



Current State of Health Status in Illinois

October 12m 2020

Presented by:

Illinois Department Of Public Health

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The Illinois Public Health Institute



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Illinois State Health Improvement Plan Health Priority and Health Status Update

October 2020

Presented by UIC SPH and IPHI



**Policy, Practice and
Prevention Research Center**



Health Priority Presentation Objectives

1. Provide key examples of the current state of health in Illinois based on the available analyzed data
2. Discuss interpretation, areas of agreement/alignment and gaps in the information provided
3. Review status of 2016-2021 SHIP Priorities
4. Review selected other Illinois health and statewide indicators
5. Reviewing results of LHD and IDPH staff surveys related the health priorities, Covid-19 and racism.

Presentation of Illinois Health Data: What to Expect

- The data being presented today are only a part of the Illinois health story
- Focus is on examining the existing 2016-2021 SHIP priorities and the need to continue or extend the work for the next 18 months
- Consider other health outcomes and conditions for prioritization
- Consider emerging issues and their impact in selecting priorities (i.e. COVID-19, racism, etc.)

What data will be presented?

"How healthy are our residents?" and "What does the health status of our state look like?"

2016-2021 SHIP Priorities

- Chronic Disease
- Behavioral/Mental Health
- Maternal and Child Health

- Local Health Department and IDPH Employee Surveys

- Selected Health Status Indicators

Data strength and limitations.

"How healthy are our residents?" and "What does the health status of our state look like?"

This is a high-level overview of the status of the current 2016-2021 SHIP priorities and selected other indicators for decisions on continuing priorities for the next 18 months.

Consequently some data were not available or could not be prepared:

- County and region-specific data (e.g. age adjusted mortality rates and trends)
- Race/ethnicity specific rate data for all indicators (e.g. age-adjusted mortality and trends)
- Demographic variations in the data for all indicators
- Detail on cause-specific outcomes for specific cancers and associated demographic variations.
- Survey response rates vary by question due to non-response on specific questions.
- About 45% of LHDs and 10% of IDPH staff participated in the surveys.

ILLINOIS PROJECT FOR
LOCAL ASSESSMENT OF
NEEDS (IPLAN) PRIORITIES



CLASSIFICATION OF IPLAN PRIORITIES

1

Step 1

- Initial and brief review of IPLANs to understand organization and structure of priorities

2

Step 2

- Compile list of health priorities

3

Step 3

- Creation of definitions, inclusion, and exclusion criteria for each priority
 - Utilize definitions from CDC

4

Step 4

- Review each IPLAN, categorize each priority, and flag priorities that are unclear/ don't fit categories

5

Step 5

- Perform quality check and refine categories as needed

COUNTY TO IPLAN RATIO

- 102 Counties (97 LHDs) and Chicago have a combined **total of 92 IPLANs**
- 87 county IPLANs + 15 counties are represented by 4 IPLANs
 - Bureau Marshall Putman Counties = 3
 - Franklin-Williamson Bi-County Health Department = 2
 - Peoria-Tazewell-Woodford County = 3
 - Southern Seven Counties = 7

EXAMPLE OF DEFINITION AND CRITERIA

Priority	Definition	Inclusion	Exclusion
Access to Care	Availability to health services	IPLAN directly states "Access to Care"	
Mental Health	Mental health includes emotional, psychological, and social wellbeing	IPLAN directly states Mental Health is priority May also include behavioral health if it combines substance abuse/mental health/behavioral health	Substance abuse listed by itself
Substance Abuse	Refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs	Prevention and Mitigation of Use for: Opioids Alcohol Heroin Tobacco	Mental health

County	SDOH	Mental Health	Substance Abuse	Oral Health
County Name	2	1	1	1
County Name + Priorities	(1)Education (2)Housing	(3) Mental Illness	(4) Alcohol	(5) Oral Health

EXAMPLE OF CODING IN TOOL

FINDINGS

330 priorities listed across 92 IPLANS

Rankings by Order

1. Chronic Disease
2. Mental Health
3. Substance Abuse
4. Access to Care

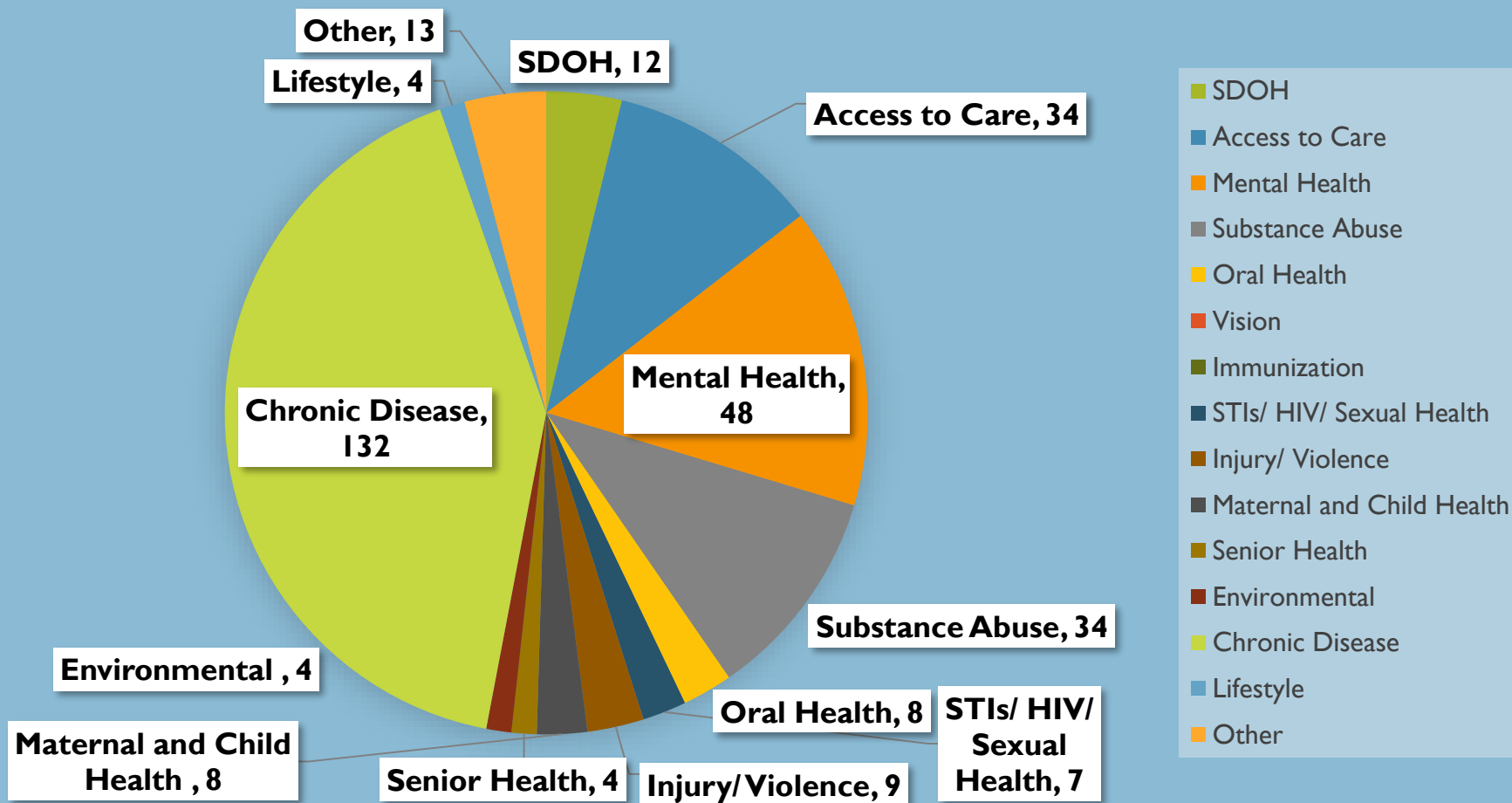
* Other category includes bullying, asthma, data and research, etc. And priorities that did not fit into the set categories

Chronic Disease	132
Mental Health	48
Access to Care	34
Substance Abuse	34
Other*	13
SDOH	12
Injury/Violence	9
Oral Health	8
Maternal and Child Health	8
STIs/ HIV/ Sexual Health	7
Senior Health	4
Environmental	4
Lifestyle	4
Vision	0
Immunization	0
TOTAL	330

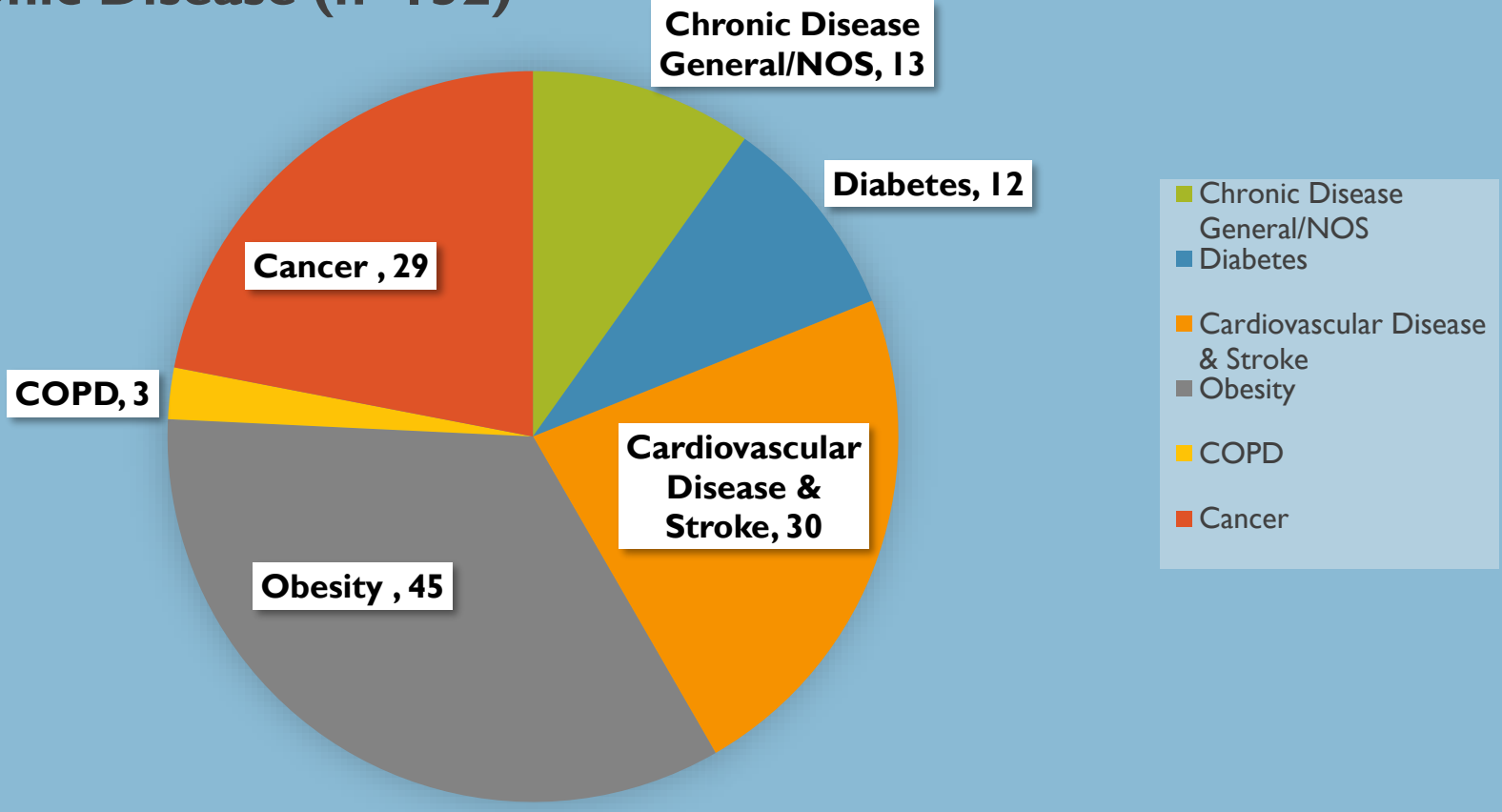
EXAMPLES OF PRIORITIES

Access to Care	Substance Abuse	Injury/Violence	Environment
<ul style="list-style-type: none">• Access to Dental Care• Primary Health Care• Community Support (Access to Care)• Access to providers for uninsured, underinsured for Medicaid Individuals	<ul style="list-style-type: none">• Opioid/Heroin Deaths• Youth Substance Abuse• Drug/Alcohol Tobacco Use• Behavioral Health: Substance Abuse Focus	<ul style="list-style-type: none">• Violence Prevention and Safety• Child Abuse• Unintentional Injuries	<ul style="list-style-type: none">• Air quality• Environmental protection services• Decreasing community population potential exposure to Lyme Disease

Priorities Across IPLANS (n=330)



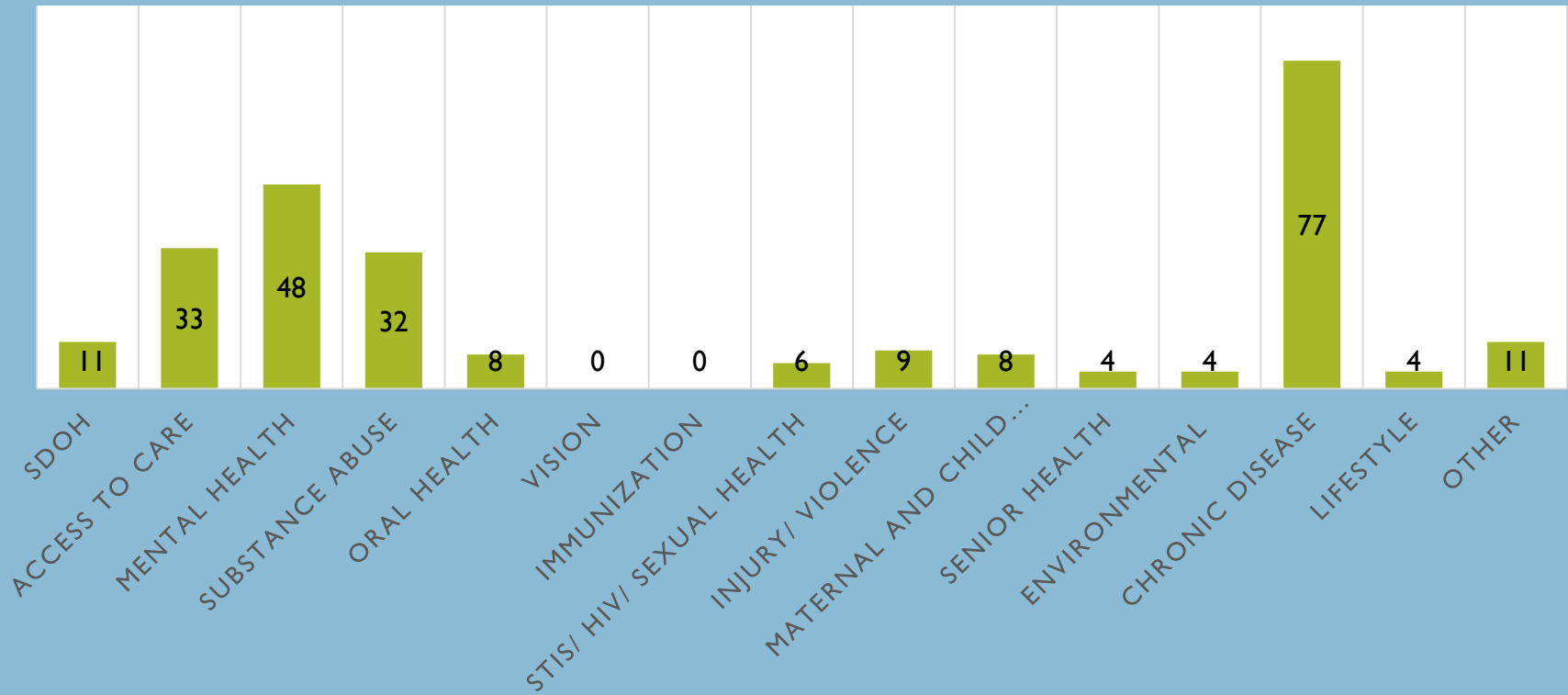
Chronic Disease (n=132)



PROPORTION OF IPLANS (N=92) & SPECIFIC PRIORITIES

- SDOH (n=11) (11.9%)
- Access to Care (n=33) (34.7%)
- Mental Health n=48 (54.3%)
- Substance Abuse n=32 (33.6%)
- Oral Health n=8 (8.6%)
- Vision n=0
- Immunization n=0
- STIs/ Sexual Health n=6 (6.5%)
- Injury n=9 (9.7%)
- MCH n=8 (8.6%)
- Senior Health n=4 (4.3%)
- Environment n=4 (4.3%)
- Chronic Disease n=77 (83.6%)
- Lifestyle n=4 (4.3%)
- Other n=11 (11.9%)

HOW MANY COUNTIES CHOSE EACH PRIORITY?



CHALLENGES

Difficult to categorize at times
due to inconsistencies

Possible misalignment within
priorities and strategies

This will be investigated within
the strategy evaluation

QUESTIONS OR FEEDBACK?

Presentation of Illinois Health Data:

In hearing the presentation of health data, consider the following questions:

- How do the previously identified health priorities align with the data?
- How do the previously identified health priorities differ from the data?
- Where does effort need to continue?
- Where do priorities need to shift?

Domain vs. Priority

- Domain – broader areas of focus vs specific health outcomes/diseases
- Reflect complex and inter-related nature of health status among disease causes and outcomes
- Provide opportunity to consider broader system level factors (vs individual factors alone) that may impact community health status



Indicators

- Indicators are thoughtfully selected data points that provide useful information about the health of a community.
- Indicators can be used to establish a baseline and measure performance/improvement on a particular data point.
- Indicators can present a profile of the community's health and/or serve as a basis to monitor performance.
- Indicators identify specific aspects of community's health and conditions, but may not detail the why or how of health status

Health Domains

- **Context**

- Demographics
- Social Determinants of Health

- **Health Status**

- Mortality
- 2016-2021 SHIP Priorities
 - Chronic Conditions
 - Behavioral Health
- Maternal and Child Health
- Communicable Disease
- Injury and Violence

- **Health Behaviors**

- **Health Care**

- Access and Utilization
- Clinical Indicators

- **Emerging Issues**

- Equity
- Climate Change
- COVID-19

Health Domains

The identified domains loosely correspond to the arenas of the ecological model of health, which offers a way to link public health action to improved population health



Health Domain: Context

Population Size

- In 2019, Illinois was home to nearly 13 million people, and is the fifth most populous state.
 - The total population has declined by 1.2% since the 2010 US Census.
 - The Hispanic population has increased by nearly 5% since 2013 to over 2.1 million - nearly 1 in 6 residents
 - The Asian/Pacific Islander population saw the greatest percentage increase of nearly 14% to nearly 800,000

Health Domain: Context

Where do people live?

- Nearly 2/3 of Illinois residents live in the counties of Cook, DuPage, Lake, Will, Kane and McHenry.
 - Since 2010:
 - Kane County's population saw the greatest increase at 3.3%; Will County increased by 1.9%
 - Cook County's population decreased 0.9%
 - Chicago remains the third largest city in the nation, with nearly 2.7 million residents; with minimal population change (0.1%).

Health Domain: Context

Age and Place of Birth

As of 2019:

- 2.8 million (22.2%) residents are under 18 years old
 - A decline of 7% since 2013
 - 39.7% of Illinoisans are 65 years or older
 - Since 2013 those 85+ have increased by 19.% to over 285,000
-

Between 2014 and 2018:

- An average of 14% of residents were foreign born
- 23% speak a language other than English at home; Spanish is the most common language

Health Domain: Context

Racial and Ethnic Diversity

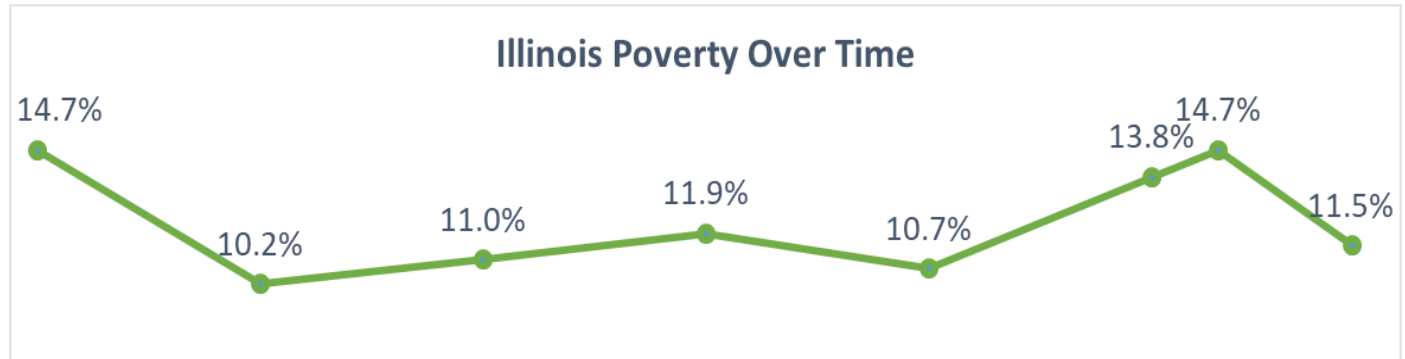
	Illinois 2019
Non-Hispanic White	61.6%
Non-Hispanic African American	14.6%
Hispanic	16.8%
Asian	6.3%
Native American	0.7%

Cook County and Chicago are more diverse:

	Cook County 2019	Chicago 2019
Non-Hispanic White	42.0%	32.8%
Non-Hispanic African American	23.8%	30.1%
Hispanic	25.6%	29.0%
Asian	7.9%	6.4%

Health Domain: Context

Poverty



Year	1960	1970	1980	1990	2000	2010	2013	2019
% Poverty	14.7%	10.2%	11.0%	11.9%	10.7%	13.8%	14.7%	11.5%

Poverty by Race/Ethnicity and Age: 2013 and 2019

	2013	2019
Illinois	14.7%	11.5%
Children	20.7%	15.7%
Age 18-64 Years	13.6%	10.7%
Seniors (65+)	8.8%	8.6%
Black Non-Hispanic	31.6%	24.2%
Hispanic	20.7%	14.1%
Asian	11.9%	9.7%
White Non-Hispanic	9.5%	7.9%

Adapted from: Terpstra, A., Clary, J., & Rynell, A. (2015, January). *Poor by comparison: Report on Illinois poverty*. Chicago: Social IMPACT Research Center at Heartland Alliance.

And U.S. Census Bureau, American Community Survey, 1-Year Estimates

Health Domain: Context

Education and Employment

For 2014-2018:

- Illinois: 88.9% HS graduates; 34.1% College graduates
- Cook County: 86.7% HS graduates; 38% College graduates

- 65.1% adults in labor force
- Median household income: \$55,198
- Per capita median income: about \$34,775
 - On average, an hourly wage of \$17.34 (\$36,067 annually) is needed to afford a 2 bedroom apartment

Unemployment*	
2013	9.5%
2019	4.0%
8/2020	11.0%

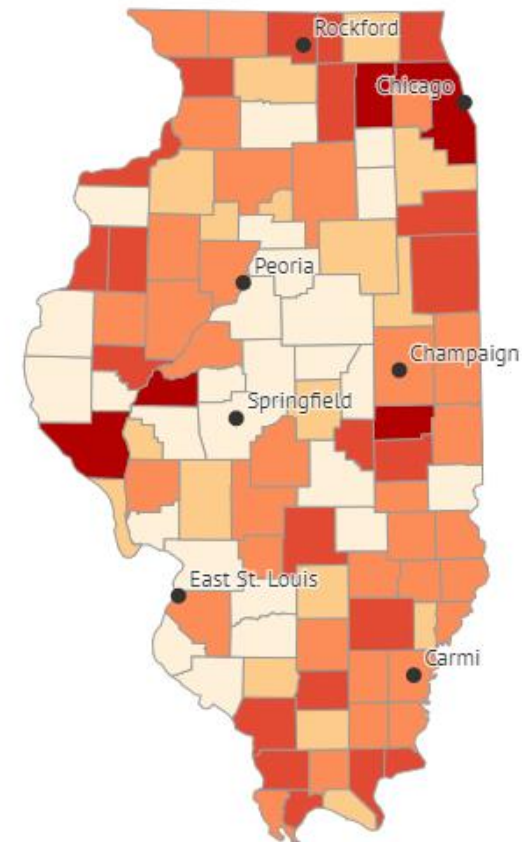
- Persons without health insurance under 65 years: 8.6%

Health Domain: Context

Health Insurance

- Under 65 years without health insurance: 8.6% (2019)
- By race/ethnicity, nearly 1 in 3 Hispanics were uninsured.

Race/Ethnicity	2016-2018
White	94.7%
Black	88.9%
Asian	90.2%
Other	89.0%
Hispanic	67.7%



In 2016, 5 Counties (dark red) are above the 95% percentile for this indicator with between 7.7% and 9.4% under 65 without health insurance.

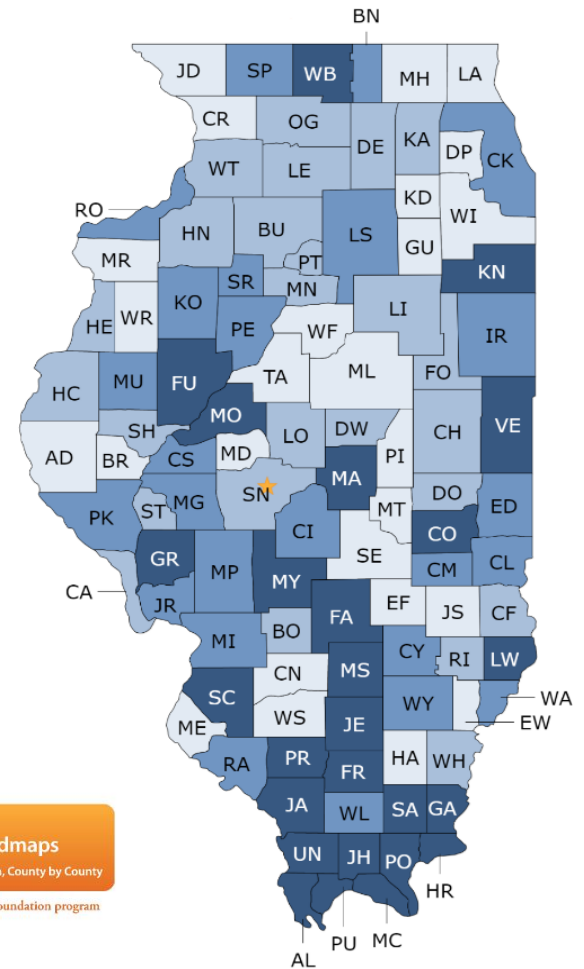
Cass – Cook – Douglas – Kane - Pike

Nineteen (19) other counties were above the 75th percentile for this measure (6.6% to 7.5%)

County Health Rankings: Health Factors

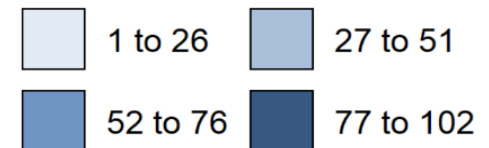
The overall rankings in health factors represent what influences the health of a county. They are an estimate of the future health of counties as compared to other counties within a state. The ranks are based on four types of measures: health behaviors, clinical care, social and economic, and physical environment factors.

For 2020, counties shown in darker BLUE were ranked lower on factors. Most of these counties are found in central /southern parts of the state.



