2012 PRC Community Health Needs Assessment Report

Swedish Covenant Hospital Service Area

Sponsored by

Swedish Covenant Hospital Foundation

In cooperation with the
Metropolitan Chicago Healthcare Council (MCHC)

PRC Experience Excellence

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Table Of Contents

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INTRODUCTION

Project Overview

Project Goals

This Community Health Needs Assessment, a follow-up to a similar study conducted in 2009, is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the service area of Swedish Covenant Hospital. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. This Community Health Needs Assessment will serve as a tool toward reaching three basic goals:

- **To improve residents' health status, increase their life spans, and elevate their overall quality of life.** A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.
- **To reduce the health disparities among residents.** By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors which have historically had a negative impact on residents' health.
- **To increase accessibility to preventive services for all community residents.** More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

This assessment was conducted by Professional Research Consultants, Inc. (PRC). PRC is a nationally-recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments such as this in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (the PRC Community Health Survey) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for trending and comparison to benchmark data at the state and national levels. Qualitative data input includes primary research gathered through a series of Key Informant Focus Groups.

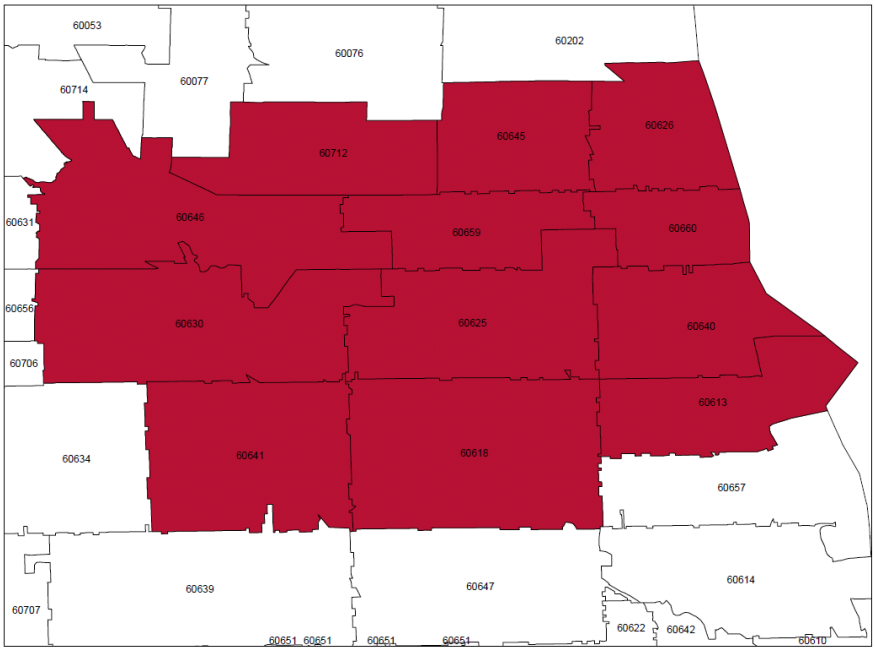
PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues.

Community Defined for This Assessment

The study area for the survey effort (referred to as the "Swedish Covenant Hospital Service Area or SCH Service Area" in this report) is defined as each of the residential ZIP Codes comprising the hospital's service area, including 60613, 60618, 60625, 60626, 60630, 60640, 60641, 60645, 60646, 60659, 60660 and 60712. A geographic description is illustrated in the following map.



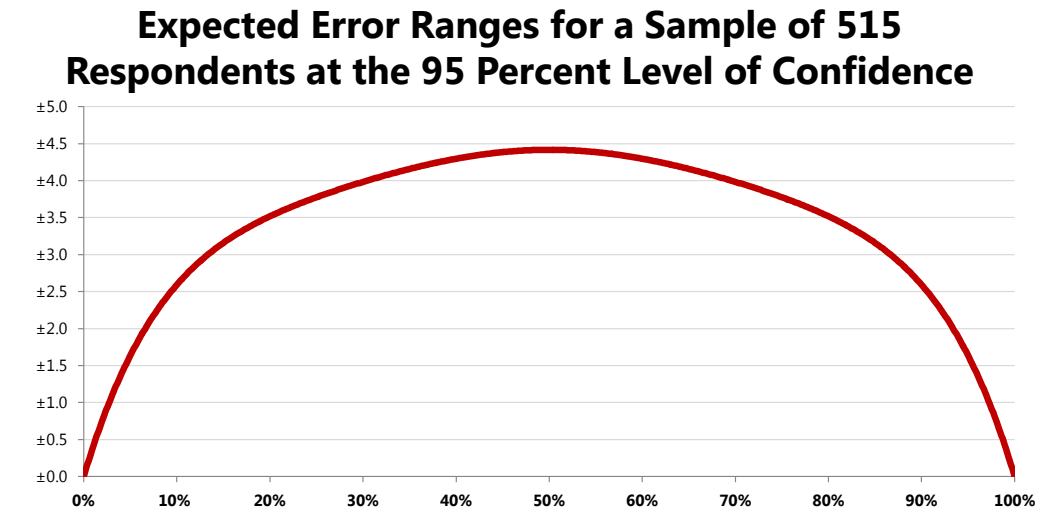
Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the *PRC Community Health Survey*. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews — was employed. The primary advantages of telephone interviewing are timeliness, efficiency and random-selection capabilities.

The sample design used for this effort consisted of a random sample of 515 individuals age 18 and older in the Swedish Covenant Hospital Service Area. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

Sampling Error

For statistical purposes, the maximum rate of error associated with a sample size of 515 respondents is ±4.4% at the 95 percent level of confidence.



Note:
- The "response rate" (the percentage of a population giving a particular response) determines the error rate associated with that response. A "95 percent level of confidence" indicates that responses would fall within the expected error range on 95 out of 100 trials.

Examples:
- If 10% of the sample of 515 respondents answered a certain question with a "yes," it can be asserted that between 7.4% and 12.6% (10% ± 2.6%) of the total population would offer this response.
- If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 45.6% and 54.4% (50% ± 4.4%) of the total population would respond "yes" if asked this question.

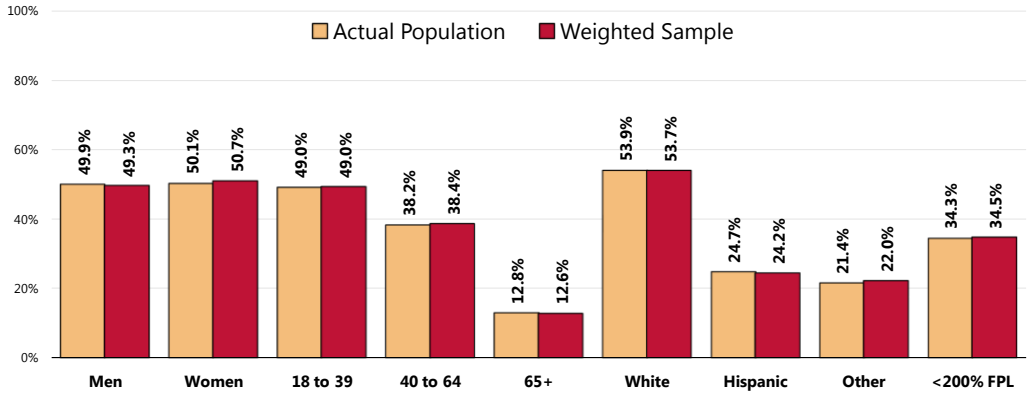
Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. And, while this random sampling of the population produces a highly representative sample, it is a common and preferred practice to "weight" the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias. Specifically, once the raw data are gathered, respondents are examined by key demographic characteristics (namely gender, age, race, ethnicity, and poverty status) and a statistical application package applies weighting variables that produce a sample which more closely matches the population for these characteristics. Thus, while the integrity of each individual's responses is maintained, one respondent's responses may contribute to the whole the same weight as, for example, 1.1 respondents. Another respondent, whose demographic characteristics may have been slightly oversampled, may contribute the same weight as 0.9 respondents.

The following chart outlines the characteristics of the Swedish Covenant Hospital Service Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child's healthcare needs, and these children are not represented demographically in this chart.]

Population & Sample Characteristics

(Swedish Covenant Hospital Service Area, 2012)



Sources:
- Census 2010, Summary File 3 (SF 3). U.S. Census Bureau.
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc.

Further note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household *(e.g., the 2012 guidelines place the poverty threshold for a family of four at $23,050 annual household income or lower)*. In sample segmentation: "**Below 200% FPL**" refers to community members living in a household with defined poverty status or living just above the federal poverty level, earning up to twice the poverty threshold; "**200%+ FPL**" refers to those households living on incomes which are twice or more the federal poverty level.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

Key Informant Focus Groups

As part of the community health needs assessment, seven focus groups were held among key informants in the community on June 21-22 and July 11-12, 2012, each focusing on needs within different geographies or among certain populations.

Focus Group Date	Geographic Focus	Participant Type
June 21, 2012	Cook County	Community Leaders
June 22, 2012	North Chicago	Community Leaders
July 11, 2012	SCH Service Area	Community Leaders
July 11, 2012	SCH Service Area	Key Informants Serving the Polish Population
July 11, 2012	SCH Service Area	Key Informants Serving the Hispanic Population
July 12, 2012	SCH Service Area	Key Informants Serving the Asian Indian Population
July 12, 2012	SCH Service Area	Representatives of Swedish Covenant Hospital

In all, 50 key informants participated, including representatives from public health; physicians, other health professionals, social service providers, minority organizations and other community leaders.

A list of recommended participants for the focus groups was provided by the sponsors. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall. Participants included a representative of public health, as well as several individuals who work with low-income, minority or other medically underserved populations, and those who work with persons with chronic disease conditions.

Focus group candidates were first contacted by letter to request their participation. Follow-up phone calls were then made to ascertain whether or not they would be able to attend. Confirmation calls were placed the day before the groups were scheduled to insure a reasonable turnout.

Audio from the focus group sessions was recorded, from which verbatim comments in this report are taken. There are no names connected with the comments, as participants were asked to speak candidly and assured of confidentiality.

NOTE: These findings represent qualitative rather than quantitative data. The group was designed to gather input from participants regarding their opinions and perceptions of the health of the residents in the area. Thus, these findings are based on perceptions, not facts.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for the Swedish Covenant Hospital Service Area were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Centers for Disease Control & Prevention
- Illinois Department of Public Health
- Illinois State Police
- National Center for Health Statistics
- US Census Bureau
- US Department of Health and Human Services
- US Department of Justice, Federal Bureau of Investigation

Note that secondary data reflect city-level data (City of Chicago) where possible, and county-level data (Cook County) where city data are unavailable.

Benchmark Data

Trending

Trending data, as revealed by comparison to prior (2009) survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

Regional MCHC Data

Because this survey was also conducted throughout the Metro Chicago area as part of a broader study facilitated by the Metropolitan Chicago Healthcare Council (MCHC), comparisons can also be made at the regional level. These regional data are referred to as the "MCHC Region" and include Cook, DuPage and Lake counties, Illinois.

Illinois Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data are reported in the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trend Data* published by the Centers for Disease Control and Prevention and the US Department of Health & Human Services. State-level vital statistics are also provided for comparison of secondary data indicators.

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2011 PRC National Health Survey*; the methodological approach for the national study is identical to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2020

Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. The Healthy People initiative is grounded in the principle that setting national objectives and monitoring progress can motivate action. For three decades, Healthy People has established benchmarks and monitored progress over time in order to:

- Encourage collaborations across sectors.
- Guide individuals toward making informed health decisions.
- Measure the impact of prevention activities.

Healthy People 2020 is the product of an extensive stakeholder feedback process that is unparalleled in government and health. It integrates input from public health and prevention experts, a wide range of federal, state and local government officials, a consortium of more than 2,000 organizations, and perhaps most importantly, the public. More than 8,000 comments were considered in drafting a comprehensive set of Healthy People 2020 objectives.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not

represented in the survey data. Other population groups — for example, pregnant women, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly a great number of medical conditions that are not specifically addressed.

Summary of Findings

Areas of Opportunity for Community Health Improvement

The following "health priorities" represent recommended areas of intervention, based on the information gathered through this Community Health Needs Assessment and the guidelines set forth in *Healthy People 2020*. From these data, opportunities for health improvement exist in the region with regard to the following health areas (see also the summary tables presented in the following section). These areas of concern are subject to the discretion of area providers, the steering committee, or other local organizations and community leaders as to actionability and priority.

Areas of Opportunity Identified Through This Assessment	
Access to Health Services	• Lack of Healthcare Coverage (Age 18-64) • Inconvenient Office Hours • Cultural Competence *(focus group concern)* • Medicaid reimbursement *(focus group concern)*
Cancer	• Cancer Deaths (Including Lung, Prostate, Breast and Colorectal) • Preventive Cancer Screenings (Breast, Colorectal)
Chronic Kidney Disease	• Kidney Disease Deaths
Family Planning	• Births to Unwed Mothers • Births to Teens
Heart Disease & Stroke	• Heart Disease Deaths • Stroke Deaths • Hypertension Screening & Prevalence
HIV	• HIV/AIDS Deaths
Infectious Diseases	• Tuberculosis Incidence
Injury & Violence Prevention	• Firearm-Related Deaths • Homicides • Violent Crime Rate & Victimization • Domestic Violence • Child Abuse
Maternal, Infant & Child Health	• Lack of Prenatal Care • Low Birthweight • Infant Mortality
Mental Health & Mental Disorders	• Stress & Depression *(focus group concern)* • Lack of Providers/Facilities *(focus group concern)* • Insurance Barriers *(focus group concern)* • Cultural Barriers *(focus group concern)* • Coordination With Primary Care *(focus group concern)*
Nutrition, Physical Activity & Weight	• Unhealthy Weight • Fruit/Vegetable Consumption • Basic Nutritional Needs *(focus group concern)* • Unhealthy Diets - Cost, Convenience, Culture *(focus group concern)* • Children's Screen Time
Respiratory Diseases	• Pneumonia/Influenza Deaths
Sexually Transmitted Diseases	• STD Incidence (Gonorrhea, Syphilis, Chlamydia)
Substance Abuse	• Cirrhosis/Liver Disease Deaths • Use of Alcohol (Current and Binge Drinking) • Illicit Drug Use

Top Community Health Concerns Among Community Key Informants

At the conclusion of each key informant focus group, participants were asked to write down what they individually perceive as the top five health priorities for the community, based on the group discussion as well as on their own experiences and perceptions. Their responses were collected, categorized and tallied to produce the top-ranked priorities as identified among key informants. These should be used to complement and corroborate findings that emerge from the quantitative dataset.

1. Access to Healthcare Services

Mentioned resources available to address this issue: Schools; Faith-Based Organizations; Community Health Centers; Hospitals; UIC School of Public Health; Federally Qualified Health Centers; Heartland International; Erie Family Health Clinic; Stroger Hospital; Swedish Covenant Hospital; Department of Family and Supportive Services (IL); Albany Park Community Center; Korean American Community Services; St. Joseph's Hospital; Weiss Memorial Hospital; Jesus House; Urgent Care Clinics

2. Mental Health

Mentioned resources available to address this issue: Private Providers; County Providers; Federally Qualified Health Centers; School-Based Health Centers; Health Departments; Chicago Public Schools; City Colleges; Chicago Park District; Advocate Illinois Masonic Behavioral Health; Thresholds; Alternatives; C4; Hay Market; Trilogy; Project Impact; Counselors; Chicago Lakeshore Hospital; Weiss Memorial Hospital; North River Community Center; Korean American Community Services; Heartland Alliance; Advocate Illinois Masonic Medical Center; Polish American Association

3. Health Education & Prevention

Mentioned resources available to address this issue: City of Chicago, Faith-Based Organizations; Physicians; Community-Based Organizations; UIC School of Public Health; Schools; Health Department; Hispanic Health Care Coalition; Community Health; Irving Park Clinic; Compassionate Care; ARK; Heartland International; Erie Family Health Clinic; WIC; Swedish Covenant Hospital; Northeastern Illinois University; North River Commission; YMCA

4. Obesity, Including Nutrition

Mentioned resources available to address this issue: Hospitals; Schools; Non-Profit Agencies; Chicago Park District; Chicago Public Schools; Business Leaders; CTA; Health Clubs; Urban Vegetable Gardens; Health Educators; Federally Qualified Health Centers; Stroger Hospital; Department of Transportation; Health Departments; Inspiration Corporation; Albany Park Community Center; Korean American Community Services; Peterson Garden Project; North Park Friendship Center

Summary Tables: Comparisons With Benchmark Data

TREND SUMMARY
(Current vs. Baseline Data)

Survey Data Indicators: Trends for survey-derived indicators represent significant changes since 2009. *Note that survey data reflect the ZIP Code-defined Swedish Covenant Hospital Service Area.*

Other (Secondary) Data Indicators: Trends for other indicators (e.g., public health data) represent point-to-point changes between the most current reporting period and the earliest presented in this report (typically representing the span of roughly a decade). *Note that secondary data reflect city-level data (City of Chicago) where available, and county-level data (Cook County) where city data are unavailable.*

The following tables provide an overview of indicators in the Swedish Covenant Hospital Service Area, including comparisons with trend data. These data are grouped to correspond with the Focus Areas presented in Healthy People 2020.

Reading the Summary Tables

■ In the following charts, Swedish Covenant Hospital Service Area results are shown in the larger, blue column.

■ The columns to the right of the Swedish Covenant Hospital Service Area column provide trending, as well as comparisons between the Swedish Covenant Hospital Service Area and any available regional, state and national findings, and Healthy People 2020 targets. Symbols indicate whether the Swedish Covenant Hospital Service Area compares favorably (), unfavorably (), or comparably () to these external data.

