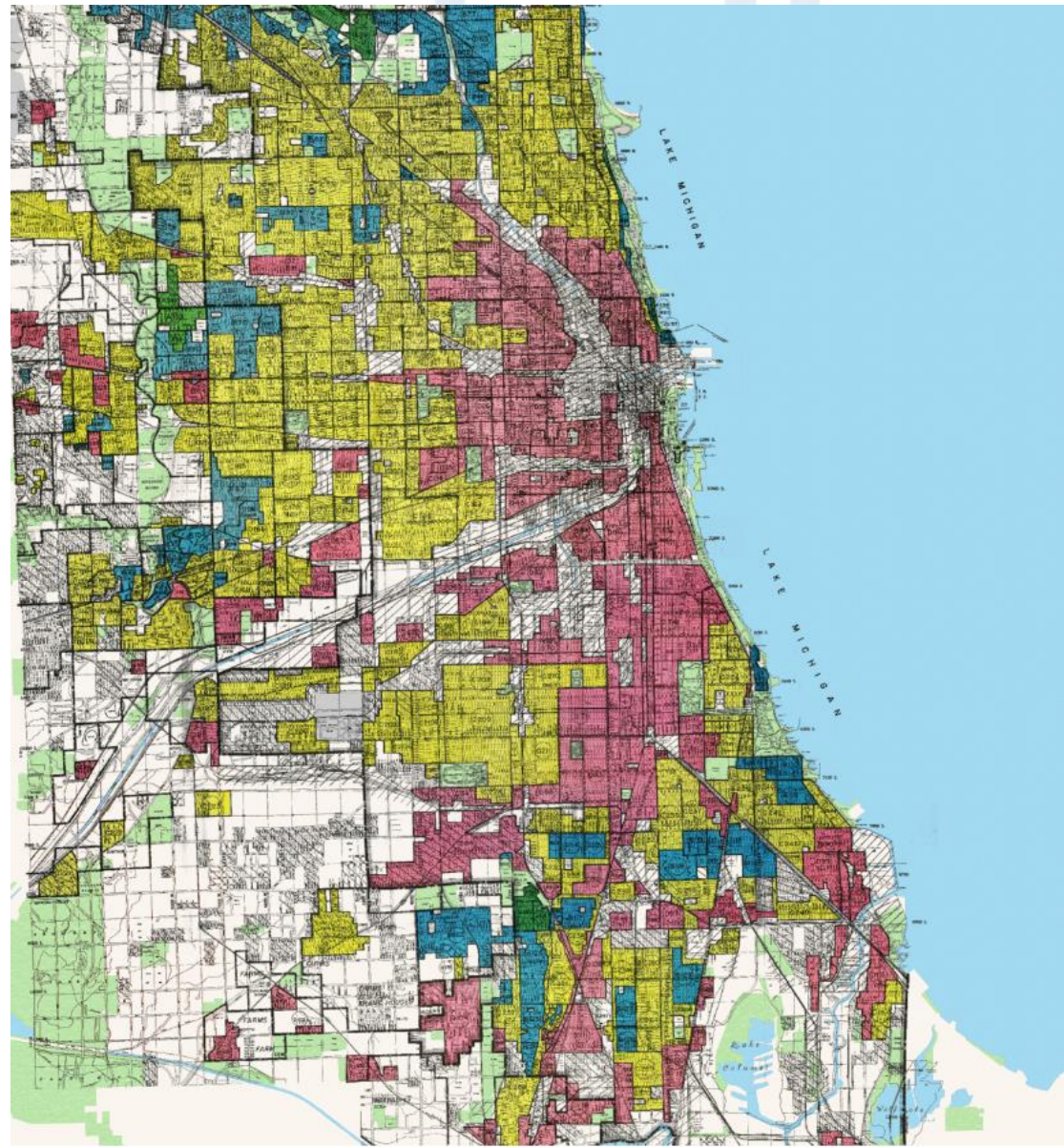
## 1934–1968: FHA Mortgage Insurance Requirements Utilize Redlining:

“The FHA also explicitly practiced a policy of “redlining” when determining which neighborhoods to approve mortgages in. “

“... color-coded maps indicating the level of security for real estate investments... appraisers divided neighborhoods by categories including occupation, income and ethnicity of inhabitants:

C (yellow) were neighborhoods that were “definitely declining.” Generally sparsely populated fringe areas that were typically bordering on all black neighborhoods.

D (red) (hence the term “red-lining”) were areas in which “things taking place in 3 (“C”) had already happened.” Black and low income neighborhoods were considered to be the worst for lending”.



Source: <http://www.bostonfairhousing.org/timeline/1934-FHA.html> Accessed 5/20/16



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# Discriminatory Lending Practices Have Continued

- “... reverse redlining involves the targeting of an area for the marketing of deceptive, predatory or otherwise unfair lending practices because of the race or ethnicity of the area's residents...”