County Health Rankings & Roadmaps
Building a Culture of Health, County by County
A Robert Wood Johnson Foundation program

Health Factor Ranks

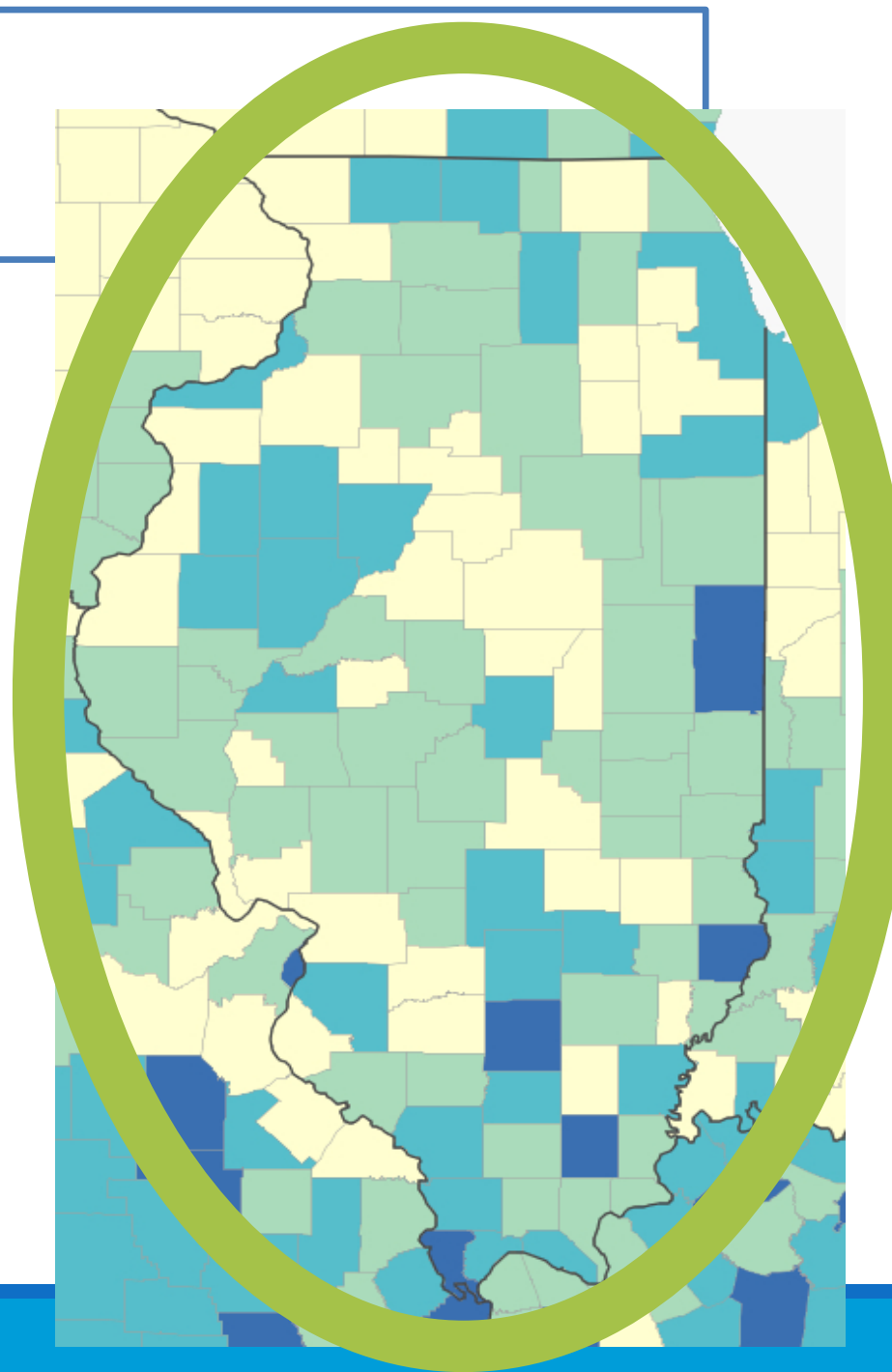


CDC Social Vulnerability Index (SVI)

The SVI ranks each region on 15 social factors, including poverty, lack of vehicle access, and crowded housing, and groups them into four related themes:

Overall Vulnerability	Socioeconomic Status	Below Poverty
		Unemployed
		Income
		No High School Diploma
	Household Composition & Disability	Aged 65 or Older
		Aged 17 or Younger
		Older than 5 with a Disability
		Single-Parent Households
	Minority Status & Language	Minority
		Speak English "Less than Well"
	Housing & Transportation	Multi-Unit Structures
		Mobile Homes
		Crowding
		No Vehicle
		Group Quarters

MAP: Areas with darker color have higher SVI



Health Domain: Health Status

Leading Causes of Death

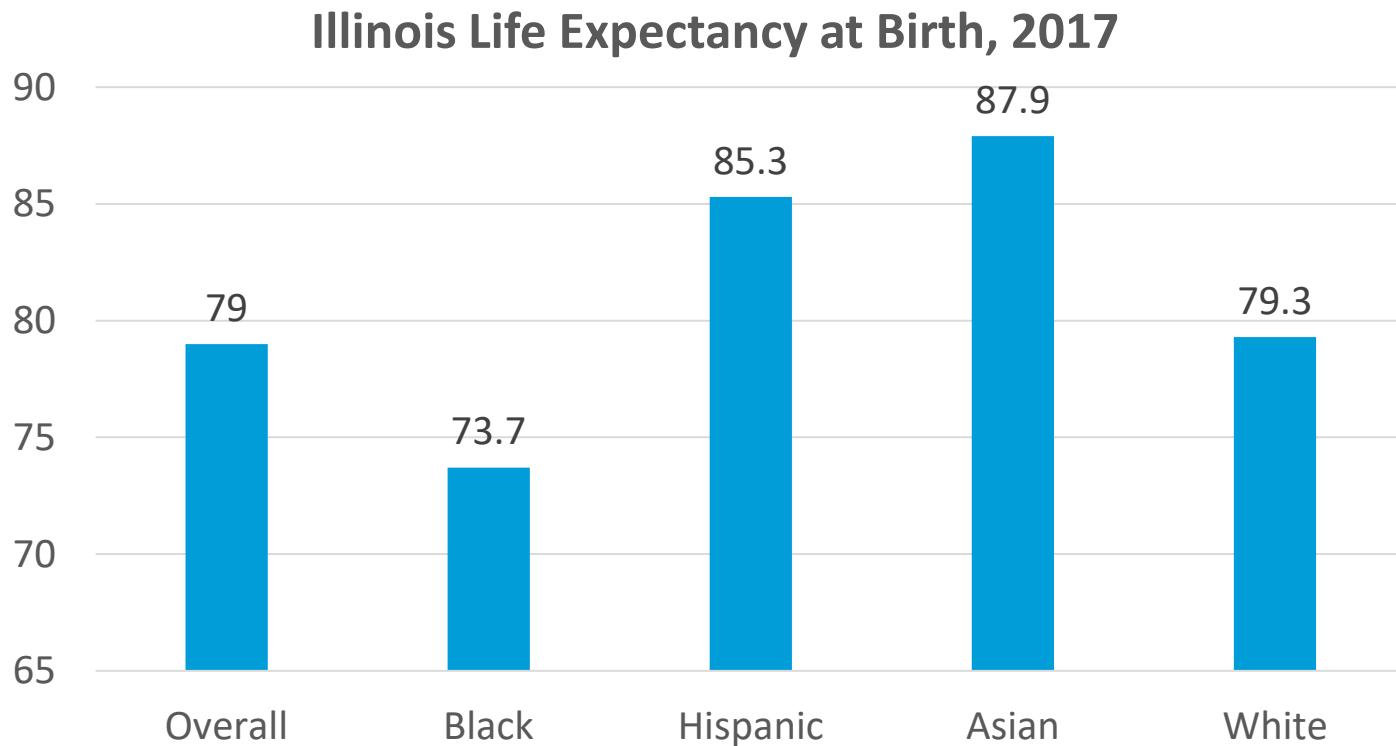
Leading 15 causes of death – all ages (2018)

Rank	Cause of Death -- All Ages	2013	2018
	All causes	101,291	110,012
1	Diseases of heart (heart disease)	24,607	25,747
2	Malignant neoplasms (cancer)	23,852	23,877
3	Accidents (unintentional injuries)	6,884	6,013
4	Cerebrovascular diseases (stroke)	5,324	5,853
5	Chronic lower respiratory diseases	5,369	5,639
6	Alzheimer disease	2,896	4,029
7	Diabetes mellitus (diabetes)	2,658	2,879
8	Nephritis, nephrotic syndrome and nephrosis	2,361	2,644
9	Influenza and pneumonia	2,394	2,562
10	Septicemia	1,828	1,790
11	Intentional self-harm (suicide)	1,041	1,488
12	Chronic liver disease and cirrhosis	1,121	1,421
13	Parkinson disease	1,024	1,415
14	Essential hypertension and hypertensive renal disease (hypertension)	1,049	1,234
15	Assault (homicide)	783	993

Health Domain: Health Status

Life Expectancy

In 2017 life expectancy at for all Illinoisans averaged 79.0 years; African Americans showed the life expectancy of 5.3 fewer years with 73.7 years.

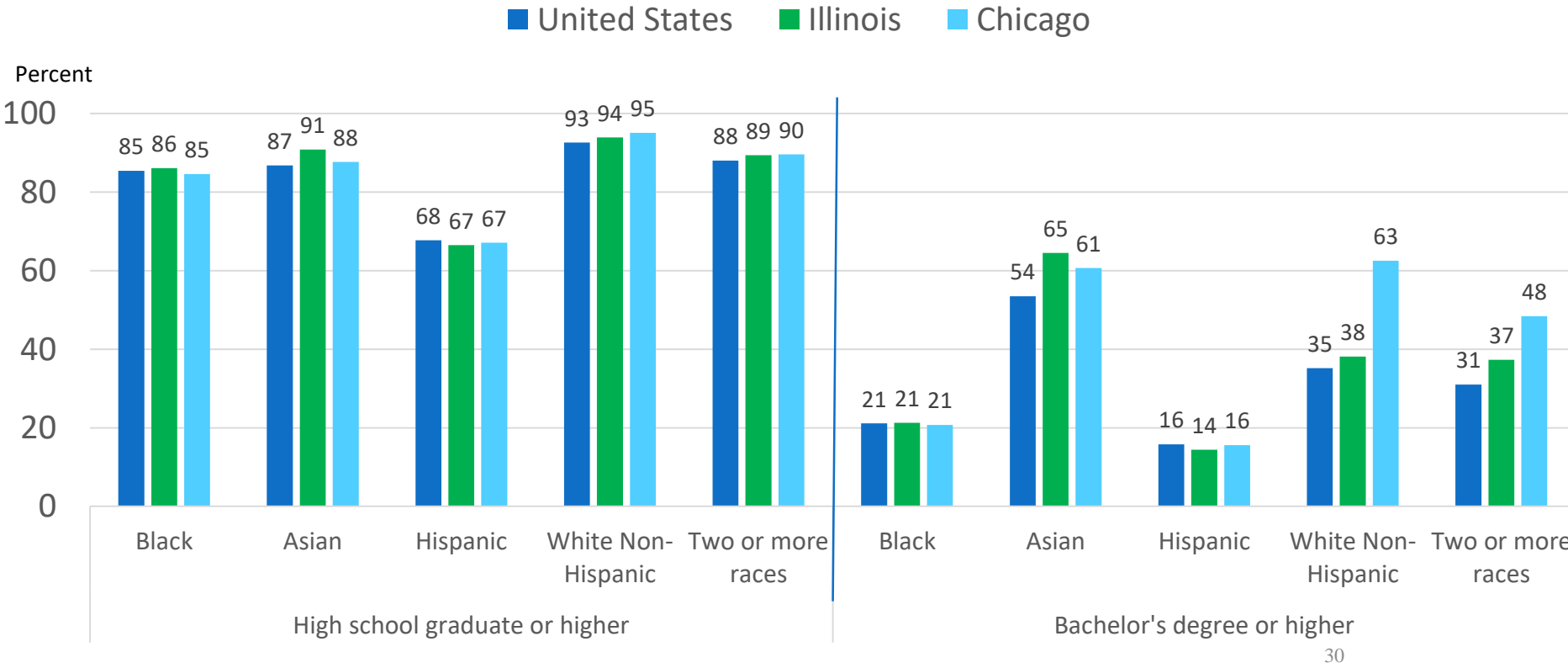


Health Domain: Context Equity

Health Domain: Context

Educational Attainment by Race/Ethnicity

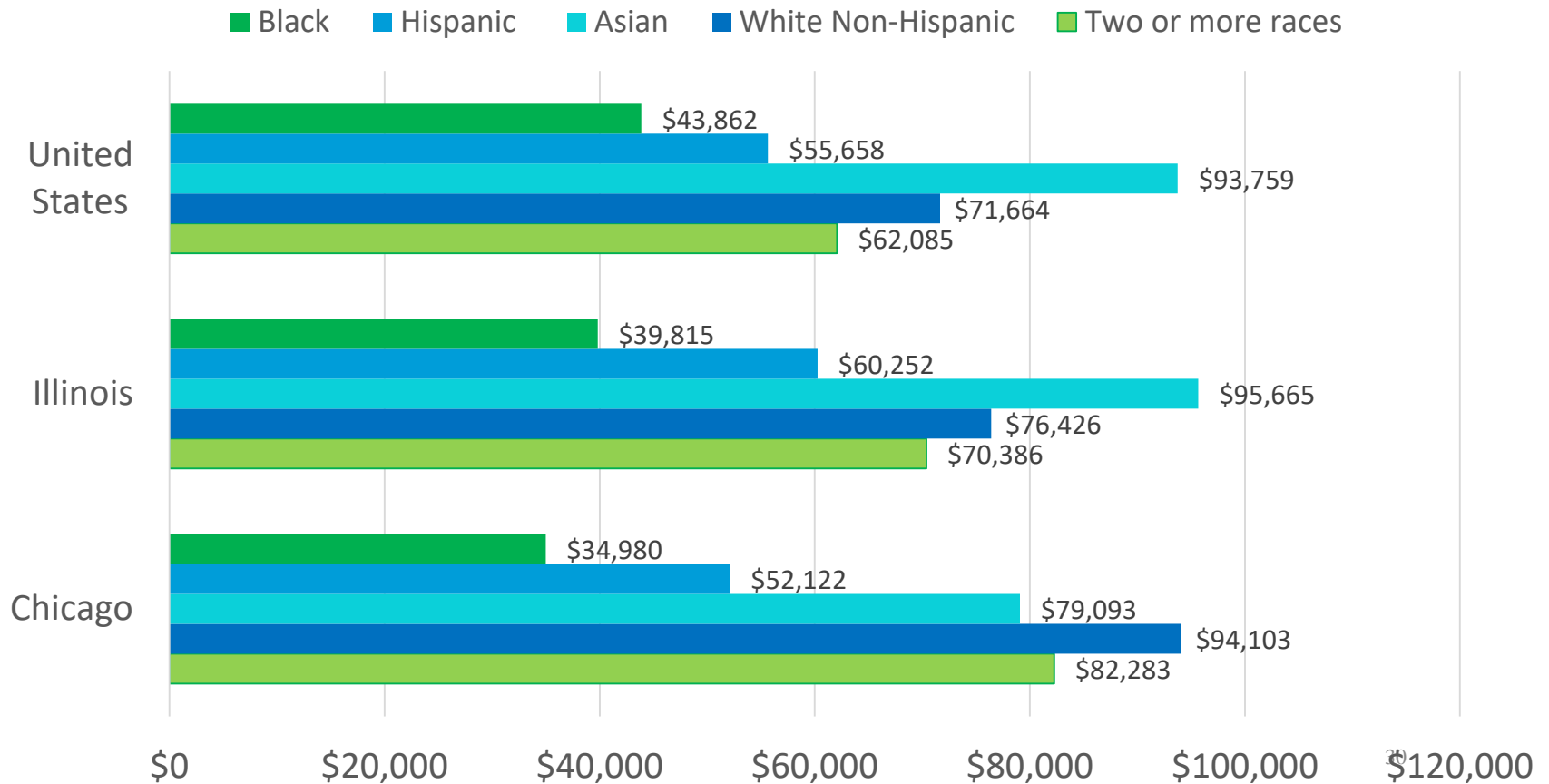
Educational Attainment by Place and Race/Ethnicity 2014-2018



Health Domain: Context

Median Income by Race/Ethnicity

Median Household Income by Place and Race/Ethnicity, 2019



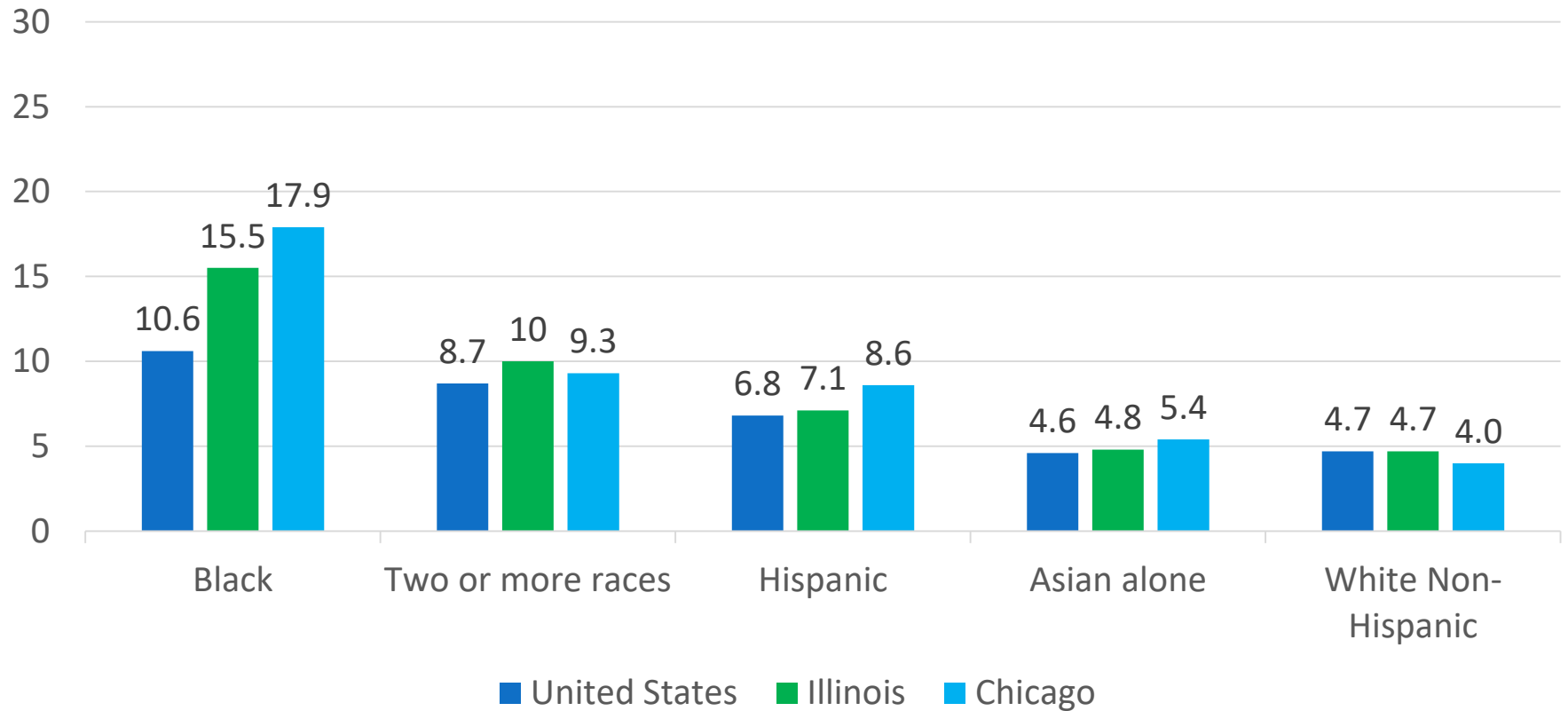
Source: US Census Bureau, American Community Survey, 1 year estimates 2019

Health Domain: Context

Unemployment

Unemployment by Place and Race/Ethnicity 2014-2018

Percent



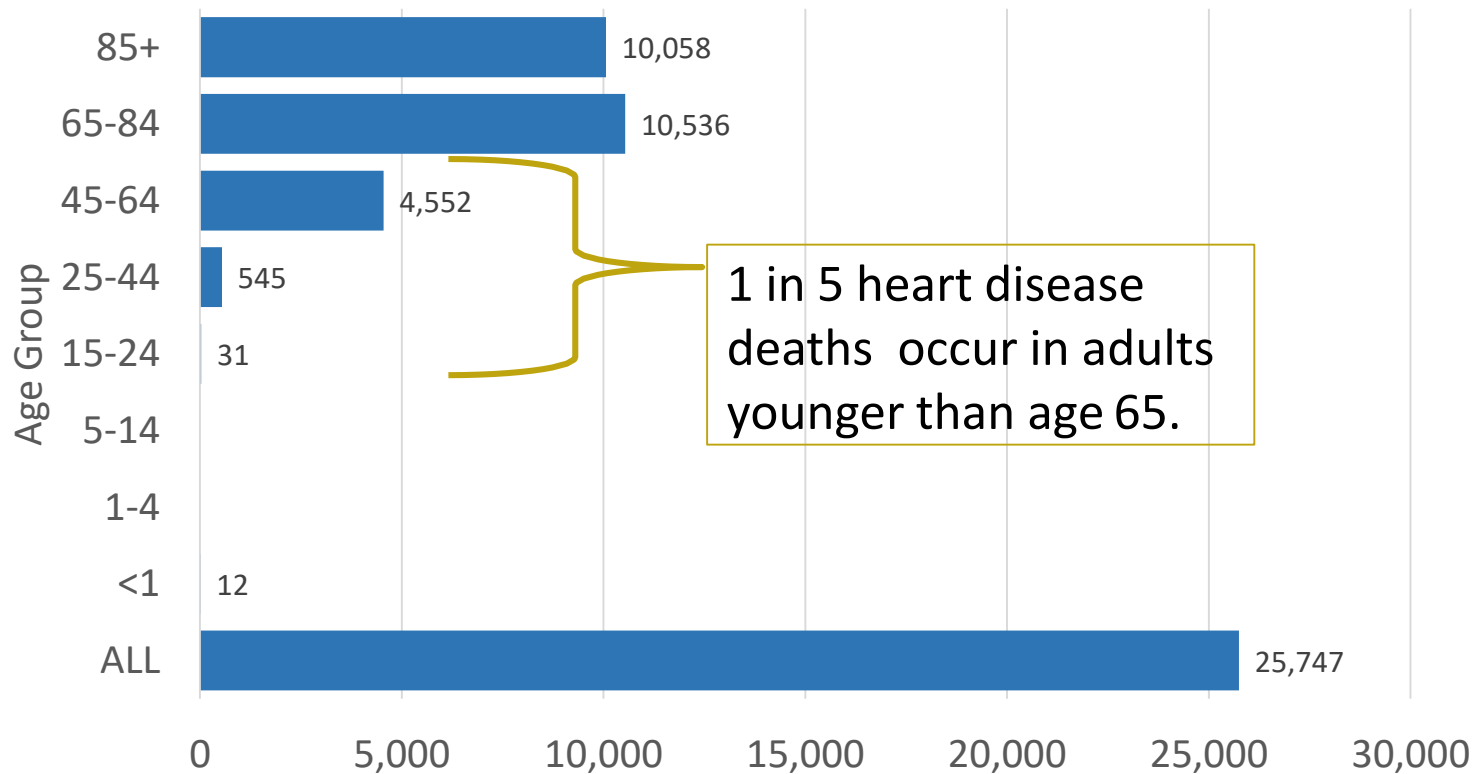
Health Domain: Health Status

SHIP 2016-2021 Priority: Chronic Diseases

Health Domain: Health Status

Heart Disease Mortality

Number of Deaths Due to Heart Disease by Age Group Illinois, 2018

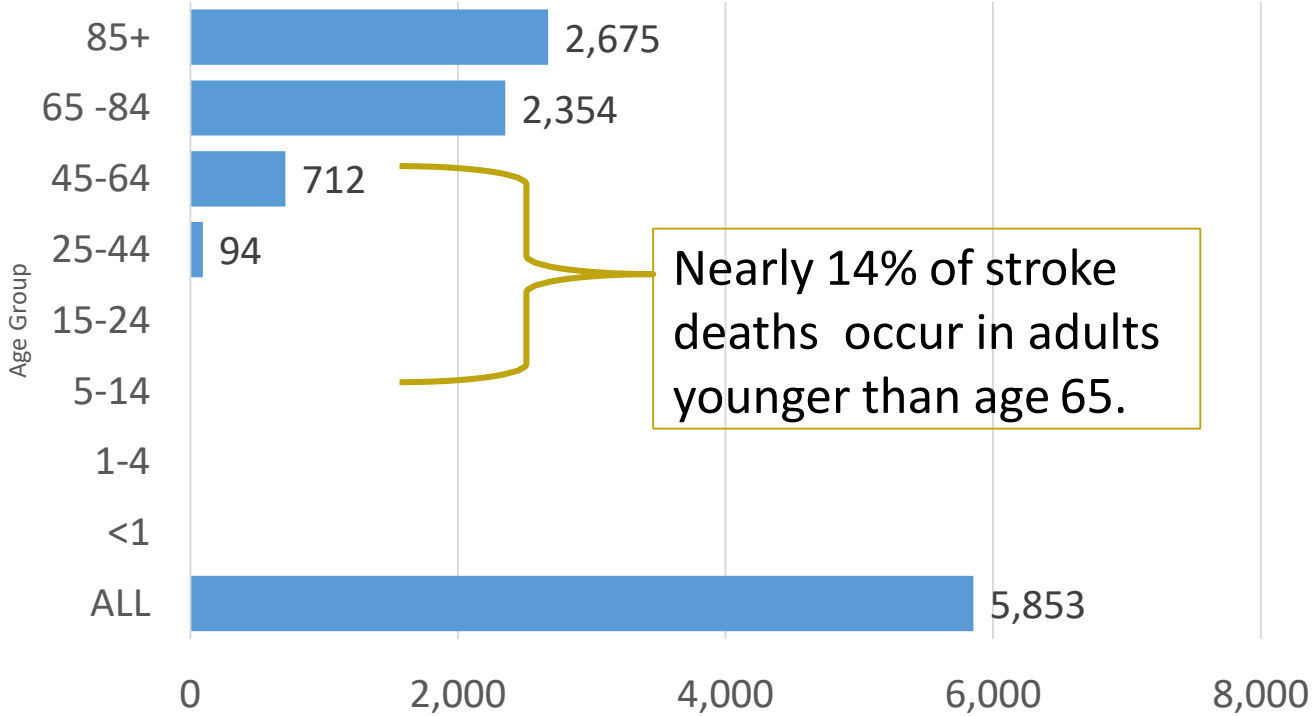


*Age-specific numbers may not sum to the total for all ages due to missing values for age.

Health Domain: Health Status

Cerebrovascular (Stroke) Mortality

Number of Deaths Due to Stroke by Age Group Illinois, 2018

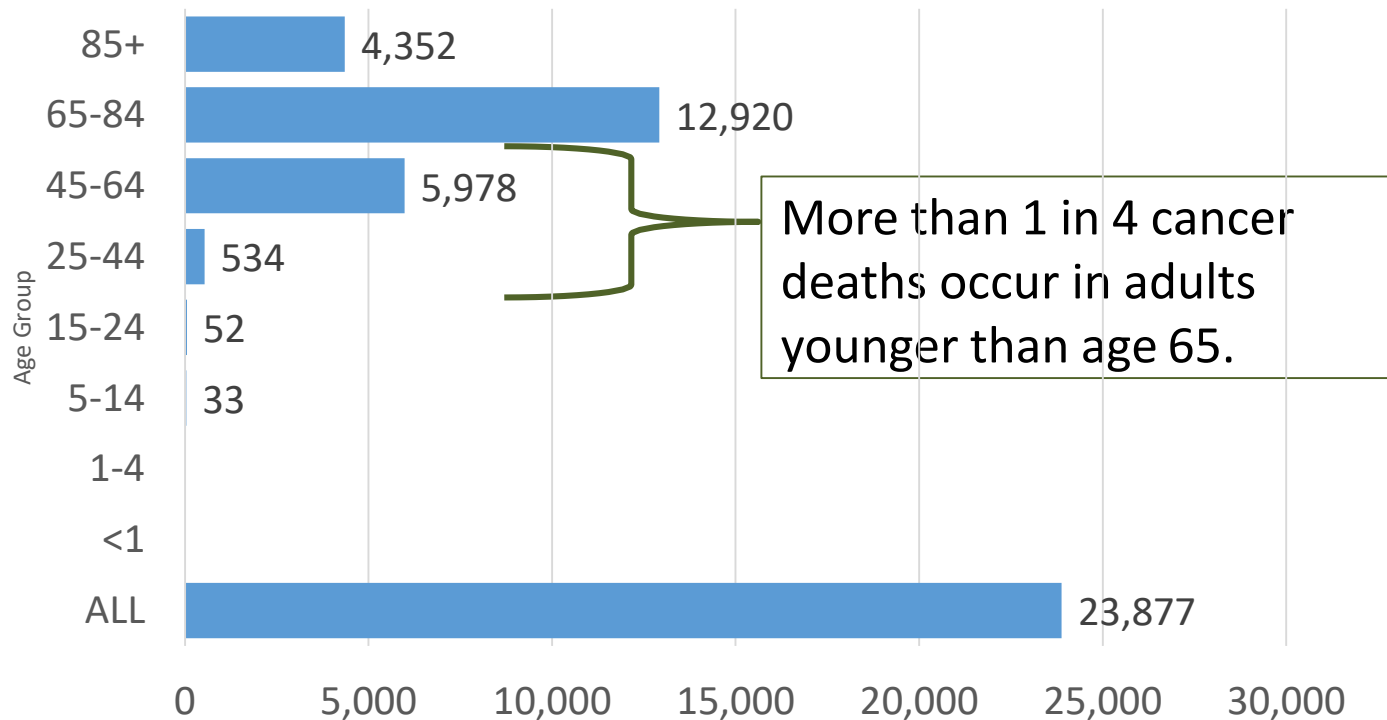


*Age-specific numbers may not sum to the total for all ages due to missing values for age.