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

Access to Health Services	SCH Service Area	SCH Service Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% [Age 18-64] Lack Health Insurance	21.7	16.6	15.3	14.9	0.0	27.8
% [65+] With Medicare Supplement Insurance	72.5	69.7		75.5		69.3
% [Insured] Insurance Covers Prescriptions	94.3	93.4		93.9		91.3
% [Insured] Went Without Coverage in Past Year	7.1	6.6		4.8		15.0
% Difficulty Accessing Healthcare in Past Year (Composite)	41.8	38.9		37.3		52.8
% Inconvenient Hrs Prevented Dr Visit in Past Year	19.7	17.1		14.3		20.5
% Cost Prevented Getting Prescription in Past Year	14.7	15.5		15.0		33.3
% Cost Prevented Physician Visit in Past Year	16.0	15.7		14.0		30.1
% Difficulty Getting Appointment in Past Year	14.9	14.4		16.5		16.4
% Difficulty Finding Physician in Past Year	9.4	9.4		10.7		17.7
% Transportation Hindered Dr Visit in Past Year	9.1	8.1		7.7		13.6
% Skipped Prescription Doses to Save Costs	12.3	14.9		14.8		16.5
% Difficulty Getting Child's Healthcare in Past Year	3.7	3.3		1.9		11.5
% [Age 18+] Have a Specific Source of Ongoing Care	72.7	75.7		76.3	95.0	66.0
% [Age 18-64] Have a Specific Source of Ongoing Care	71.6	75.2		75.1	89.4	
% [Age 65+] Have a Specific Source of Ongoing Care	79.9	79.0		82.6	100.0	
% Have Had Routine Checkup in Past Year	70.5	71.6		67.3		62.9

Access to Health Services (continued)	SCH Service Area	SCH Service Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% Child Has Had Checkup in Past Year	92.8	90.9		87.0		95.7
% Two or More ER Visits in Past Year	7.8	7.9		6.5		4.9
% Rate Local Healthcare "Fair/Poor"	16.1	15.5		15.3		13.8
			better	similar	worse	

Arthritis, Osteoporosis & Chronic Back Conditions	SCH Service Area	SCH Service Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% [50+] Arthritis/Rheumatism	32.7	37.3		35.4		31.5
% [50+] Osteoporosis	12.7	10.3		11.4	5.3	15.9
% Sciatica/Chronic Back Pain	14.0	16.0		21.5		17.1
% Migraine/Severe Headaches	12.4	13.2		16.9		17.4
% Chronic Neck Pain	6.6	8.5		8.3		4.5
			better	similar	worse	

Cancer	SCH Service Area	SCH Service Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
Cancer (Age-Adjusted Death Rate)	194.2	179.3	183.9	178.1	160.6	212.4
Lung Cancer (Age-Adjusted Death Rate)	51.6	46.9	52.1	50.5	45.5	
Prostate Cancer (Age-Adjusted Death Rate)	34.6	26.6	24.3	23.1	21.2	

Cancer (continued)	SCH Service Area	SCH Service Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
Female Breast Cancer (Age-Adjusted Death Rate)	26.9	24.8	23.7	23.0	20.6	
Colorectal Cancer (Age-Adjusted Death Rate)	21.8	18.0	18.1	16.8	14.5	
% Skin Cancer	2.4	2.9		8.1		1.5
% Cancer (Other Than Skin)	5.7	4.6		5.5		2.5
% [Men 50+] Prostate Exam in Past 2 Years	70.0	72.2		70.5		69.6
% [Women 50-74] Mammogram in Past 2 Years	64.7	77.6	73.0	79.9	81.1	72.7
% [Women 21-65] Pap Smear in Past 3 Years	85.3	85.9	83.2	84.7	93.0	77.2
% [Age 50+] Sigmoid/Colonoscopy Ever	63.6	68.3	61.9	72.0		53.4
% [Age 50+] Blood Stool Test in Past 2 Years	28.9	28.0	12.4	28.3		21.5
% [Age 50-75] Colorectal Cancer Screening	66.7	67.3			70.5	
			better	similar	worse	

Chronic Kidney Disease	SCH Service Area	SCH Service Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
Kidney Disease (Age-Adjusted Death Rate)	23.0	20.0	19.5	14.6		23.0
% Kidney Disease	1.9	2.0				
			better	similar	worse	

Diabetes	SCH Service Area	SCH Service Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
Diabetes Mellitus (Age-Adjusted Death Rate)	22.7	20.9	21.3	22.5	19.6	26.5
% Diabetes/High Blood Sugar	9.6	10.7	8.7	10.1		6.1
			better	similar	worse	

Dementias, Including Alzheimer's Disease	SCH Service Area	SCH Service Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
Alzheimer's Disease (Age-Adjusted Death Rate)	15.2	17.8	21.2	23.2		13.0
			better	similar	worse	

Educational & Community-Based Programs	SCH Service Area	SCH Service Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% Attended Health Event in Past Year	21.1	20.2		22.2		16.3
			better	similar	worse	

Family Planning	SCH Service Area	SCH Service Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% of Births to Unwed Mothers	52.6	41.6	38.0	40.4		51.5
% Births to Teenagers	12.8	9.7	9.9	10.3		15.3
			better	similar	worse	

General Health Status	SCH Service Area	SCH Service Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% "Fair/Poor" Physical Health	14.2	15.4	15.5	16.8		12.1
% Activity Limitations	16.2	19.0	17.8	17.0		12.5
			better	similar	worse	

Hearing & Other Sensory or Communication Disorders	SCH Service Area	SCH Service Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% Deafness/Trouble Hearing	4.6	5.8		9.6		5.0
			better	similar	worse	

Heart Disease & Stroke	SCH Service Area	SCH Service Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
Diseases of the Heart (Age-Adjusted Death Rate)	199.3	188.3	189.3	192.5	152.7	269.8
Stroke (Age-Adjusted Death Rate)	44.8	39.7	41.8	42.2	33.8	56.7
% Heart Disease (Heart Attack, Angina, Coronary Disease)	3.4	5.1		6.1		3.2
% Stroke	2.8	3.2	2.7	2.7		1.9
% Blood Pressure Checked in Past 2 Years	91.9	94.8		94.7	94.9	93.6
% Told Have High Blood Pressure (Ever)	27.6	33.0	28.9	34.3	26.9	17.4
% [HBP] Taking Action to Control High Blood Pressure	86.8	92.9		89.1		
% Cholesterol Checked in Past 5 Years	91.9	91.4	75.7	90.7	82.1	90.0
% Told Have High Cholesterol (Ever)	27.6	29.6	37.5	31.4	13.5	26.5

Heart Disease & Stroke (continued)	SCH Service Area	SCH Service Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% [HBC] Taking Action to Control High Blood Cholesterol	84.2	88.6		89.1		
% 1+ Cardiovascular Risk Factor	80.9	81.0		86.3		81.9
			better	similar	worse	

HIV	SCH Service Area	SCH Service Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
HIV/AIDS (Age-Adjusted Death Rate)	8.2	3.8	2.2	3.9	3.3	12.0
% [Age 18-44] HIV Test in the Past Year	21.2	26.6		19.9	16.9	23.5
			better	similar	worse	

Immunization & Infectious Diseases	SCH Service Area	SCH Service Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% [Age 65+] Flu Shot in Past Year	69.6	65.0	65.5	71.6	90.0	68.7
% [High-Risk 18-64] Flu Shot in Past Year	60.7	51.4		52.5	90.0	46.3
% [Age 65+] Pneumonia Vaccine Ever	68.2	57.1	61.9	68.1	90.0	71.9
% [High-Risk 18-64] Pneumonia Vaccine Ever	37.2	35.3		32.0	60.0	26.1
Tuberculosis Incidence per 100,000	6.9	4.9	3.3	4.1	1.0	12.7
% Ever Vaccinated for Hepatitis B	40.4	37.5		38.4		48.0
			better	similar	worse	

Injury & Violence Prevention	SCH Service Area	SCH Service Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
Unintentional Injury (Age-Adjusted Death Rate)	**33.9**	25.8	31.9	39.5	36.0	38.3
Motor Vehicle Crashes (Age-Adjusted Death Rate)	**7.8**	6.4	9.3	14.1	12.4	12.7
% "Always" Wear Seat Belt	**89.9**	88.7		85.3	92.4	86.6
% Child [Age 0-17] "Always" Uses Seat Belt/Car Seat	**95.5**	94.4		91.6		94.5
% Child [Age 5-17] "Always" Wears Bicycle Helmet	**49.2**	32.8		35.3		21.2
Firearm-Related Deaths (Age-Adjusted Death Rate)	**10.9**	9.2	8.1	10.2	9.2	13.5
% Firearm in Home	**7.5**	12.4		37.9		5.2
% [Homes With Children] Firearm in Home	**9.2**	11.9		34.4		5.9
Homicide (Age-Adjusted Death Rate)	**15.1**	9.1	6.7	6.1	5.5	19.7
Violent Crime per 100,000	**785.3**	634.1	519.5	431.4		1009.3
% Victim of Violent Crime in Past 5 Years	**5.2**	5.9		1.6		6.0
% Perceive Neighborhood to be "Not At All Safe" from Crime	**2.3**	6.1				
Domestic Violence Offenses per 100,000	**1297.9**	1068.0	1224.3			1462.5
% Ever Threatened With Violence by Intimate Partner	**11.4**	10.6		11.7		12.1
% Victim of Domestic Violence (Ever)	**13.1**	12.1		13.5		13.6
Child Abuse Offenses per 1,000 Children	**21.9**	21.3	30.0	10.1		23.7
			better	similar	worse	

Maternal, Infant & Child Health	SCH Service Area	SCH Service Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% No Prenatal Care in First Trimester	23.6	20.1	19.1		22.1	24.9
% of Low Birthweight Births	9.7	8.8	8.4	8.2	7.8	9.9
Infant Death Rate	7.4	6.8	6.7	6.7	6.0	9.0
			better	similar	worse	

Mental Health & Mental Disorders	SCH Service Area	SCH Service Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% "Fair/Poor" Mental Health	10.2	12.5		11.7		9.6
% Major Depression	10.7	8.6		11.7		6.6
% Symptoms of Chronic Depression (2+ Years)	29.7	26.6		26.5		27.1
Suicide (Age-Adjusted Death Rate)	6.5	7.7	8.9	11.3	10.2	7.3
% 3+ Days Without Enough Sleep in the Past Month	62.1	61.6				
% Have Ever Sought Help for Mental Health	26.4	23.7		24.4		28.5
% [Those With Major Depression] Seeking Help	87.1	82.4		82.0	75.1	
% Typical Day Is "Extremely/Very" Stressful	10.6	11.7		11.5		15.8
% Child [Age 5-17] Takes Prescription for ADD/ADHD	2.1	4.6		6.5		1.8
			better	similar	worse	

Nutrition & Weight Status	SCH Service Area	SCH Service Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% Eat 5+ Servings of Fruit or Vegetables per Day	42.1	44.4		48.8		40.4
% "Very/Somewhat Difficult" to Buy Fresh Produce Affordably	17.3	18.4				
% Medical Advice on Nutrition in Past Year	46.0	44.4		41.9		37.9
% Healthy Weight (BMI 18.5-24.9)	31.4	34.1		31.7	33.9	41.0
% Overweight	66.4	64.3	63.2	66.9		58.8
% Obese	29.7	29.0	28.7	28.5	30.6	25.2
% Medical Advice on Weight in Past Year	30.4	28.4		25.7		27.5
% [Overweights] Counseled About Weight in Past Year	39.4	38.4		30.9		35.2
% [Obese Adults] Counseled About Weight in Past Year	60.5	52.6		47.4	31.8	
% [Overweights] Trying to Lose Weight Both Diet/Exercise	45.8	47.2		38.6		49.5
% Children [Age 5-17] Overweight	23.2	32.5		30.7		32.3
% Children [Age 5-17] Obese	12.5	18.2		18.9	14.6	8.7
			better	similar	worse	

Oral Health	SCH Service Area	SCH Service Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% [Age 18+] Dental Visit in Past Year	66.0	68.8	69.7	66.9	49.0	61.0
% Child [Age 2-17] Dental Visit in Past Year	87.6	84.5		79.2	49.0	76.3
% Have Dental Insurance	59.4	65.2		60.8		50.6
			better	similar	worse	

Physical Activity	SCH Service Area	SCH Service Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% [Employed] Job Entails Mostly Sitting/Standing	70.7	66.4		63.2		73.2
% No Leisure-Time Physical Activity	21.4	17.8	25.7	28.7	32.6	21.9
% Meeting Physical Activity Guidelines	49.7	50.3	51.8	42.7		40.6
% Moderate Physical Activity	29.2	27.8		23.9		22.0
% Vigorous Physical Activity	39.2	39.0	31.8	34.8		32.6
% "Very/Somewhat Difficult" to Access a Place for Exercise	17.7	16.8				
% Medical Advice on Physical Activity in Past Year	52.0	49.9		47.8		47.4
% Child [Age 5-17] Watches TV 3+ Hours per Day	18.5	17.7		19.7		
% Child [Age 5-17] Uses Computer 3+ Hours per Day	18.7	17.5		9.9		
% Child [Age 5-17] 3+ Hours per Day of Total Screen Time	47.5	48.2		43.4		
			better	similar	worse	

Respiratory Diseases	SCH Service Area	SCH Service Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
CLRD (Age-Adjusted Death Rate)	29.4	31.5	39.9	41.8		33.0
Pneumonia/Influenza (Age-Adjusted Death Rate)	23.1	19.0	18.6	17.0		25.3
% Nasal/Hay Fever Allergies	24.7	25.3		27.3		18.8
% Sinusitis	11.5	12.5		19.4		13.1
% Chronic Lung Disease	6.9	7.4		8.4		2.4
% [Adult] Currently Has Asthma	8.9	8.2	9.2	7.5		4.5
% [Child 0-17] Currently Has Asthma	5.4	7.5		6.8		3.8
			better	similar	worse	

Sexually Transmitted Diseases	SCH Service Area	SCH Service Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
Gonorrhea Incidence per 100,000	306.2	160.1	127.3	103.2		427.9
Primary & Secondary Syphilis Incidence per 100,000	29.2	14.1	8.5	4.5		10.6
Chlamydia Incidence per 100,000	884.8	525.2	449.6	409.8		809.4
% [Unmarried 18-64] 3+ Sexual Partners in Past Year	14.5	10.6		7.1		5.6
% [Unmarried 18-64] Using Condoms	50.0	45.7		18.9		48.0
			better	similar	worse	

Sickle-Cell Anemia	SCH Service Area	SCH Service Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% Sickle-Cell Anemia	0.8	0.6				
			better	similar	worse	

Substance Abuse	SCH Service Area	SCH Service Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)	11.0	8.2	8.2	9.0	8.2	12.0
% Liver Disease	1.4	1.6				
% Current Drinker	66.0	61.3	59.1	58.8		61.3
% Chronic Drinker (Average 2+ Drinks/Day)	4.7	4.4	5.7	5.6		2.0
% Binge Drinker (Single Occasion - 5+ Drinks Men, 4+ Women)	25.6	19.8	17.8	16.7	24.3	19.1
% Drinking & Driving in Past Month	1.1	2.1		3.5		2.5
% Driving Drunk or Riding with Drunk Driver	5.2	5.8		5.5		5.2
Drug-Induced Deaths (Age-Adjusted Death Rate)	10.3	10.2	10.5	12.6	11.3	10.1
% Illicit Drug Use in Past Month	4.7	3.7		1.7	7.1	5.3
% Ever Sought Help for Alcohol or Drug Problem	3.0	3.6		3.9		2.5
			better	similar	worse	

Tobacco Use	SCH Service Area	SCH Service Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% Current Smoker	14.6	15.0	16.9	16.6	12.0	14.1
% Someone Smokes at Home	14.0	15.9		13.6		12.2
% [Non-Smokers] Someone Smokes in the Home	5.9	9.0		5.7		
% [Household With Children] Someone Smokes in the Home	8.2	13.8		12.1		8.8
% [Smokers] Received Advice to Quit Smoking	71.1	71.1		63.7		
% [Smokers] Have Quit Smoking 1+ Days in Past Year	56.2	57.5		56.2	80.0	
% Smoke Cigars	4.3	4.5		4.2	0.2	4.9
% Use Smokeless Tobacco	2.7	1.8		2.8	0.3	2.7
			better	similar	worse	

Vision	SCH Service Area	SCH Service Area vs. Benchmarks				
		vs. MCHC Region	vs. IL	vs. US	vs. HP2020	TREND
% Blindness/Trouble Seeing	8.2	7.6		6.9		8.4
% Eye Exam in Past 2 Years	58.7	58.8		57.5		65.0
			better	similar	worse	

GENERAL HEALTH STATUS

Overall Health Status

Self-Reported Health Status

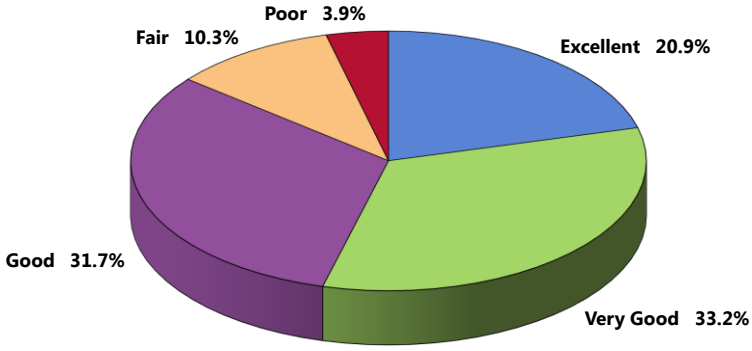
The initial inquiry of the PRC Community Health Survey asked respondents the following:

"Would you say that in general your health is: excellent, very good, good, fair or poor?"

A total of 54.1% of Swedish Covenant Hospital Service Area adults rate their overall health as "excellent" or "very good."

- Another 31.7% gave "good" ratings of their overall health.

Self-Reported Health Status
(Swedish Covenant Hospital Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: • Asked of all respondents.

However, 14.2% of service area adults believe that their overall health is "fair" or "poor."

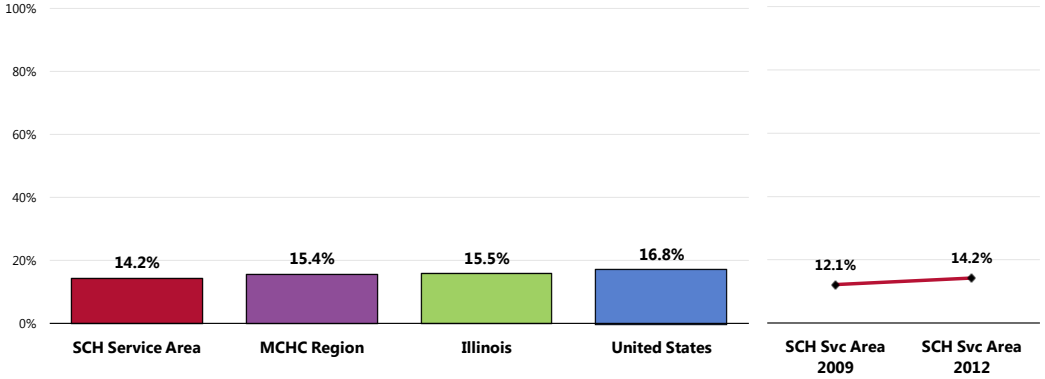
NOTE:

- Differences noted in the text represent significant differences determined through statistical testing.

- Comparable to findings in the MCHC Region.
- Comparable to statewide findings.
- Comparable to the national percentage.
- No statistically significant change has occurred when comparing "fair/poor" overall health reports to previous survey results.

Trends are measured against baseline data – i.e., the earliest year that data are available or that is presented in this report.

Experience "Fair" or "Poor" Overall Health



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 5]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

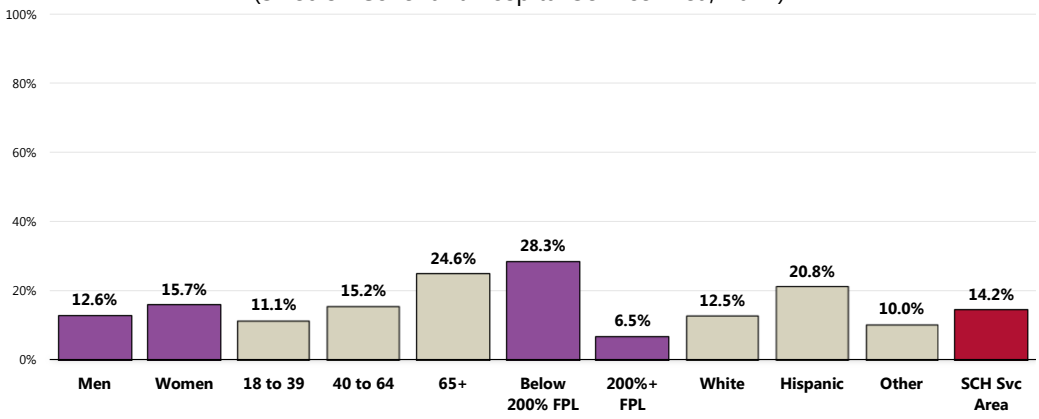
Adults more likely to report experiencing "fair" or "poor" overall health include:

- Respondents age 65 or older (note the positive correlation with age).
- Residents living at lower incomes.
- Other differences within demographic groups, as illustrated in the following chart, are not statistically significant.

Charts throughout this report (such as that here) detail survey findings among key demographic groups – namely by gender, age groupings, income (based on poverty status), and race/ethnicity.

Experience "Fair" or "Poor" Overall Health

(Swedish Covenant Hospital Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Activity Limitations

An individual can get a disabling impairment or chronic condition at any point in life. Compared with people without disabilities, people with disabilities are more likely to:

- Experience difficulties or delays in getting the health care they need.
- Not have had an annual dental visit.
- Not have had a mammogram in past 2 years.
- Not have had a Pap test within the past 3 years.
- Not engage in fitness activities.
- Use tobacco.
- Be overweight or obese.
- Have high blood pressure.
- Experience symptoms of psychological distress.
- Receive less social-emotional support.
- Have lower employment rates.