Source: Vedantam, S. (2008). *Subprime Mortgages and Race: A Bit of Good News May Be Illusory*. *Washington Post*, A02 from <http://www.washingtonpost.com/wpdyn/content/story/2008/06/29/ST2008062902089.html?sid=ST2008062902089> accessed 5/20/16

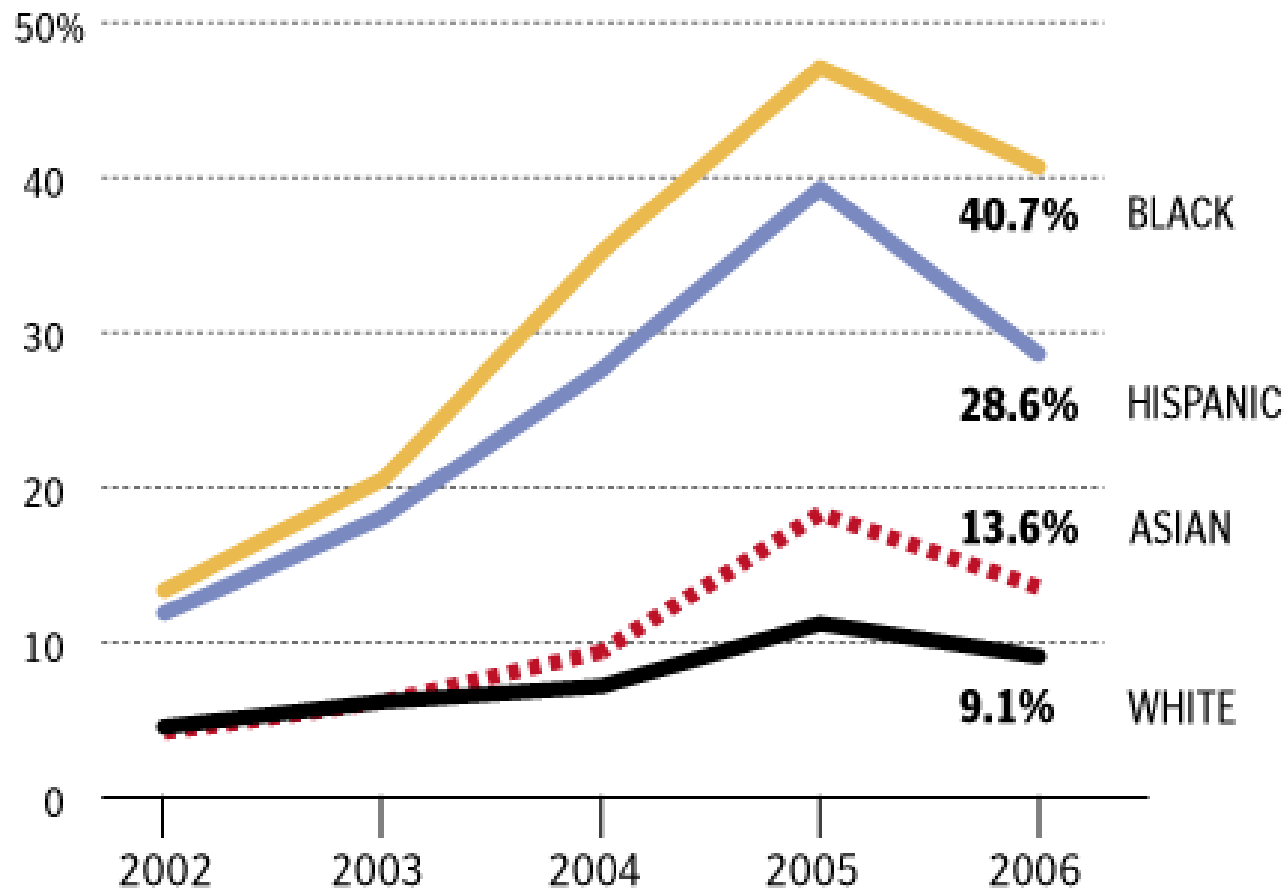
- “By 1999 the proportion of black borrowers receiving loans from subprime lenders was six times what it was in 1992.”

Source: Bond, C., & Williams, R. (2007). *Residential segregation and the transformation of home mortgage lending*. *Social Forces*, 86(2), 671-698.