Health Domain: Health Status

Cancer Mortality

Number of Deaths Due to Malignant Neoplasms by Age Group Illinois, 2018

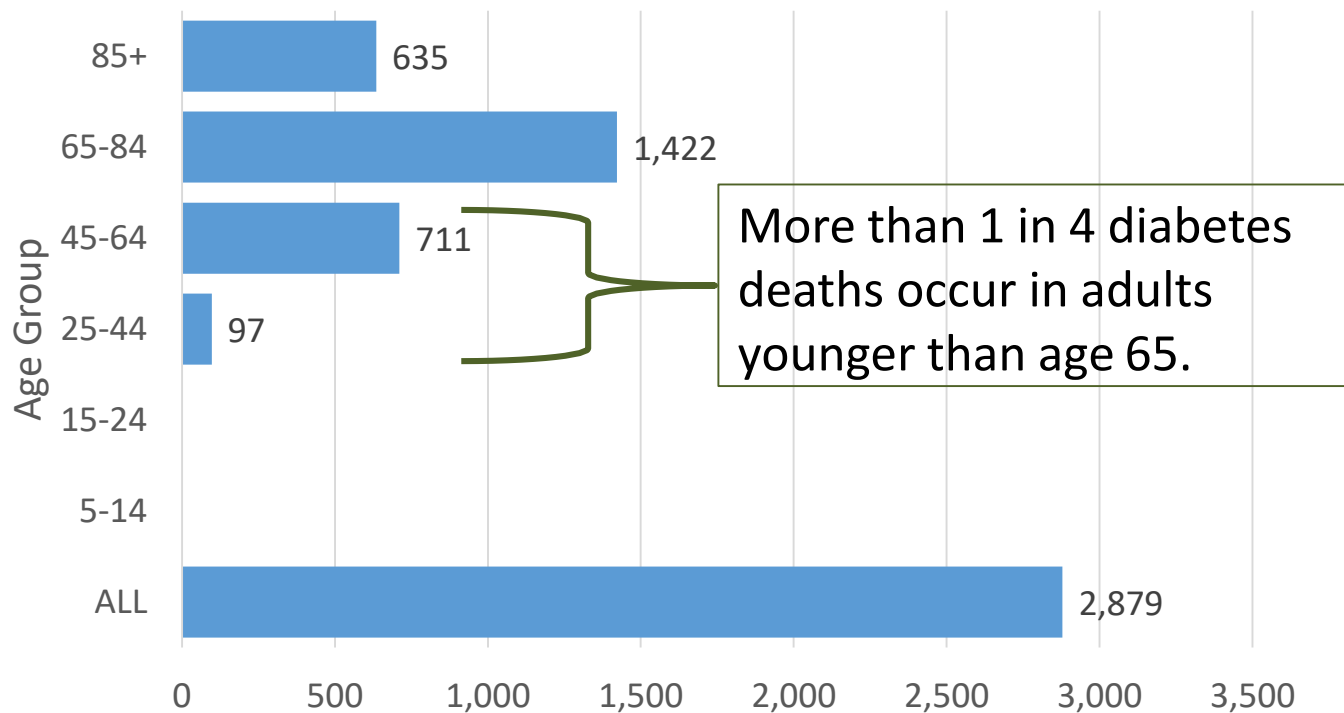


*Age-specific numbers may not sum to the total for all ages due to missing values for age.

Health Domain: Health Status

Diabetes Mortality

Number of Deaths Due to Diabetes Mellitus by Age Group Illinois, 2018



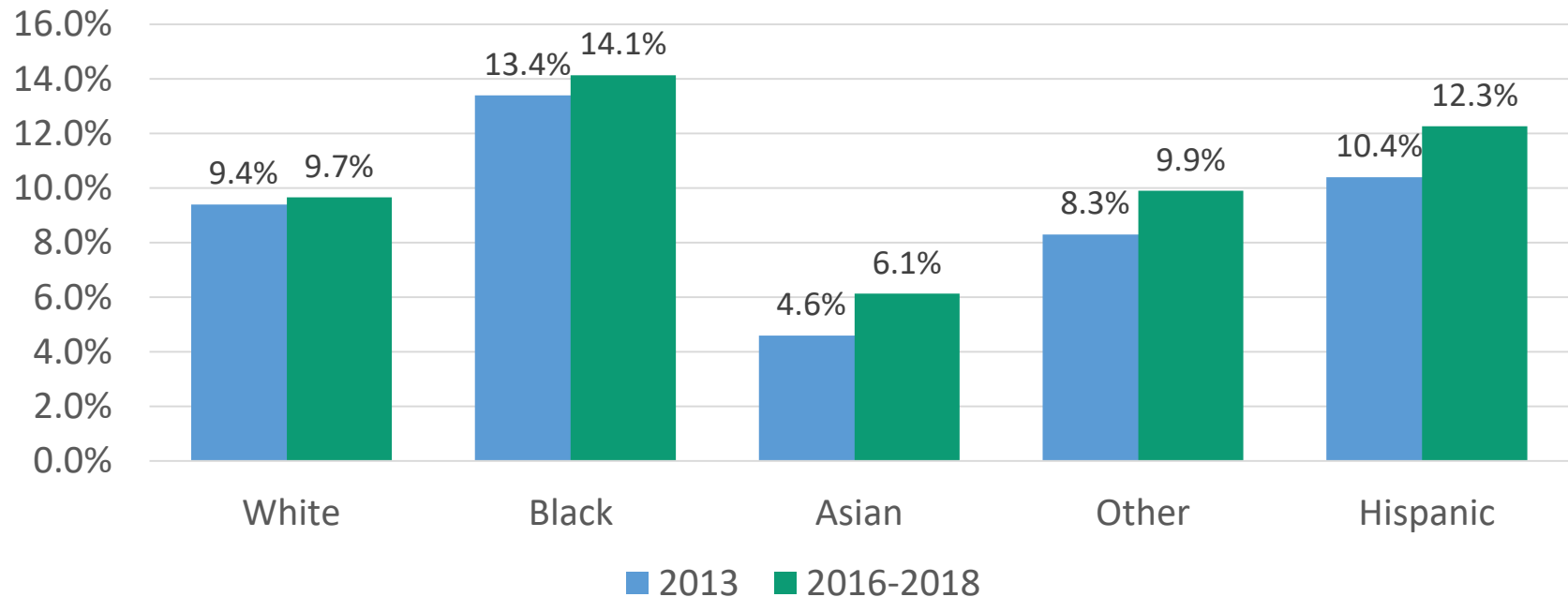
*Age-specific numbers may not sum to the total for all ages due to missing values for age.

Health Domain: Health Status

Diabetes Prevalence

African Americans continue to have the highest prevalence at 14.1%. The greatest percent increases were seen in Asians (33%) and Hispanics (18%)

Diabetes Prevalence by Race/Ethnicity



Health Domain: Health Status

Chronic Conditions

In 2018 half of all adults had 1 or more chronic conditions

8.7% have asthma

10.0% have diabetes

24.8% have arthritis

6.6% have chronic obstructive pulmonary disease (COPD)

5.0% have skin cancer

6.9% have another form of cancer

2.8% have kidney disease

Health Domain: Health Status and Behavior

Obesity and Exercise

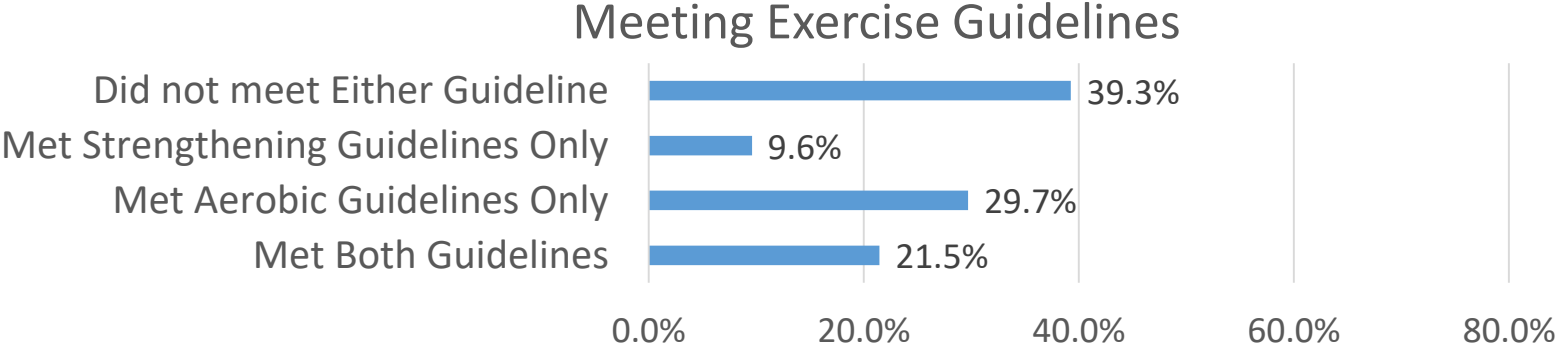
Obesity prevalence continues to increase.

- In 2013, obesity was reported in 27.7% of all Illinois adult
- For 2016-2018 obesity increased to an average of 31.5%;
- African American rates are highest (2019).

Year	Black	Hispanic	White
2019	40.5%	34.6%	31.0%

Data from 2015 and 2017 show:

- Less than one-third of adults meet aerobic exercise guidelines;
- Less than 10% few meet strength guidelines
- Only 1 in 5 meet both guidelines



Health Domain: Health Behavior

Smoking

Smoking prevalence declined; e-cigarette use increased.

- In 2013 a total of 18% of adults were smokers; for 2016-2018, smoking prevalence averaged 15.6%.
- Disparities remain by race/ethnicity with African American highest

Race/Ethnicity	2013	2016-2018
White	18.0%	15.9%
Black	20.4%	20.9%
Hispanic	11.2%	10.6%

- In 2016 and 2017 e-cigarette use stood at 4.3% of adults
- In 2018, this rose with 6.0% of adults using e-cigs

Health Domain: Health Status
SHIP 2016-2021 Priority:
Maternal and Child Health

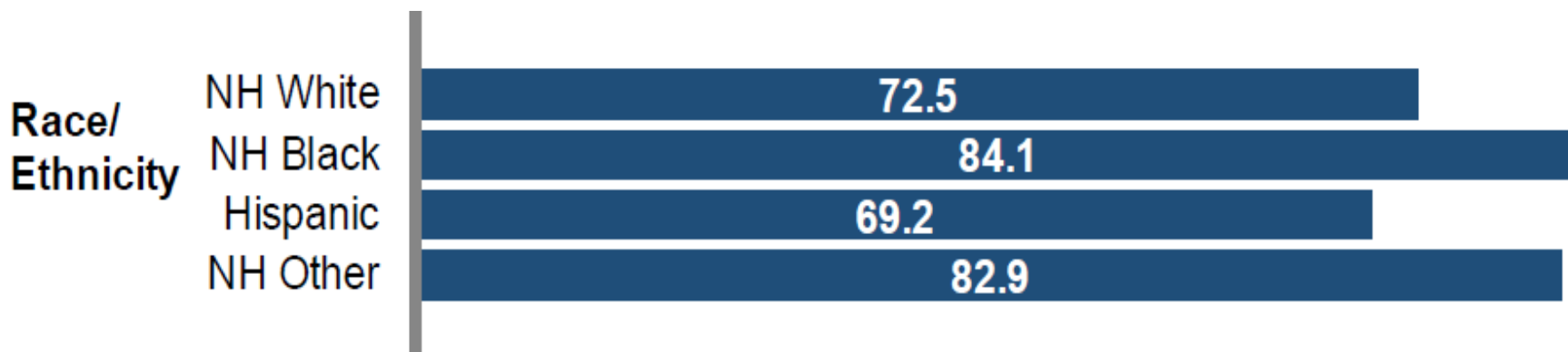
Health Domain: Healthcare

Well Women Care

The vast majority of Illinois women received a routine checkup in the last year. This increased to 74.5% in 2018, from a low of 62% in 2013. Non-Hispanic Black women were slightly more likely to report receiving a checkup; Hispanic women were less likely.

Percent of Women 18-44

Receiving a Routine Check-up in the Past Year by Race/Ethnicity (BRFSS, 2018)



Health Domain: Healthcare

Adequate Prenatal Care

- Healthy People 2020 objective: 83.2% receive early and adequate prenatal care
- Illinois overall:
 - 2014 - 78.1%
 - 2018 - 76.3%
 - Black women – 61.1%
 - Hispanic women – 70.9%
 - Women < 20 – 61.9%

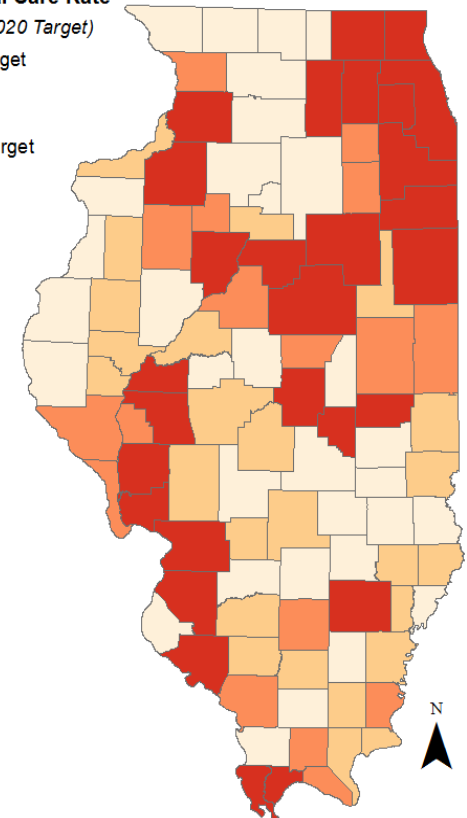
Less than Adequate Prenatal Care Rate by Illinois County, 2016 - 2018

Less than Adequate Prenatal Care Rate

(Compared to Healthy People 2020 Target)

- Significantly better than target
- Slightly better than target
- Slightly worse than target
- Significantly worse than target

Healthy People 2020 Target:
16.8% or lower



Data Sources

Map File: Illinois State Geological Survey

Birth Data: IDPH Vital Statistics, 2018

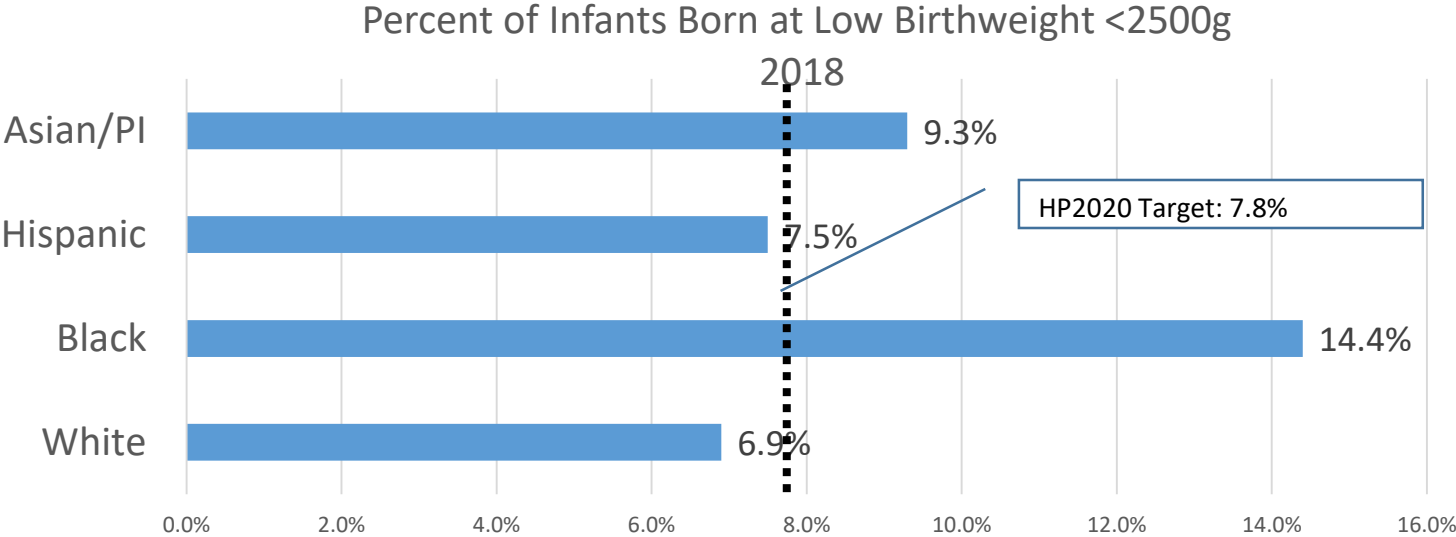
Numerator: Births to women who received no, inadequate or intermediate prenatal care

Denominator: Births with known prenatal care entry and number of visits

Health Domain: Health Status

Low Birthweight (< 2500g)

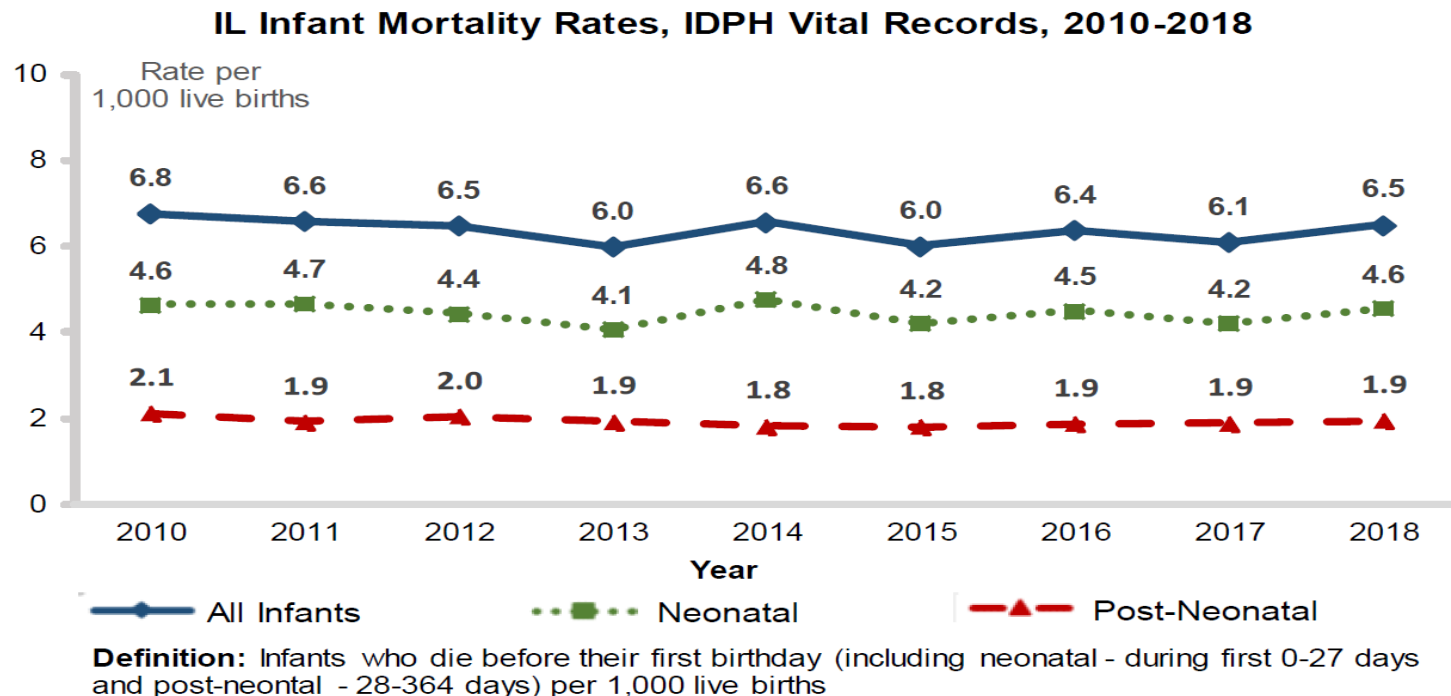
In 2018, 8.5% of Illinois infants were born at low birthweight. Non-Hispanic Black infants remain more than 2x as likely to be born at low birthweight than non-Hispanic White infants



Health Domain: Health Status

Infant Mortality

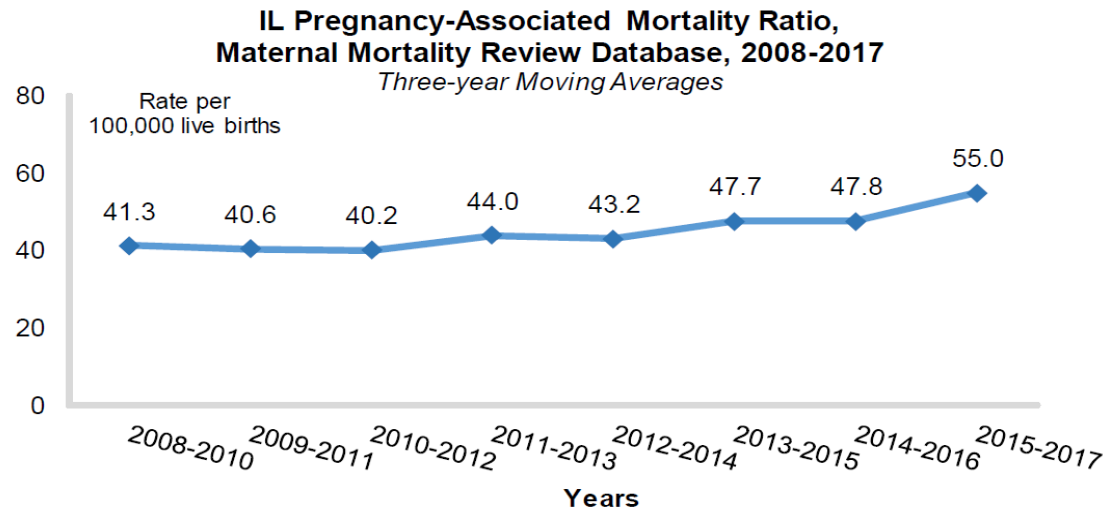
Between 2010 and 2018 Illinois' infant mortality rates did not decline; rates have been above the HP2020 goal of 6.0 deaths per 1,000 live births throughout the period. In 2018, infant mortality of non-Hispanic Black infants (13.5) is almost three times that of non-Hispanic White infants (4.7).



Health Domain: Health Status

Maternal Mortality

For 2015-2017 the pregnancy-associated mortality ratio was 55 per 100,000 live births – highest since 2008-2010



Significant disparities exist in the pregnancy-related mortality ratio, with non-Hispanic Black women 6 times more likely to die of complications related to pregnancy. Women 40 and over had 3 times higher rate of death than women in their 30s.



Health Domain: Health Status

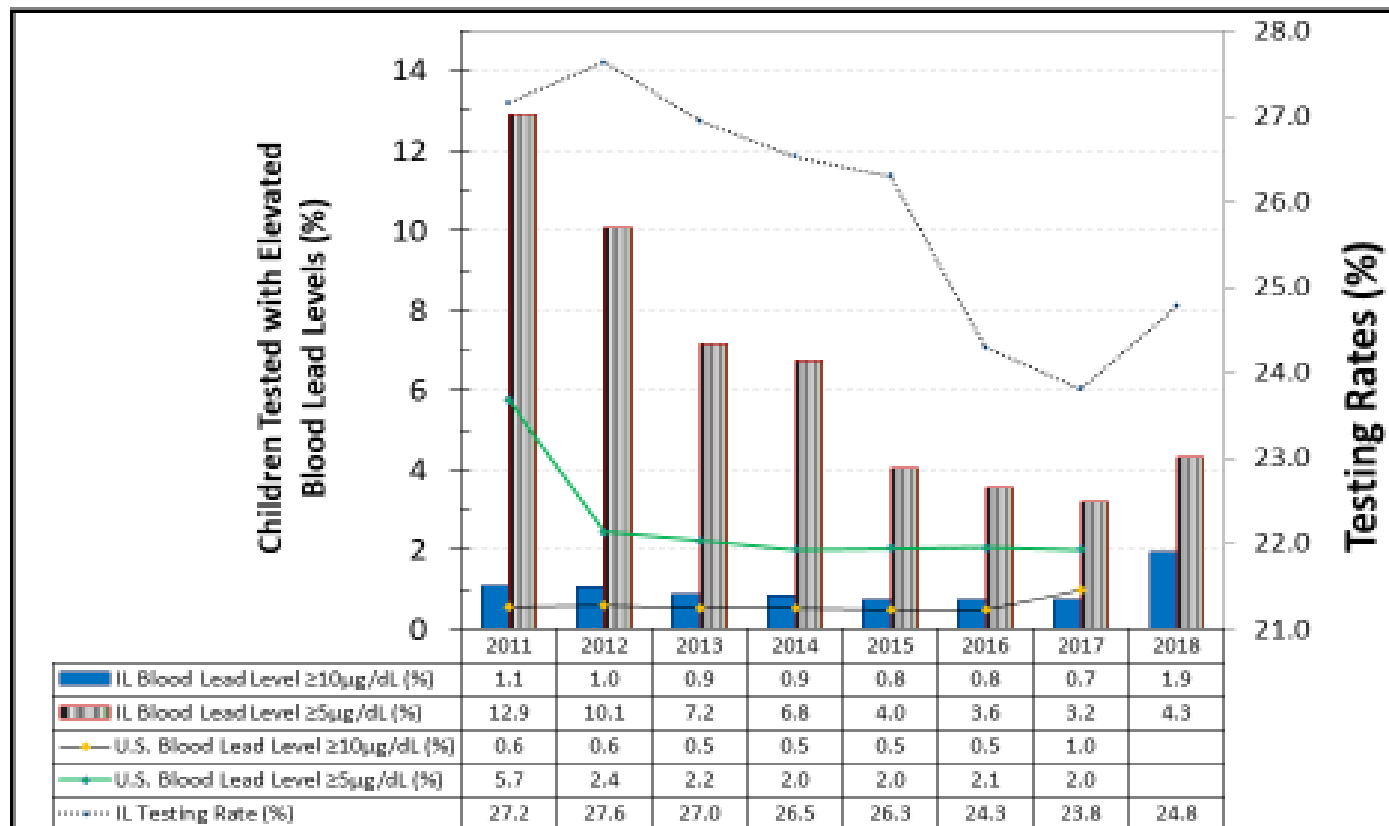
Childhood Lead Exposure

In 2018, a total of 5.5% children tested had blood lead levels ≥ 5 $\mu\text{g}/\text{dL}$. Lead levels varies by location within the state and by race/ethnicity.

Illinois continues to make progress in reducing childhood blood lead exposure. Children five years of age with BLLs ≥ 5 $\mu\text{g}/\text{dL}$ have significantly decreased from 12.9% in 2011 to 4.3% in 2018.



Childhood Lead Exposure



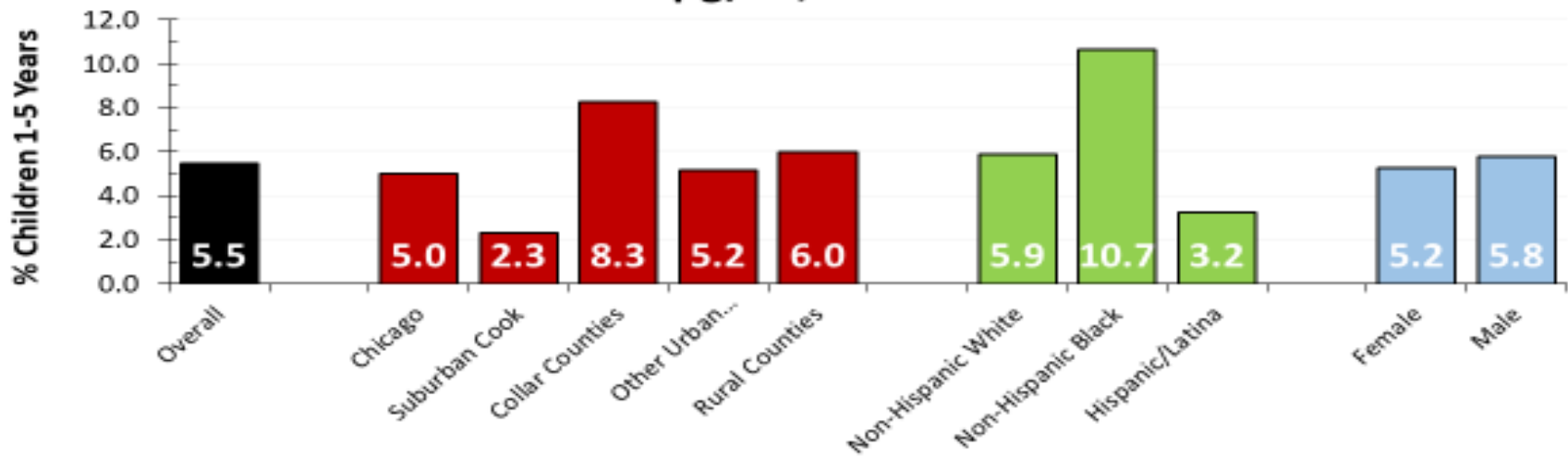
Data source: Illinois Department of Public Health

Health Domain: Health Status

Childhood Lead Exposure

In 2018, a total of 5.5% children tested had blood lead levels ≥ 5 $\mu\text{g}/\text{dL}$. Lead levels varies by location within the state and by race/ethnicity.