There are many social and physical factors that influence the health of people with disabilities. The following three areas for public health action have been identified, using the International Classification of Functioning, Disability, and Health (ICF) and the three World Health Organization (WHO) principles of action for addressing health determinants.

- **Improve the conditions of daily life** by: encouraging communities to be accessible so all can live in, move through, and interact with their environment; encouraging community living; and removing barriers in the environment using both physical universal design concepts and operational policy shifts.
- **Address the inequitable distribution of resources among people with disabilities and those without disabilities** by increasing: appropriate health care for people with disabilities; education and work opportunities; social participation; and access to needed technologies and assistive supports.
- **Expand the knowledge base and raise awareness about determinants of health for people with disabilities** by increasing: the inclusion of people with disabilities in public health data collection efforts across the lifespan; the inclusion of people with disabilities in health promotion activities; and the expansion of disability and health training opportunities for public health and health care professionals.

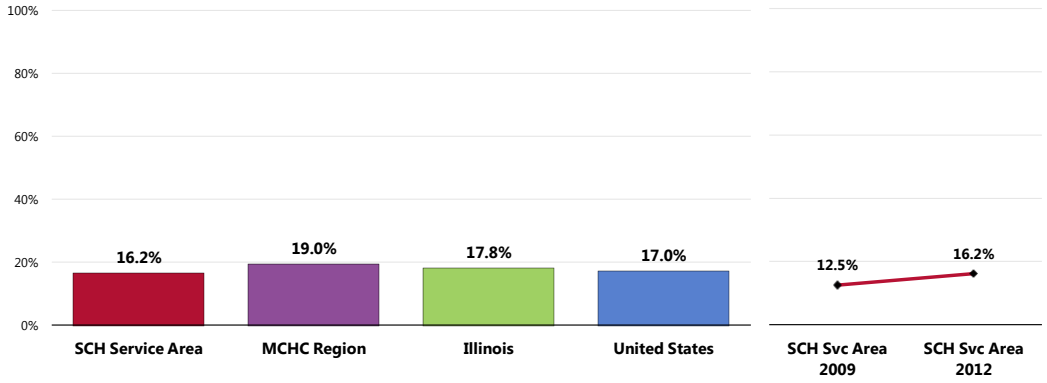
– Healthy People 2020 (www.healthypeople.gov)

A total of 16.2% of Swedish Covenant Hospital Service Area adults are limited in some way in some activities due to a physical, mental or emotional problem.

- Similar to the regional findings
- Similar to the prevalence statewide.
- Similar to the national prevalence.
- Similar to the prevalence of activity limitations in 2009.

RELATED ISSUE:
See also *Potentially Disabling Conditions* in the **Death, Disease & Chronic Conditions** section of this report.

Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 125]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

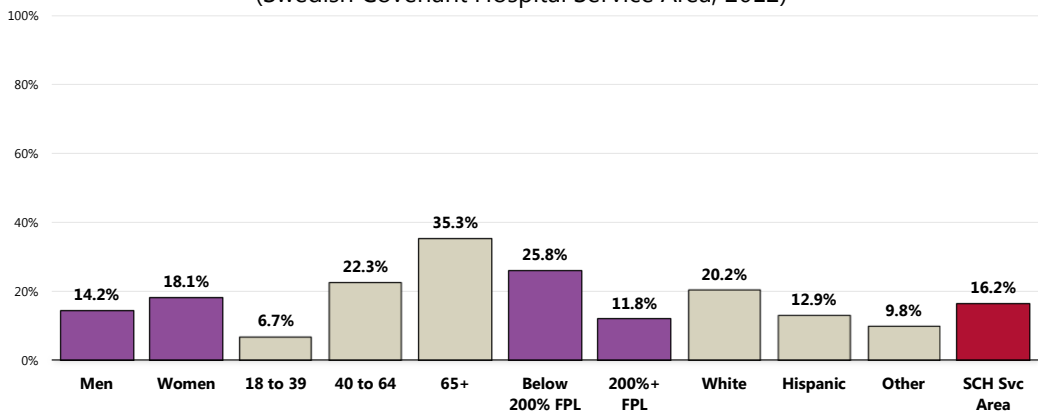
Notes:
- Asked of all respondents.

In looking at responses by key demographic characteristics, note the following:

- Adults age 40 and older are much more often limited in activities (note the positive correlation with age).
- Respondents living in the lower income category are more often limited in activities.
- Whites are more likely than others to report activity limitations.

Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem

(Swedish Covenant Hospital Service Area, 2012)



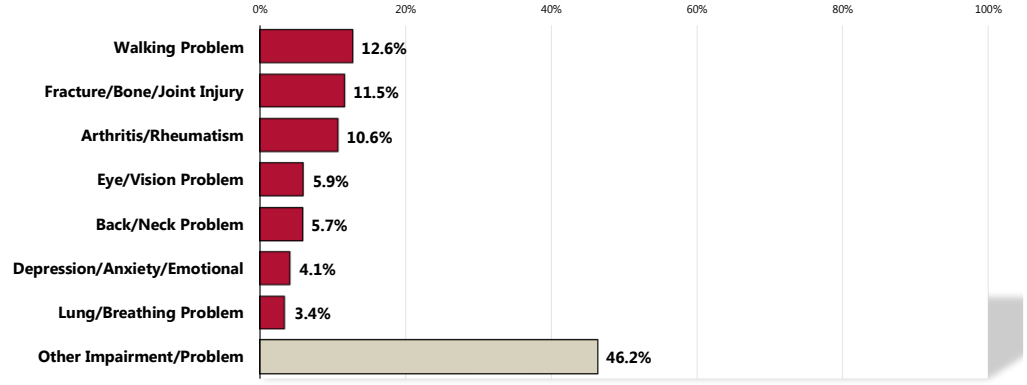
Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 125]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Among persons reporting activity limitations, these are most often attributed to musculoskeletal issues, such as difficulty walking, fractures or bone/joint injuries, arthritis/rheumatism, or back/neck problems.

Type of Problem That Limits Activities

(Among Those Reporting Activity Limitations; SCH Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 126]
Notes: • Asked of those respondents reporting activity limitations.

Mental Health & Mental Disorders

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. Mental disorders are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning. Mental disorders contribute to a host of problems that may include disability, pain, or death. Mental illness is the term that refers collectively to all diagnosable mental disorders.

Mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases. According to the national Institute of Mental Health (NIMH), in any given year, an estimated 13 million American adults (approximately 1 in 17) have a seriously debilitating mental illness. Mental health disorders are the leading cause of disability in the United States and Canada, accounting for 25% of all years of life lost to disability and premature mortality. Moreover, suicide is the 11th leading cause of death in the United States, accounting for the deaths of approximately 30,000 Americans each year.

Mental health and physical health are closely connected. Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.

The existing model for understanding mental health and mental disorders emphasizes the interaction of social, environmental, and genetic factors throughout the lifespan. In behavioral health, researchers identify: **risk factors**, which predispose individuals to mental illness; and **protective factors**, which protect them from developing mental disorders. Researchers now know that the prevention of mental, emotional, and behavioral (MEB) disorders is inherently interdisciplinary and draws on a variety of different strategies. Over the past 20 years, research on the prevention of mental disorders has progressed. The understanding of how the brain functions under normal conditions and in response to stressors, combined with knowledge of how the brain develops over time, has been essential to that progress. The major areas of progress include evidence that:

- MEB disorders are common and begin early in life.
- The greatest opportunity for prevention is among young people.
- There are multiyear effects of multiple preventive interventions on reducing substance abuse, conduct disorder, antisocial behavior, aggression, and child maltreatment.
- The incidence of depression among pregnant women and adolescents can be reduced.
- School-based violence prevention can reduce the base rate of aggressive problems in an average school by 25 to 33%.
- There are potential indicated preventive interventions for schizophrenia.
- Improving family functioning and positive parenting can have positive outcomes on mental health and can reduce poverty-related risk.
- School-based preventive interventions aimed at improving social and emotional outcomes can also improve academic outcomes.
- Interventions targeting families dealing with adversities, such as parental depression or divorce, can be effective in reducing risk for depression among children and increasing effective parenting.
- Some preventive interventions have benefits that exceed costs, with the available evidence strongest for early childhood interventions.
- Implementation is complex, and it is important that interventions be relevant to the target audiences.

In addition to advancements in the prevention of mental disorders, there continues to be steady progress in treating mental disorders as new drugs and stronger evidence-based outcomes become available.

– Healthy People 2020 (www.healthypeople.gov)

Mental Health Status

Self-Reported Mental Health Status

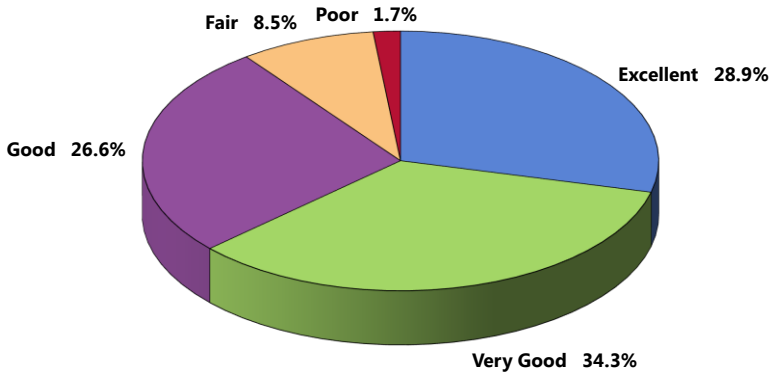
"Now thinking about your mental health, which includes stress, depression and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair or poor?"

A total of 63.2% of SCH Service Area adults rate their overall mental health as "excellent" or "very good."

- Another 26.6% gave "good" ratings of their own mental health status.

Self-Reported Mental Health Status

(Swedish Covenant Hospital Service Area, 2012)

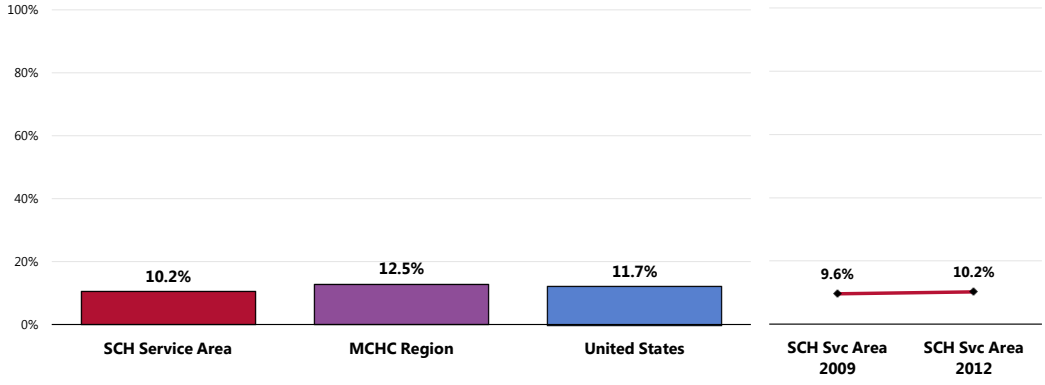


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 120]
Notes: • Asked of all respondents.

A total of 10.2% of area adults, however, believe that their overall mental health is "fair" or "poor."

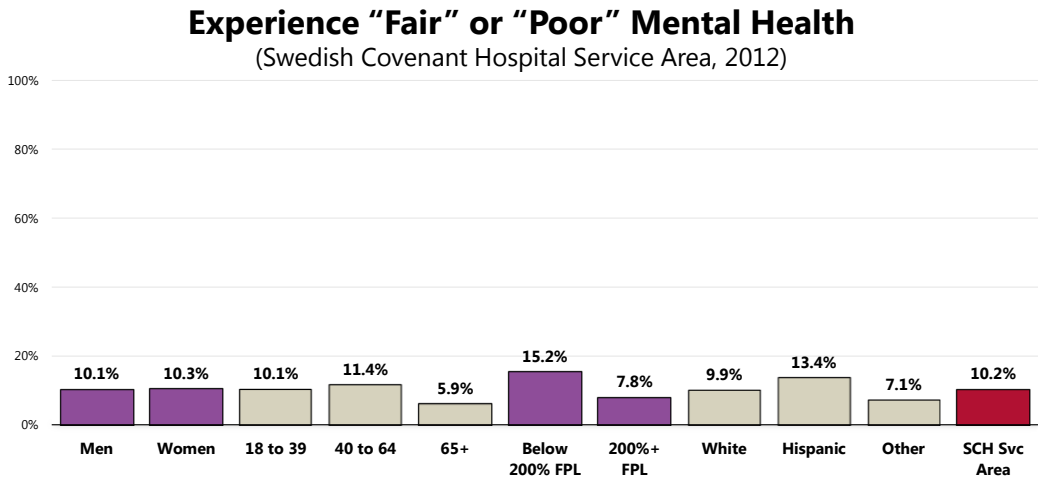
- Similar to regional findings.
- Similar to the "fair/poor" response reported nationally.
- Statistically unchanged since 2009.

Experience "Fair" or "Poor" Mental Health



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 120]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

- Adults in the lower income category are much more likely to report experiencing "fair/poor" mental health.



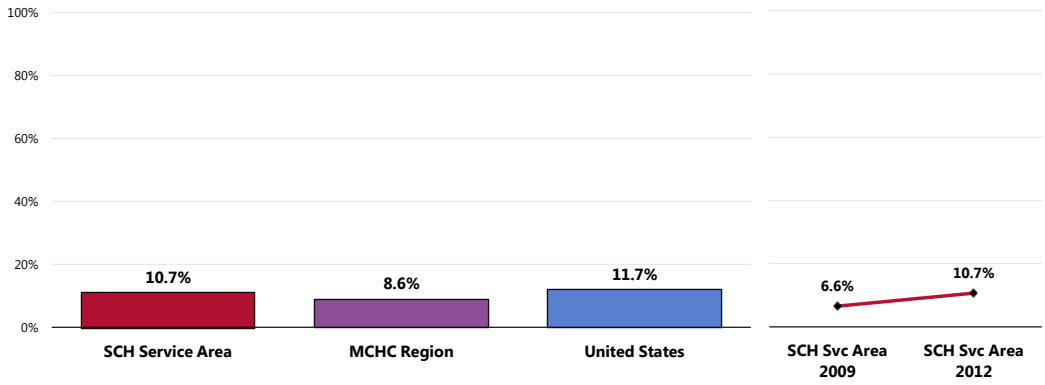
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 120]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Depression

Major Depression

A total of 10.7% of Swedish Covenant Hospital Service Area adults have been diagnosed with major depression by a physician.

- Similar to the prevalence found in the MCHC Region.
- Similar to national findings.
- Statistically unchanged over time.



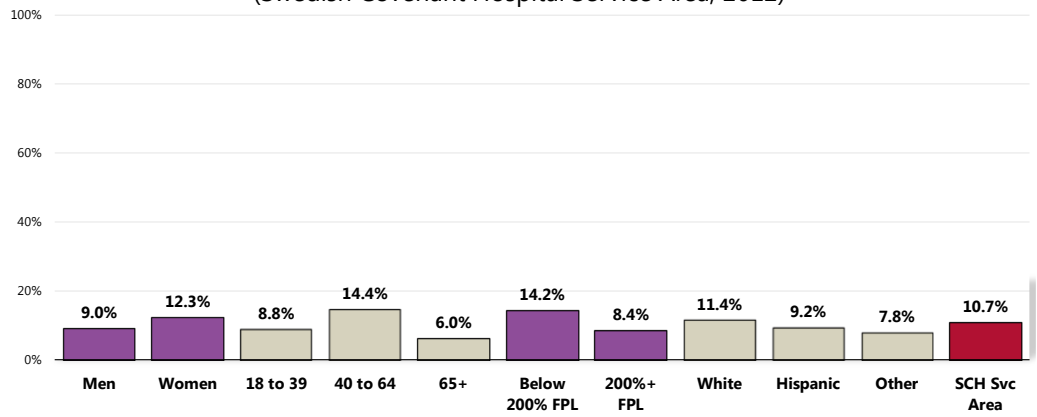
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 33]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

The prevalence of major depression is notably higher among:

- Adults between the ages of 40 and 64.

Have Been Diagnosed With Major Depression

(Swedish Covenant Hospital Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 33]

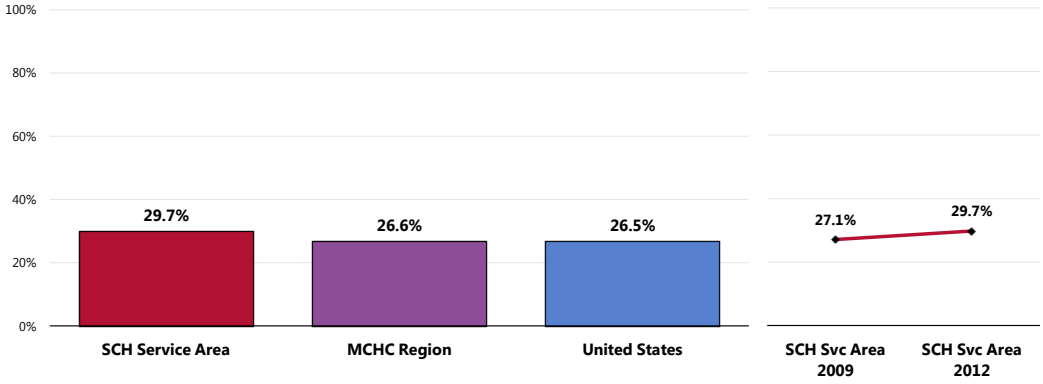
Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Symptoms of Chronic Depression

A total of 29.7% of Swedish Covenant Hospital Service Area adults have had two or more years in their lives when they felt depressed or sad on most days, although they may have felt okay sometimes (chronic depression).

- Similar to regional findings.
- Similar to national findings.
- Similar to that reported in the Swedish Covenant Hospital Service Area in 2009.

Have Experienced Symptoms of Chronic Depression



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 121]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

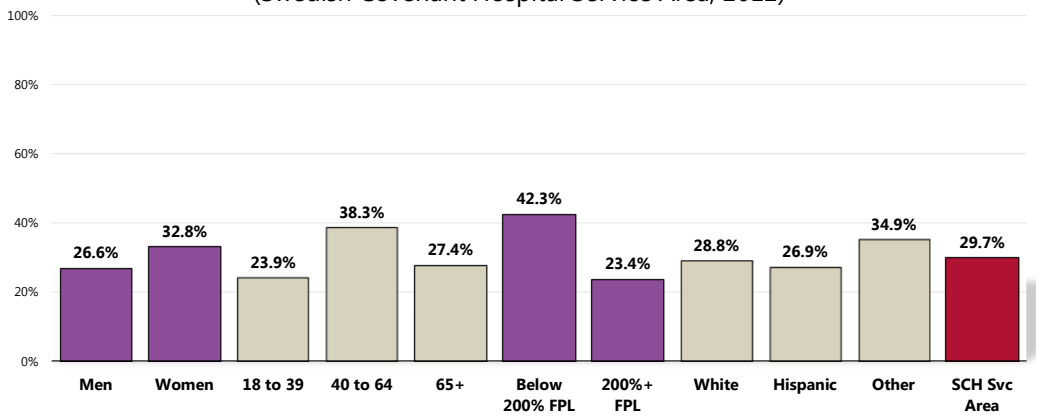
Notes:
- Asked of all respondents.

Note that the prevalence of chronic depression is notably higher among:

- Those between ages 40 and 64.
- Adults with lower incomes.