- Several local governments have filed lawsuits against prominent banks for discriminatory lending



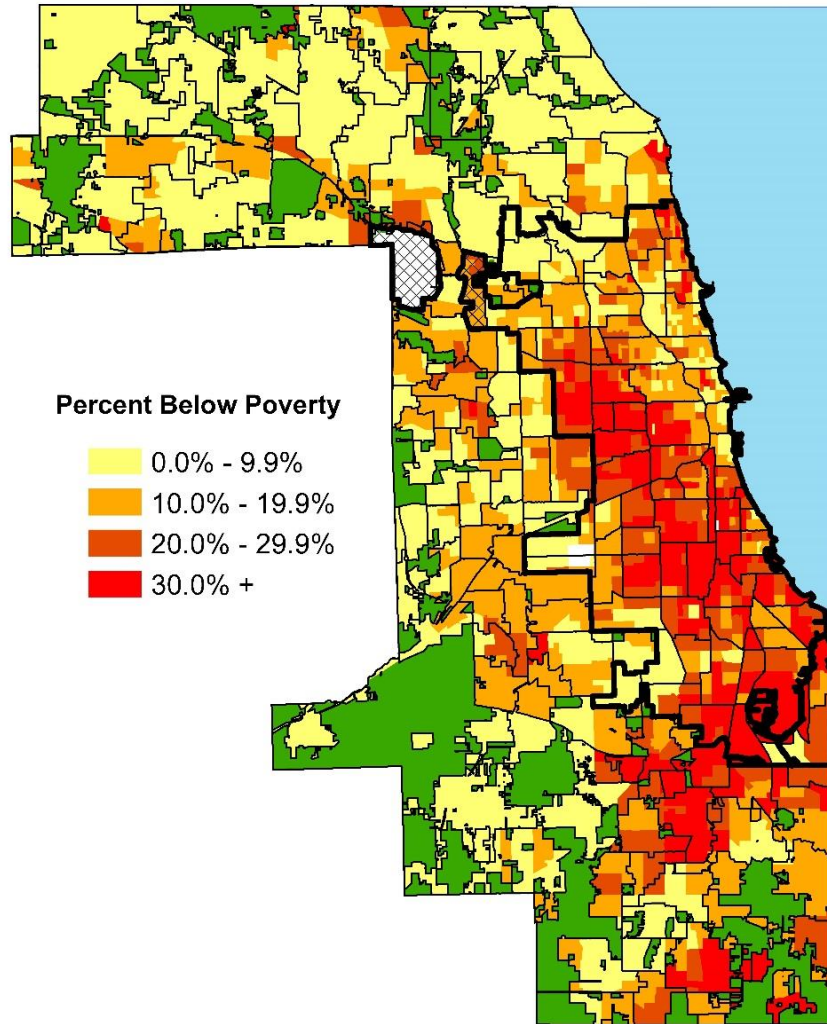
## Rate of conventional subprime lending by race, New York City



Source: Vedantam, S. (2008). *Subprime Mortgages and Race: A Bit of Good News May Be Illusory*. *Washington Post*, A02 from <http://www.washingtonpost.com/wp-dyn/content/story/2008/06/29/ST2008062902089.html?sid=ST2008062902089> accessed 5/20/16