Children Ages 1-5 Years Tested with Elevated Blood Lead Level ≥ 5 $\mu\text{g}/\text{dL}$, 2018



Data source: Illinois Department of Public Health - Healthy Homes and Lead Poisoning Surveillance System (HHLPSS, 2018)

Related Healthy People 2020 Objective(s):

EH-8.1: Reduce blood lead level in children aged 1–5 years; target of 97.5% of the population aged 1-5 years is below 5.2 $\mu\text{g}/\text{dL}$.

There is no safe level of lead in the body. Lead exposure is one of the most prevalent, yet preventable environmental health hazards that can affect the brain and nervous system. Childhood lead exposure is known to contribute to learning disabilities, developmental delays, behavioral problems and other negative health effects.

Overall, 5.5% had blood lead levels ≥ 5 $\mu\text{g}/\text{dL}$, the threshold that triggered public health intervention. Elevated blood lead levels varied significantly by location of residence. Over 8% of children living in the collar counties of Chicago and 6% living in Rural Counties had elevated blood lead levels, compared to only 2% in suburban Cook County, the lowest in the State. Elevated blood lead levels varied by race/ethnicity. About 11% of non-Hispanic Black children had elevated blood lead levels, compared to about 6% of non-Hispanic white and 3% of Hispanic children.

Health Domain: Health Status

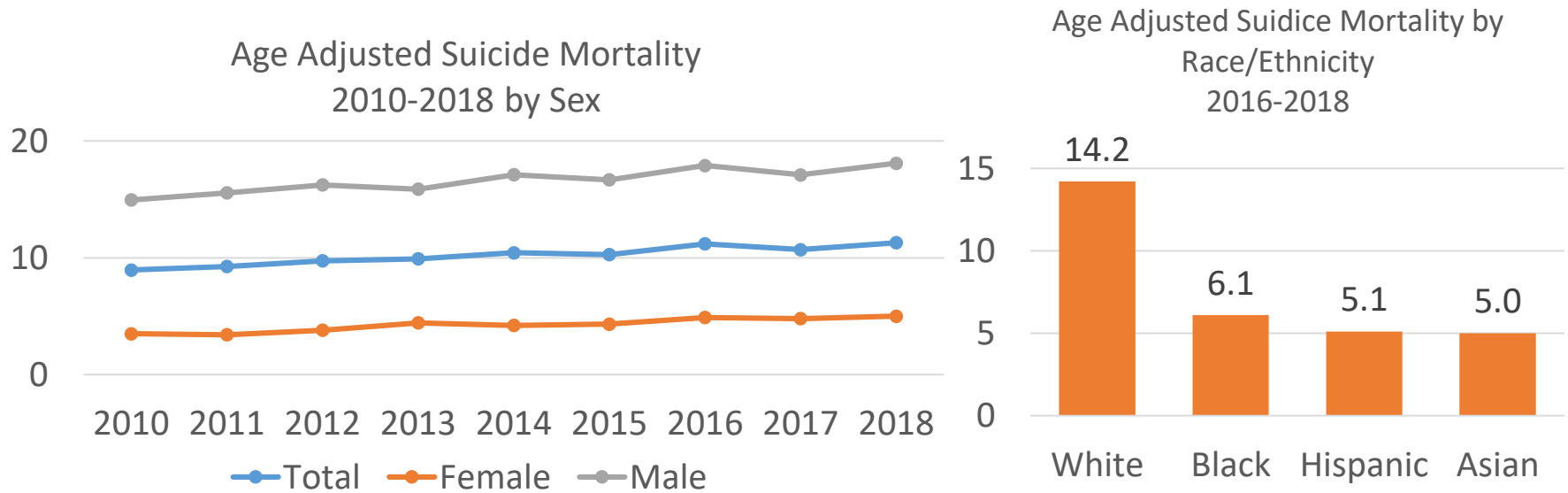
SHIP 2016-2021 Priority:

Behavioral/Mental Health/Substance Misuse

Health Domain: Health Status

Suicide Mortality

Suicide, the 11th leading cause of death in 2018 with 1488 deaths, showed increases in rates since 2010 overall and by sex; males were higher than females. White rates are more than double other racial/ethnic groups.

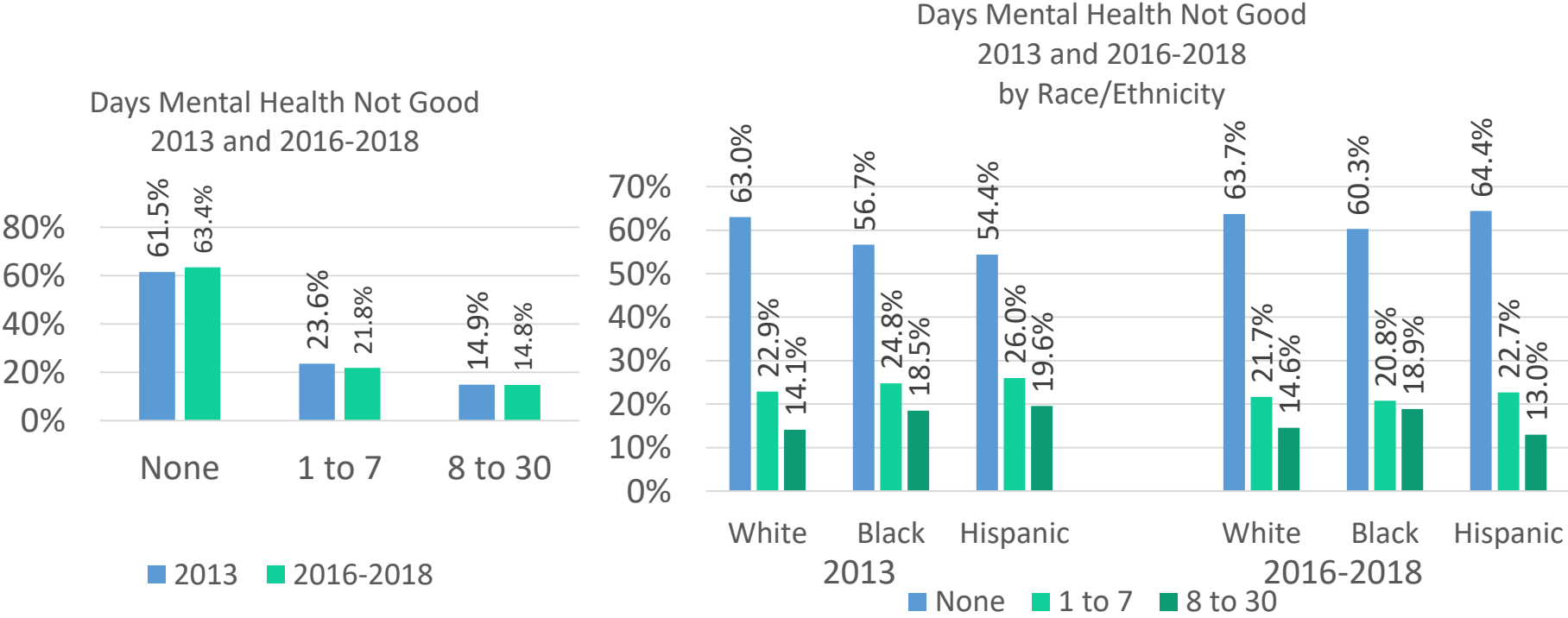


In 2018, nearly 18% of residents report that they have been diagnosed with a depressive disorder.

Health Domain: Health Status

Mental Health

- More than 1 out of 6 Illinoisans reported experiencing poor mental health more than one week in each month.
- Between 2013 and 2016-2018 slight decreases were seen for those reporting 1 to 7 days of poor mental health overall.
- By race/ethnicity Black and Hispanic rates showed greatest change

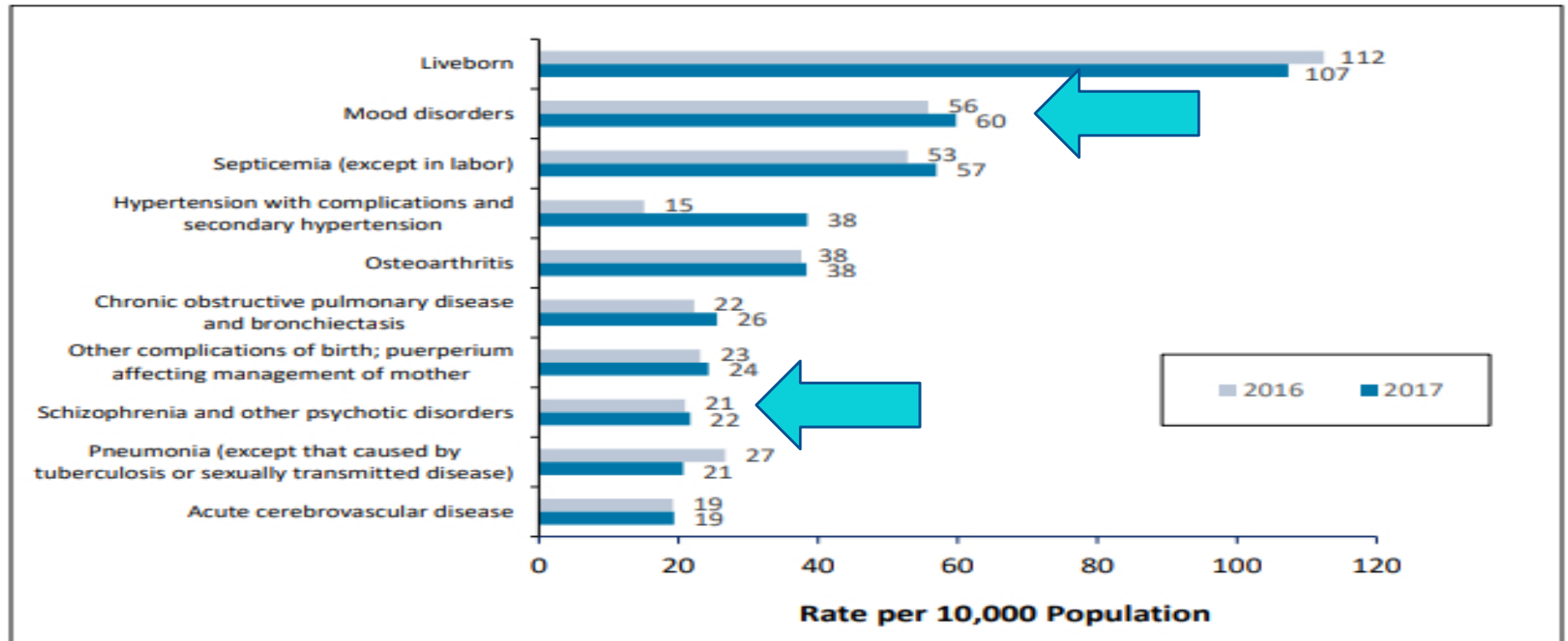


Health Domain: Health Status

Mental Health

For 2016-2017 hospitalization for mood disorders was the second most common diagnosis. In 2018 the Illinois hospitalization rate for mood disorders was 54.4 per 10,000. Schizophrenia and psychotic disorders were the 8th leading diagnosis.

Figure 3. Hospitalization rates (per 10,000 population) of the 10 most common diagnoses, 2016-2017

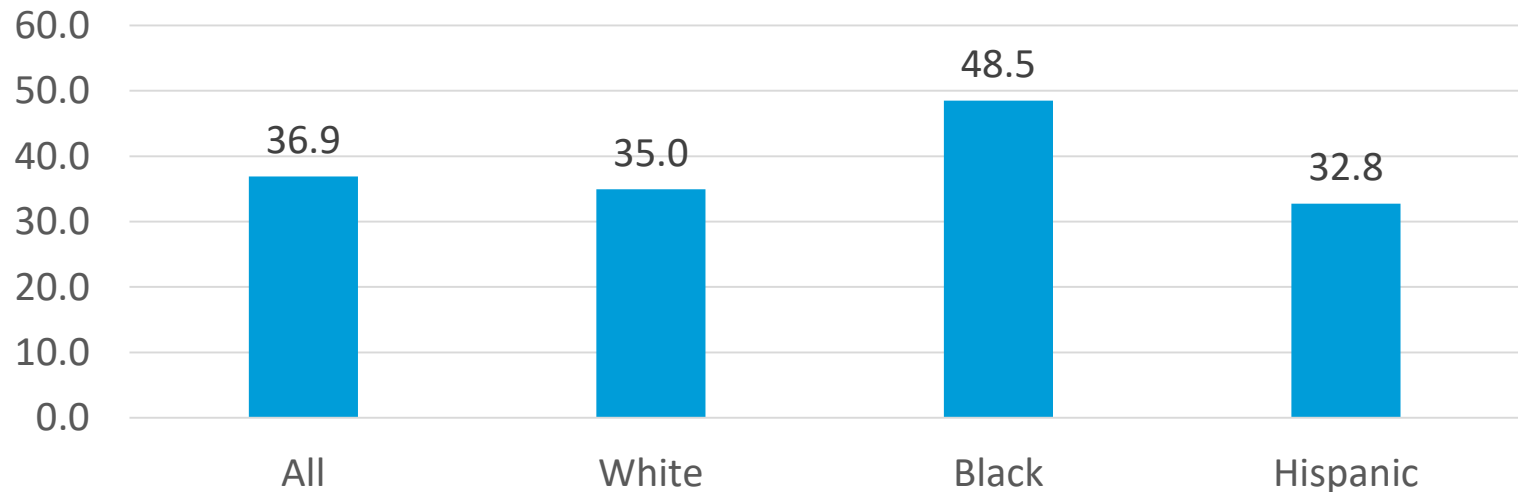


Health Domain: Healthcare

Mental Health: Anxiety-related ED Visits

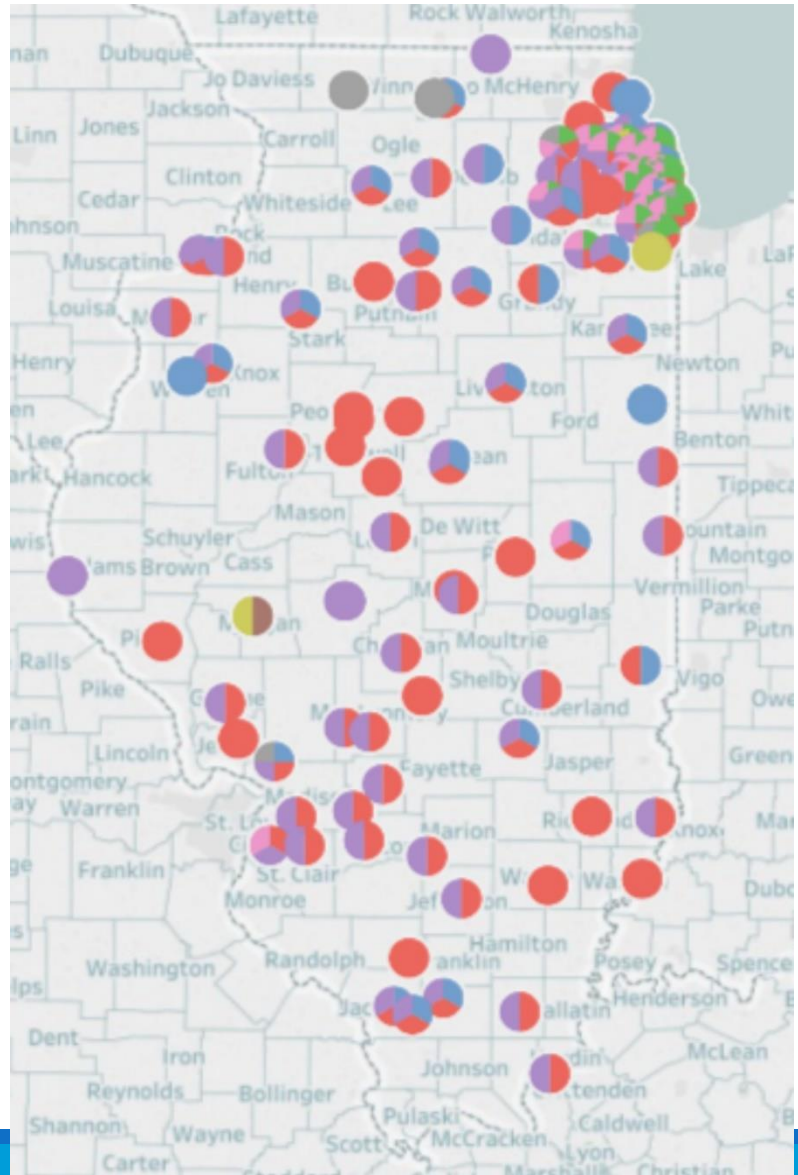
Black rates of emergency department (ED) visits for anxiety related disorders were highest for 2016-2018.

2016 -2018 Emergency Room Visits for Anxiety-related Disorders by Race/Ethnicity per 10,000 Population



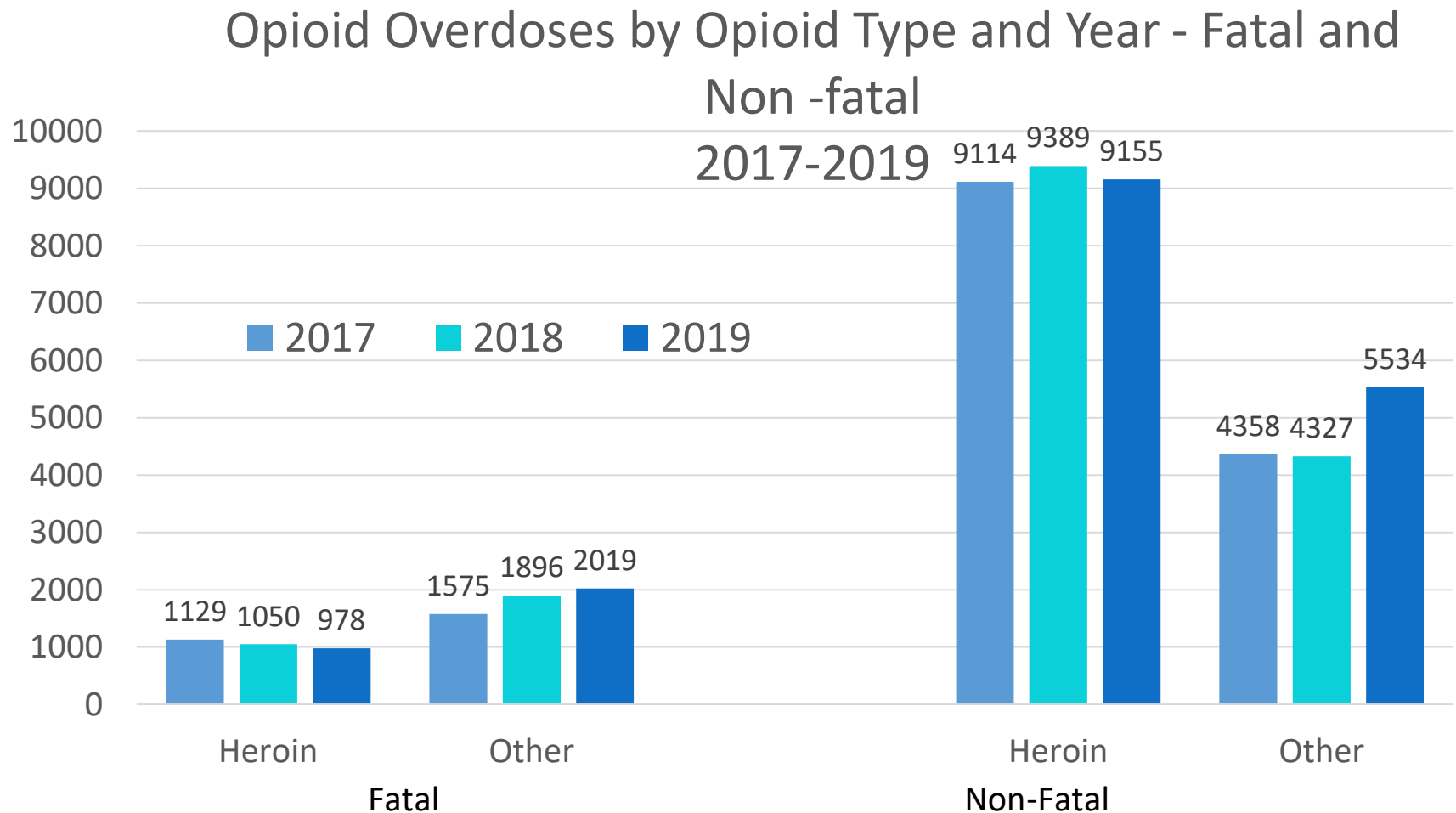
Hospital Community Health Needs Assessment (CHNA) Priorities: Behavioral/Mental Health, Injury, Violence, Suicide

Behavioral (blue) and mental health (red) are identified as priorities in a majority of Illinois hospital CHNAs.



Health Domain: Health Status

Substance Misuse: Opioids

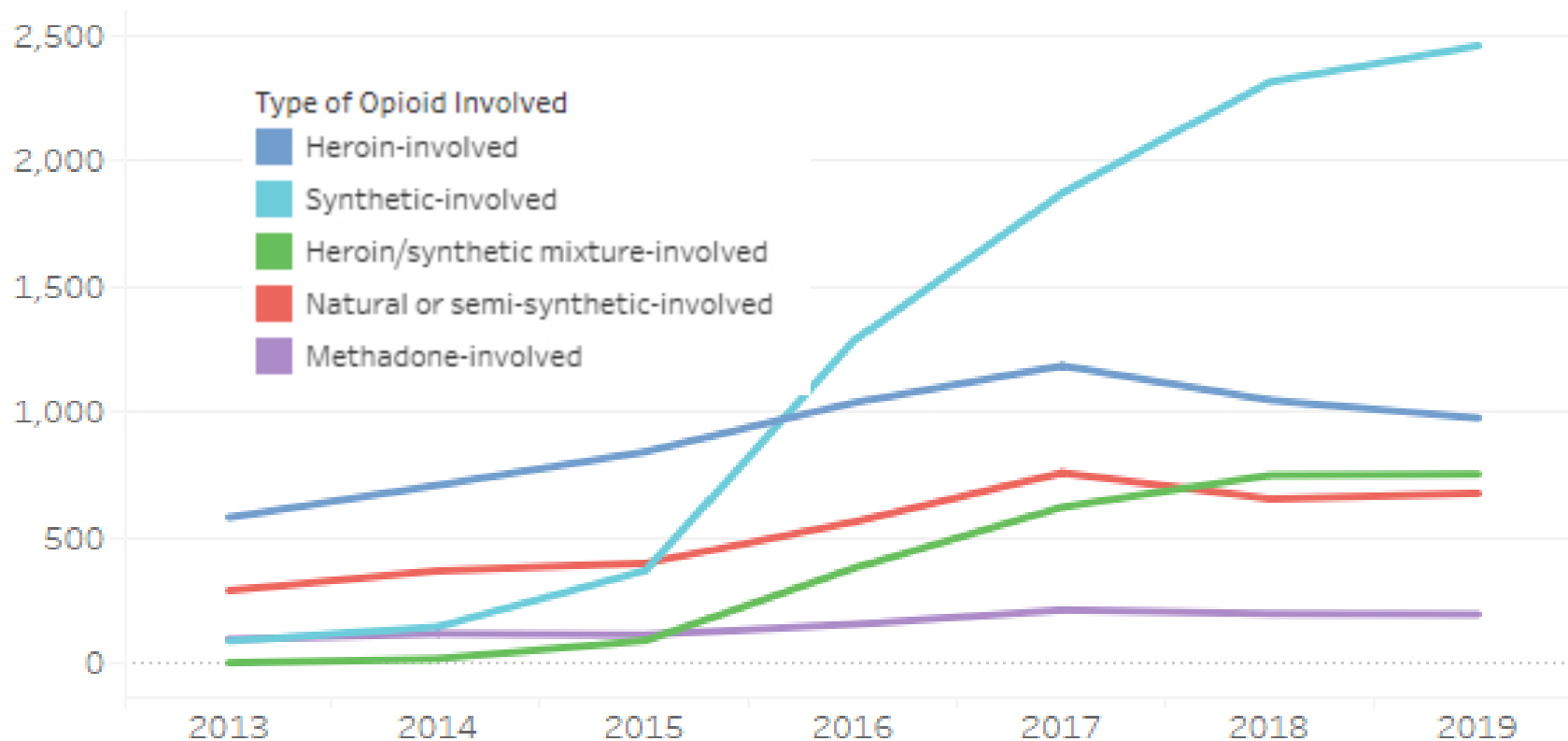


Health Domain: Health Status

Substance Misuse: Opioids

Mortality Trend By Type of Opioid Involved

Trends by Year



Health Domain: Health Status

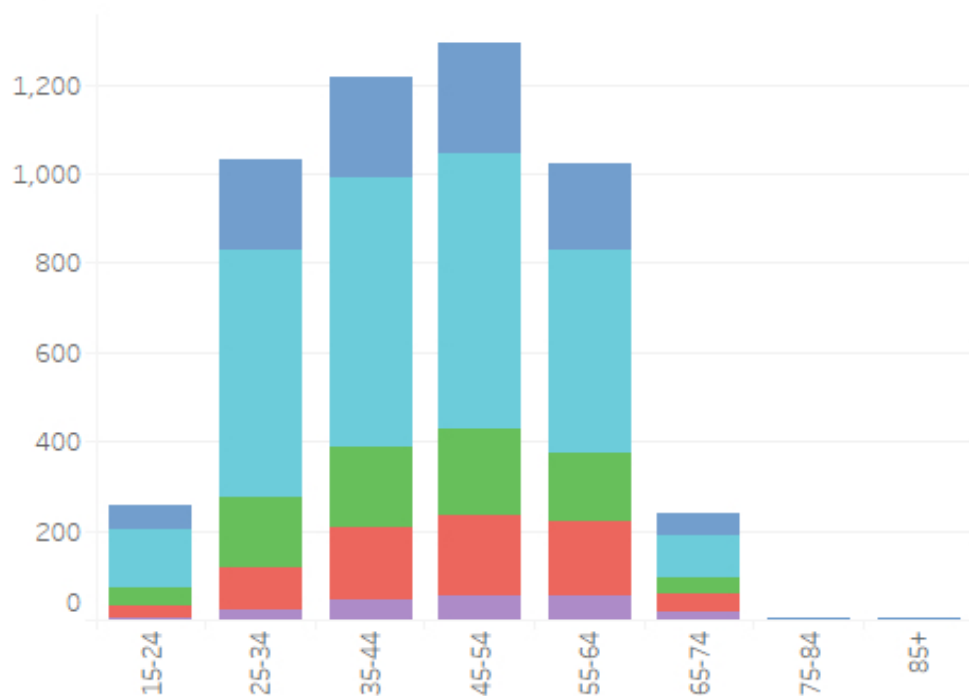
Substance Misuse: Opioids Mortality

2019 Age and Race/Ethnicity
Deaths by Type of Opioid Involved

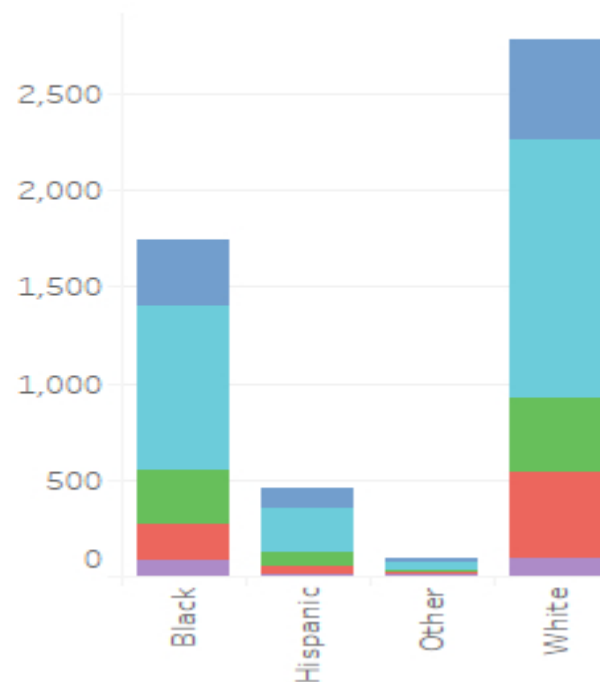
Type of Opioid Involved

- Heroin-involved
- Synthetic-involved
- Heroin/synthetic mixture-involved
- Natural or semi-synthetic-involved
- Methadone-involved