Have Experienced Symptoms of Chronic Depression

(Swedish Covenant Hospital Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 121]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Stress

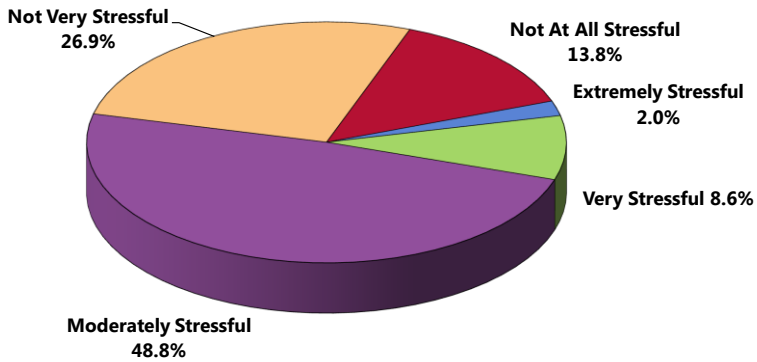
RELATED ISSUE: See also *Substance Abuse* in the **Modifiable Health Risks** section of this report.

Less than one-half of Swedish Covenant Hospital Service Area adults considers their typical day to be "not very stressful" (26.9%) or "not at all stressful" (13.8%).

- Another 48.8% of survey respondents characterize their typical day as "moderately stressful."

Perceived Level of Stress On a Typical Day

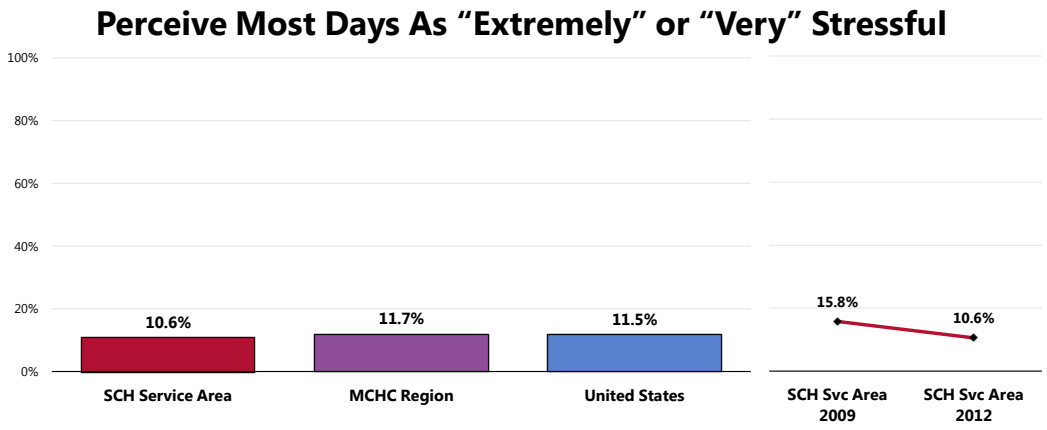
(Swedish Covenant Hospital Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 122]
Notes: • Asked of all respondents.

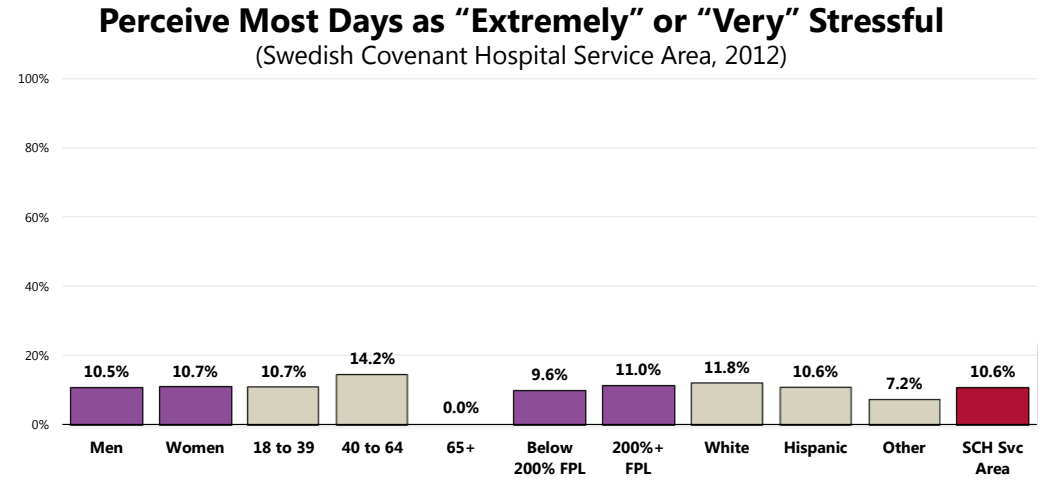
In contrast, 10.6% of Swedish Covenant Hospital Service Area adults experience "very" or "extremely" stressful days on a regular basis.

- Comparable to regional findings.
- Comparable to national findings.
- Statistically comparable to the 2009 findings.



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 122]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Note the disparity in high stress levels by age in the service area.



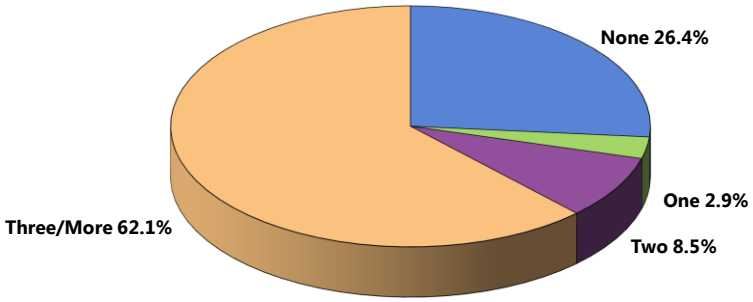
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 122]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Sleep

While more than one in four survey respondents (26.4%) did not experience any days in the past month on which they did not get enough sleep, the majority (62.1%) reports experiencing three or more days in the past month on which they did not get enough rest or sleep.

Number of Days Without Enough Rest or Sleep in the Past Month

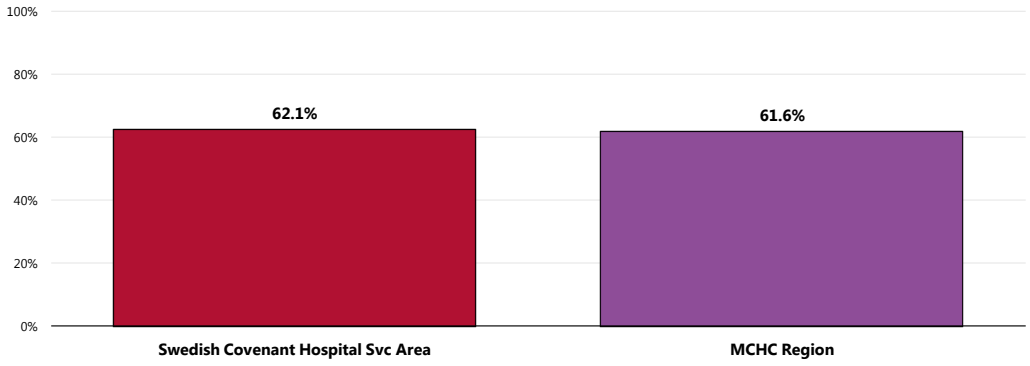
(Swedish Covenant Hospital Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 124]
Notes: • Asked of all respondents.

- The percentage of service area residents reporting three or more days on which they did not get enough sleep is similar to MCHC regional results.

Had 3+ Days in the Past Month Without Enough Sleep

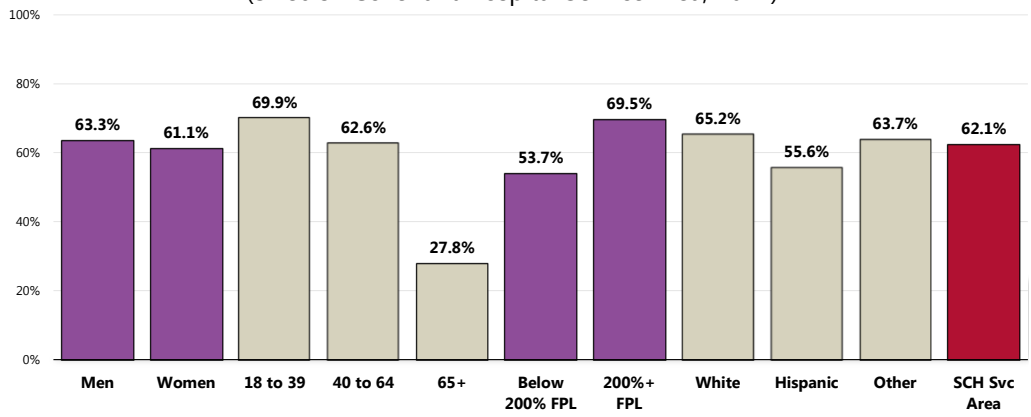


Sources: • 2012 PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 124]
Notes: • Asked of all respondents.

- Adults more likely to report 3+ days of poor sleep in the past month include those under 65 and higher-income residents.

Had 3+ Days in the Past Month Without Enough Sleep

(Swedish Covenant Hospital Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 124]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

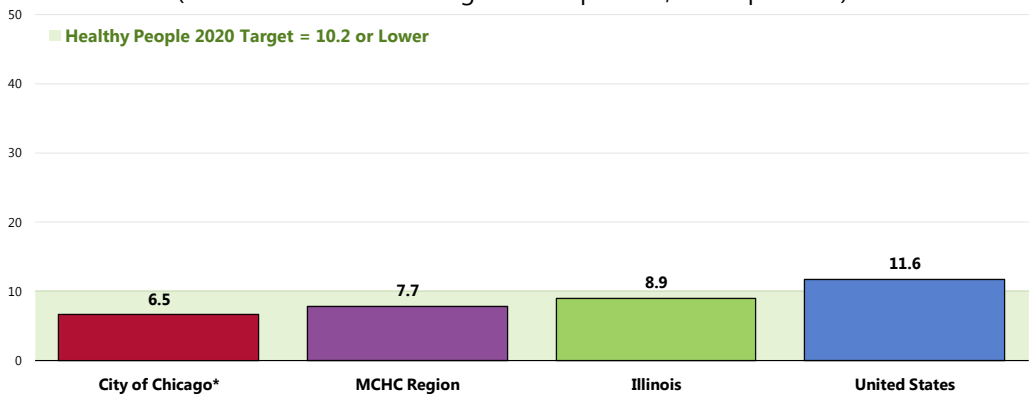
Suicide

Between 2006 and 2008, the City of Chicago experienced an annual average age-adjusted suicide rate of 6.5 deaths per 100,000 population.

- Lower than the regional rate (2007-2009 data).
- Lower than the statewide rate (2007-2009 data).
- Lower than the national rate data (2007-2009 data).
- Satisfies the Healthy People 2020 target of 10.2 or lower.

Suicide: Age-Adjusted Mortality

(2007-2009 Annual Average Deaths per 100,000 Population)



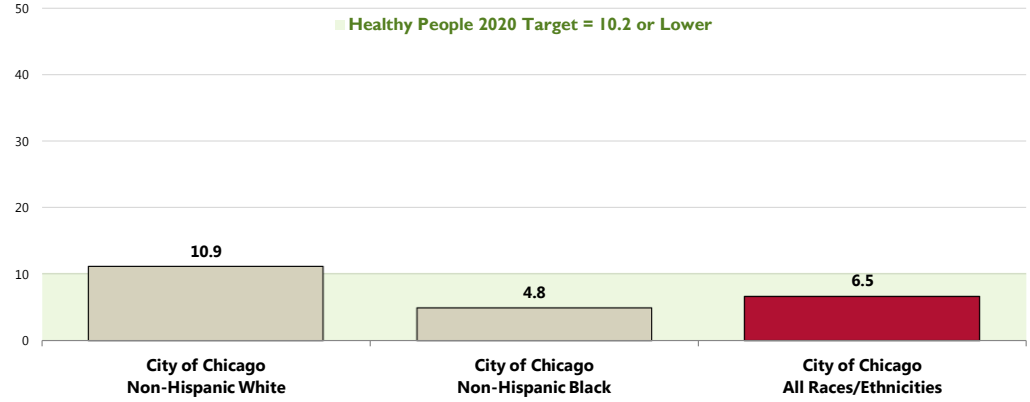
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MHMD-1]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- *City of Chicago rate represents 2006-2008 data.

The City of Chicago suicide rate is more than twice as high among Non-Hispanic Whites as among Non-Hispanic Blacks.

Suicide: Age-Adjusted Mortality by Race

(2006-2008 Annual Average Deaths per 100,000 Population)



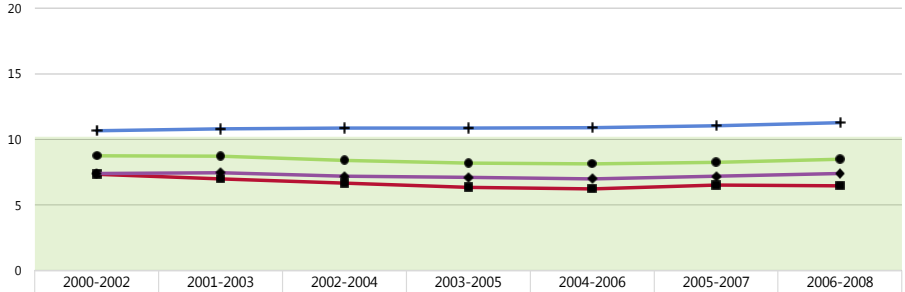
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MHMD-1]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

The City of Chicago suicide rate has decreased overall, and is similar to the statewide trend. The national suicide rate has increased.

Suicide: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2020	10.2	10.2	10.2	10.2	10.2	10.2	10.2
City of Chicago	7.3	7.0	6.7	6.3	6.2	6.5	6.5
MCHC Region	7.4	7.5	7.2	7.1	7.0	7.2	7.4
Illinois	8.8	8.7	8.4	8.2	8.1	8.3	8.5
United States	10.7	10.8	10.9	10.9	10.9	11.0	11.3

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MHMD-1]

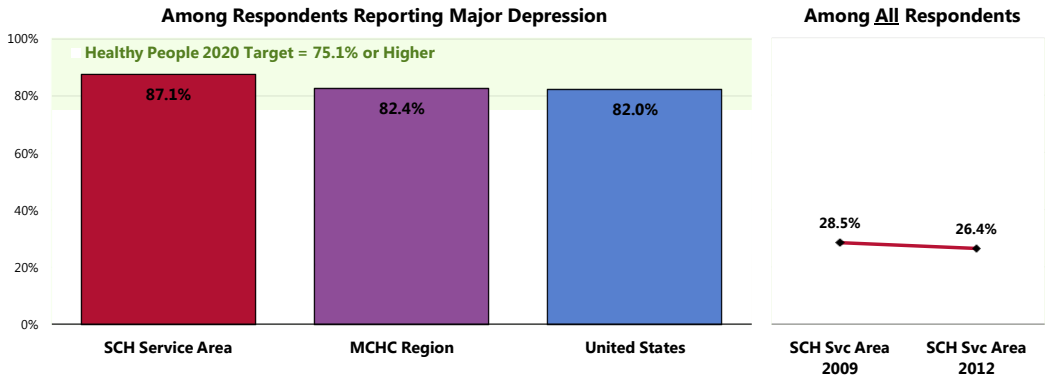
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

Among adults with diagnosed depression, 87.1% acknowledge that they have sought professional help for a mental or emotional problem.

- Similar to regional findings.
- Similar to national findings.
- Satisfies the Healthy People 2020 target of 75.1% or higher.
- Among the total sample of adults, the percentage of those who have sought professional help for a mental or emotional problem has not changed statistically over time.

"Diagnosed depression" includes respondents reporting a past diagnosis of major depression by a physician.

Have Sought Professional Help for a Mental or Emotional Problem



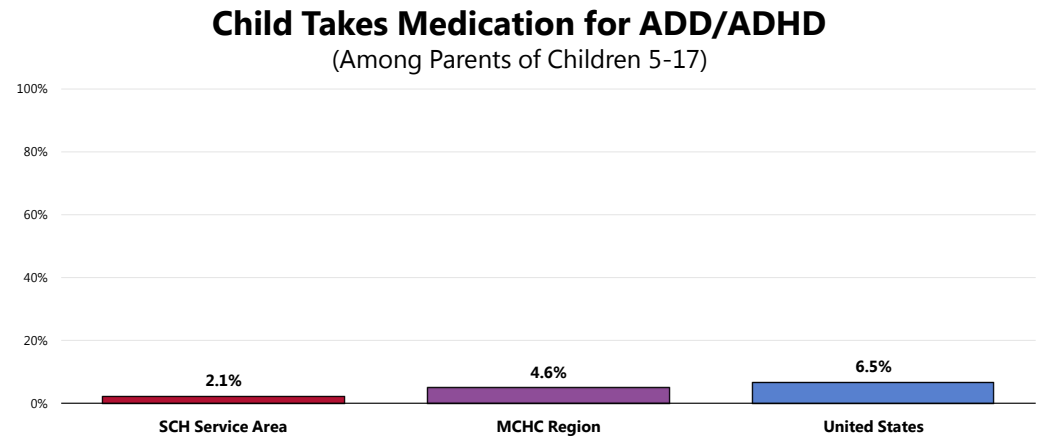
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 123, 150]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MHMD-9.2]

Notes:
- Asked of those respondents with major depression diagnosed by a physician.
- Trend data represent those adults with "recognized depression," including those who have been diagnosed with major depression OR have experienced 2+ years of depression at some point in their lives.

Children & ADD/ADHD

Among Swedish Covenant Hospital Service Area adults with children age 5 to 17, 2.1% report that their child takes medication for ADD/ADHD.

- Comparable to regional findings.
- Lower than the national prevalence.



Sources:
- 2012 PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 140]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents with children age 5 to 17.

Related Focus Group Findings: Mental Health

Many focus group participants discussed mental health in the community, with emphasis placed on these themes:

- High levels of depression in minority populations
- Stress
- Limited number of psychiatrists and inpatient facilities/closing of local clinics
- Insurance barriers
- Coordination with primary care
- Education
- Stigma surrounding mental illness
- Cultural barriers

During the focus groups, issues surrounding mental health coverage arose several times. Overall, behavioral healthcare is overlooked and under-funded for all demographics of the population. Participants believe that some minority residents suffer from **depression** and post-traumatic stress disorder. Many immigrants feel isolated and this can be a contributor to depression, as a respondent recalls.

> *"The main cause of the depression is their isolation, but they feel that they are isolated and they don't have the company. They don't have the outlet of socializing and mixing. That's a very common thing that happens to people in India (socialization)… It is not possible here, so they are confined to their own four walls and they can't understand what is happening with the TV and*

> *the radio. They are not also accustomed to reading. So the outlet is not there for them for the emotions that they have to express, so that's the biggest problem." — Key Informant Representing Asian Indian Residents*

With the current economic climate, many residents live under much **stress**. Attendees believe that stress contributes to high levels of obesity and other poor health outcomes:

> *"I think part of it is also that mental health is not seen as something that has a visible health – connections are not made and having depression is not seen as something that's going to affect your physical health, and only when it gets to something that's starting to affect your physical health you start seeking care when the underlying issue is not what's being observed, it's something else that's not being addressed." — Cook County Community Leader*

In general, individuals suffering from mental illness are more likely to be vulnerable and less likely to successfully navigate the multifaceted healthcare system. Furthermore, mental illness affects many parts of a person's life, as an attendee describes:

> *"Health can limit people, but mental health has sort of a three-dimensional impact because it's a family situation, not just an individual situation. It also limits people in their access to jobs and their ability to maintain jobs, to get jobs, to adjust to the community, to be effective civilians and contributors to the society." — Key Informant Representing Hispanic Residents*

Group attendees agree that residents suffer due to a **limited number of psychiatrists and inpatient facilities** as well as the **closing of local clinics**. The remaining clinics are overwhelmed and have wait lists; state budget cuts have affected the number of available mental health resources. Federally Qualified Health Centers (FQHCs) have limited numbers of psychiatrists on staff and some are only part-time. Many times community members must enter into crisis mode before they can access treatment, as one participant explains:

> *"Frequently the trigger to actually accessing some mental health services is a bad thing has to happen to you: you have to have HIV, you have to have been shot, and you have to precipitate a psychotic crisis. Then you get hooked up -- or you go to jail." — Cook County Community Leader*

Once someone arrives at the hospital, the emergency room becomes a holding pen for these patients. Individuals may have to wait for several days before an inpatient bed becomes available, as a participant explains:

> *"So it's kind of like you're stuck in the middle and unfortunately for us in the Emergency Department, because we can't place these patients for the most part in other than a state facility with the cutbacks there, we're holding patients for many, many days and that's a drain on our resources as well. And truly the patients aren't benefitting from just being held. I mean they're not really getting therapy." — Swedish Covenant Hospital Representative*

According to focus group participants, outpatient prospects are just as abysmal for the **under- and uninsured**. Many local psychiatrists have long waiting periods before initial appointments take place, and generally insurance coverage for mental health services is inadequate.