# Cook County Percent of Population Below Poverty By Census Tract 2010-2014



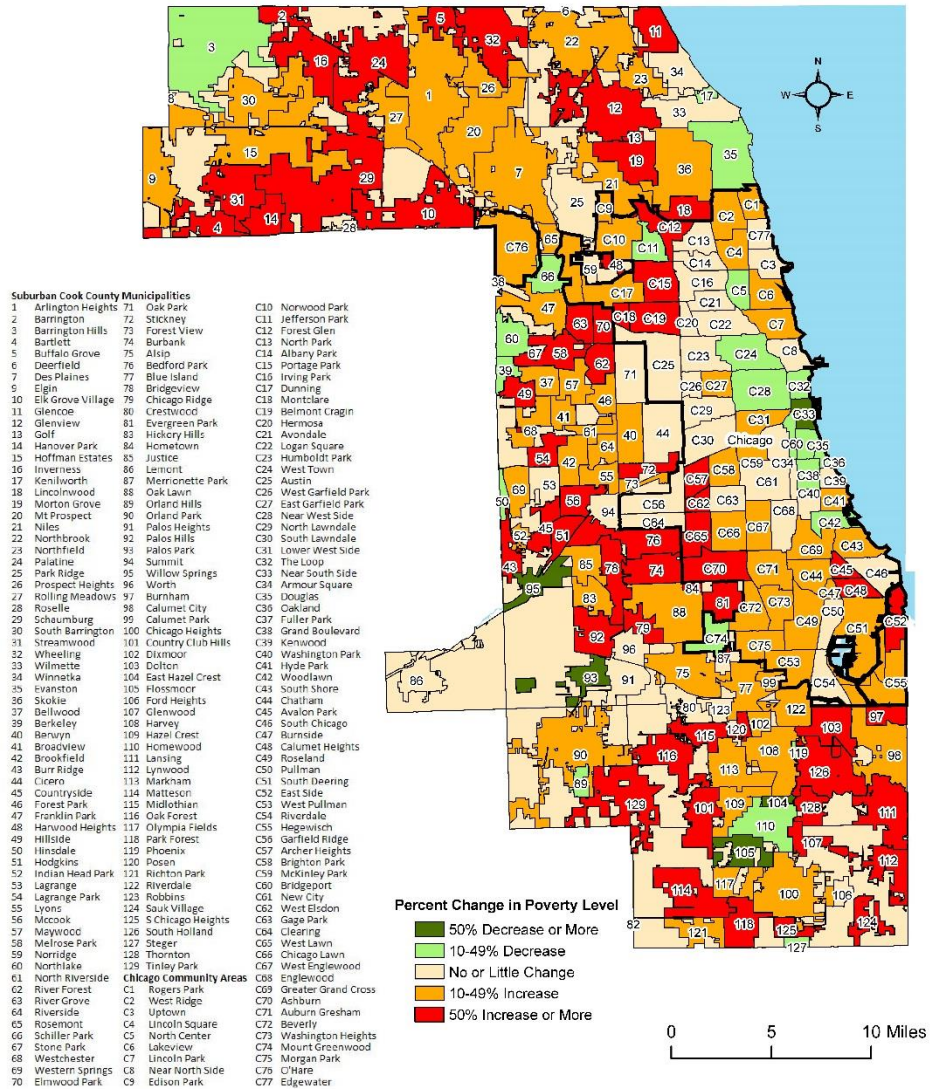
## FEDERAL POVERTY GUIDELINES

Household Size	100% FPL*
1	\$11,770
2	\$15,930
3	\$20,090
4	\$24,250
5	\$28,410
6	\$32,570
7	\$36,730
8	\$40,890

\*2016 poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C.



# Cook County Percent Change in Population At or Below Federal Poverty Level\* From 2000\*\* to 2005-2009\*\*\*



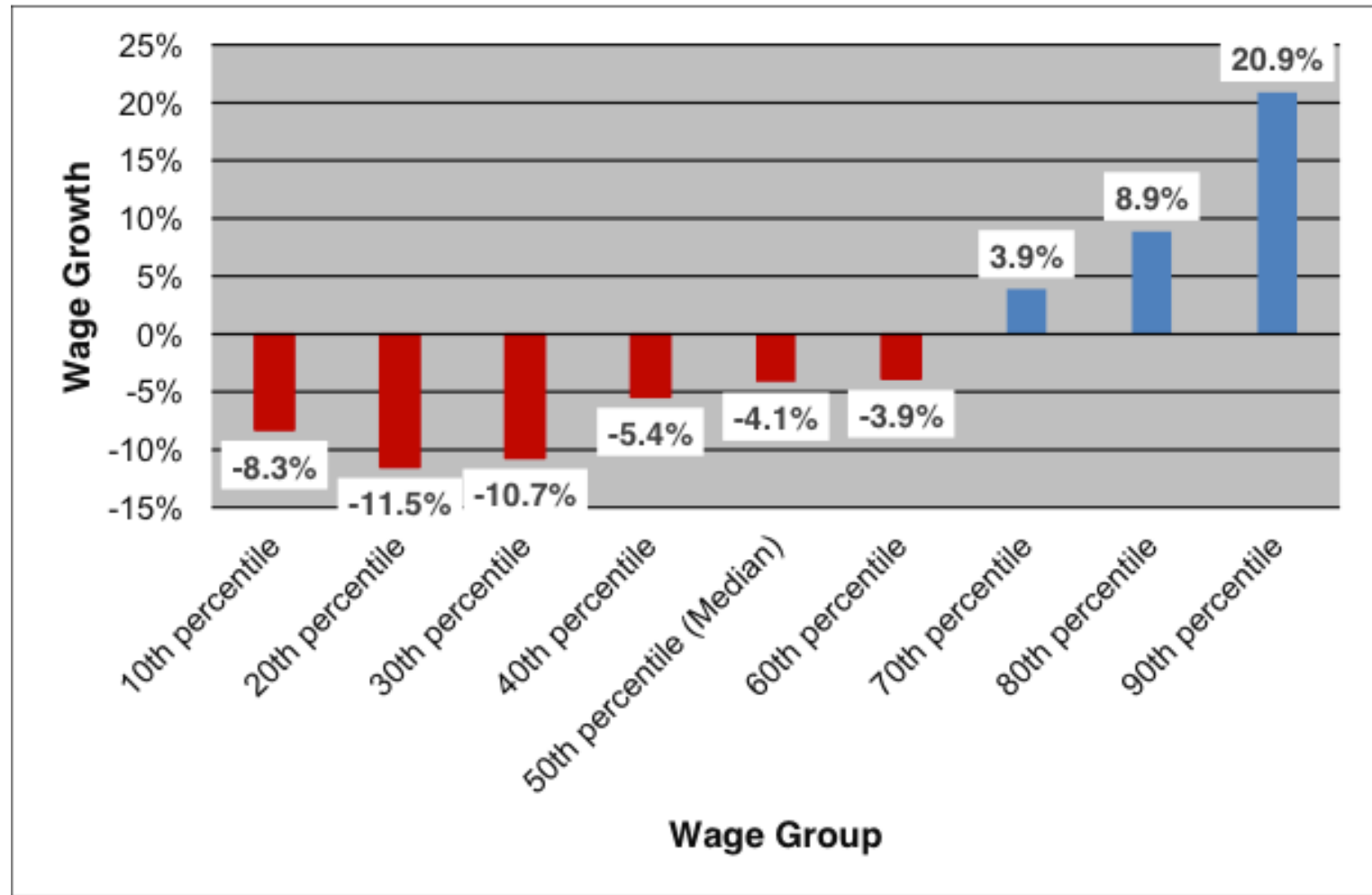
Cook County Department Of Public Health, Epidemiology Unit  
Data Source: \*\*U.S. Census Bureau  
\*\*\*2005-2009 American Community Survey