Age Group



Race

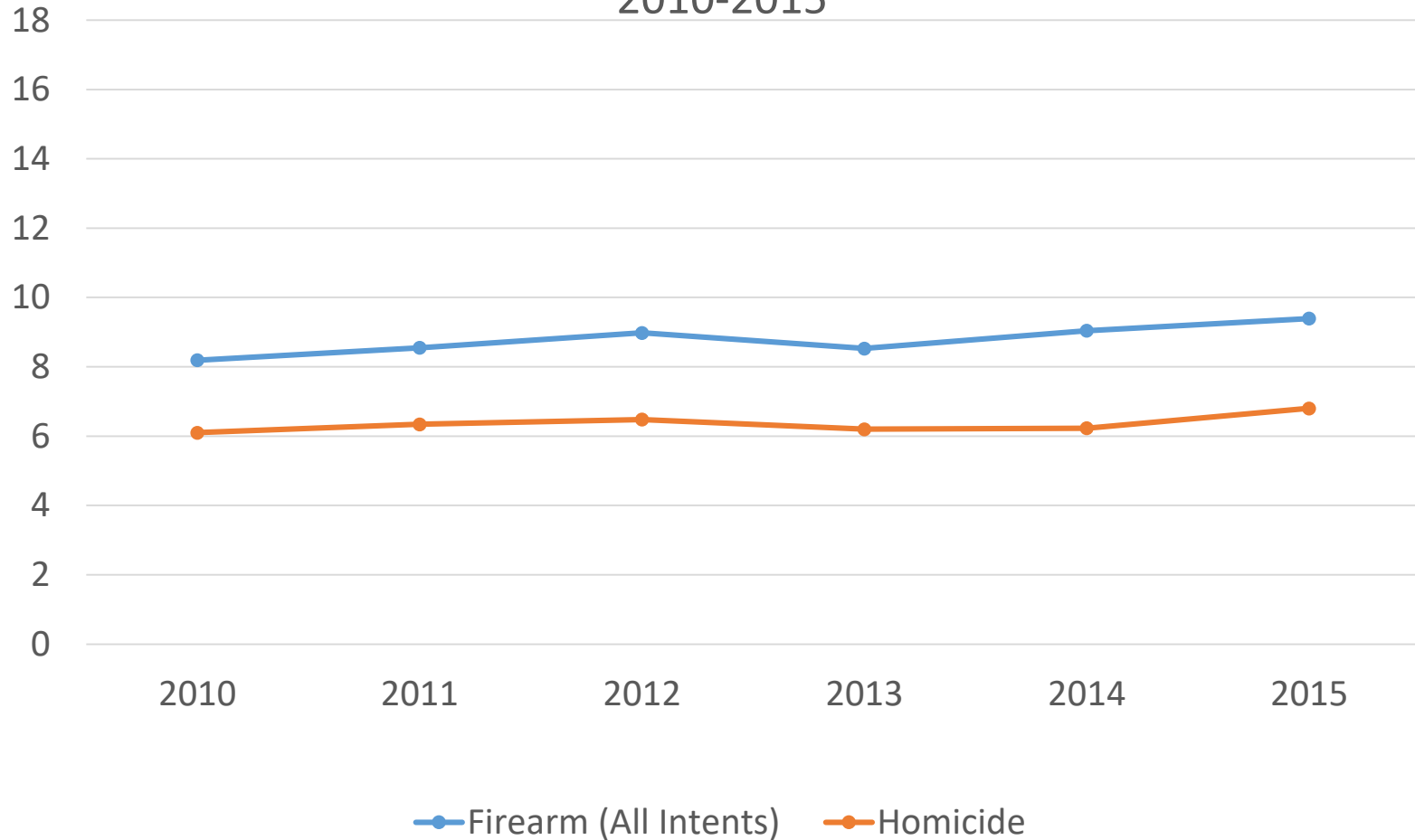


Health Domain: Health Status
Injury and Violence

Health Domain: Health Status

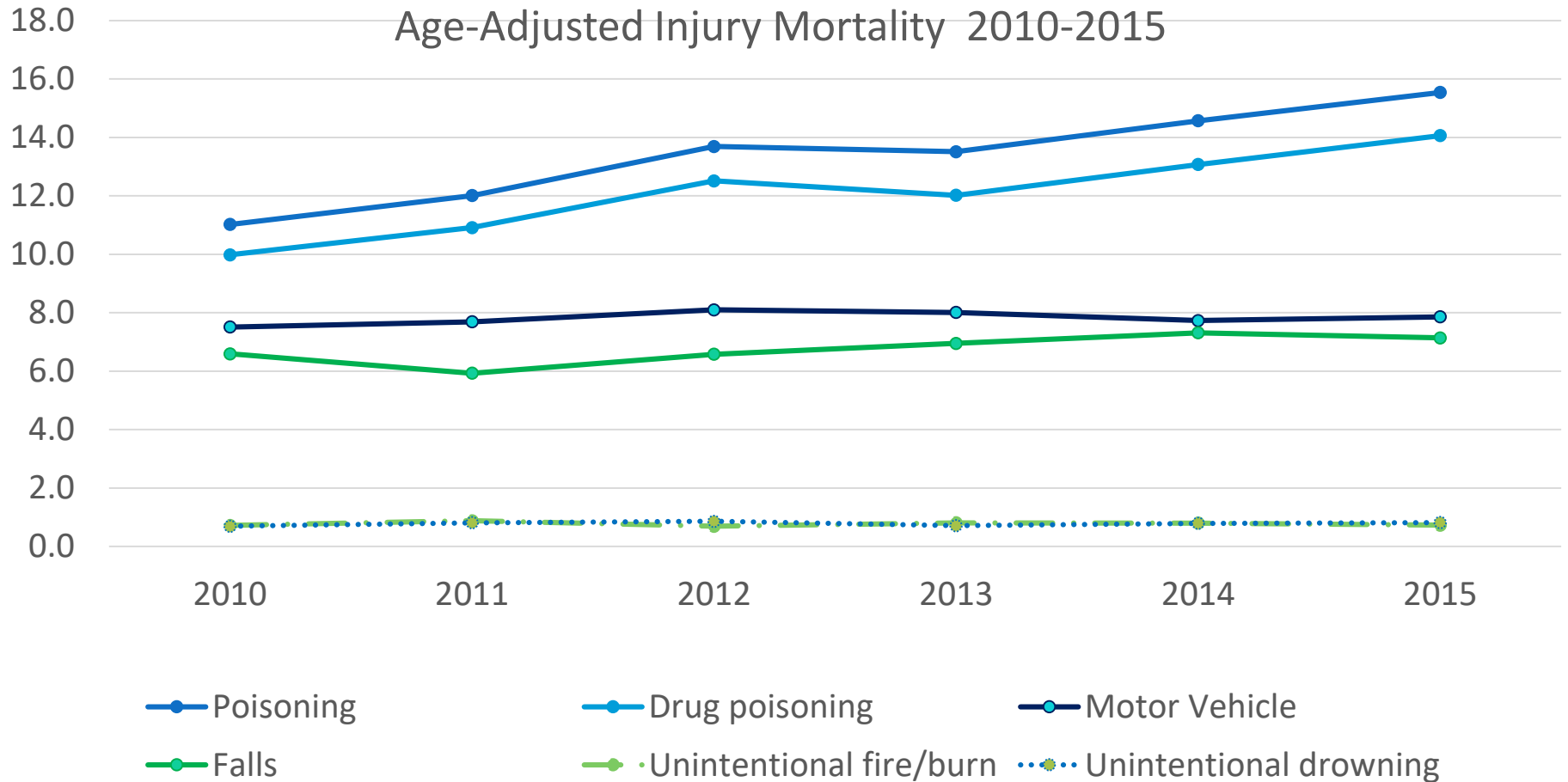
Firearm and Homicide Mortality

Age-Adjusted Firearm and Homicide Mortality
2010-2015



Health Domain: Health Status

Injury Mortality



Health Domain: Health Status

Communicable Diseases

Health Domain: Health Status

Foodborne Outbreaks

In 2019 there were 77 foodborne outbreaks investigated and counted in Illinois.

Twenty-six (26) were multistate outbreaks led by CDC and 51 were foodborne outbreaks led by Illinois.

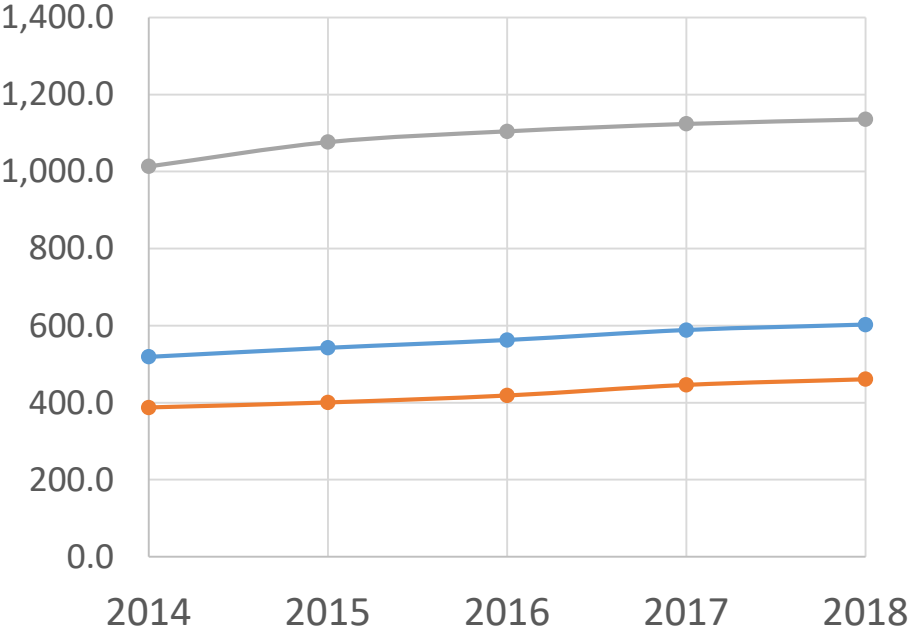
Agent	Count
Norovirus	32
Salmonella	20
Escherichia	11
Bacillus cereus/Clostridium perfringens	2
Cyclospora	2
Campylobacter	1
Campylobacter/Salmonella	1
Clostridium perfringens	1
Foodborne toxin, unknown type	1
Listeria	1
Other - Chemical/Toxin	1
Plant/Herbal toxins	1
Shigella/Vibrio	1
Unknown	1
Vibrio	1
Total	77

Health Domain: Health Status

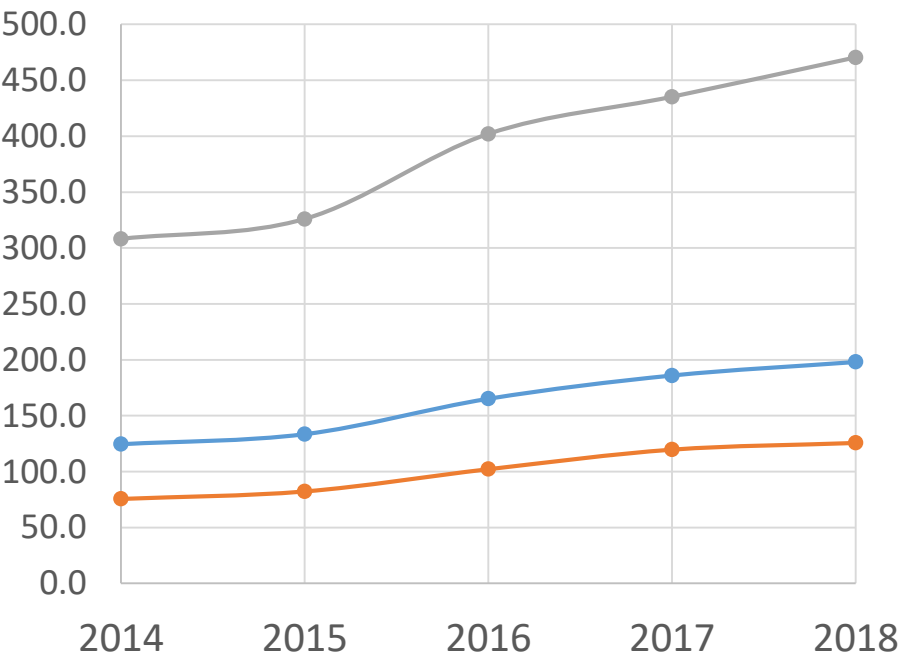
Sexually Transmitted Infections

Chlamydia and Gonorrhea

Chlamydia Rate per 100,000
2014 -2018



Gonorrhea Rate per 100,000
2014 -2018



—●— Total Illinois —●— Illinois Excluding Chicago —●— Chicago

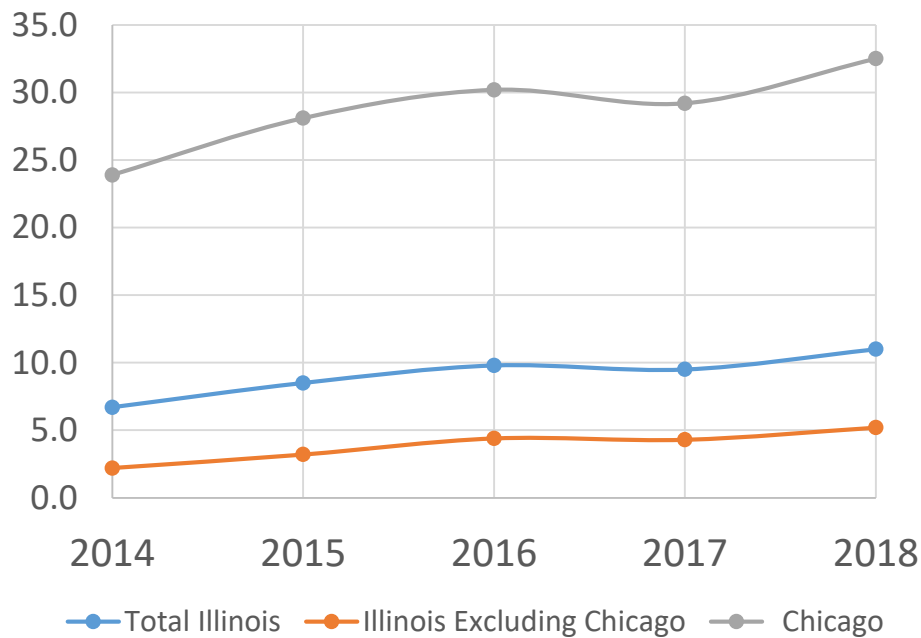
—●— Total Illinois —●— Illinois Excluding Chicago —●— Chicago

Health Domain: Health Status

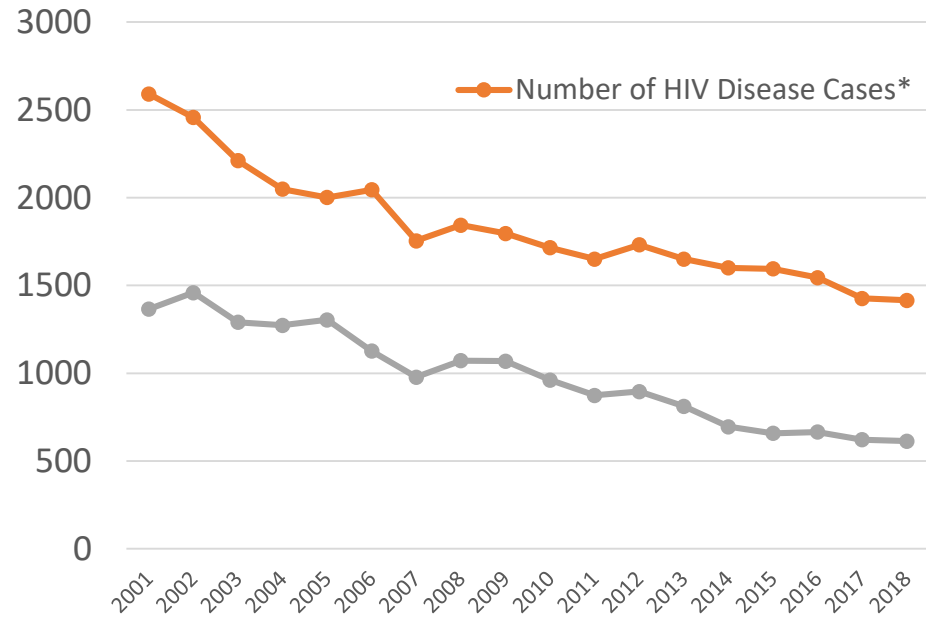
Sexually Transmitted Infections

Primary/Secondary Syphilis and HIV

Primary and Secondary Syphilis
Rate per 100,000
2014 -2018



Reported HIV Infection and AIDS
Cases
2001 - 2018

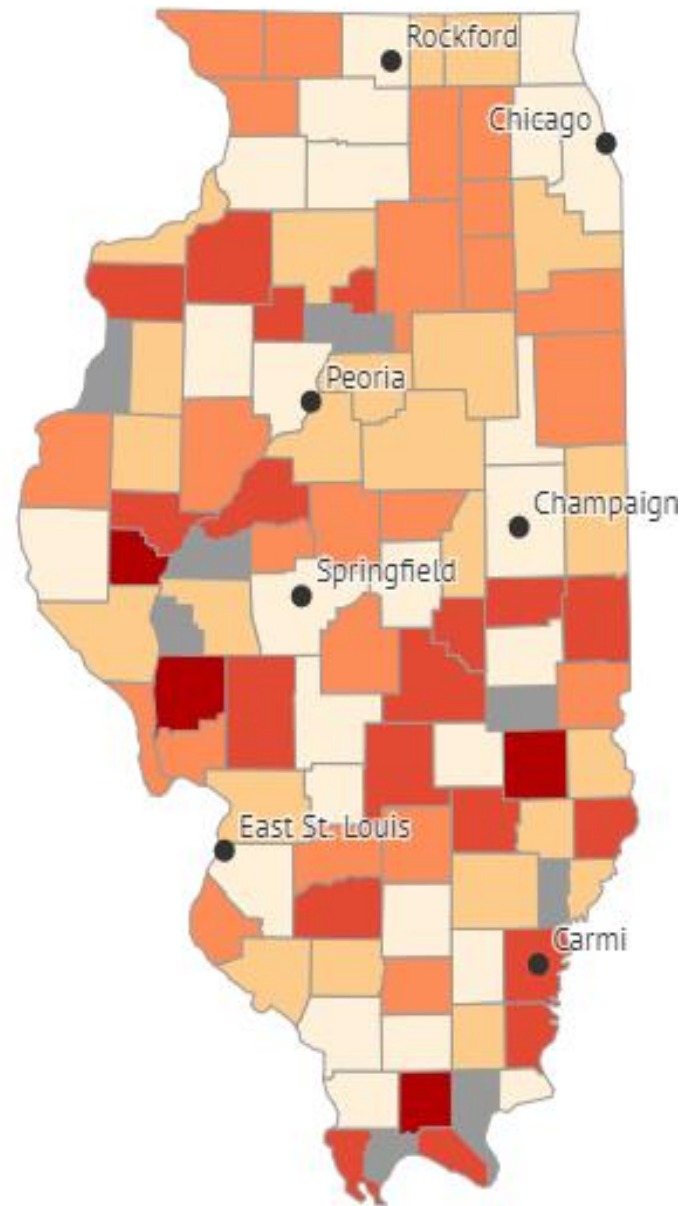


Health Domain: Healthcare Primary Care Supply

The average number of people per Primary Care Provider in Illinois was 1,234 in 2016.

Five counties (in dark red):

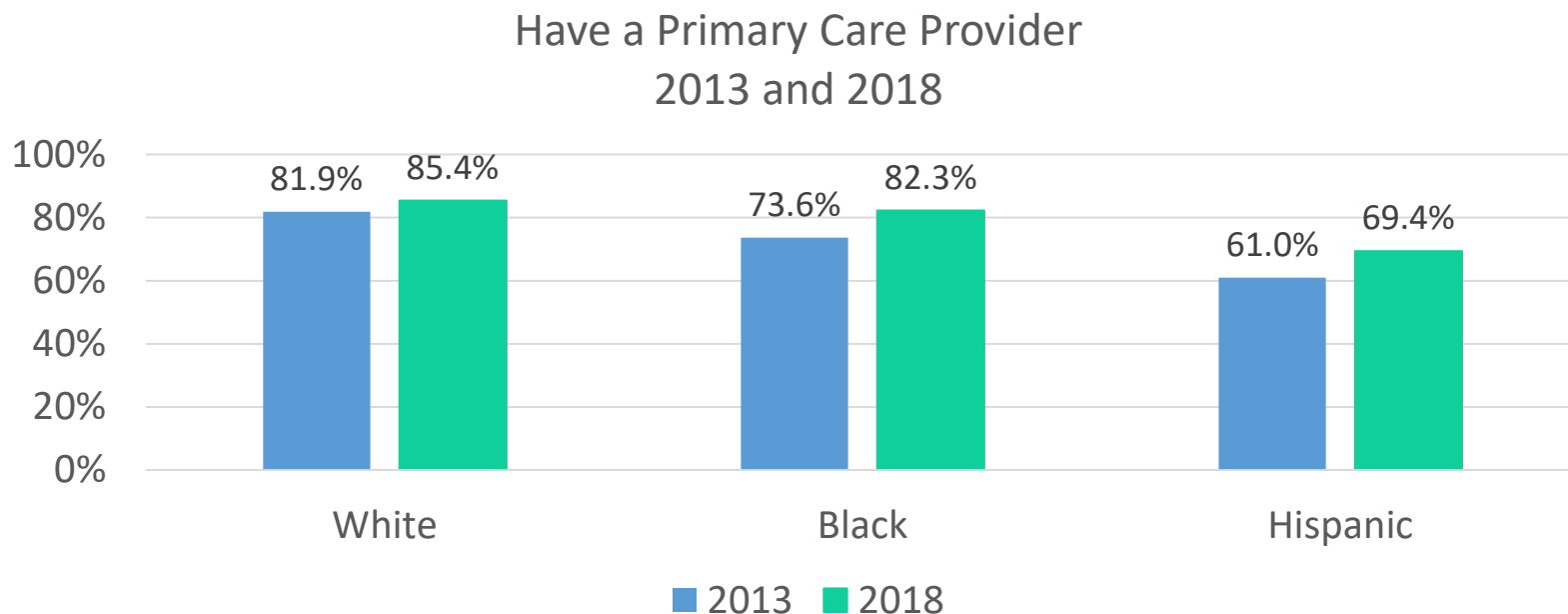
Alexander, Brown, Green, Jasper and Johnson have only 1 provider for between 6,100 and 12,900 people



Health Domain: Healthcare

Primary Care Providers

- Increases were seen among Blacks and Hispanics reporting a regular primary care provider between 2013 and 2018
- Hispanic/Latinos have the highest rate of not having a consistent source of primary care

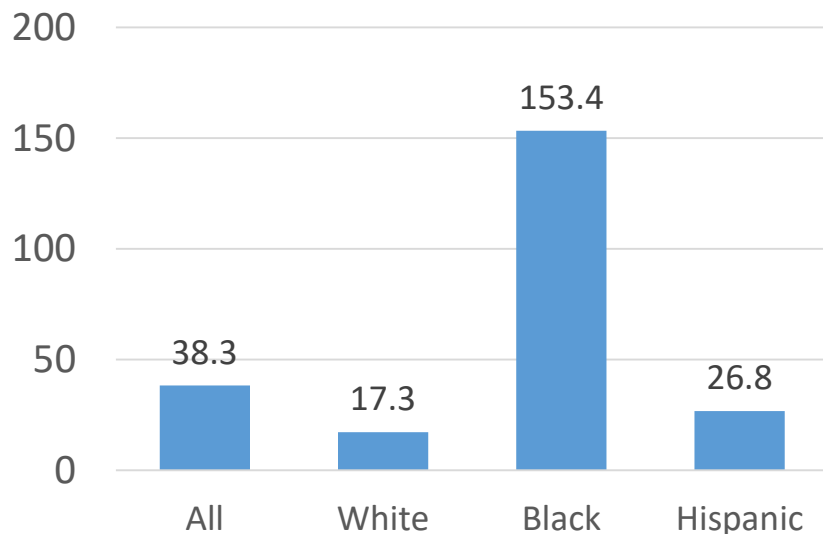


Health Domain: Health Care

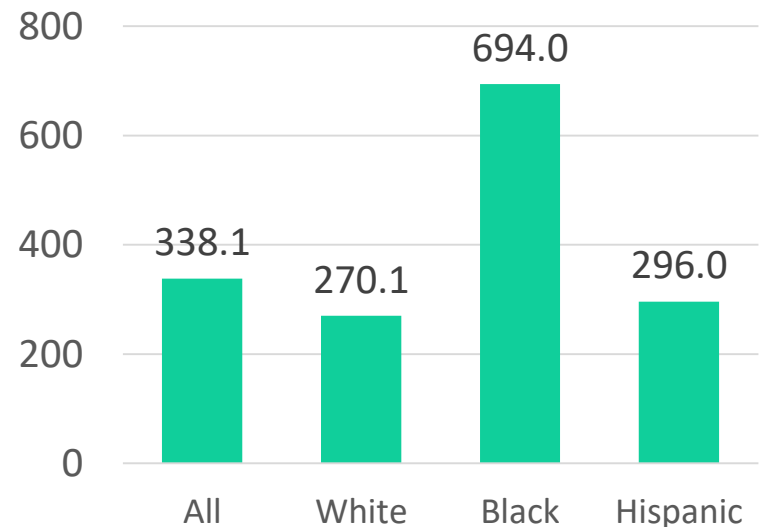
ED Visits for Asthma and Diabetes

Visits to the Emergency Department (ED) for conditions such as diabetes and asthma are markers of access to care since they should predominantly be managed in a primary care setting.