> *"Well, congestive heart failure(CHF) treatment is through insurance so that's covered; that's a medical disease but when you try to give some kind of counseling for somebody it's a whole different thing as far as what insurance will cover. If you have a chronic mental illness they'll cover you for six visits. Well then why can you go forever with CHF? It's always been a stepchild." — Cook County Community Leader*

Residents with private insurance have access to many options for psychiatrists and counselors; however, participants worry about the ease of individuals' ability to enter the mental health system, as one participant explains:

> *"I would say, even for people who are insured - I would feel more comfortable picking my primary healthcare provider out of a list than my mental health – so I think there's a lot of people who go without treatment because they don't know who to go see. It's more like the hidden world." — North Chicago Community Leader*

It is also important for **primary care physicians to coordinate** and refer patients to psychiatrists or counseling services. Group participants worry that individuals do not know what to expect from the behavioral health system and may expect a quick fix. One participant describes:

> *"Or you don't know what to expect. I have people who go once or twice, 'Well, all they did was listen to me talk.' And I'm kind of like, 'Well, they have to figure out – yes, that's part of it.' But there's just that understanding of what to expect too. So a lot of people don't want to – they want to be fixed, they don't want to go and talk. And they don't give it a shot. Medication takes a little while to take effect, talking takes a little while – you know you go once or twice and you're like, 'I'm done.'" — North Chicago Community Leader*

Educating community members about the mental health system needs to occur in order to dispel the **stigma** associated with mental health in the community. Focus group attendees believe that the negative stigma greatly impacts residents' and family members' desire to obtain mental healthcare.

> *"The stigma associated with mental health issues too is difficult; not just for the people with chronic mental health issues but for people who maybe don't but who see the stigma and then don't want to seek services too. So you can't find a service, and when you do the client doesn't want to go is what I'm trying to say." — North Chicago Community Leader*

Many **cultures** have stigma towards mental illness and organizations and providers must recognize these **barriers** to care. For example, some Hispanic residents believe that one's own actions cause the disease, or it is deserved, which means mental illness may go untreated:

> *"Something that we run into working with teenage moms is that the stigma, their parents or grandparents don't want them to come see our social worker. Sometimes the beliefs of, 'Well you went outside before the 40 days and you kind of brought it on yourself', and they really believe it, so then it's the guilt that they say, 'I did this to myself. My grandmother said that because of this I wasn't.' So it's going to go away because she said it's going to go away. Trying to respect the family's beliefs at the same time like, 'Okay, why don't we just try to see the social worker and get some counseling?'" — Key Informant Representing Hispanic Residents*

Some Asian Indian residents do not see the connection between mental and physical health:

> *"I think part of it is also that mental health is not seen as something that has a visible health – connections are not made and having depression is not seen as something that's going to affect your physical health, and only when it gets to something that's starting to affect your physical health you start seeking care when the underlying issue is not what's being observed, it's something else that's not being addressed." — Key Informant Representing Asian Indian Residents*

Participants believe that culturally-sensitive therapists and counseling in multiple languages can begin to combat the cultural barriers.

> *"We were trying to locate as many Polish-speaking providers for those services as possible. So if someone was calling and actually decided to maybe get some help, we could refer. And it's a very limited number of Polish-speaking psychiatrists or therapists and that is a problem…because it's different for the mental health because for therapy to be successful, you just really need to have a certain fluency of the language to be able to go through this." — Key Informant Representing Polish Residents*

In addition, if psychiatrists worked in primary care physician offices, or if healthcare providers worked in teams, these changes could lessen the stigma attached to mental health, as one member describes:

> *"I used to work in Minnesota and the diabetes program that I worked there we had a psychiatrist on our staff and everyone who came in had to see the psychiatrist because that was part of the team so that if they ever had problems there wouldn't be that stigma, that they would know that that's comfortable. I have been trying for 23 years to get a psychiatrist on my staff." — Cook County Community Leader*

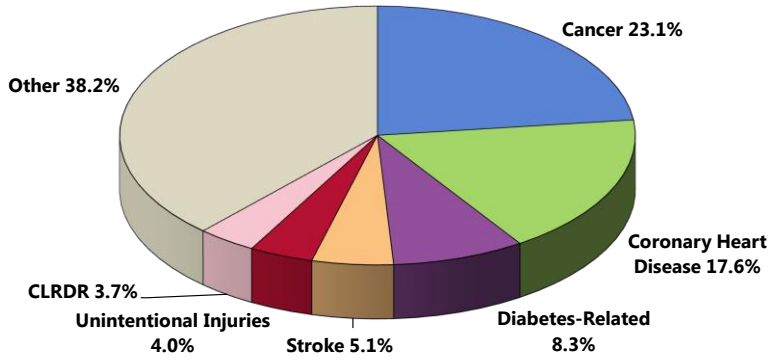
DEATH, DISEASE & CHRONIC CONDITIONS

Leading Causes of Death

Distribution of Deaths by Cause

Together, cardiovascular disease (coronary heart disease and stroke) and cancers accounted for nearly one-half of all deaths in the City of Chicago in 2008.

Leading Causes of Death
(City of Chicago, 2008)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• CLRD is chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

In order to compare mortality in the region with other localities (in this case, Illinois and the United States), it is necessary to look at *rates* of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these "age-adjusted" rates provides the most valuable means of gauging mortality against benchmark data, as well as *Healthy People 2020* targets.

The following chart outlines 2006-2008 annual average age-adjusted death rates per 100,000 population for selected causes of death in the City of Chicago. Where city data is unavailable, Cook County rates are used (reflecting 2007-2009 data).

For infant mortality data, see "Birth Outcomes & Risks" in the **Births** section of this report.

Age-adjusted mortality rates in the City of Chicago (or Cook County) are worse than national rates for heart disease, stroke, cancer, pneumonia/influenza, homicide, firearm-related deaths, kidney disease, HIV/AIDS and cirrhosis/liver disease.

Of the causes outlined in the following chart for which Healthy People 2020 objectives have been established, City of Chicago/Cook County rates fail to satisfy the related goals for heart disease, stroke, cancer, firearm-related deaths, homicide, diabetes mellitus, HIV/AIDS and cirrhosis/liver disease.

Age-Adjusted Death Rates for Selected Causes

(2007-2009 Deaths per 100,000)

	City of Chicago	MCHC Region	Illinois	United States	Healthy People 2020
Diseases of the Heart	**199.3****	188.3	189.3	185.8	152.7*
Malignant Neoplasms (Cancers)	**194.2**	179.3	183.9	175.6	160.6
Cerebrovascular Disease (Stroke)	**44.2**	39.7	41.8	40.6	33.8
Unintentional Injuries	**33.9**	25.8	31.9	38.7	36.0
Chronic Lower Respiratory Disease (CLRD)	**29.4**	31.5	39.9	42.4	n/a
Pneumonia/Influenza	**23.1**	19.0	18.6	16.4	n/a
Kidney Disease	**23.0**	20.0	19.5	14.7	n/a
Diabetes Mellitus	**22.7****	20.9	21.3	21.7	19.6*
Alzheimer's Disease	**15.2**	17.8	21.2	23.5	n/a
Homicide/Legal Intervention	**15.1**	9.1	6.7	5.8	5.5
Cirrhosis/Liver Disease	**11.0**	8.2	8.2	9.2	8.2
Firearm-Related	**10.9****	9.2	8.1	10.2	9.2
Drug-Induced	**10.3****	10.1	10.5	12.6	11.3
Motor Vehicle Crashes	**7.8**	6.4	9.3	13.0	12.4
Intentional Self-Harm (Suicide)	**6.5**	7.7	8.9	11.6	10.2
HIV/AIDS	**8.2**	3.8	2.2	3.3	3.3

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov.

Note:
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population and coded using ICD-10 codes.
- *The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart; the Diabetes target is adjusted to reflect only diabetes mellitus-coded deaths.
- Local, state and national data are simple three-year averages. City of Chicago data is 2006-2008. **Cook County data is used here; City of Chicago rates not available.

Related Focus Group Findings: Chronic Disease

Focus group participants mentioned several chronic health conditions which persist in the community, including congestive heart failure, obesity, diabetes, chronic obstructive pulmonary disease, arthritis, hypertension, anemia and allergies. Group attendees agree that residents need a lifestyle change in order to affect the high prevalence of chronic disease conditions in the community.

> *"It ends up becoming a lifestyle change, which is very difficult for anybody, to lose weight, to watch your blood sugars, to keep weighing yourself. All of those things that will help, they really have to start thinking that they have to change their entire lifestyle and their lifestyle up to this point for the most part is what got them to those diseases." — Swedish Covenant Hospital Representative*

Cardiovascular Disease

Heart disease is the leading cause of death in the United States, with stroke following as the third leading cause. Together, heart disease and stroke are among the most widespread and costly health problems facing the nation today, accounting for more than $500 billion in healthcare expenditures and related expenses in 2010 alone. Fortunately, they are also among the most preventable.

The leading modifiable (controllable) risk factors for heart disease and stroke are:

- High blood pressure
- High cholesterol
- Cigarette smoking
- Diabetes
- Poor diet and physical inactivity
- Overweight and obesity

The risk of Americans developing and dying from cardiovascular disease would be substantially reduced if major improvements were made across the US population in diet and physical activity, control of high blood pressure and cholesterol, smoking cessation, and appropriate aspirin use.

The burden of cardiovascular disease is disproportionately distributed across the population. There are significant disparities in the following based on gender, age, race/ethnicity, geographic area, and socioeconomic status:

- Prevalence of risk factors
- Access to treatment
- Appropriate and timely treatment
- Treatment outcomes
- Mortality

Disease does not occur in isolation, and cardiovascular disease is no exception. Cardiovascular health is significantly influenced by the physical, social, and political environment, including: maternal and child health; access to educational opportunities; availability of healthy foods, physical education, and extracurricular activities in schools; opportunities for physical activity, including access to safe and walkable communities; access to healthy foods; quality of working conditions and worksite health; availability of community support and resources; and access to affordable, quality healthcare.

– Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Heart Disease & Stroke Deaths

The greatest share of cardiovascular deaths is attributed to heart disease.

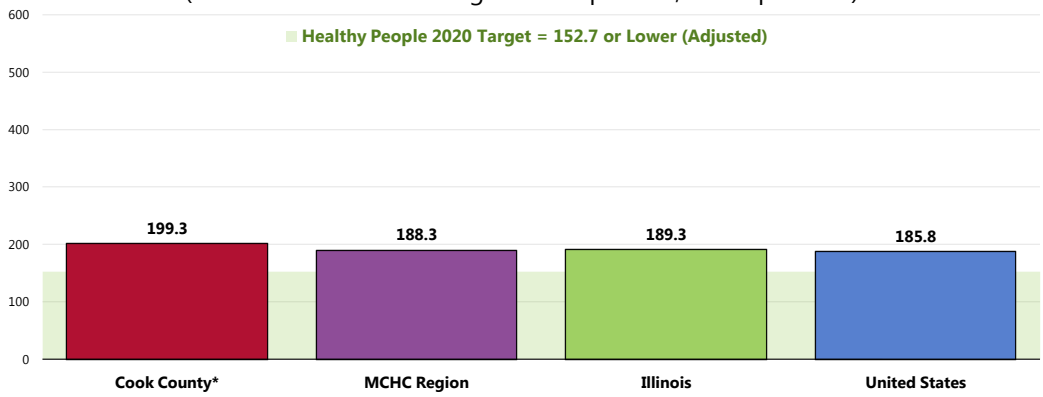
Heart Disease Deaths

Between 2007 and 2009 there was an annual average age-adjusted heart disease mortality rate of 199.3 deaths per 100,000 population in Cook County (City of Chicago data not available).

- Higher than the regional rate.
- Higher than the statewide rate.
- Higher than the national rate.
- Fails to satisfy the Healthy People 2020 target (as adjusted to account for all diseases of the heart).

Heart Disease: Age-Adjusted Mortality

(2007-2009 Annual Average Deaths per 100,000 Population)



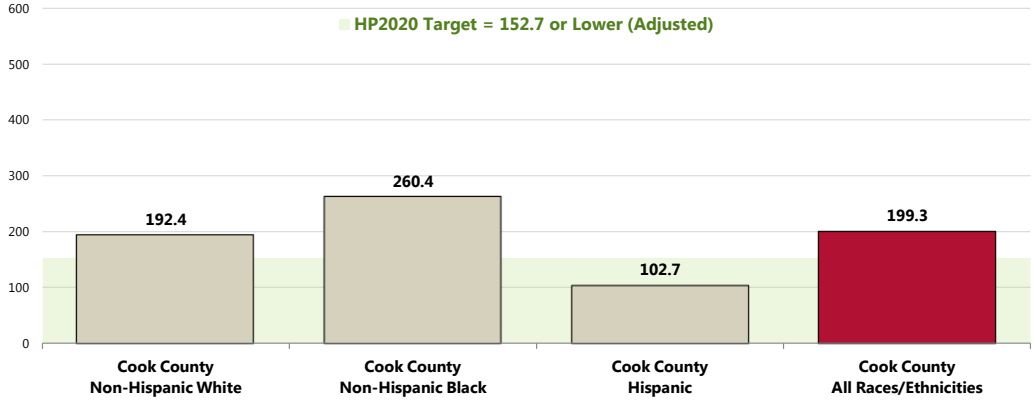
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-2]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.
- *City of Chicago rate not available; Cook County rate is shown here.

By race, Cook County heart disease mortality is unfavorably high among Non-Hispanic Blacks. It is also higher among Non-Hispanic Whites when compared with Hispanics.

Heart Disease Deaths: Age-Adjusted Mortality by Race

(2007-2009 Annual Average Deaths per 100,000 Population)



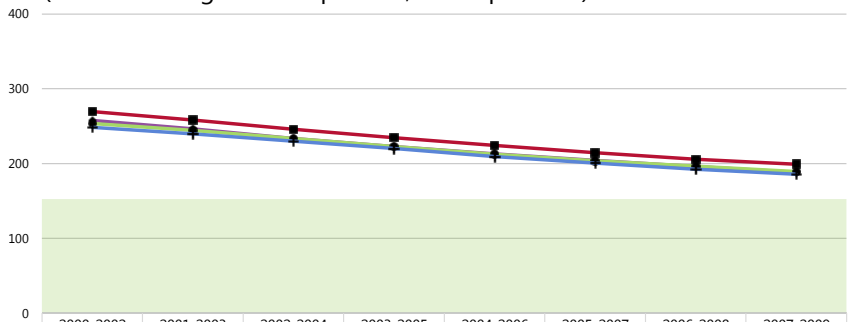
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-2]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.
- Local, state and national data are simple three-year averages.

- The heart disease mortality rate has decreased in Cook County, echoing the decreasing regional, state and national trends.

Heart Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
Healthy People 2020 (Adjusted)	152.7	152.7	152.7	152.7	152.7	152.7	152.7	152.7
Cook County*	269.8	258.5	245.9	234.9	224.2	214.4	205.8	199.3
MCHC Region	257.9	246.4	233.5	222.7	212.9	204.2	196.2	188.3
Illinois	253.9	244.3	233.5	222.8	212.6	203.8	196.4	189.3
United States	248.4	240.0	230.0	220.1	209.4	200.7	192.5	185.8

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-2]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.
- *City of Chicago data not available; Cook County rates are shown here.

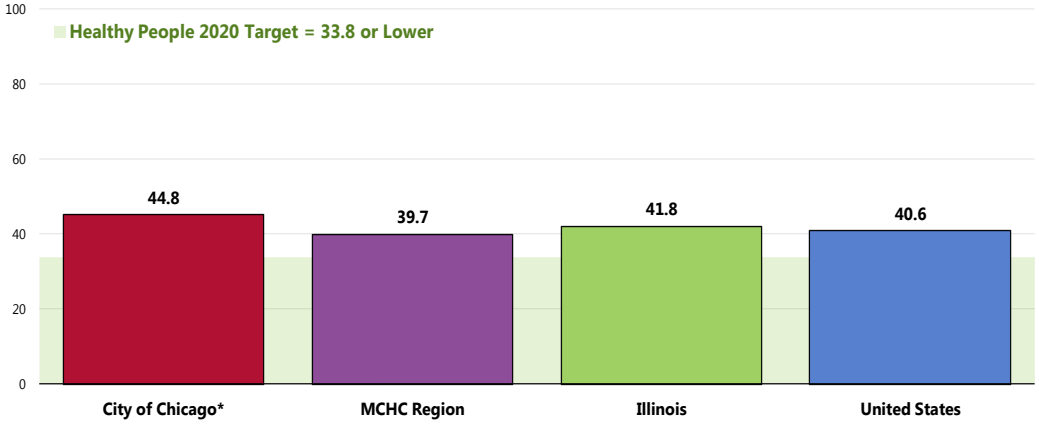
Stroke Deaths

Between 2006 and 2008, there was an annual average age-adjusted stroke mortality rate of 44.8 deaths per 100,000 population in the City of Chicago.

- Worse than the regional rate.
- Worse than the Illinois rate.
- Worse than the national rate.
- Fails to satisfy the Healthy People 2020 target of 33.8 or lower.

Stroke: Age-Adjusted Mortality

(2007-2009 Annual Average Deaths per 100,000 Population)



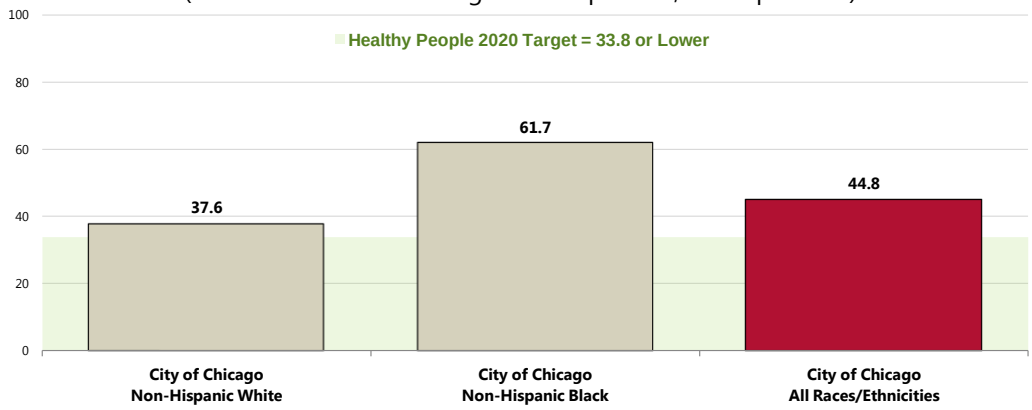
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-3]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- *City of Chicago rate represents 2006-2008 data.

Stroke mortality is much higher among City of Chicago Non-Hispanic Blacks than Whites.