\*Note: The percent of persons in households or group quarters, other than institutions, with income levels at or below 100% of the federally defined poverty level.



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## Change in Inflation Adjusted Real Wages in Illinois, 1979-2014

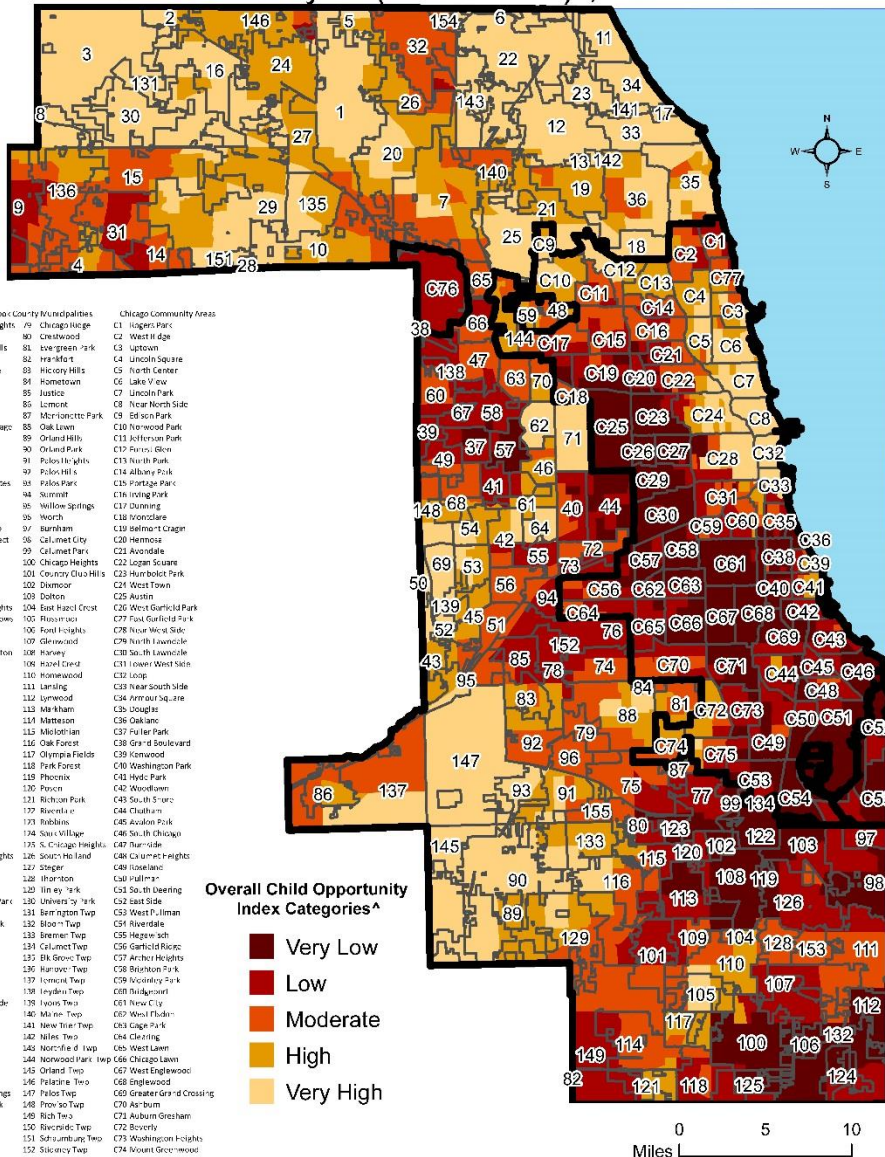


Source: Economic Policy Institute analysis of Current Population Survey data, adjusted for inflation using the CPI-U-RS.