2016-2018 Asthma
Emergency Department Visits
by Race/Ethnicity per 10,000

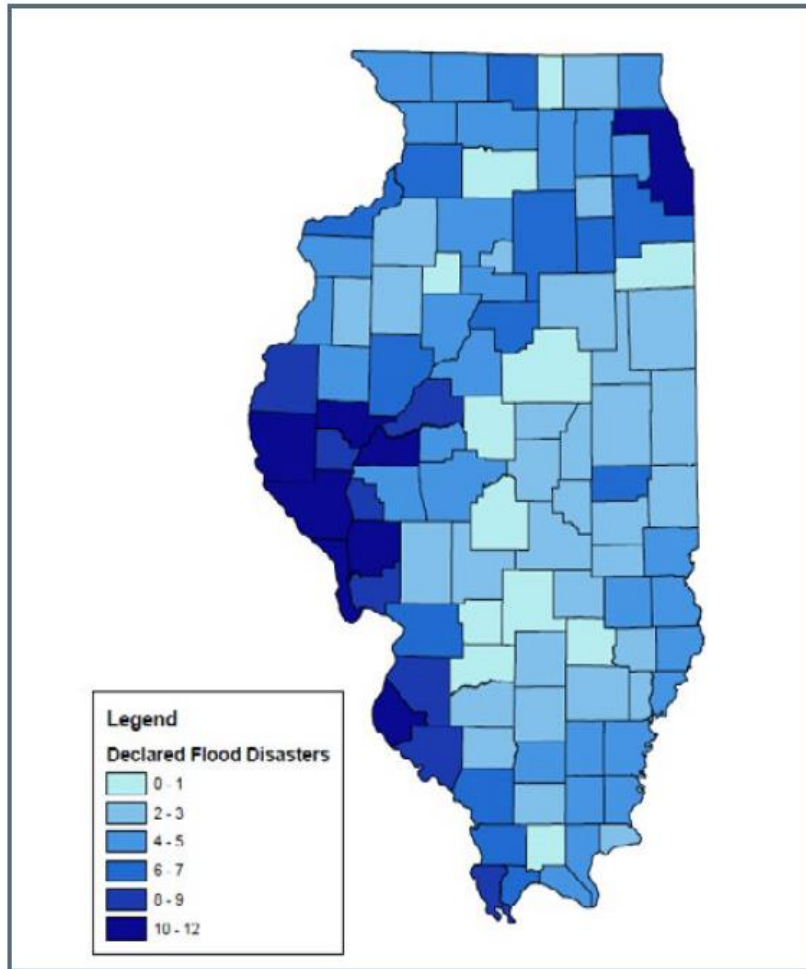


2016-2018 Diabetes
Emergency Department Visits
by Race/Ethnicity per 10,000

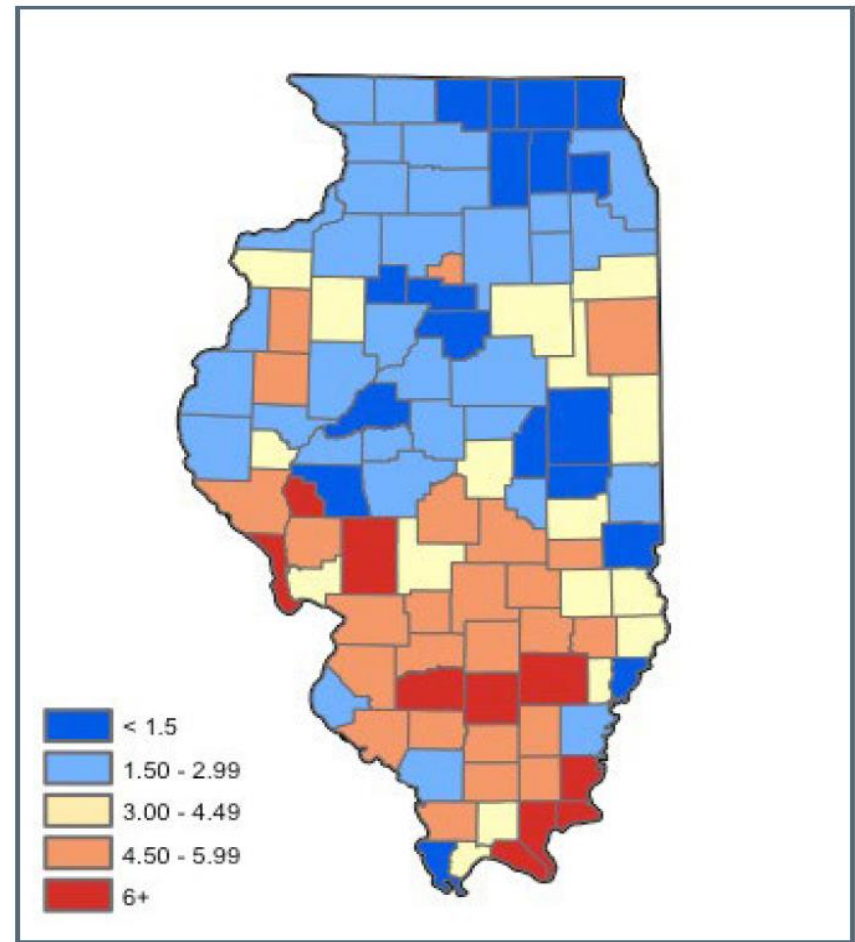


Health Domain: Emergent Issues Climate Change

Climate Change and Health



Number of federal flood disaster declarations by county from 1981–2013

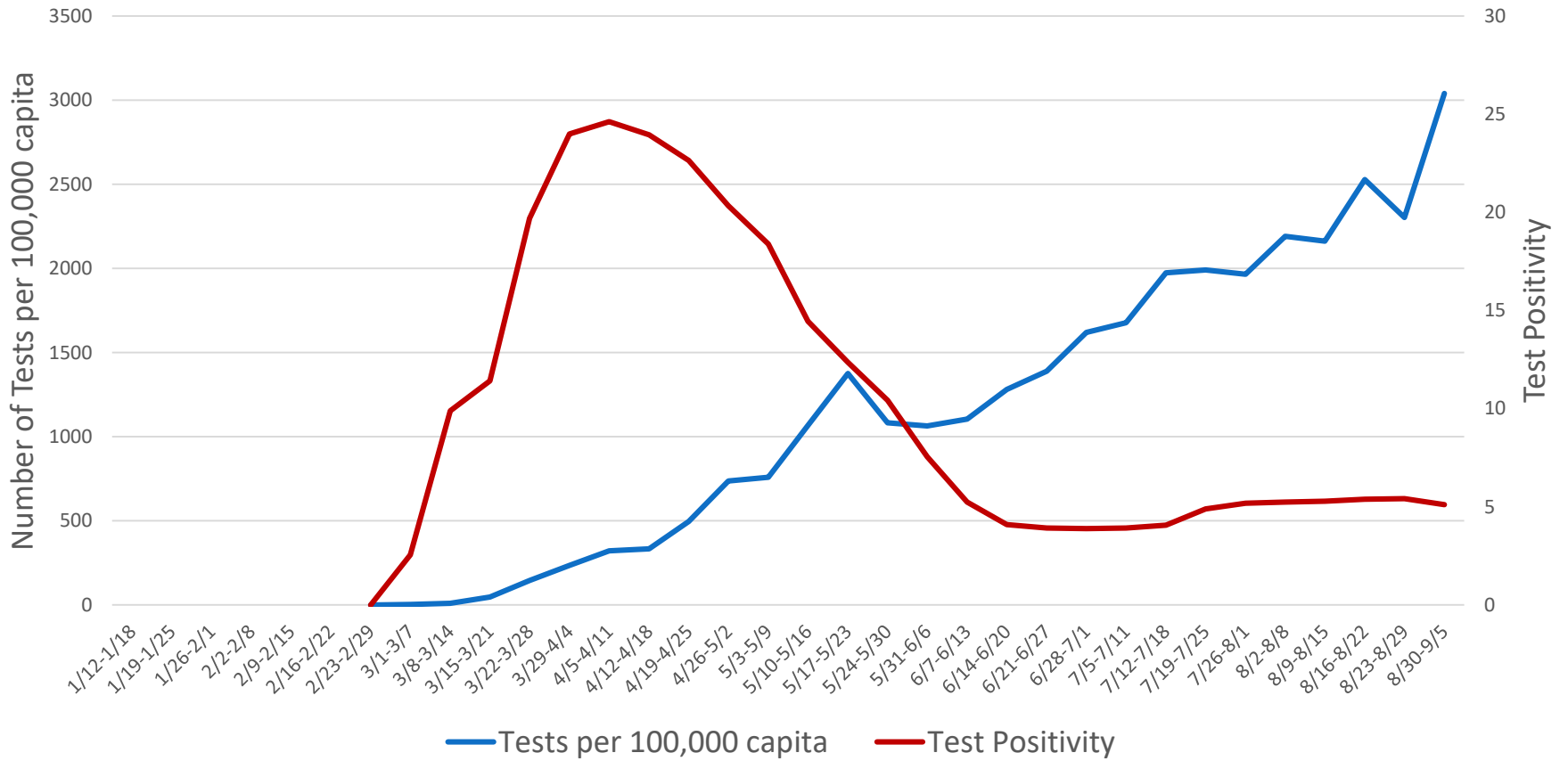


Rates of hospitalization for heat-stress illness in Illinois from 1987–2014. This map shows the risk of being hospitalized for a heat-stress illness in each county. Red is a high risk and blue is a low risk.

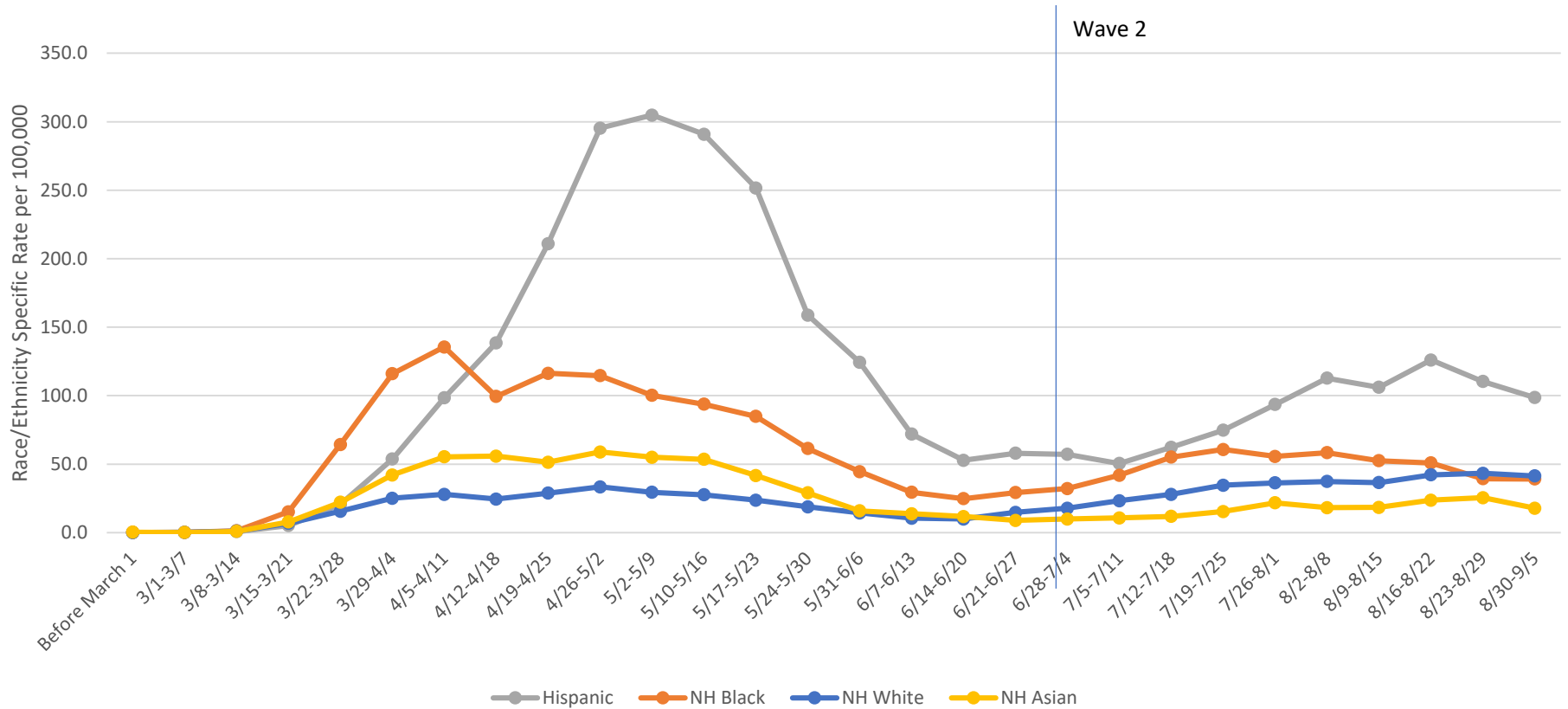
Health Domain: Emergent Issues

COVID-19

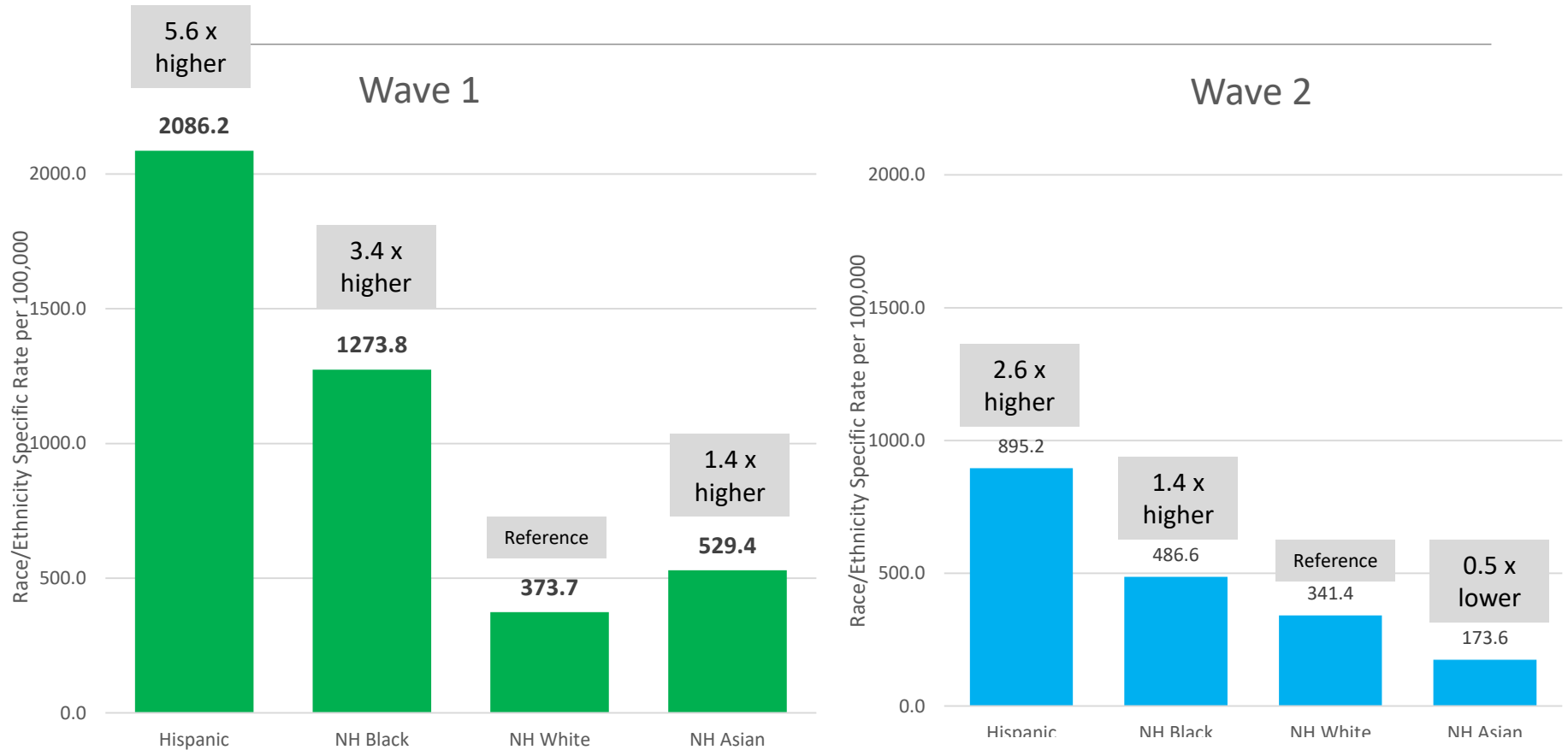
Illinois Weekly COVID-19 Test Positivity and Testing Rate



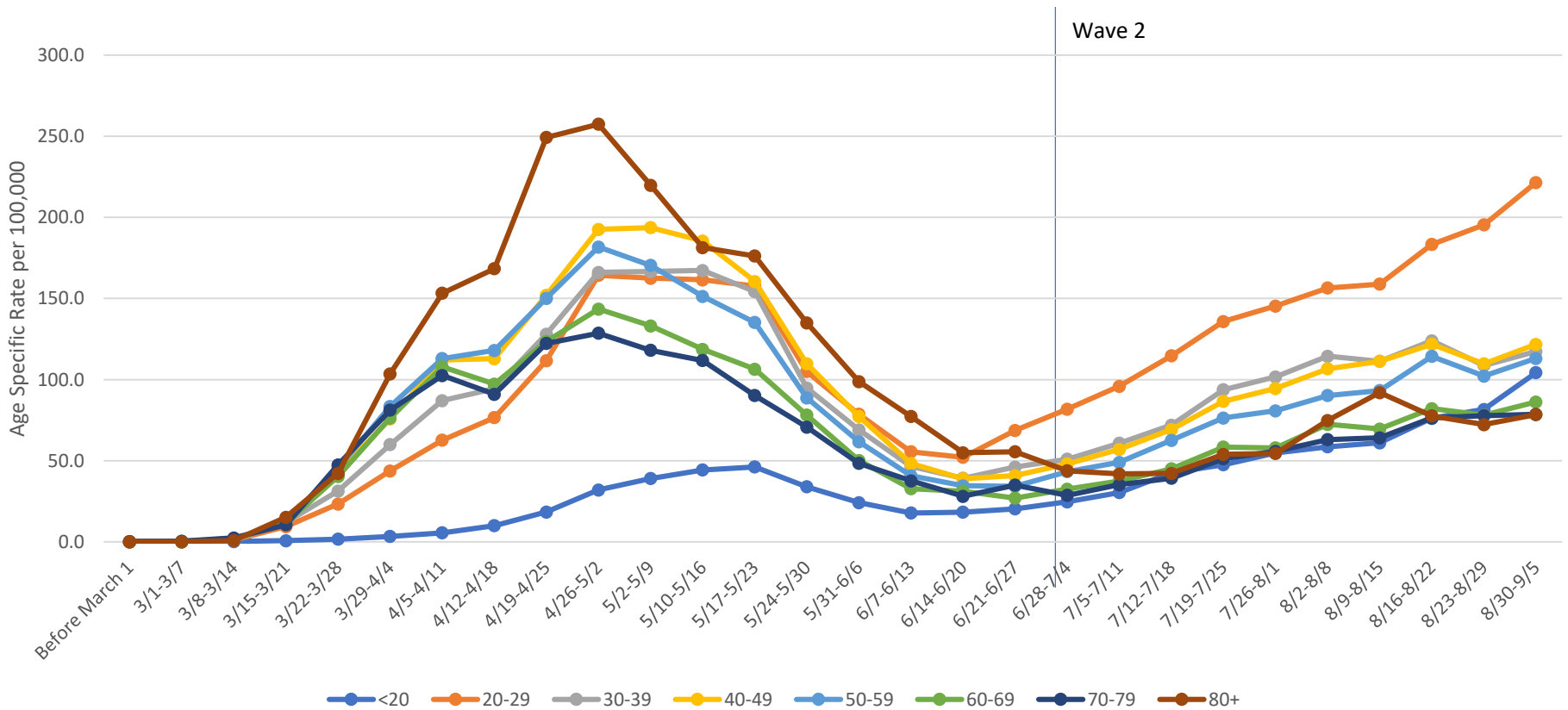
COVID-19: Weekly Case Rate by Race/Ethnic Group



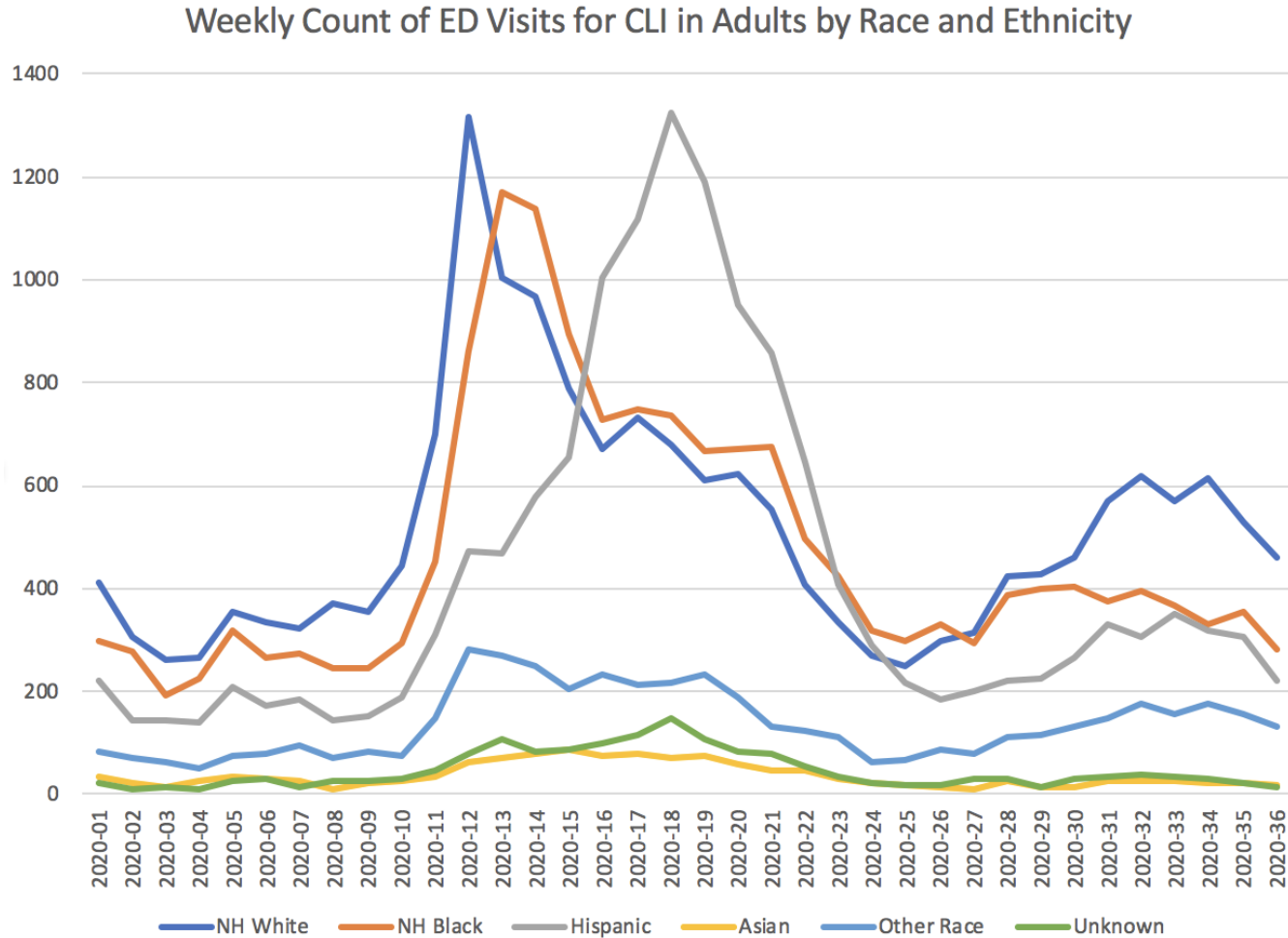
COVID-19: Case Rate by Race/Ethnicity



COVID-19: Weekly Case Rate by Age Group

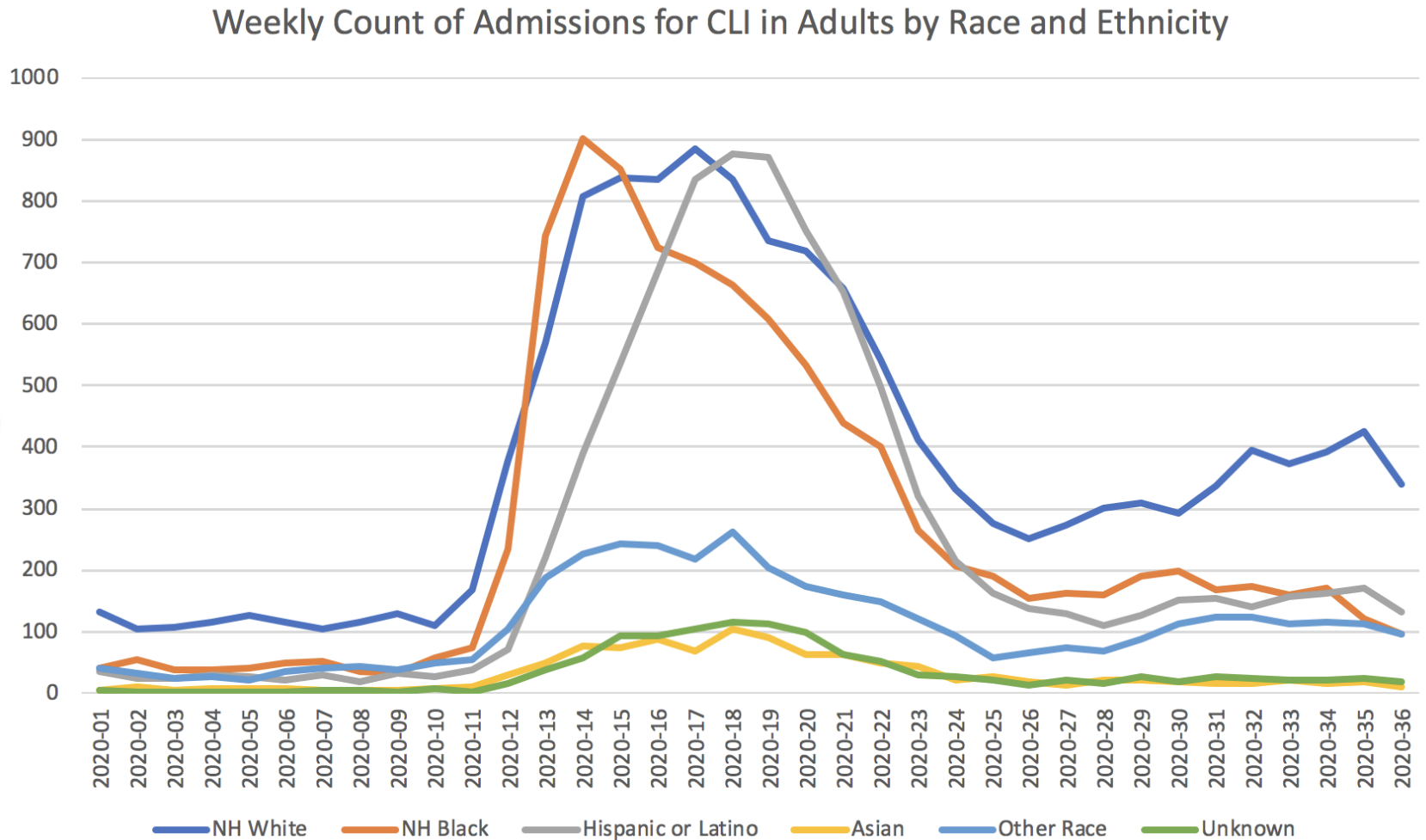


COVID-like Illness ED Visits by Race and Ethnicity (through MMWR Week 36)



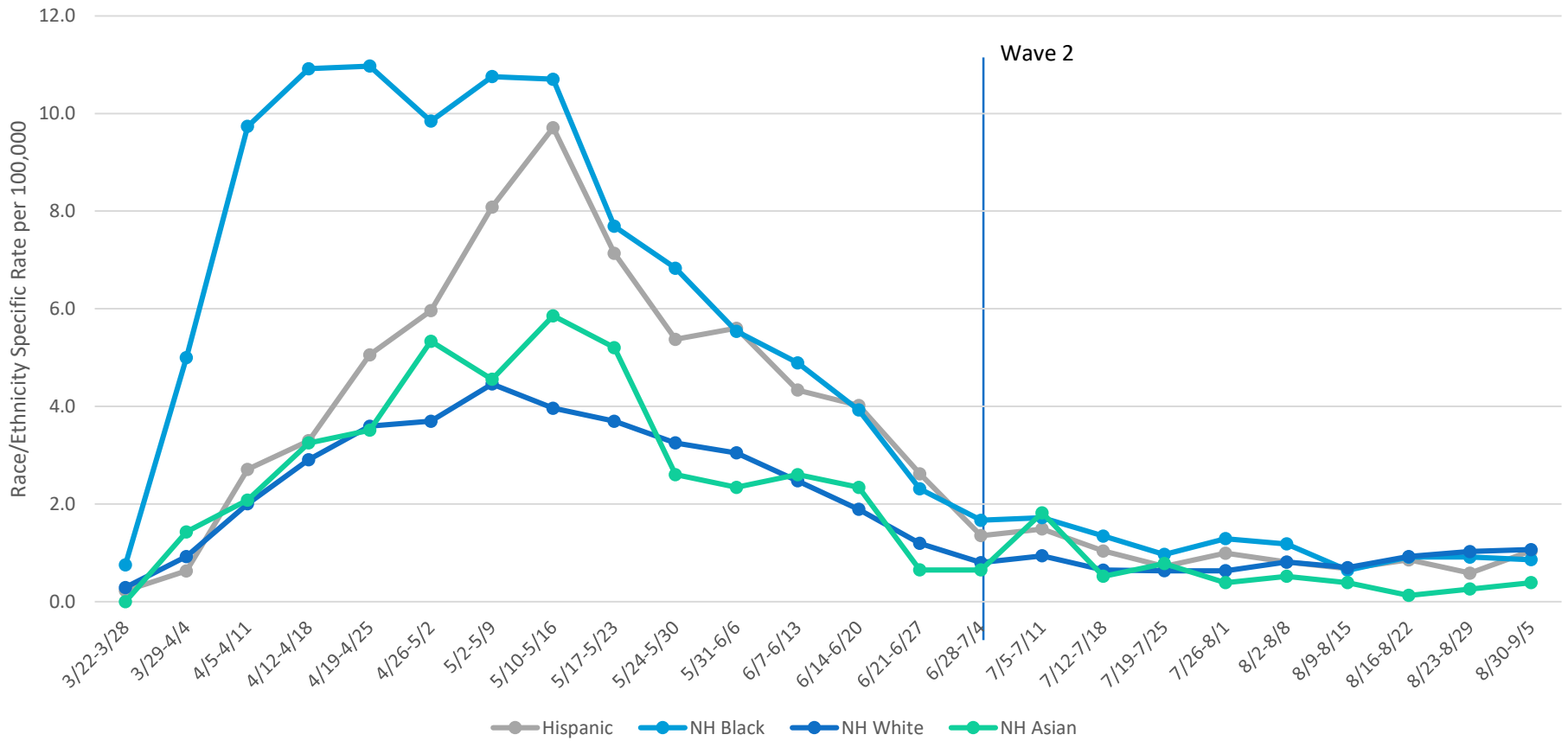
Slide Updated 9/7/2020

COVID-like Illness Hospital Admissions by Race and Ethnicity (through MMWR Week 36)