Stroke: Age-Adjusted Mortality by Race

(2006-2008 Annual Average Deaths per 100,000 Population)



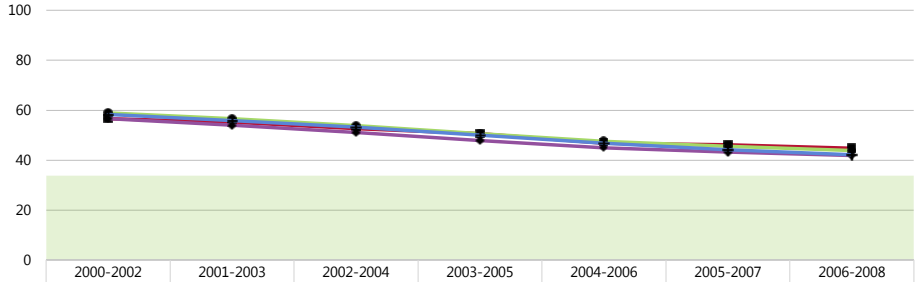
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-3]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.

The stroke rate has declined in recent years, echoing the trends reported across the MCHC Region, Illinois and the US overall.

Stroke: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2020	33.8	33.8	33.8	33.8	33.8	33.8	33.8
City of Chicago	56.7	55.3	52.7	50.7	46.8	46.1	44.8
MCHC Region	56.7	54.0	51.1	47.8	45.0	43.3	41.8
Illinois	59.0	56.6	53.8	50.6	47.6	45.6	43.9
United States	58.3	55.8	53.2	50.0	46.7	44.1	42.2

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-3]

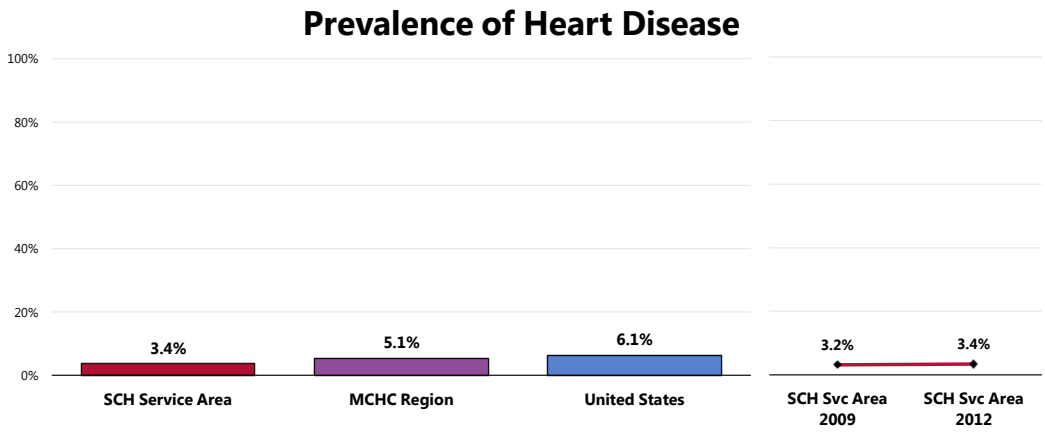
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.

Prevalence of Heart Disease & Stroke

Prevalence of Heart Disease

A total of 3.4% of surveyed adults report that they suffer from or have been diagnosed with heart disease, such as coronary heart disease, angina or heart attack.

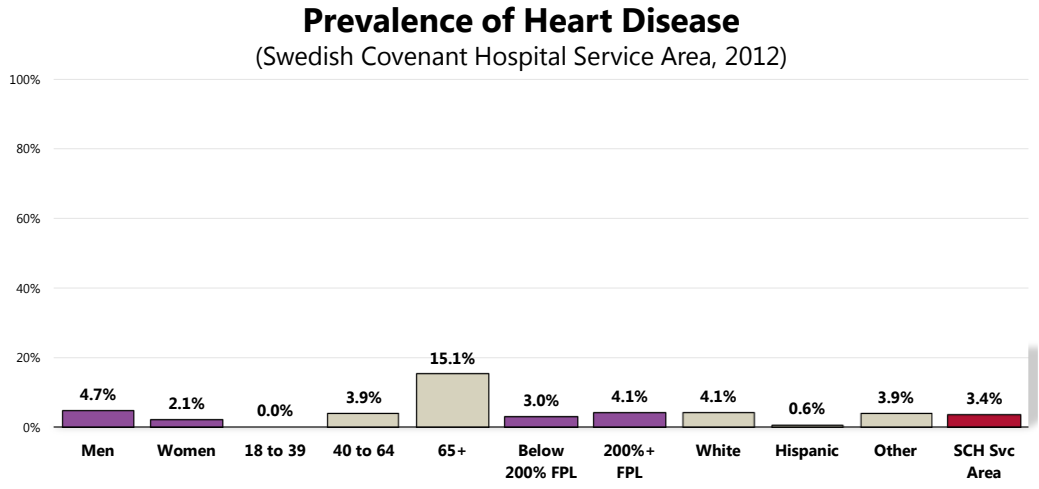
- Statistically similar to findings in the MCHC Region.
- Better than the national prevalence.
- Statistically unchanged since 2009.



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 151]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Adults more likely to have been diagnosed with chronic heart disease include:

- Respondents age 40+ (note the positive correlation with age).
- Non-Hispanics.



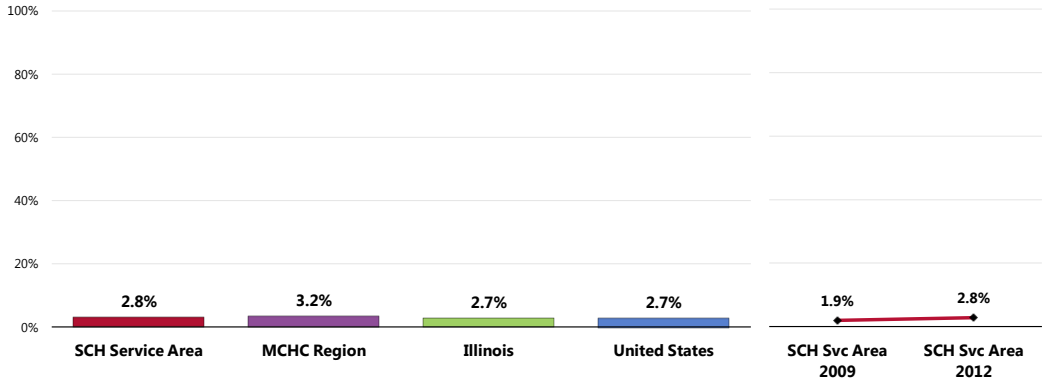
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 151]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Prevalence of Stroke

A total of 2.8% of surveyed adults report that they suffer from or have been diagnosed with cerebrovascular disease (a stroke).

- Similar to regional findings.
- Nearly identical to statewide findings.
- Nearly identical to national findings.
- Stroke prevalence is statistically unchanged over time.

Prevalence of Stroke



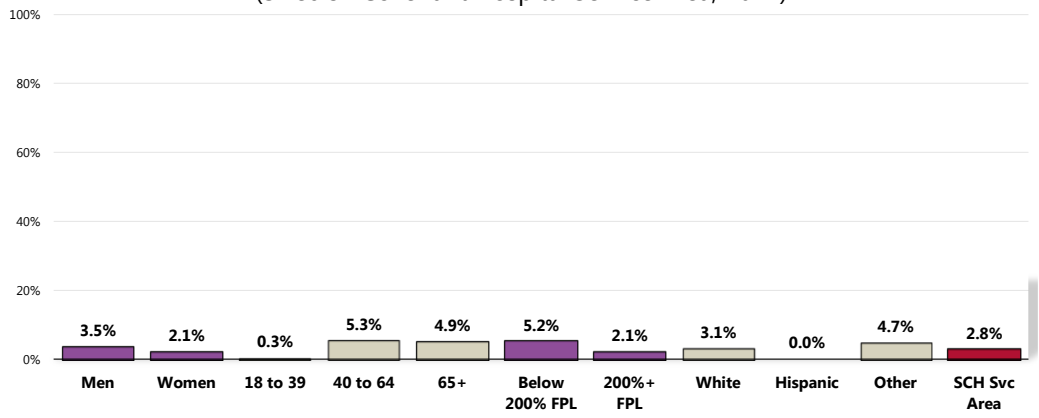
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 43]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.

Notes:
- Asked of all respondents.

Adults more likely to have been diagnosed with stroke include:

- Community members age 40 or older.
- Non-Hispanics.

Prevalence of Stroke
(Swedish Covenant Hospital Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 43]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Cardiovascular Risk Factors

Hypertension (High Blood Pressure)

Controlling risk factors for heart disease and stroke remains a challenge. High blood pressure and cholesterol are still major contributors to the national epidemic of cardiovascular disease. High blood pressure affects approximately 1 in 3 adults in the United States, and more than half of Americans with high blood pressure do not have it under control. High sodium intake is a known risk factor for high blood pressure and heart disease, yet about 90% of American adults exceed their recommendation for sodium intake.

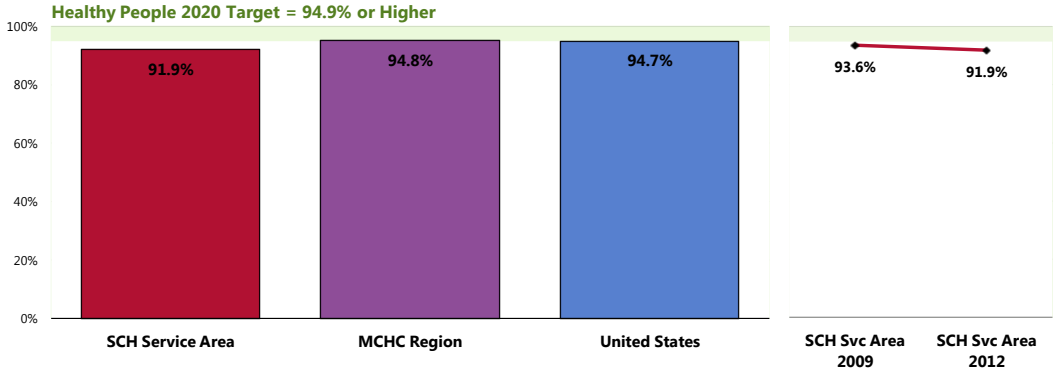
– Healthy People 2020 (www.healthypeople.gov)

High Blood Pressure Testing

A total of 91.9% of Swedish Covenant Hospital Service Area adults have had their blood pressure tested within the past two years.

- Less favorable than regional findings.
- Less favorable than US findings.
- Fails to meet the Healthy People 2020 target (94.9% or higher).
- Statistically unchanged since 2009.

Have Had Blood Pressure Checked in the Past Two Years



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 53]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-4]

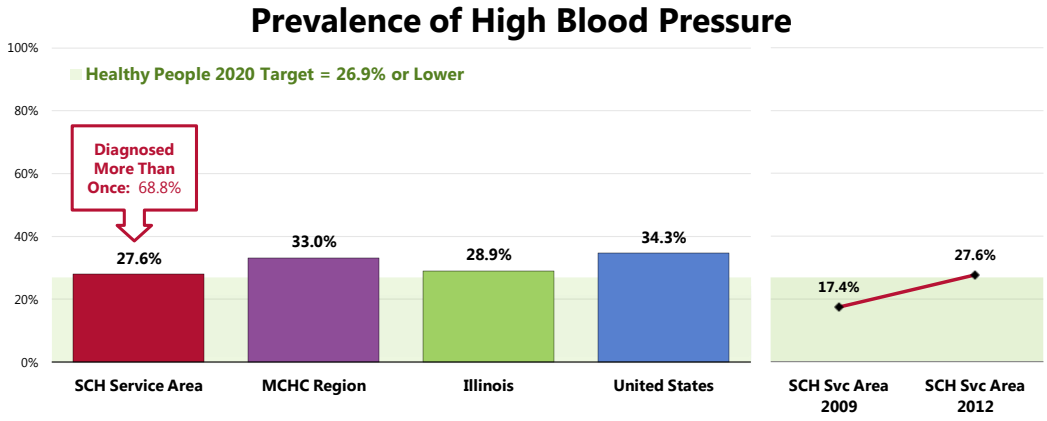
Notes:
- Asked of all respondents.

Prevalence of Hypertension

A total of 27.6% of adults have been told at some point that their blood pressure was high.

- More favorable than was found in the MCHC Region.
- Comparable to the Illinois prevalence.
- More favorable than the national prevalence.
- Comparable to the Healthy People 2020 target (26.9% or lower).

- Marks a significant increase in the prevalence of high blood pressure since 2009.
- Among hypertensive adults, 68.8% have been diagnosed with high blood pressure more than once.



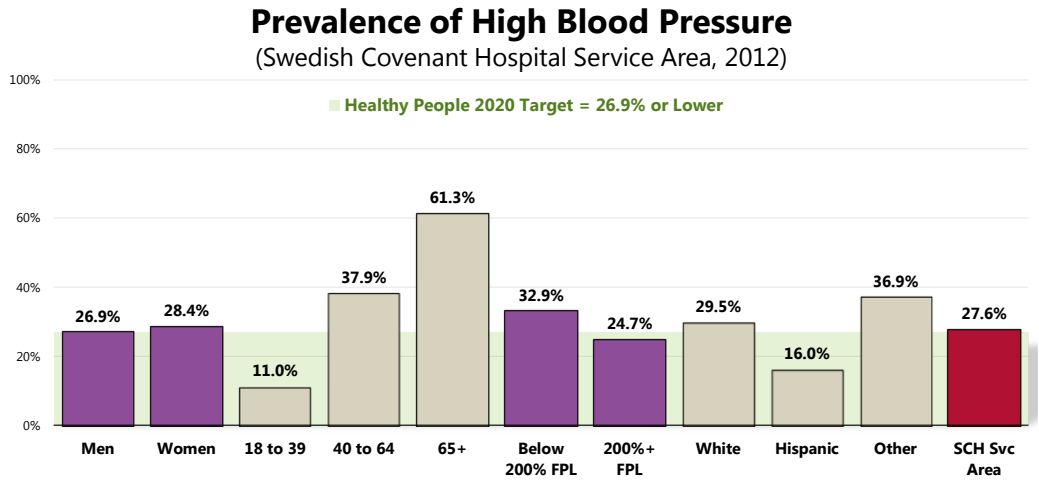
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 51, 152]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Illinois data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-5.1]

Notes:
- Asked of all respondents.

Note that 4.3% of Swedish Covenant Hospital Service Area adults report not having high blood pressure, but: 1) have never had their blood pressure tested; 2) have not been screened in the past 5 years; or 3) do not recall when their last screening was. For these individuals, current prevalence is unknown.

Hypertension diagnoses are higher among:

- Adults age 40 and older, and especially those age 65+.
- Non-Hispanics.



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 152]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-5.1]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Hypertension Management

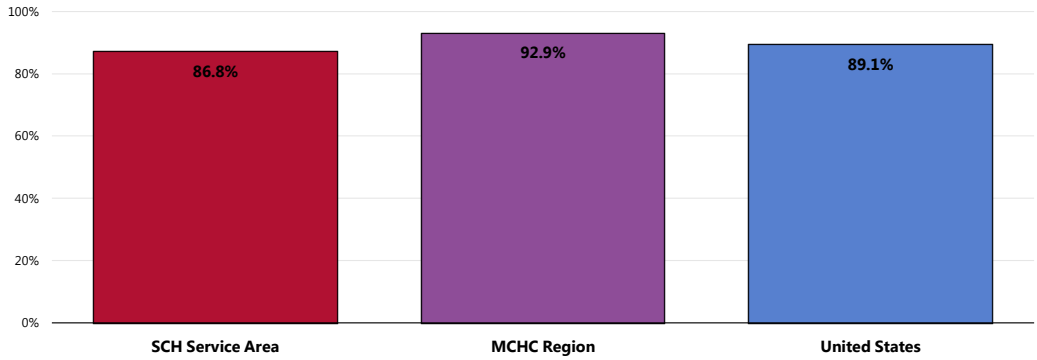
Respondents reporting high blood pressure were further asked:

"Are you currently taking any action to help control your high blood pressure, such as taking medication, changing your diet, or exercising?"

Among respondents who have been told that their blood pressure was high, 86.8% report that they are currently taking actions to control their condition.

- Similar to findings in the MCHC Region.
- Similar to national findings.

Taking Action to Control Hypertension
(Among Adults With High Blood Pressure)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 52]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents who have been diagnosed with high blood pressure.
- In this case, the term "action" refers to medication, change in diet, and/or exercise.

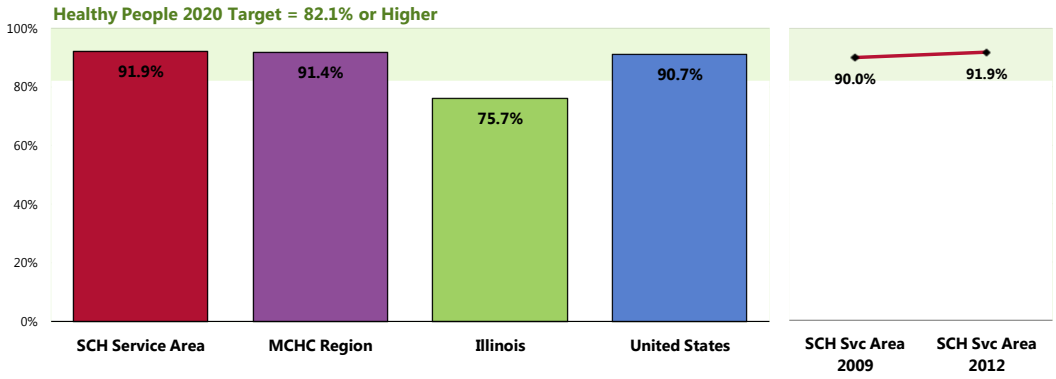
High Blood Cholesterol

Blood Cholesterol Testing

A total of 91.9% of Swedish Covenant Hospital Service Area adults have had their blood cholesterol checked within the past five years.

- Similar to regional findings.
- More favorable than the Illinois findings.
- Similar to national findings.
- Satisfies the Healthy People 2020 target (82.1% or higher).
- Statistically unchanged since 2009.

Have Had Blood Cholesterol Levels Checked in the Past Five Years



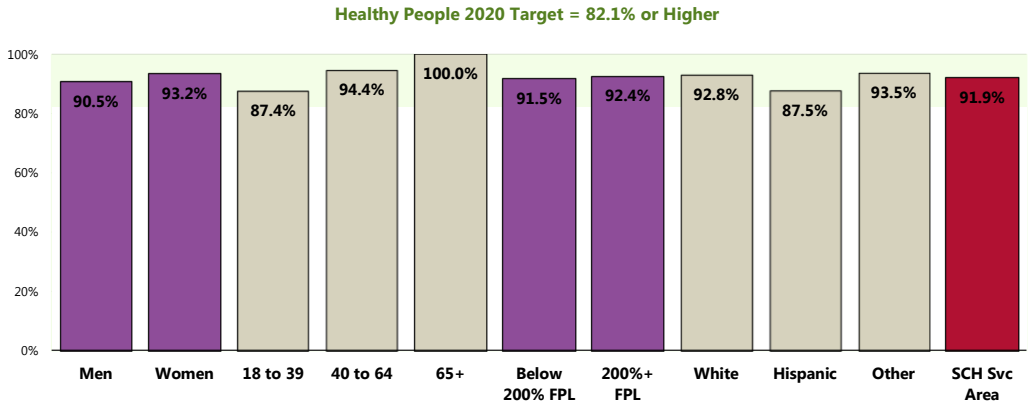
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 56]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Illinois data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-6]

Notes:
- Asked of all respondents.

Adults under age 40 report lower screening levels (note the positive correlation with age).