# Childhood Opportunity Index by Census Tract Cook County-IL (Metro Area)\*, 2007-2013\*\*



## Educational Opportunity

- Student poverty rates
- Student math/reading proficiency levels
- Early childhood education (ECE) indicators:
  - Proximity to licensed ECE centers/ high-quality ECE centers
  - Participation patterns
- High school graduation rates
- Adult educational attainment

## Health & Environmental Opportunity

- Proximity to health facilities
- Retail healthy food environment index
- Proximity to toxic waste release sites
- Volume of nearby toxic release
- Proximity to parks and open spaces
- Housing vacancy rates

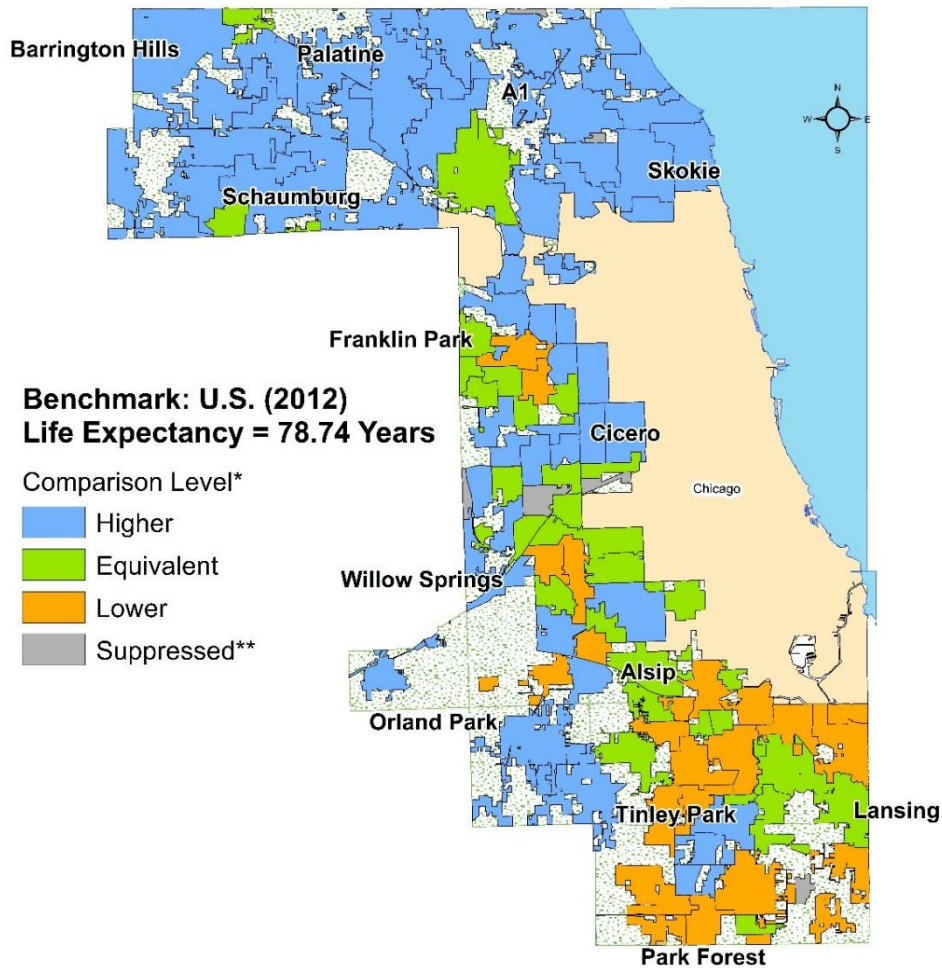
## Social & Economic Opportunity

- Foreclosure rates
- Poverty rates
- Unemployment rates
- Public assistance rates
- Proximity to employment

<sup>▲</sup> Each Census Tract is shaded according to its Opportunity Index category representing childhood opportunity levels ranging from "very low" to "very high" relative to the other tracts in the Chicago-Joliet-Naperville, IL-IN-WI Metro Area.