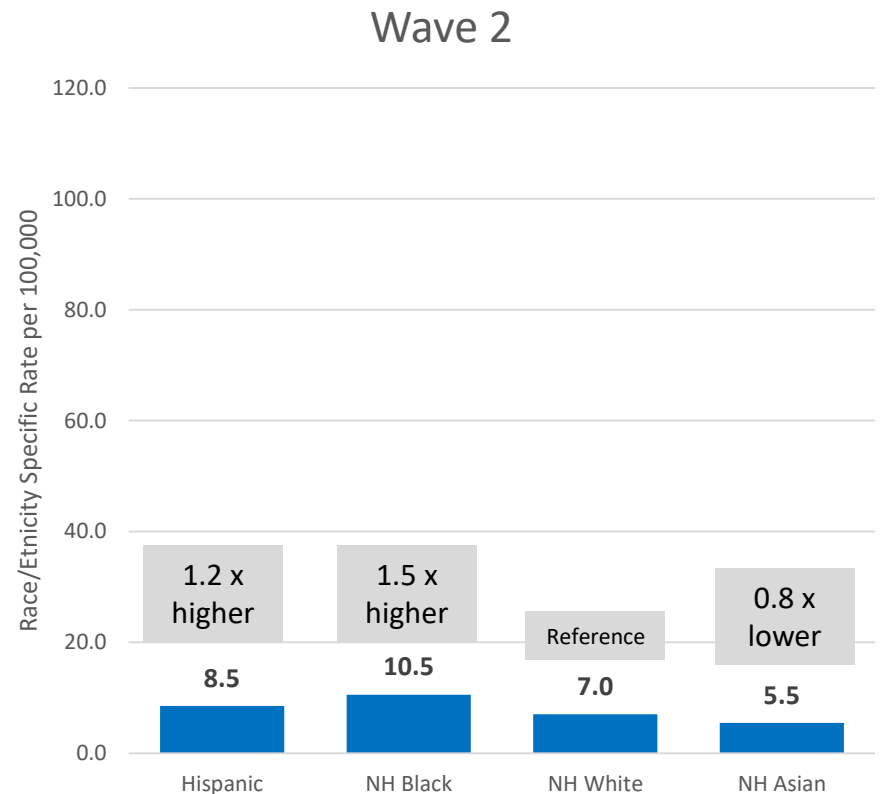
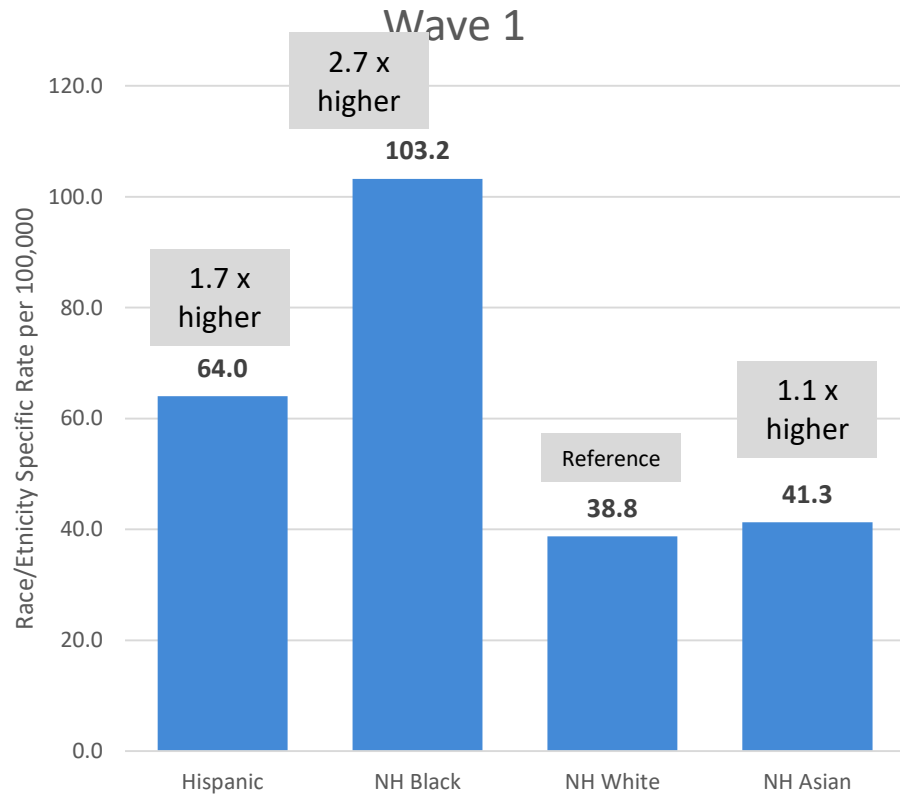


Slide Updated 9/7/2020

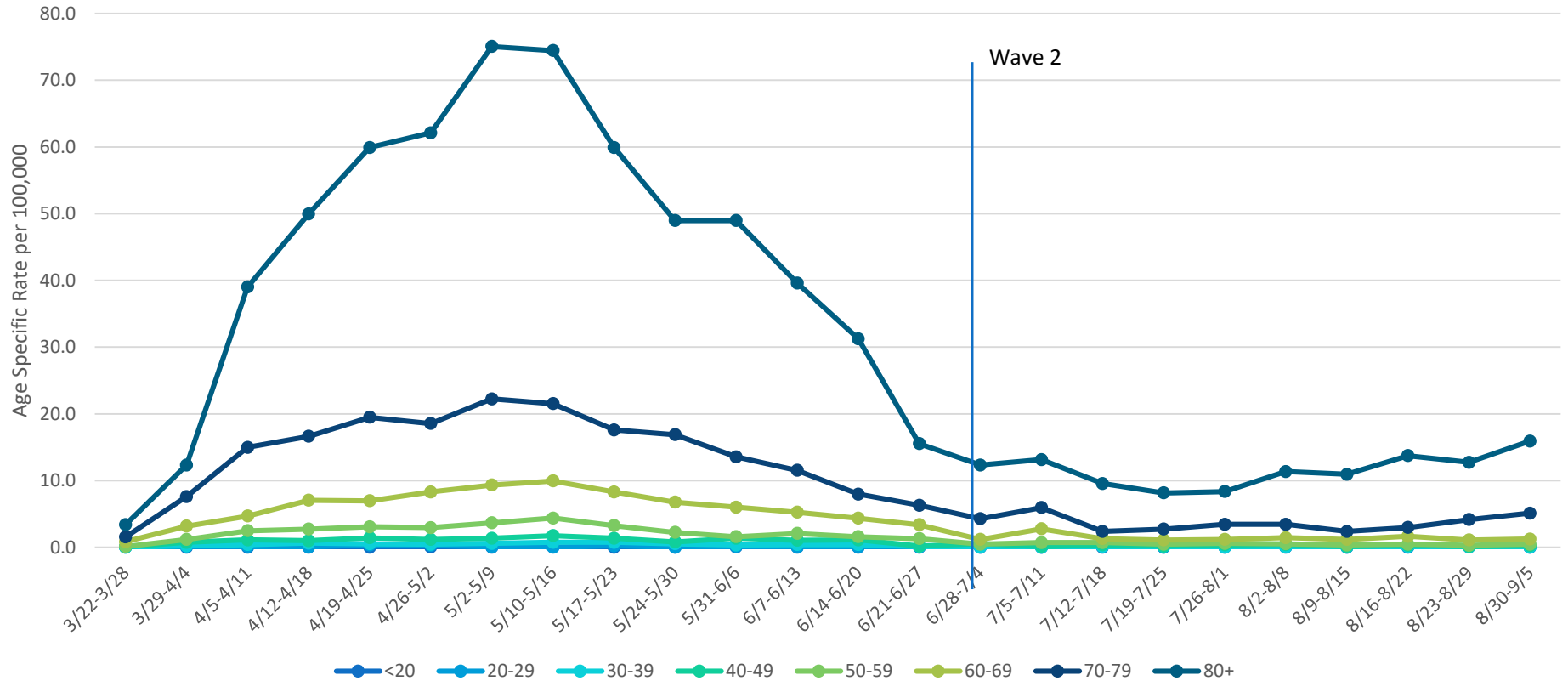
COVID-19: Death Rate by Race/Ethnicity



Death Rate by Race/Ethnicity



COVID-19: Death Rate by Age Group



LHD Survey:

During COVID-19, how well has each of the following been conducted by the public health system? N=51

	1 (Poor)	2	3	4	5 (Excellent)	Don't Know
Use of incident command	3 (5.9%)	4 (7.8%)	12 (23.5%)	17 (33.3%)	7 (13.7%)	6 (11.8%)
Planning	2 (3.9%)	2 (3.9%)	23 (45.1%)	15 (29.4%)	1 (2.0%)	5 (9.8%)
Evaluation	3 (5.9%)	6 (11.8%)	20 (39.2%)	13 (25.5%)	0	8 (15.7%)
Bi-directional communication with IDPH	5 (9.8%)	6 (11.8%)	14 (27.5%)	19 (37.3%)	2 (3.9%)	4 (7.8%)
Partnerships and coordination with IDPH	2 (3.9%)	8 (15.7%)	18 (35.3%)	16 (31.4%)	4 (7.8%)	2 (3.9%)
Partnerships and coordination between local organizations	1 (2.0%)	4 (7.8%)	13 (25.5%)	18 (35.3%)	11 (21.6%)	3 (5.9%)
Risk communication and public education	2 (3.9%)	1 (2.0%)	15 (29.4%)	22 (43.1%)	5 (9.8%)	4 (7.8%)
Community engagement	2 (3.9%)	5 (9.8%)	22 (43.1%)	11 (21.6%)	5 (9.8%)	5 (9.8%)
Addressing population specific groups	0	1 (2.0%)	17 (33.3%)	21 (41.2%)	6 (11.8%)	5 (9.8%)

IDPH Staff Survey:

During COVID-19, how well has each of the following been conducted by the public health system? (N=136)

	1 (Poor)	2	3	4	5 (Excellent)	Don't Know
Use of incident command	8 (4.5%)	7 (4.0%)	23 (13.1%)	34 (19.3%)	23 (13.1%)	41 (23.3%)
Planning	10 (5.7%)	10 (5.7%)	31 (17.6%)	44 (25.0%)	22 (12.5%)	19 (10.8%)
Evaluation	6 (3.4%)	7 (4.0%)	37 (21.0%)	39 (22.2%)	21 (11.9%)	25 (14.2%)
Bi-directional communication with IDPH	8 (4.5%)	13 (7.4%)	30 (17.0%)	39 (22.2%)	23 (13.1%)	24 (13.6%)
Partnerships and coordination with IDPH	6 (3.4%)	12 (6.8%)	30 (17.0%)	36 (20.5%)	29 (16.5%)	24 (13.6%)
Partnerships and coordination between local organizations	4 (2.3%)	10 (5.7%)	33 (18.8%)	41 (23.3%)	24 (13.6%)	25 (14.2%)
Risk communication and public education	6 (3.4%)	11 (6.2%)	31 (17.6%)	44 (25.0%)	34 (19.3%)	11 (6.2%)
Community engagement	8 (4.5%)	10 (5.7%)	42 (23.9%)	36 (20.5%)	24 (13.6%)	16 (9.1%)
Addressing population specific groups	8 (4.5%)	8 (4.5%)	31 (17.6%)	41 (23.3%)	24 (13.6%)	22 (12.5%)

LHD Survey:

During COVID-19, how well has each of the following been conducted by the public health system? N=51

	1 (Poor)	2	3	4	5 (Excellent)	Don't Know
Equity, anti-racism and justice	0	2 (3.9%)	22 (43.1%)	14 (27.5%)	3 (5.9%)	7 (13.7%)
Surveillance and outbreak monitoring	1 (2.0%)	1 (2.0%)	11 (21.6%)	25 (49.0%)	9 (17.6%)	2 (3.9%)
Case investigation	1 (2.0%)	0 (0%)	13 (25.5%)	22 (43.1%)	9 (17.6%)	3 (5.9%)
Contact tracing	1 (2.0%)	1 (2.0%)	20 (39.2%)	15 (29.4%)	8 (15.7%)	4 (7.8%)
Testing policy and practices	1 (2.0%)	7 (13.7%)	26 (51.0%)	9 (17.6%)	3 (5.9%)	3 (5.9%)
Infection prevention and control	2 (3.9%)	0	15 (29.4%)	23 (45.1%)	7 (13.7%)	2 (3.9%)
Maintaining essential public health services	0	5 (9.8%)	16 (31.4%)	20 (39.2%)	4 (7.8%)	4 (7.8%)
Policy recommendations	1 (2.0%)	5 (9.8%)	22 (43.1%)	13 (25.5%)	2 (3.9%)	5 (9.8%)

IDPH Staff Survey:

During COVID-19, how well has each of the following been conducted by the public health system? (N=136)

	1 (Poor)	2	3	4	5 (Excellent)	Don't Know
Equity, anti-racism and justice	10 (5.7%)	8 (4.5%)	39 (22.2%)	34 (19.3%)	18 (10.2%)	27 (15.3%)
Surveillance and outbreak monitoring	4 (2.3%)	7 (4.0%)	27 (15.3%)	39 (22.2%)	48 (27.3%)	11 (6.2%)
Case investigation	5 (2.8%)	7 (4.0%)	30 (17.0%)	40 (22.7%)	26 (14.8%)	28 (15.9%)
Contact tracing	9 (5.1%)	9 (5.1%)	31 (17.6%)	29 (16.5%)	24 (13.6%)	33 (18.8%)
Testing policy and practices	9 (5.1%)	12 (6.8%)	27 (15.3%)	42 (23.9%)	28 (15.9%)	18 (10.2%)
Infection prevention and control	6 (3.4%)	4 (2.3%)	33 (18.8%)	42 (23.9%)	34 (19.3%)	18 (10.2%)
Maintaining essential public health services	5 (2.8%)	5 (2.8%)	26 (14.8%)	41 (23.3%)	46 (26.1%)	14 (8.0%)
Policy recommendations	6 (3.4%)	6 (3.4%)	31 (17.6%)	34 (19.3%)	32 (18.2%)	26 (14.8%)

LHD Survey:

During the COVID-19 response thus far from March-August 2020, in which areas were **public health system gaps and challenges** most frequently/strongly highlighted and needed urgent improvement? (Select up to 3).

Response	Frequency	%
Coordination	23	16.3%
Communication	20	14.2%
Access to services	18	12.8%
Preparedness and response	16	11.3%
Community engagement	15	10.6%
Policies	15	10.6%
Monitoring and surveillance	11	7.8%
Planning	9	6.4%
Evaluation	6	4.3%
Equity and anti-racism	4	2.8%
Research and innovation	4	2.8%
Total selections	141	

IDPH Staff Survey:

During the COVID-19 response thus far (March 2020-Current), in which areas were **public health system gaps and challenges** most frequently/strongly highlighted and need urgent improvement? (Select up to 3).

Item	Number	%
Communication	63	15.0%
Preparedness and response	53	12.6%
Community engagement	47	11.2%
Access to services	47	11.2%
Monitoring and surveillance	45	10.7%
Coordination	41	9.8%
Research and innovation	33	7.9%
Planning	30	7.1%
Equity and anti-racism	23	5.5%
Policies	22	5.2%
Evaluation	16	3.8%
Total selections	420	

COVID-19 RESPONSE

What has been **most effective** in IDPH's role in the response to COVID-19 and why?

• Communication

- **Daily press briefings by the Pritzker and Dr. Ezike were very well received**
- *Regular, frequent communication by Governor and IDPH Director with public briefings. public awareness campaign like wearing mask and social distancing*
- *Public risk communication via social media has improved dramatically during the pandemic.*
- *Visibility/Communications. Everyone is relying on what they see from local leaders as the response has been catastrophic at the national level.*
- **Effective communication was frequently linked with praise of Dr. Ezike's Leadership.**

• Leadership

- *The medical Director having joint press conferences with the Governor. She is so well spoken, smart and empathetic. A great leader for our organization at this time. And she takes the time to send messages to Team IDPH. This is the first time someone has done such a gesture and its appreciated.*
- *In addition to praise for Dr. Ezike, many examples emphasized IDPH's statewide response.*
- *Stay data and science focused, establishing objective parameters applied to regions statewide to trigger mitigation actions in the Restore IL plan. Dr. Ezike has been an amazingly effective leader throughout this unprecedented event by being data and science-based, clearly and consistently communicating difficult information, and being empathetic to the needs and hurts of the general population and IDPH staff.*

• Testing and Data Use

- *Testing because we quickly developed a system and have done a great job of reporting results overall*
- *Looking at the data and placing testing sites.*
- *Increasing testing to provide robust and accurate data*

COVID-19 RESPONSE

What has been **least effective** in IDPH's role in the response to COVID-19 and why?

• Issues with testing

- *Lack of testing coordination with private providers resulted in very confusing information and selection of the appropriate testing areas and population. Public information of testing addresses. Contracted labs that delayed positive test reporting.*
- *Nursing home delays in Lab Support with testing and result and expectations for the Nursing Homes*
- *Testing sites is not clear to communities; lack of response is not acceptable.*

• Enforcement of guidelines

- *Enforcement of regulatory authority. Enforcement has been largely left to local entities leading to inconsistency statewide.*
- *Enforcing rules about social distancing and mask wearing*

• Communication

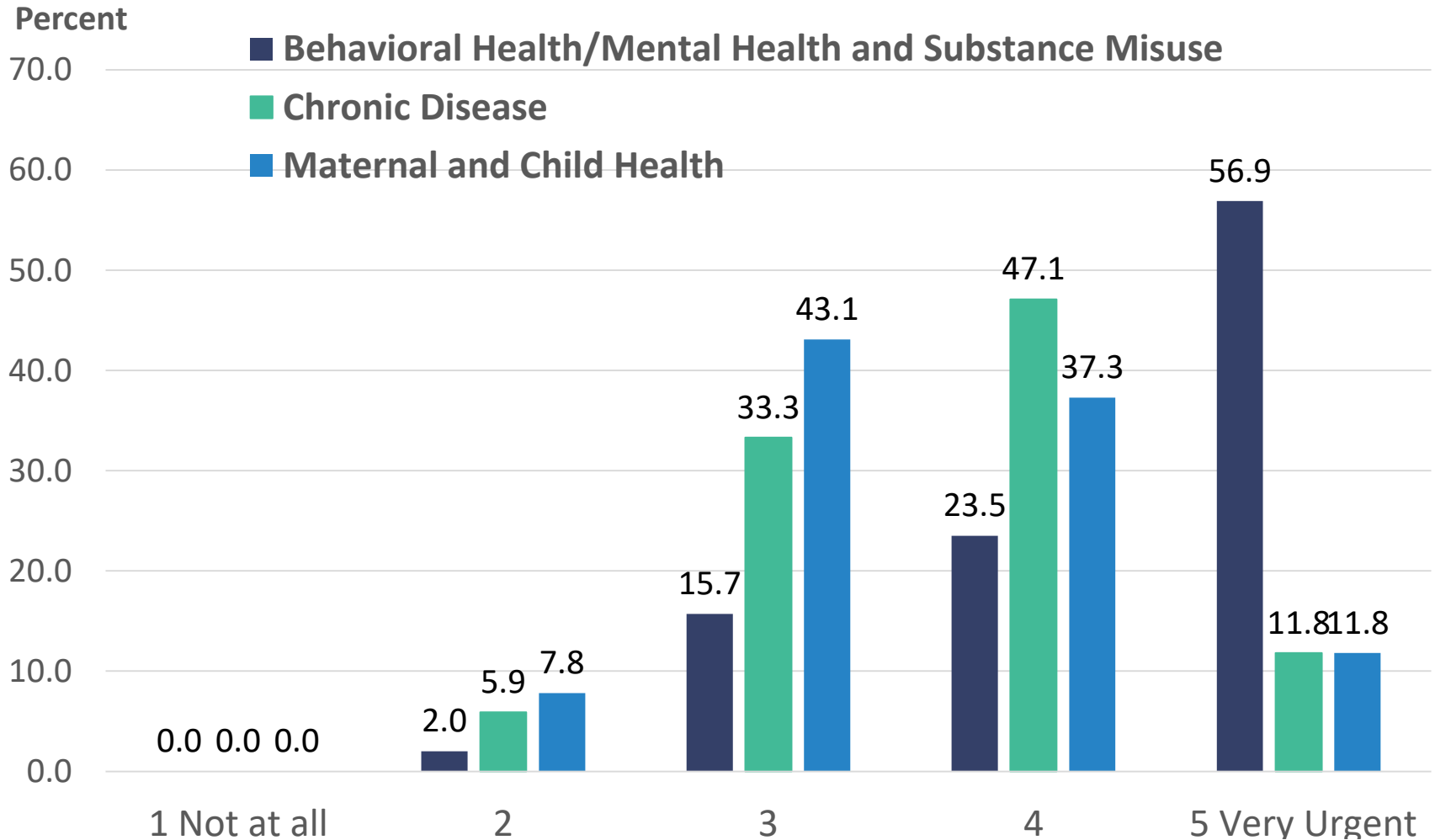
- *Lack of direct guidance (particularly on testing) for clinicians, though primary deficit begins with lack of national/federal leadership and coordination.*
- *Combating the pseudoscience in the media, too many conspiracy theories surrounding the pandemic.*
- *Lack of communication among programs within IDPH. Lack of communication causes multiple people to work on the same lines of effort and catches staff off guard when external groups ask questions.*

LHD and IDPH Staff Survey Results

SHIP Update Related Questions

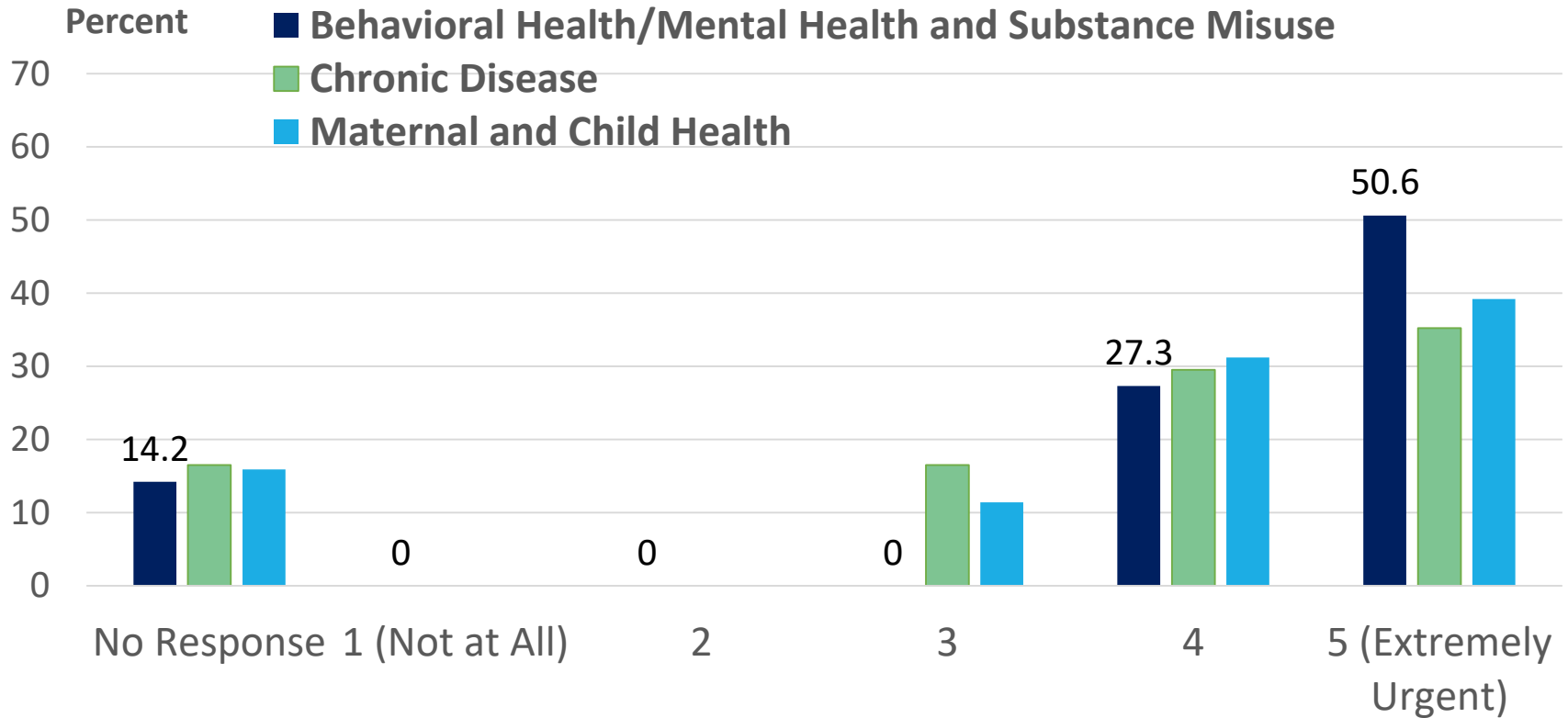
LHD SURVEY Question:

Given the current state of public health activities, how urgent are these past SHIP priorities for the public health system to address in the next 18 months ? (N=51)



IDPH STAFF SURVEY Question:

Given the current state of public health activities, how urgent are these past SHIP priorities for the public health system to address in the next 18 months ? (N=177)



If urgent or extremely urgent--what about this is most urgent or needed at this time?

BEHAVIORAL HEALTH

- **Access to care** for those with mental health needs (services, screening, counseling, treatment, housing)
COVID-19 crisis and impact on individuals as well as communities, gaps in healthcare coverage and access.
- **Impact of COVID-19 (opioid use, mental health)**
 - *Dealing with the emotional and behavioral side effects and aftermath from the COVID-19 pandemic.*

CHRONIC DISEASE

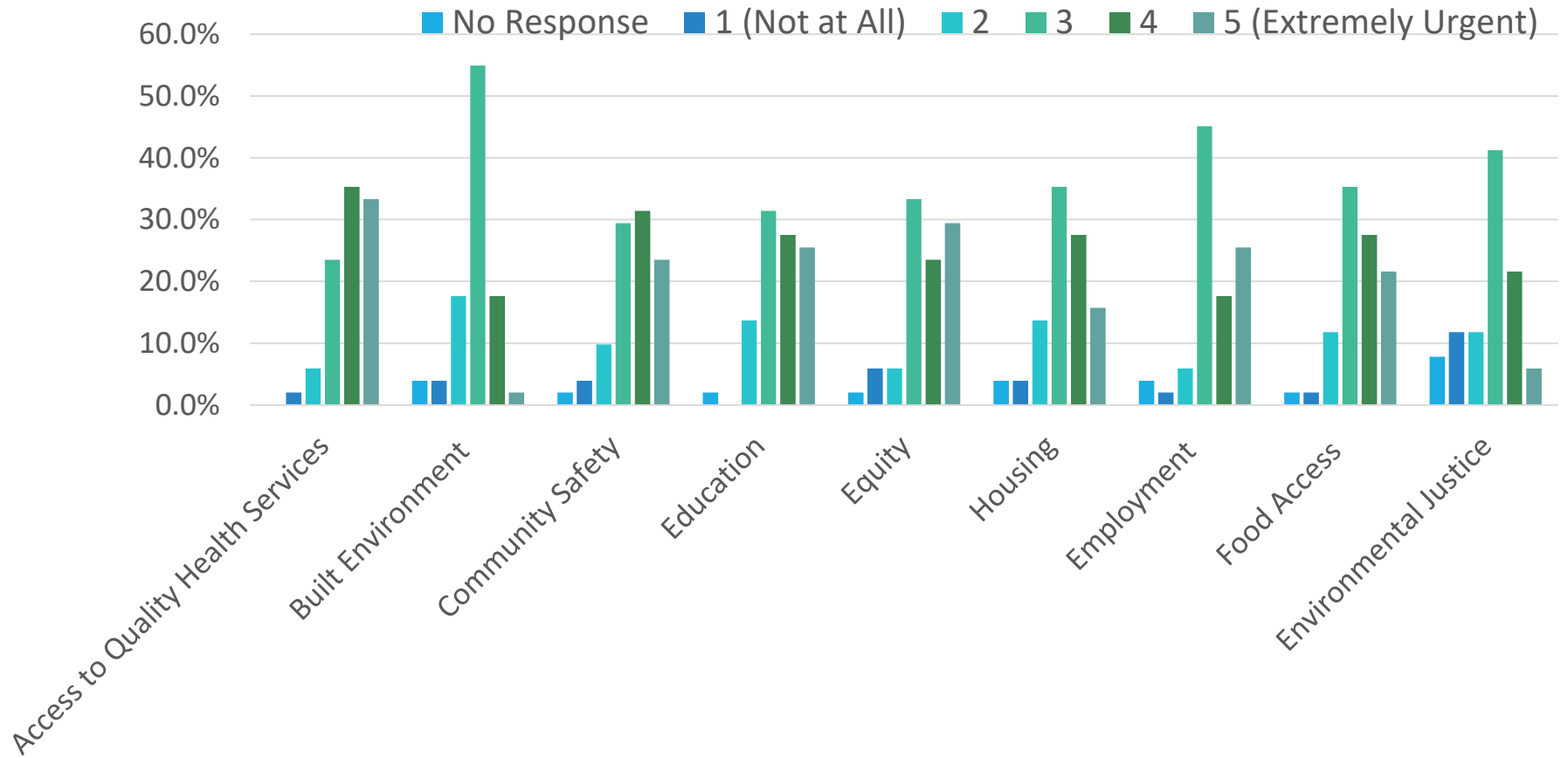
- **Increased education and prevention**
Focus on primary and secondary prevention of cancer, heart disease, and diabetes through health in all policies approach.
- **Access to care**
Continue health care to address chronic disease and affordable treatment plans. And treatment
- **Challenges with COVID-19**
 - *COVID-19 has demonstrated in a very concrete way how important it is to prevent and effectively manage chronic diseases because comorbidities increase severity of COVID and risk of death*

MATERNAL AND CHILD HEALTH

- **Disparities** (mention of disparities, minorities, Black mothers, racial disparities)
High maternal mortality and morbidity is still concern in underserved communities.
- **Access to Care** (programs, medical care)
 - *Must continue focus on unacceptably high rates of maternal mortality, particularly among Black women.*