Have Had Blood Cholesterol Levels Checked in the Past Five Years

(Swedish Covenant Hospital Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 56]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-6]

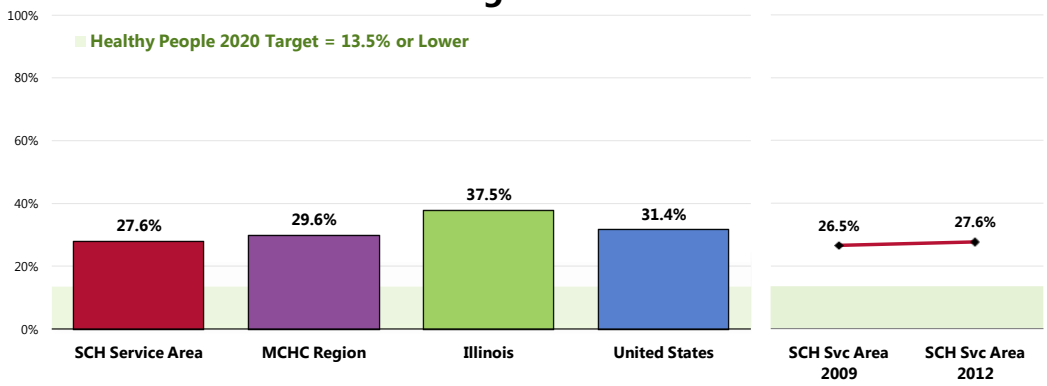
Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Self-Reported High Blood Cholesterol

A total of 27.6% of adults have been told by a health professional that their cholesterol level was high.

- Similar to regional findings.
- More favorable than the Illinois findings.
- Similar to the national prevalence.
- Twice the Healthy People 2020 target (13.5% or lower).
- Statistically unchanged since 2009.

Prevalence of High Blood Cholesterol



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 153]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Illinois data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-7]

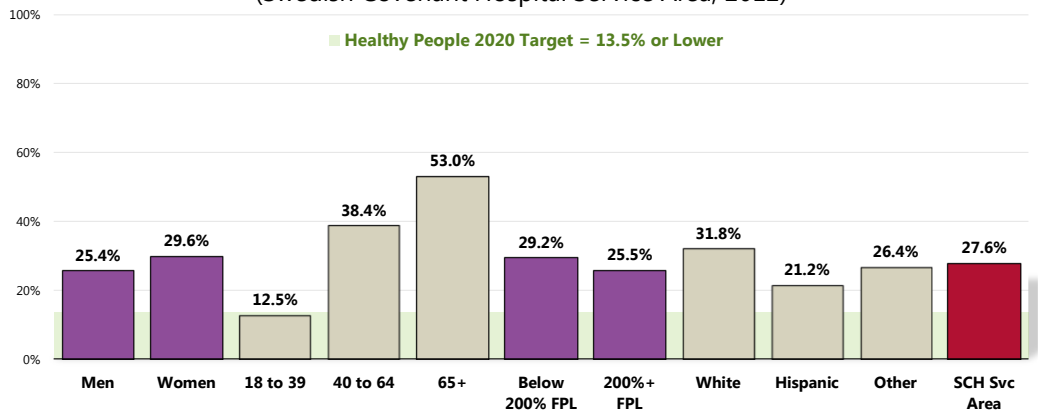
Notes:
- Asked of all respondents.
- *The IL data reflects those adults who have been tested for high cholesterol and who have been diagnosed with it.

Note that 15.4% of Swedish Covenant Hospital Service Area adults report not having high blood cholesterol, but: 1) have never had their blood cholesterol levels tested; 2) have not been screened in the past 5 years; or 3) do not recall when their last screening was. For these individuals, current prevalence is unknown.

- Note the positive correlation between age and high blood cholesterol, with adults age 40+ being considerably more likely to report high blood cholesterol diagnoses.
- Note the higher prevalence among Whites.
- Keep in mind that "unknowns" are relatively high in young adults and lower-income residents.

Prevalence of High Blood Cholesterol

(Swedish Covenant Hospital Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 153]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-7]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Respondents reporting high cholesterol were further asked:

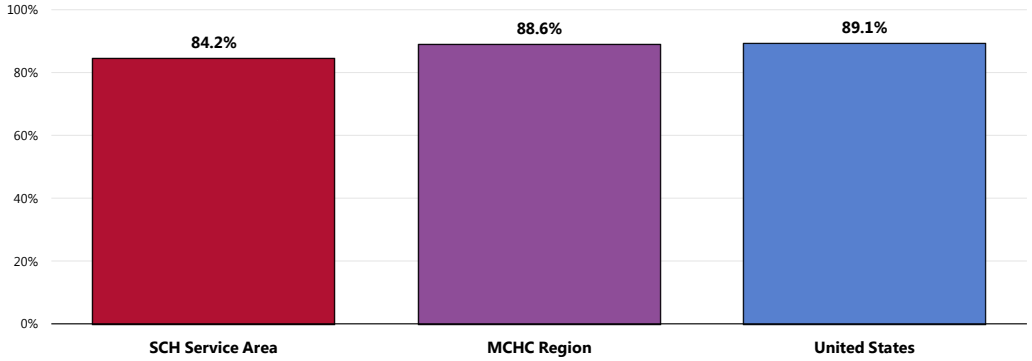
"Are you currently taking any action to help control your high cholesterol, such as taking medication, changing your diet, or exercising?"

Among adults who have been told that their blood cholesterol was high, 84.2% report that they are currently taking actions to control their cholesterol levels.

- Similar to regional findings.
- Similar to national findings.

Taking Action to Control High Blood Cholesterol Levels

(Among Adults with High Cholesterol)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 55]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents who have been diagnosed with high blood cholesterol levels.
- In this case, the term "action" refers to medication, change in diet, and/or exercise.

Total Cardiovascular Risk

Individual level risk factors which put people at increased risk for cardiovascular diseases include:

- High Blood Pressure
- High Blood Cholesterol
- Tobacco Use
- Physical Inactivity
- Poor Nutrition
- Overweight/Obesity
- Diabetes

– National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Three health-related behaviors contribute markedly to cardiovascular disease:

Poor nutrition. People who are overweight have a higher risk for cardiovascular disease. Almost 60% of adults are overweight or obese. To maintain a proper body weight, experts recommend a well-balanced diet which is low in fat and high in fiber, accompanied by regular exercise.

Lack of physical activity. People who are not physically active have twice the risk for heart disease of those who are active. More than half of adults do not achieve recommended levels of physical activity.

Tobacco use. Smokers have twice the risk for heart attack of nonsmokers. Nearly one-fifth of all deaths from cardiovascular disease, or about 190,000 deaths a year nationally, are smoking-related. Every day, more than 3,000 young people become daily smokers in the US

Modifying these behaviors is critical both for preventing and for controlling cardiovascular disease. Other steps that adults who have cardiovascular disease should take to reduce their risk of death and disability include adhering to treatment for high blood pressure and cholesterol, using aspirin as appropriate, and learning the symptoms of heart attack and stroke.

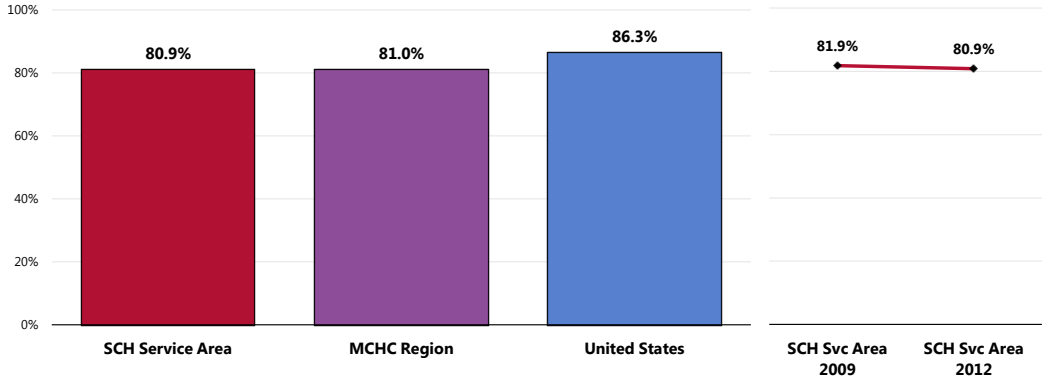
– National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

A total of 80.9% of Swedish Covenant Hospital Service Area adults report one or more cardiovascular risk factors, such as being overweight, smoking cigarettes, being physically inactive, or having high blood pressure or cholesterol.

- Nearly identical to MCHC regional findings.
- More favorable than national findings.
- Statistically similar to the 2009 findings.

RELATED ISSUE:
See also *Nutrition & Overweight, Physical Activity & Fitness* and *Tobacco Use* in the **Modifiable Health Risk** section of this report.

Present One or More Cardiovascular Risks or Behaviors



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 154]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

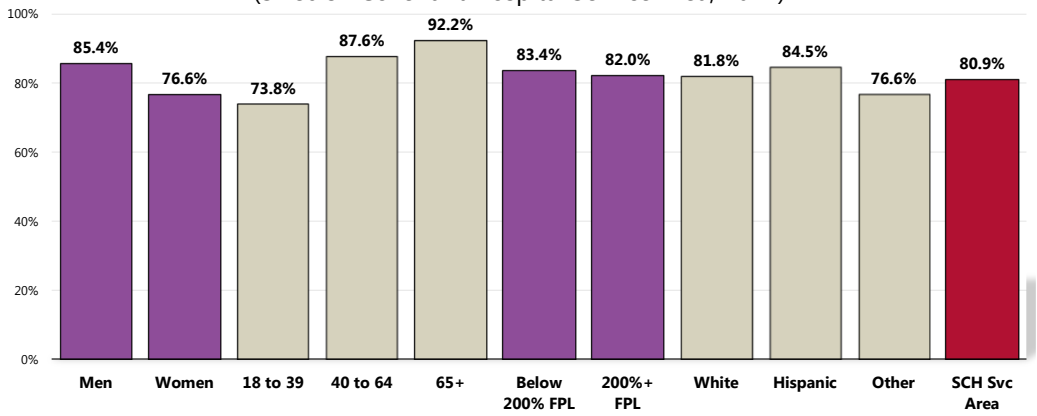
Notes:
- Asked of all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.

Adults more likely to exhibit cardiovascular risk factors include:

- Men.
- Adults age 40 and older, especially seniors.

Present One or More Cardiovascular Risks or Behaviors

(Swedish Covenant Hospital Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 154]

Notes:
- Asked of all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Cancer

Continued advances in cancer research, detection, and treatment have resulted in a decline in both incidence and death rates for all cancers. Among people who develop cancer, more than half will be alive in five years. Yet, cancer remains a leading cause of death in the United States, second only to heart disease.

Many cancers are preventable by reducing risk factors such as: use of tobacco products; physical inactivity and poor nutrition; obesity; and ultraviolet light exposure. Other cancers can be prevented by getting vaccinated against human papillomavirus and hepatitis B virus. In the past decade, overweight and obesity have emerged as new risk factors for developing certain cancers, including colorectal, breast, uterine corpus (endometrial), and kidney cancers. The impact of the current weight trends on cancer incidence will not be fully known for several decades. Continued focus on preventing weight gain will lead to lower rates of cancer and many chronic diseases.

Screening is effective in identifying some types of cancers (see US Preventive Services Task Force [USPSTF] recommendations), including:

- Breast cancer (using mammography)
- Cervical cancer (using Pap tests)
- Colorectal cancer (using fecal occult blood testing, sigmoidoscopy, or colonoscopy)

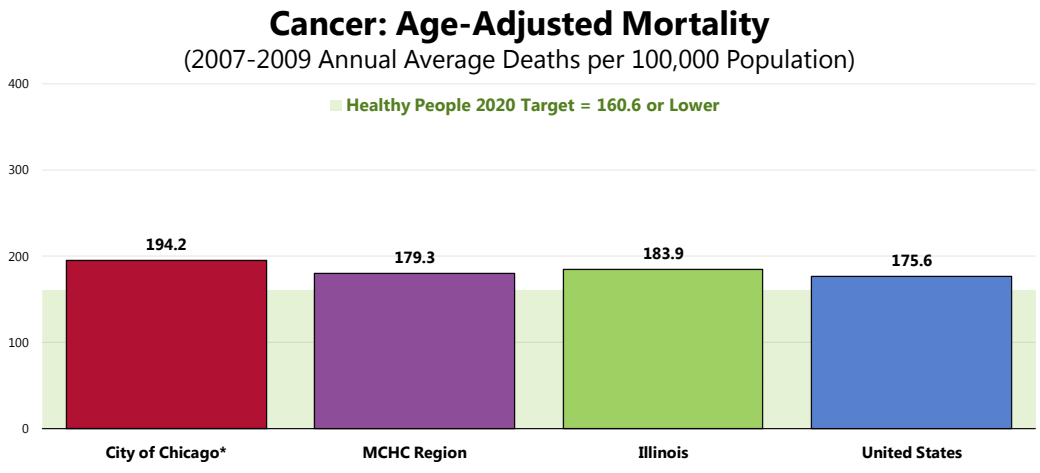
– Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Cancer Deaths

All Cancer Deaths

Between 2006 and 2008, the City of Chicago experienced an annual average age-adjusted cancer mortality rate of 194.2 deaths per 100,000 population.

- Higher than the regional cancer death rate.
- Higher than the statewide rate.
- Higher than the national rate.
- Fails to satisfy the Healthy People 2020 target of 160.6 or lower.



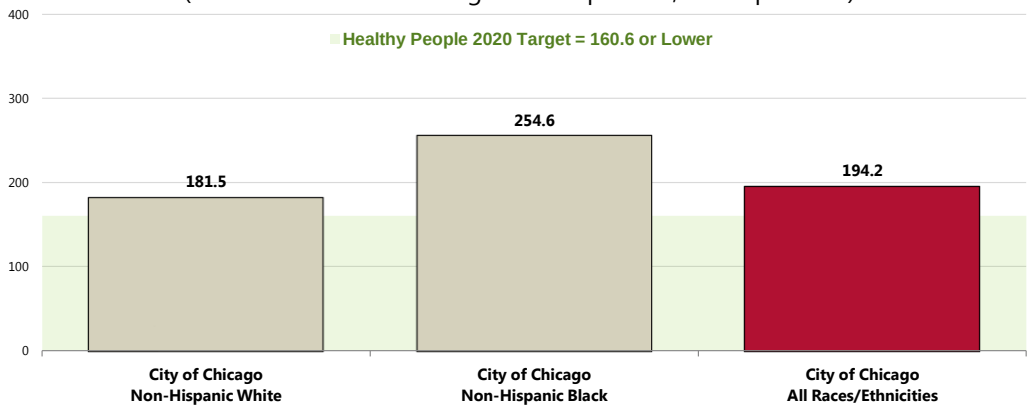
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-1]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- *City of Chicago rate represents 2006-2008 data.

The City of Chicago cancer mortality rate is notably higher among Non-Hispanic Blacks than Whites.

Cancer: Age-Adjusted Mortality by Race

(2006-2008 Annual Average Deaths per 100,000 Population)



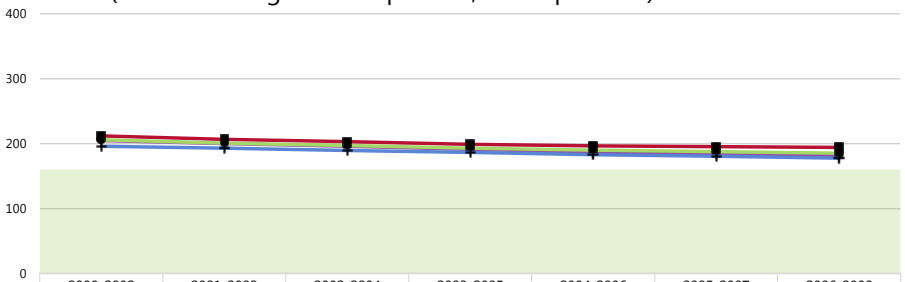
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-1]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.

Cancer mortality has <u>decreased</u> over the past decade in the City of Chicago; the same trend is apparent regionally and both statewide and nationwide.

Cancer: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2020	160.6	160.6	160.6	160.6	160.6	160.6	160.6
City of Chicago	212.4	207.0	203.4	199.4	197.1	195.9	194.2
MCHC Region	204.9	200.2	196.1	191.4	187.5	183.5	182.0
Illinois	206.1	201.2	197.4	193.5	190.2	187.7	185.8
United States	196.2	193.1	189.8	186.6	183.4	181.0	178.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-1]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

Lung cancer is by far the leading cause of cancer deaths in the City of Chicago.

Other leading sites include prostate cancer among men, breast cancer among women, and colorectal cancer (both genders).

As can be seen in the following chart (referencing 2006-2008 annual average age-adjusted death rates):

- The City of Chicago **lung cancer** death rate is higher than the regional rate but similar to the state and national rates.
- The City's **prostate cancer** death rate is higher than regional, state and national rates.
- The City of Chicago **female breast cancer** death rate is also higher than regional, state and national rates.
- The City of Chicago **colorectal cancer** death rate is higher than regional, state and national rates.

Note that **each** of the City's cancer death rates detailed below fails to satisfy the related Healthy People 2020 target.

Age-Adjusted Cancer Death Rates by Site

(2007-2009 Annual Average Deaths per 100,000 Population)

	City of Chicago*	MCHC Region	IL	US	HP2020
Lung Cancer	**51.6**	**46.9**	**52.1**	**49.5**	**45.5**
Prostate Cancer	**34.6**	**26.6**	**24.3**	**22.6**	**21.2**
Female Breast Cancer	**26.9**	**24.8**	**23.7**	**22.6**	**20.6**
Colorectal Cancer	**21.8**	**18.0**	**18.1**	**16.4**	**14.5**

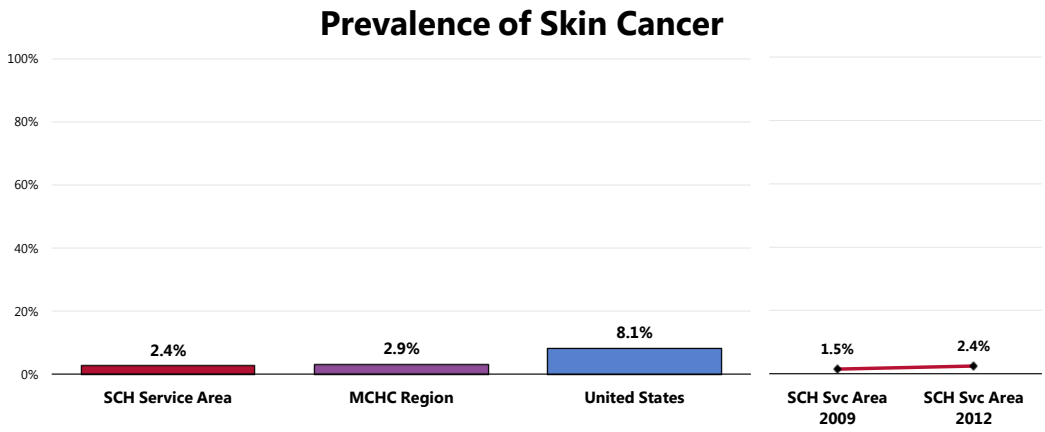
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov
- *City of Chicago rates represent 2006-2008 data.

Prevalence of Cancer

Skin Cancer

A total of 2.4% of surveyed Swedish Covenant Hospital Service Area adults report having been diagnosed with skin cancer.

- Similar to MCHC regional findings.
- More favorable than the national average.
- The prevalence of skin cancer has remained statistically unchanged over time.

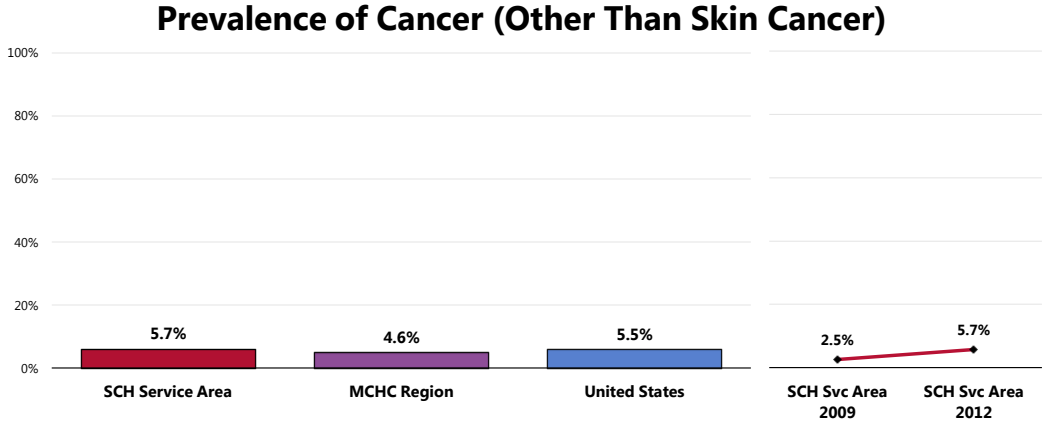


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 31]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Other Cancer

A total of 5.7% of respondents have been diagnosed with some type of (non-skin) cancer.