\*Cook County Department of Public Health, Epidemiology Program Unit  
 \*\*Chicago Office of Neighborhood Development  
 \*\*\*Data and maps courtesy of diversitydatalab.com & The Urban Institute

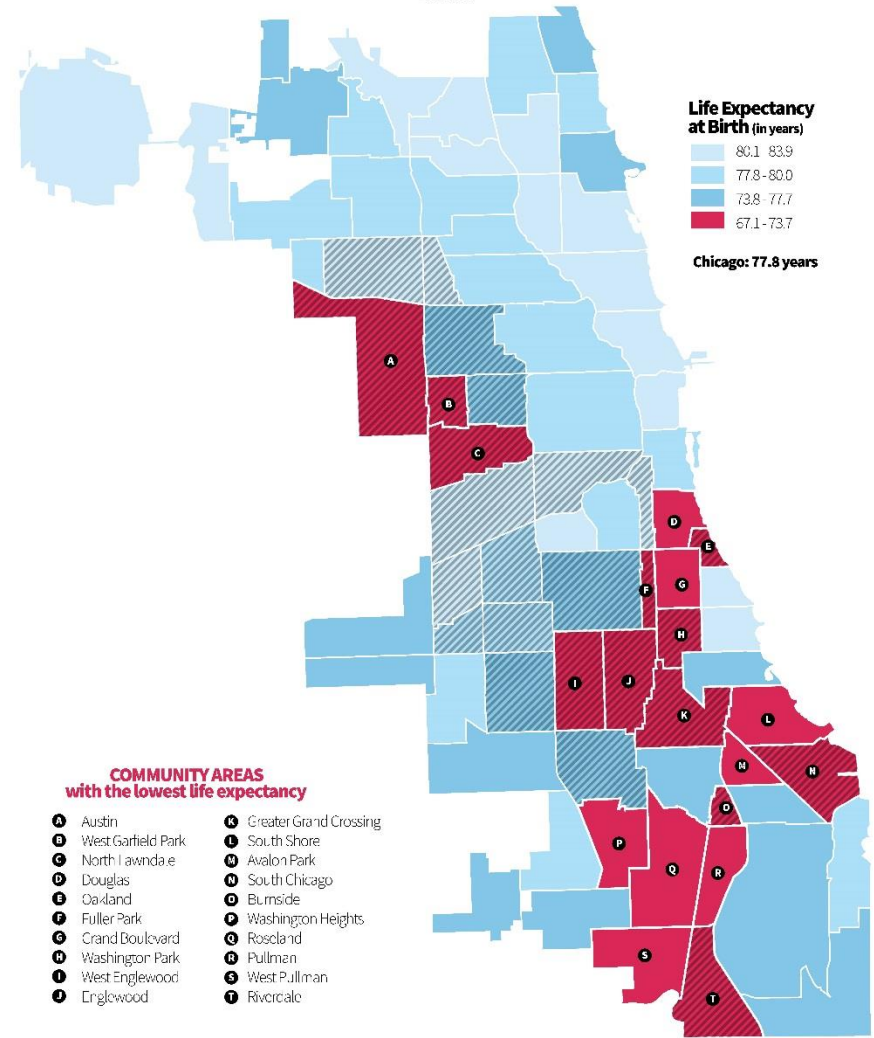
## Cook County Department of Public Health Life Expectancy at Birth by Town 2008-2012