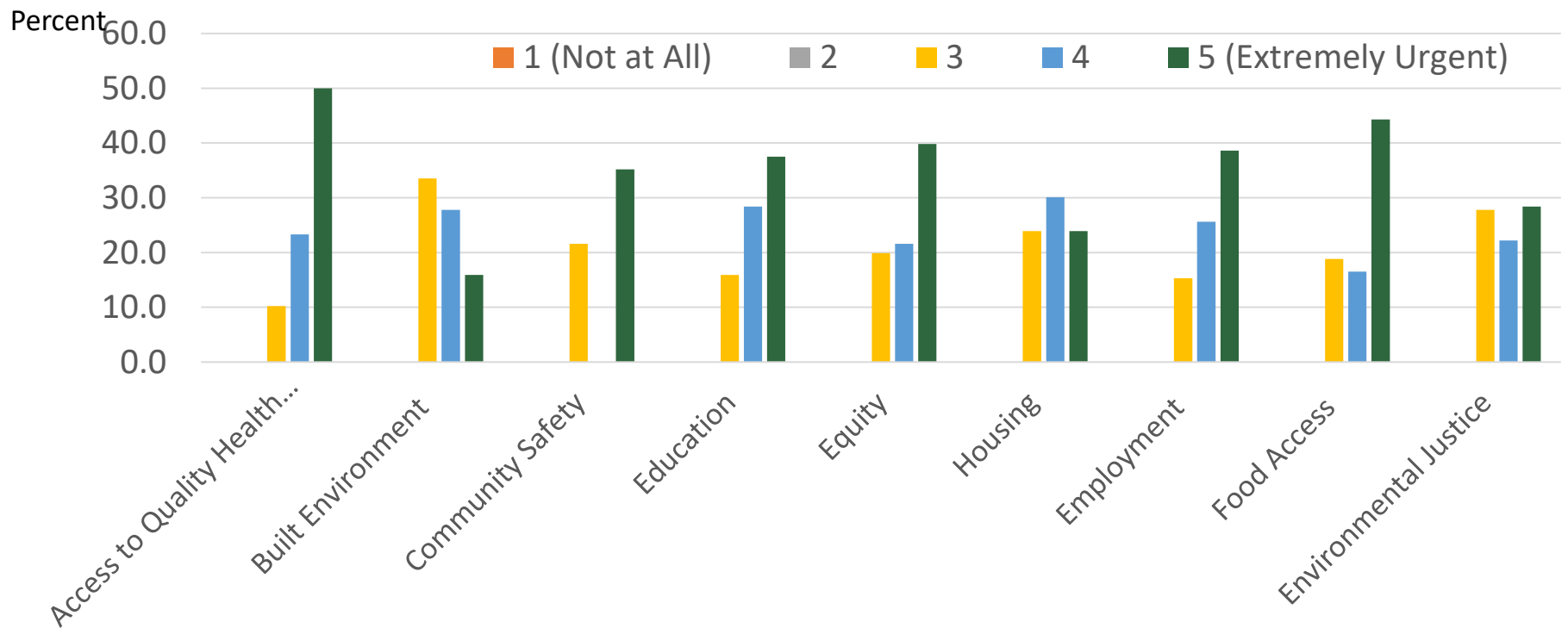
LHD SURVEY QUESTION

Given the current state of public health activities, how urgent is addressing the social and structural determinants of health? (N=51)



IDPH Staff QUESTION

Given the current state of public health activities, how urgent is addressing the social and structural determinants of health? (N=176)



IDPH Staff Survey: Addressing Internal and External Racism

	Don't Know	Strongly disagree	Disagree	Somewhat Agree	Agree	Strongly agree
Coworkers at IDPH are comfortable talking about race and racism.	20 (11.4%)	13 (7.4%)	24 (13.6%)	29 (16.5%)	40 (22.7%)	17 (9.7%)
My coworkers at IDPH talk about race and racism as a public health issue.	23 (13.1%)	15 (8.5%)	17 (9.7%)	36 (20.5%)	27 (15.3%)	24 (13.6%)
IDPH Division directors, managers and supervisors are comfortable talking about race and racism.	20 (11.4%)	13 (7.4%)	24 (13.6%)	29 (16.5%)	40 (22.7%)	17 (9.7%)
IDPH Division directors, managers, and supervisors talk about race and racism as a public health issue.	23 (13.1%)	15 (8.5%)	17 (9.7%)	36 (20.5%)	27 (15.3%)	24 (13.6%)

IDPH Staff Survey: Addressing Internal and External Racism

	Don't Know	Strongly disagree	Disagree	Somewhat Agree	Agree	Strongly agree
In the past 2 years, my section and/or division at IDPH has engaged in group discussions about how our work could advance health equity and dismantle racism.	20 (11.4%)	13 (7.4%)	24 (13.6%)	29 (16.5%)	40 (22.7%)	17 (9.7%)
I understand how to advance health equity and dismantle racism as part of my job at IDPH.	23 (13.1%)	15 (8.5%)	17 (9.7%)	36 (20.5%)	27 (15.3%)	24 (13.6%)
I understand how to advance health equity and dismantle racism as part of my office/programs work at IDPH.	20 (11.4%)	13 (7.4%)	24 (13.6%)	29 (16.5%)	40 (22.7%)	17 (9.7%)

RACISM and EQUITY

What should IDPH CONTINUE doing that is working well towards achieving equity and dismantling racism

Continue

• Education and Engagement

- *Continue to offer awareness classes and discussions*
- *Keep it on the table - keep pushing agenda*
- *Address it directly. Zero tolerance*

• Formalized plans to address equity

- *Having open conversation and making policy in an effort to achieve equity. Created a Health Equity Checklist*
- *Identifying where inequities exist and seeking to provide data to inform policies and programs.*
- *Tie health equity related questioning to pre-award process in grant awards*

• Staffing

- *Hire people of diverse background, race, gender and ethnicity*
- *Having a minority ambassador represent the department*

RACISM and EQUITY

What should IDPH START or STOP doing towards achieving equity and dismantling racism?

START

Provide training

- Provide courses that address cultural awareness.
- Require Mandatory training
- Provide training sessions on how to achieve equity and dismantle racism.

Provide opportunities for engagement

- Start having forums for honest and open discussions hosted by an external/neutral moderator.
- Office of Health Equity with staff and leadership solely dedicated to this Office. Having honest conversations (town halls) across all levels of the agency on racism, not just at the Senior Staff level.

Focus on individual responsibility and collective humanity

- Regardless of race, everyone walks in with their own baggage. A good way to dismantle racism at the work place is to promote camaraderie and present issues from a human perspective. An emphasis on basic good behavior from everyone is a good place to start. Some people are immersed in tech and are simply not cognizant of good behavior.
- Have discussion to celebrate all ethnicities. Start speaking up to co-workers who make insensitive and racial comments
- Hold everyone accountable for his/her actions

STOP

STOP PRETENDING RACISM DOESN'T EXIST

- Not openly addressing and planning for this topic.
- Being silent about the issues among staff members - true public health workers all belong to the same family
- Stop treating racism as a taboo subject

STOP FOCUSING SO MUCH ON RACISM

- We should stop focusing exclusively on racism as a means of achieving equity. Yes, race/racism is extremely important. IDPH should also address groups affected by bias in the work we do.
- Stop: Trying to bring racism into the work place when we don't see race we simply see coworkers
- By implying that white society is the cause of racism (and I'm not white) The implication happens by virtue of who is engaged in the conversation and an apparent lack of black leaders EVER talking about personal responsibility in that conversation. It's sad. People today just do not get it.

Data Review Summary

1. Chronic disease was identified as a main priority prior to the Covid-19 pandemic.
2. Behavioral health as identified in the surveys, is a priority now.
3. A related issue – Access to Care, was noted as urgent and important by survey respondents. Although health insurance coverage was higher for most group, disparities still remain, especially among Hispanic residents.
4. Social and structural determinants of health were consistently rated as urgent across all domains, however this is not consistently noted in IPLAN priorities.
5. The Covid-19 pandemic has shown disparities in rates of positivity and mortality, with Hispanic and Black residents showing the highest rates.
6. Survey respondents overall reported better than average perceptions of the public health systems response across characteristics.
7. Despite generally good ratings overall, communication, preparedness, community engagement and access to services were identified as most frequent gaps or areas for improvement in system's response.

Thank you!

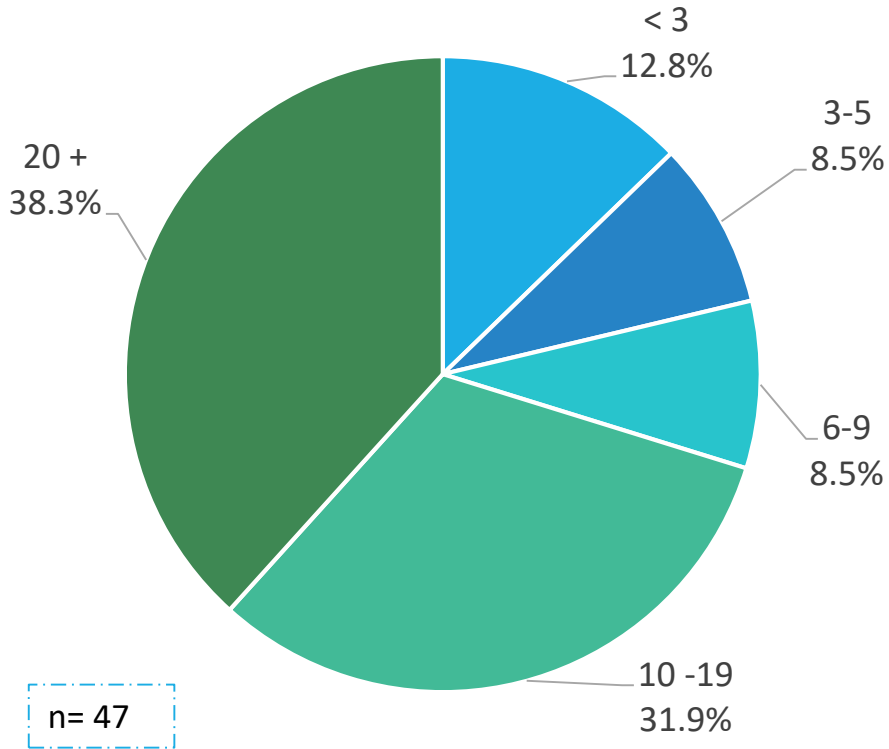
“Social advance depends as much upon the process through which it is secured as upon the result itself.”

— **Jane Addams**

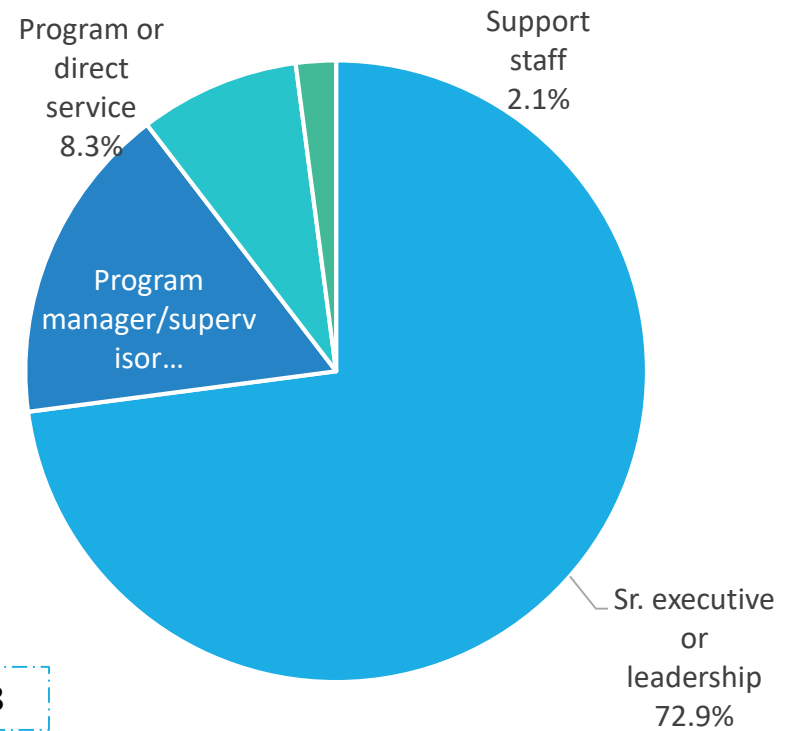
Respondent Information

LOCAL HEALTH DEPARTMENT SURVEY

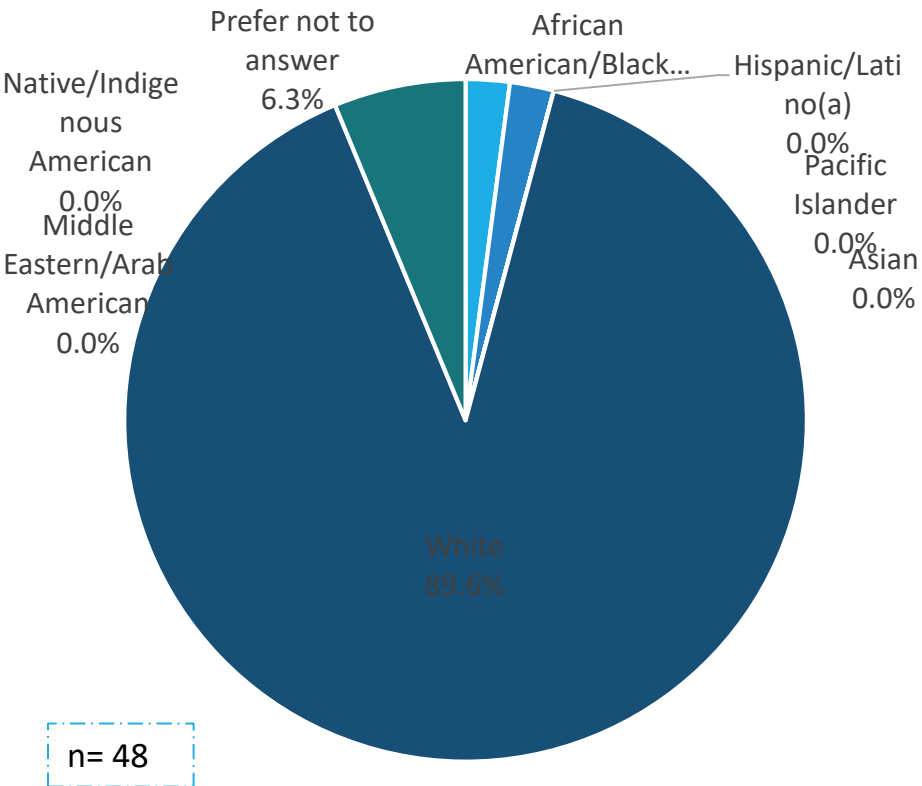
Number of Years Working in Public Health



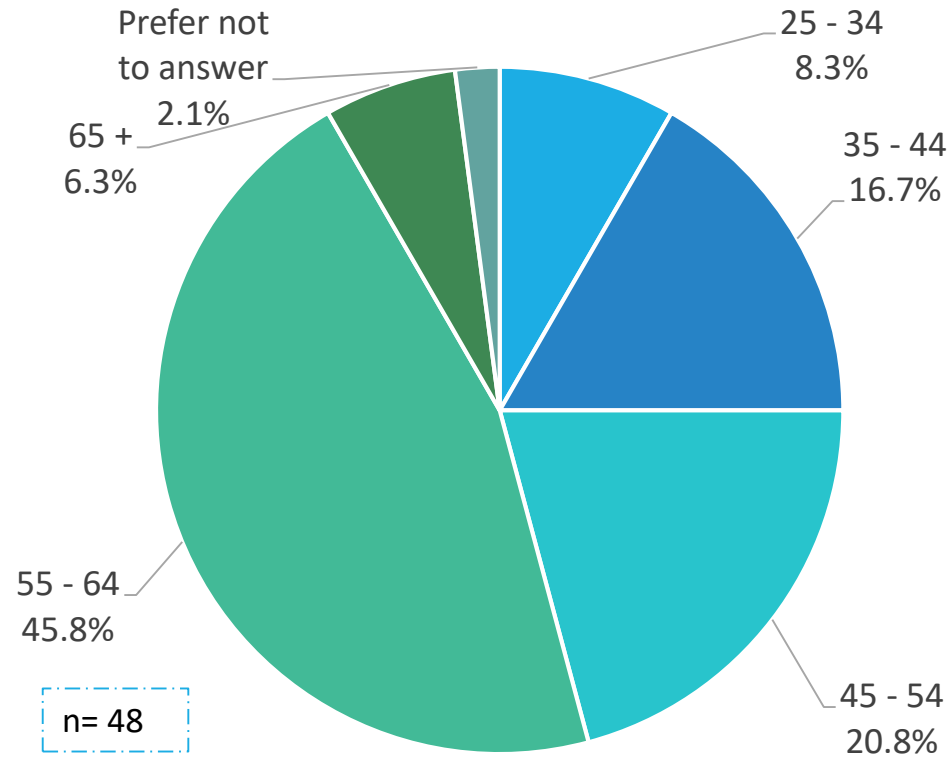
Respondent Role



Respondent Race/Ethnicity



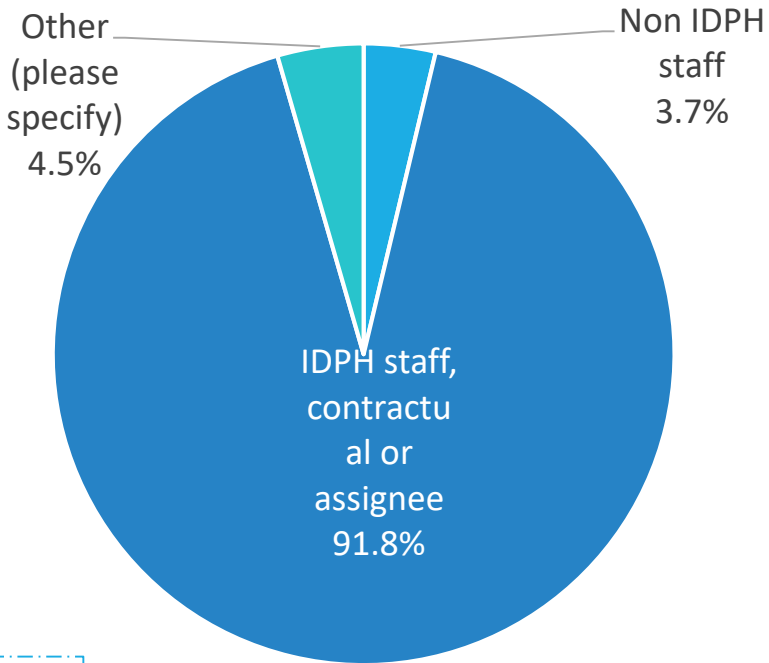
Respondent Age Range



Respondent Information

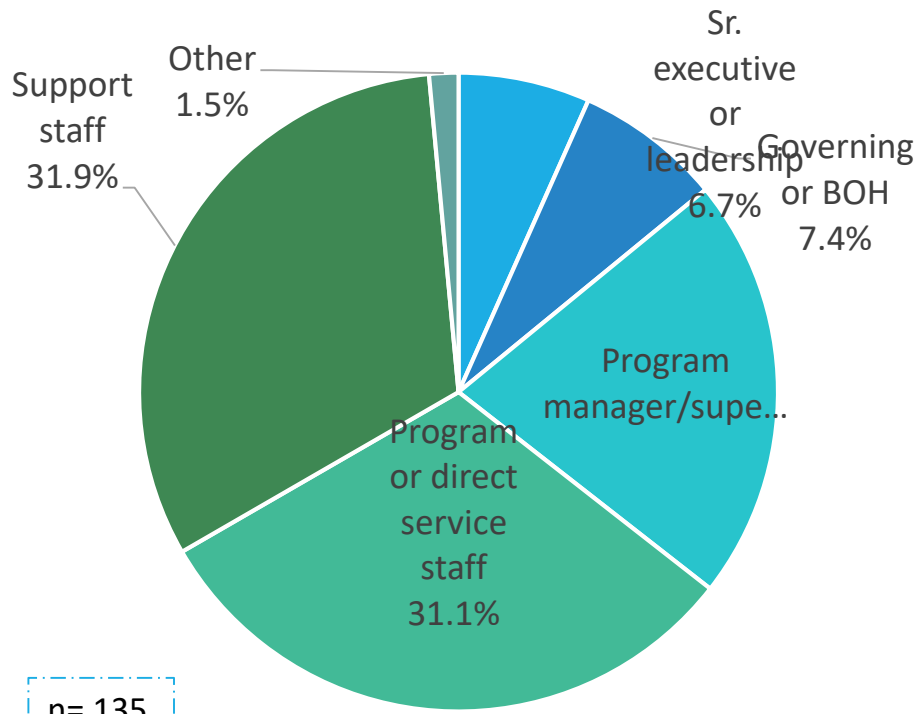
IDPH STAFF AND BOARD OF HEALTH SURVEY

Relationship to IDPH



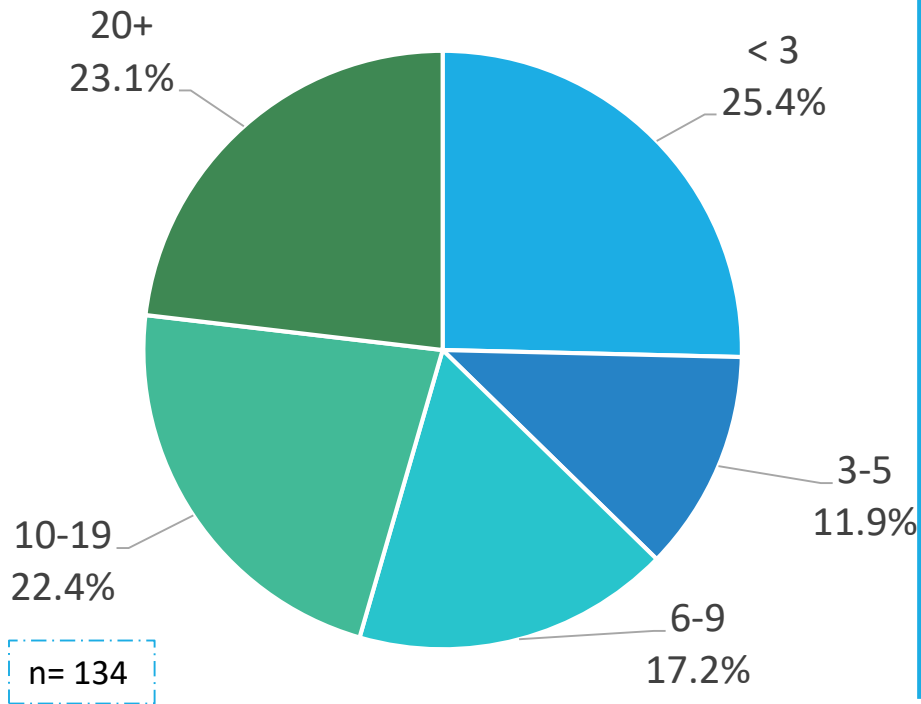
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Role with IDPH

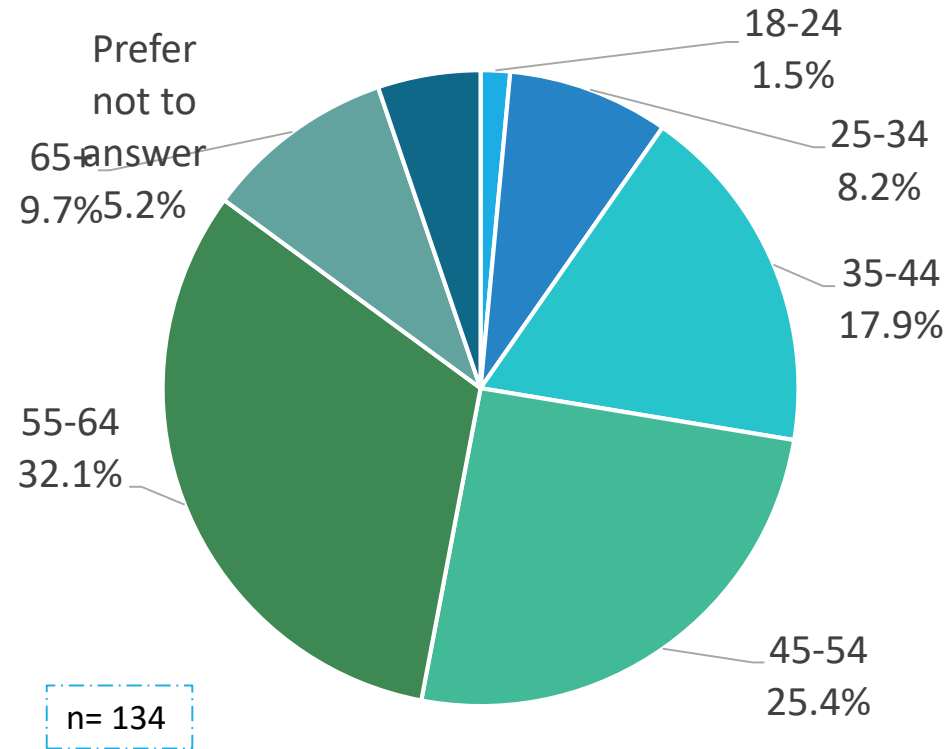


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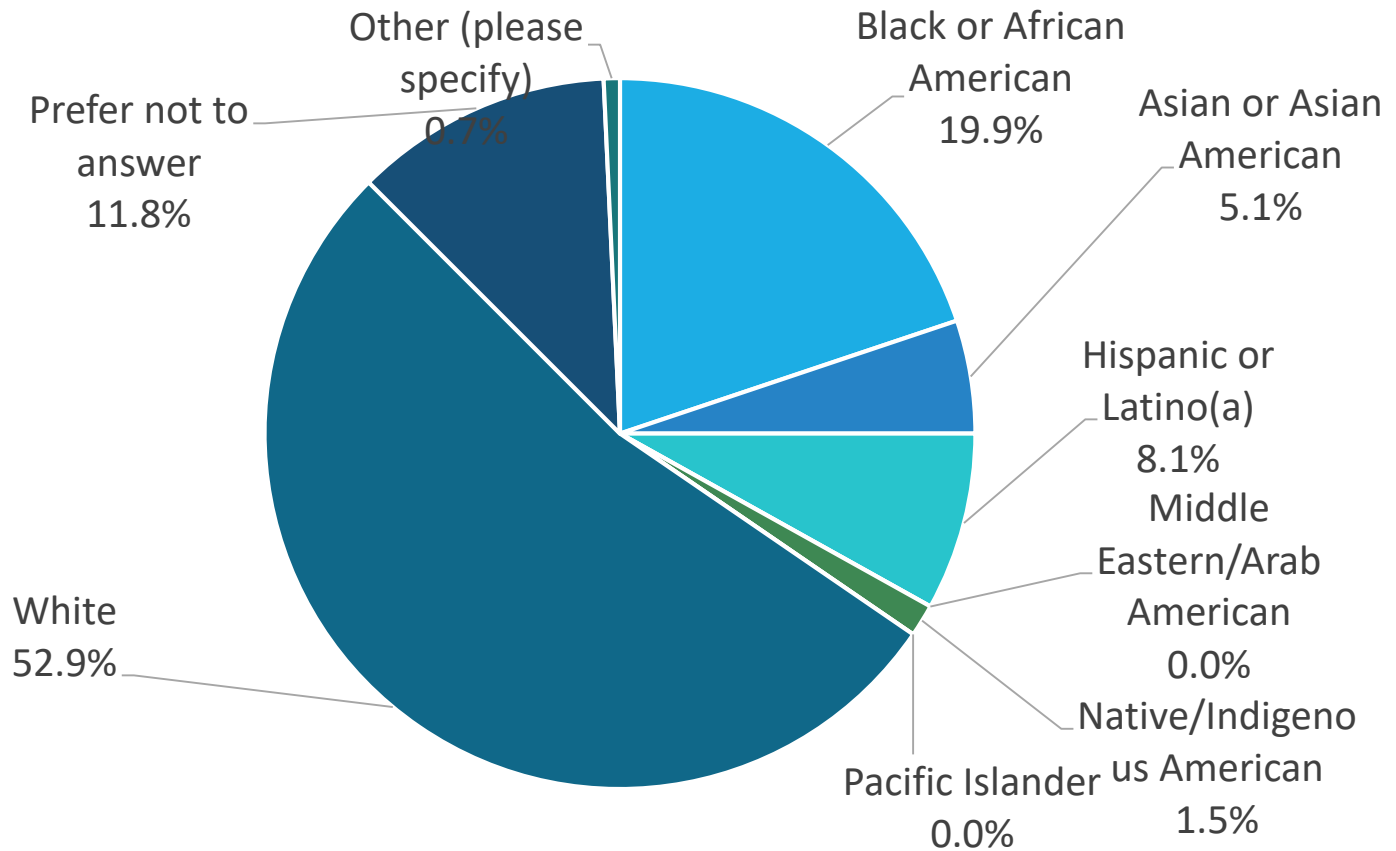
Number of Years Working in IDPH or State Gov't



Respondent Age Range



Respondent Race/Ethnicity



n= 130