\* Significant at  $p < .05$   
\*\*Suppressed due to small cell counts

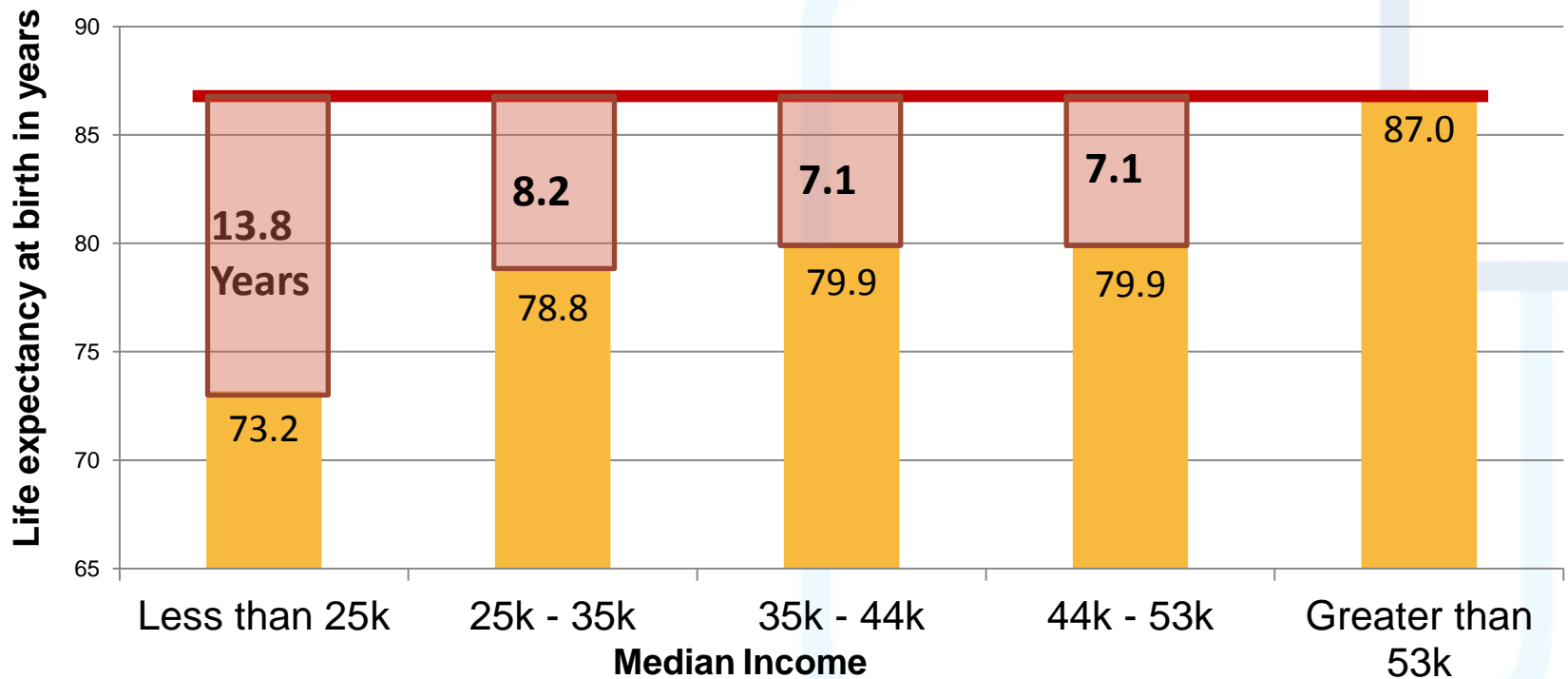


## Chicago Department of Public Health Life Expectancy at Birth by Community Area 2012



Source: Department of Public Health, 2012

# Average Life Expectancy (2003-2007) by Median Income of Census Tract/Municipality (2009), Cook County



**Source:** Life expectancy calculated by the VCU Center on Human Needs from 2003-2007 data provided by Cook County Health Department: Median Income from 2009 Geolytics Premium Estimates.



# In Summary

- Long history of discrimination and racist practices disproportionately affecting residents of the near west and southern parts of Cook County
- This has resulted in areas of concentrated poverty and low opportunity
- As a result, populations residing in those areas suffer from disproportionately poor health care and health outcomes



- Strengthening health equity... means **going beyond the contemporary concentration on the immediate causes of disease**

*Source: Commission on Social Determinants of Health. (2007). Achieving health equity: from root causes to fair outcomes: Commission on Social Determinants of Health, Interim statement.*



# Recommendations for Advancing Health Equity

- Continue to support pro-equity policies
- Staff training
  - Health equity
  - Unconscious bias
  - Cultural competence
  - Adverse Childhood Experiences (ACEs)
- Stratify quality metrics by race, ethnicity, and primary language



# Coming Soon

- WePlan 2020 - 5 year community Health Improvement Plan tied to PHAB Accreditation and IDPH Certification
- Will review and require approval of CCHHS System Board and BOH Cook County Commissioners before formal adoption.



# Recommendations for Advancing Health Equity

- Work across Cook County government to leverage resources
- Utilize CCDPH and CDPH information to identify drivers of inequity
- Integrated, collaborative approach to address social determinants of health





# Recommendations for Advancing Health Equity

- Pro-equity policies
  - Tobacco 21
  - Food insecurity
  - Integrating behavioral health into primary care
  - Early childhood development
  - Lead bill and program expansion



# Lead Program Expansion

- Funded by Lead Poisoning Prevention Fund
  - Current balance: \$10,891,209
- Current IDPH recommended lead intervention level: 10 mcg/dL
  - Total yearly expenditure: \$1 million
  - Total new cases/year: 125
  - Estimated date of fund depletion: 2026-27
- CDC recommended lead intervention level: 5 mcg/dL
  - Total yearly expenditure: \$4.1 million
  - Estimated total new cases/year: 2300
  - Estimated date of fund depletion: 2018-19
  - Additional required resources:
    - 7 lead risk assessors (6 Sanitarian II, 1 Sanitarian IV) - \$560,000
    - 4 public health nurses (3 PHN I, 1 PHN III) - \$460,000
    - 1 administrative assistant - \$80,000
    - Additional homes abated - \$2 million
    - 5 XRF machines - \$100,000 (one time cost)



# Annual Reports

- Annual Tuberculosis Surveillance Report 2013
- Annual Tuberculosis Surveillance Report 2014
- Sexually Transmitted Infections Annual Surveillance Report 2014
- HIV/AIDS Surveillance Report 2013