- Similar to findings in the MCHC Region.
- Similar to the national prevalence.
- The prevalence of cancer has increased significantly since 2009.



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 30]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

RELATED ISSUE: See also *Nutrition & Overweight, Physical Activity & Fitness* and *Tobacco Use* in the **Modifiable Health Risk** section of this report.

Reducing the nation's cancer burden requires reducing the prevalence of behavioral and environmental factors that increase cancer risk.

- All cancers caused by cigarette smoking could be prevented. At least one-third of cancer deaths that occur in the United States are due to cigarette smoking.
- According to the American Cancer Society, about one-third of cancer deaths that occur in the United States each year are due to nutrition and physical activity factors, including obesity.

– National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Cancer Screenings

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor's checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.

Screening levels in the community were measured in the PRC Community Health Survey relative to four cancer sites: prostate cancer (prostate-specific antigen testing and digital rectal examination); female breast cancer (mammography); cervical cancer (Pap smear testing); and colorectal cancer (sigmoidoscopy and fecal occult blood testing).

Prostate Cancer Screenings

The US Preventive Services Task Force (USPSTF) concludes that the current evidence is insufficient to assess the balance of benefits and harms of prostate cancer screening in men younger than age 75 years.

Rationale: Prostate cancer is the most common nonskin cancer and the second-leading cause of cancer death in men in the United States. The USPSTF found convincing evidence that prostate-specific antigen (PSA) screening can detect some cases of prostate cancer.

In men younger than age 75 years, the USPSTF found inadequate evidence to determine whether treatment for prostate cancer detected by screening improves health outcomes compared with treatment after clinical detection.

The USPSTF found convincing evidence that treatment for prostate cancer detected by screening causes moderate-to-substantial harms, such as erectile dysfunction, urinary incontinence, bowel dysfunction, and death. These harms are especially important because some men with prostate cancer who are treated would never have developed symptoms related to cancer during their lifetime.

There is also adequate evidence that the screening process produces at least small harms, including pain and discomfort associated with prostate biopsy and psychological effects of false-positive test results.

The USPSTF recommends against screening for prostate cancer in men age 75 years or older.

Rationale: In men age 75 years or older, the USPSTF found adequate evidence that the incremental benefits of treatment for prostate cancer detected by screening are small to none.

Given the uncertainties and controversy surrounding prostate cancer screening in men younger than age 75 years, a clinician should not order the PSA test without first discussing with the patient the potential but uncertain benefits and the known harms of prostate cancer screening and treatment. Men should be informed of the gaps in the evidence and should be assisted in considering their personal preferences before deciding whether to be tested.

– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services.

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

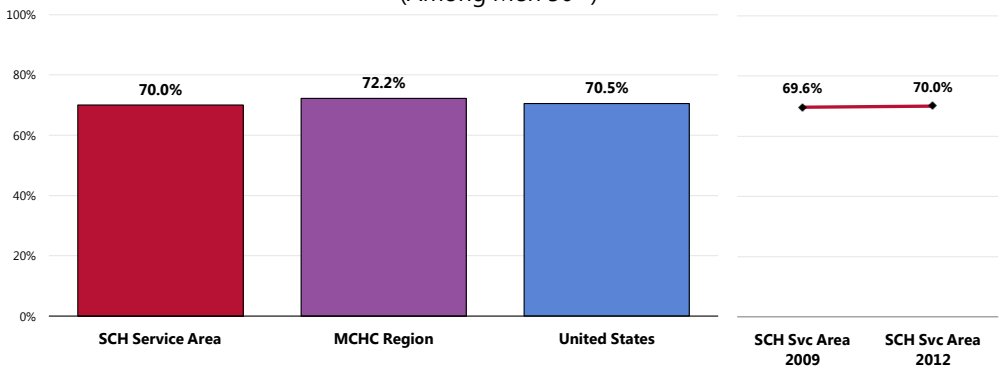
PSA Testing and/or Digital Rectal Examination

Note: Due to recent (2008) changes in clinical recommendations against routine PSA testing, it is anticipated that testing levels will begin to decline.

Among men age 50+, 7 in 10 (70.0%) have had a PSA (prostate-specific antigen) test and/or a digital rectal examination for prostate problems in the past two years.

- Comparable to MCHC regional findings.
- Comparable to national findings.
- Statistically unchanged since 2009.

Have Had a Prostate Screening in the Past Two Years
(Among Men 50+)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 158]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all male respondents 50 and older.

Female Breast Cancer Screening

The US Preventive Services Task Force (USPSTF) recommends screening mammography, with or without clinical breast examination (CBE), every 1-2 years for women age 40 and older.

Rationale: The USPSTF found fair evidence that mammography screening every 12-33 months significantly reduces mortality from breast cancer. Evidence is strongest for women age 50-69, the age group generally included in screening trials. For women age 40-49, the evidence that screening mammography reduces mortality from breast cancer is weaker, and the absolute benefit of mammography is smaller, than it is for older women. Most, but not all, studies indicate a mortality benefit for women undergoing mammography at ages 40-49, but the delay in observed benefit in women younger than 50 makes it difficult to determine the incremental benefit of beginning screening at age 40 rather than at age 50.

The absolute benefit is smaller because the incidence of breast cancer is lower among women in their 40s than it is among older women. The USPSTF concluded that the evidence is also generalizable to women age 70 and older (who face a higher absolute risk for breast cancer) if their life expectancy is not compromised by comorbid disease. The absolute probability of benefits of regular mammography increase along a continuum with age, whereas the likelihood of harms from screening (false-positive results and unnecessary anxiety, biopsies, and cost) diminish from ages 40-70. The balance of benefits and potential harms, therefore, grows more favorable as women age. The precise age at which the potential benefits of mammography justify the possible harms is a subjective choice. The USPSTF did not find sufficient evidence to specify the optimal screening interval for women age 40-49.

– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services.

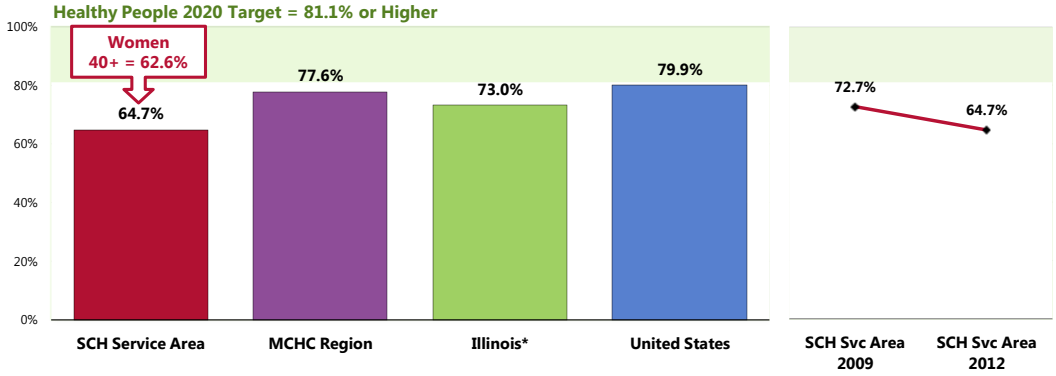
Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Mammography

Among women age 50-74, 64.7% had a mammogram within the past two years.

- Less favorable than regional findings.
- Similar to statewide findings (which represent all women 50+).
- Less favorable than national findings.
- Fails to meet the Healthy People 2020 target (81.1% or higher).
- Statistically unchanged since 2009.
- Among women 40+, 62.6% had a mammogram in the past two years.

Have Had a Mammogram in the Past Two Years
(Among Women 50-74)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 155-156]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-17]

Notes:
- Reflects female respondents 50-74.
- *Note that state data reflects all women 50 and older (vs. women 50-74 in local, US and Healthy People data).

Cervical Cancer Screenings

The US Preventive Services Task Force (USPSTF) strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.

Rationale: The USPSTF found good evidence from multiple observational studies that screening with cervical cytology (Pap smears) reduces incidence of and mortality from cervical cancer. Direct evidence to determine the optimal starting and stopping age and interval for screening is limited. Indirect evidence suggests most of the benefit can be obtained by beginning screening within 3 years of onset of sexual activity or age 21 (whichever comes first) and screening at least every 3 years. The USPSTF concludes that the benefits of screening substantially outweigh potential harms.

The USPSTF recommends against routinely screening women older than age 65 for cervical cancer if they have had adequate recent screening with normal Pap smears and are not otherwise at high risk for cervical cancer.

Rationale: The USPSTF found limited evidence to determine the benefits of continued screening in women older than 65. The yield of screening is low in previously screened women older than 65 due to the declining incidence of high-grade cervical lesions after middle age. There is fair evidence that screening women older than 65 is associated with an increased risk for potential harms, including false-positive results and invasive procedures. The USPSTF concludes that the potential harms of screening are likely to exceed benefits among older women who have had normal results previously and who are not otherwise at high risk for cervical cancer.

The USPSTF recommends against routine Pap smear screening in women who have had a total hysterectomy for benign disease.

Rationale: The USPSTF found fair evidence that the yield of cytologic screening is very low in women after hysterectomy and poor evidence that screening to detect vaginal cancer improves health outcomes. The USPSTF concludes that potential harms of continued screening after hysterectomy are likely to exceed benefits.

– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services.

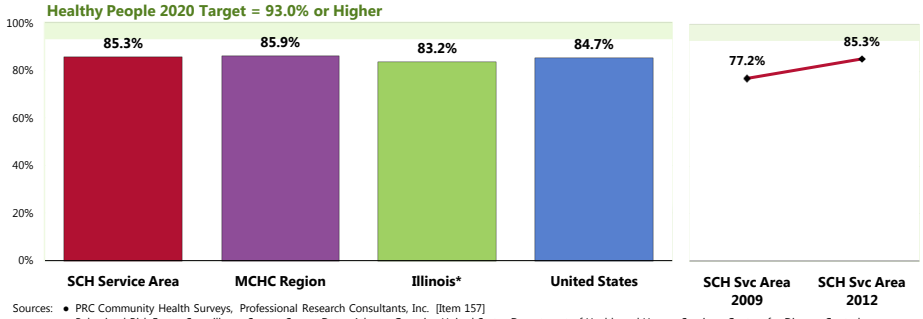
Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Pap Smear Testing

Among women age 21 to 65, 85.3% had a Pap smear within the past three years.

- Comparable to MCHC regional findings.
- Comparable to Illinois findings (which represents all women 18+).
- Comparable to national findings.
- Fails to satisfy the Healthy People 2020 target (93% or higher).
- A statistically significant improvement since 2009.

Have Had a Pap Smear in the Past Three Years
(Among Women 21-65)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 157]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-15]

Notes:
- Reflects female respondents age 21 to 65.
- *Note that the IL percentage represents all women age 18 and older.

Colorectal Cancer Screenings

The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults, beginning at age 50 years and continuing until age 75 years.

The evidence is convincing that screening for colorectal cancer with fecal occult blood testing, sigmoidoscopy, or colonoscopy detects early-stage cancer and adenomatous polyps. There is convincing evidence that screening with any of the three recommended tests (FOBT, sigmoidoscopy, colonoscopy) reduces colorectal cancer mortality in adults age 50 to 75 years. Follow-up of positive screening test results requires colonoscopy regardless of the screening test used.

– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services.

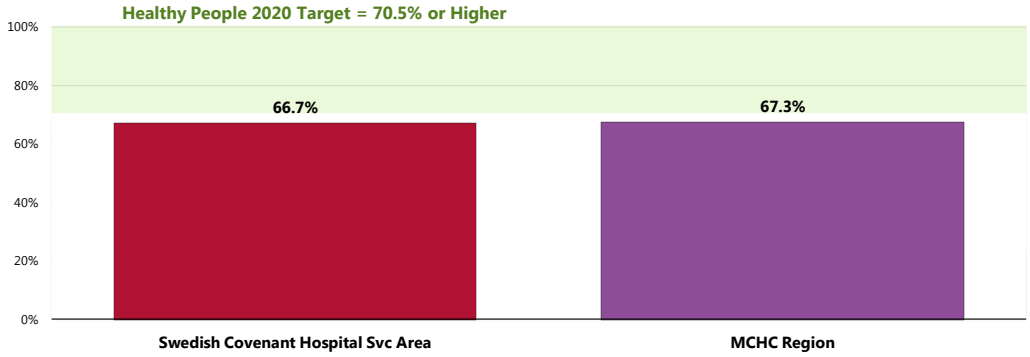
Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Colorectal Cancer Screening

Among adults age 50-75, 66.7% have had an appropriate colorectal cancer screening (fecal occult blood testing within the past year and/or sigmoidoscopy/colonoscopy [lower endoscopy]) within the past 10 years.

- Similar to regional findings.
- Similar to the Healthy People 2020 target (70.5% or higher).

Have Had a Colorectal Cancer Screening
(Among Adults 50-75; 2012)



Sources:
- 2012 PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 161]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-16]

Notes:
- Asked of all respondents age 50 through 75.
- In this case, the term "colorectal screening" refers to adults age 50-75 receiving a FOBT (fecal occult blood test) in the past year and/or a lower endoscopy (sigmoidoscopy/colonoscopy) in the past 10 years.

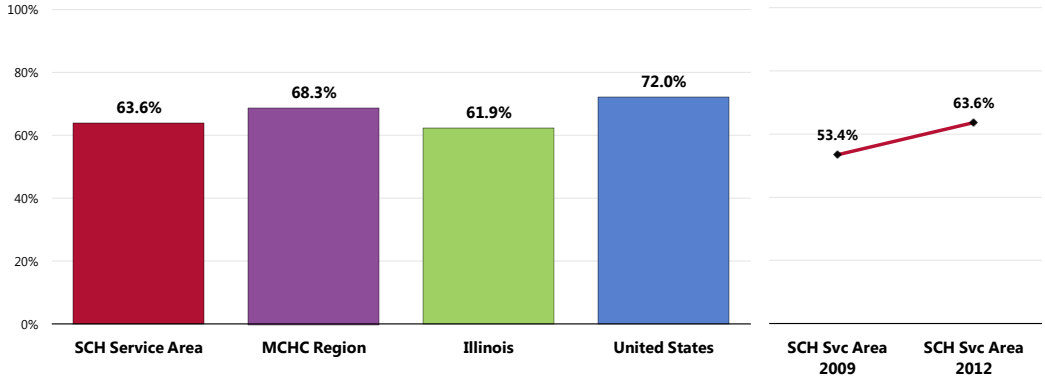
Lower Endoscopy

Among adults age 50 and older, 63.6% have had a lower endoscopy (sigmoidoscopy or colonoscopy) at some point in their lives.

- Similar to findings in the MCHC Region.
- Similar to Illinois findings.
- Less favorable than national findings.
- Statistically similar to the 2009 survey findings.

Have Ever Had a Lower Endoscopy Exam

(Among Adults 50+)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 159]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents 50+.
- Lower endoscopy includes either sigmoidoscopy or colonoscopy.

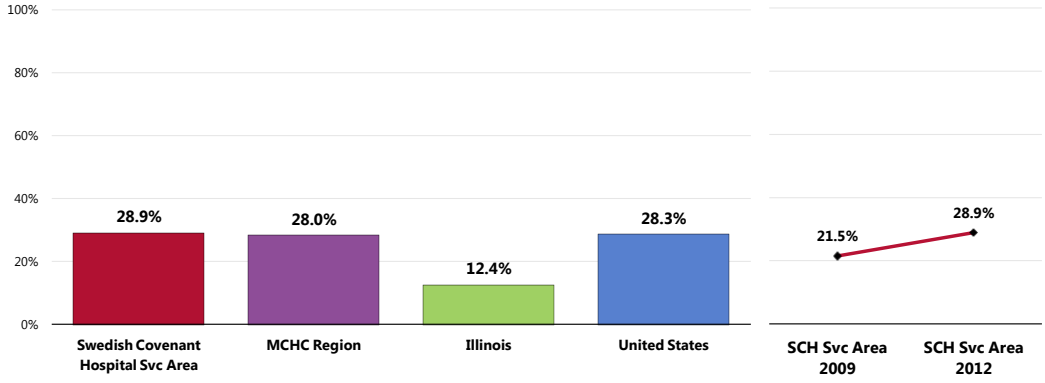
Blood Stool Testing

Among adults age 50 and older, 28.9% have had a blood stool test (aka "fecal occult blood test") within the past two years.

- Similar to regional findings.
- More favorable than Illinois findings.
- Similar to national findings.
- Statistically unchanged since 2009.

Have Had a Blood Stool Test in the Past Two Years

(Among Adults 50+)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 160]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents 50+.

Respiratory Disease

Asthma and chronic obstructive pulmonary disease (COPD) are significant public health burdens. Specific methods of detection, intervention, and treatment exist that may reduce this burden and promote health.

Asthma is a chronic inflammatory disorder of the airways characterized by episodes of reversible breathing problems due to airway narrowing and obstruction. These episodes can range in severity from mild to life threatening. Symptoms of asthma include wheezing, coughing, chest tightness, and shortness of breath. Daily preventive treatment can prevent symptoms and attacks and enable individuals who have asthma to lead active lives.

COPD is a preventable and treatable disease characterized by airflow limitation that is not fully reversible. The airflow limitation is usually progressive and associated with an abnormal inflammatory response of the lung to noxious particles or gases (typically from exposure to cigarette smoke). Treatment can lessen symptoms and improve quality of life for those with COPD.

Several additional respiratory conditions and respiratory hazards, including infectious agents and occupational and environmental exposures, are covered in other areas of Healthy People 2020. Examples include tuberculosis, lung cancer, acquired immunodeficiency syndrome (AIDS), pneumonia, occupational lung disease, and smoking. Sleep Health is now a separate topic area of Healthy People 2020.

Currently in the United States, more than 23 million people have asthma. Approximately 13.6 million adults have been diagnosed with COPD, and an approximately equal number have not yet been diagnosed. The burden of respiratory diseases affects individuals and their families, schools, workplaces, neighborhoods, cities, and states. Because of the cost to the healthcare system, the burden of respiratory diseases also falls on society; it is paid for with higher health insurance rates, lost productivity, and tax dollars. Annual healthcare expenditures for asthma alone are estimated at $20.7 billion.

Asthma. The prevalence of asthma has increased since 1980. However, deaths from asthma have decreased since the mid-1990s. The causes of asthma are an active area of research and involve both genetic and environmental factors.

Risk factors for asthma currently being investigated include:

- Having a parent with asthma
- Sensitization to irritants and allergens
- Respiratory infections in childhood
- Overweight

Asthma affects people of every race, sex, and age. However, significant disparities in asthma morbidity and mortality exist, in particular for low-income and minority populations. Populations with higher rates of asthma include: children; women (among adults) and boys (among children); African Americans; Puerto Ricans; people living in the Northeast United States; people living below the Federal poverty level; and employees with certain exposures in the workplace.

While there is not a cure for asthma yet, there are diagnoses and treatment guidelines that are aimed at ensuring that all people with asthma live full and active lives.

– Healthy People 2020 (www.healthypeople.gov)

[NOTE: COPD was changed to chronic lower respiratory disease (CLRD) with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.]

Age-Adjusted Respiratory Disease Deaths

Note: COPD was changed to chronic lower respiratory disease (CLRD) in 1999 with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.

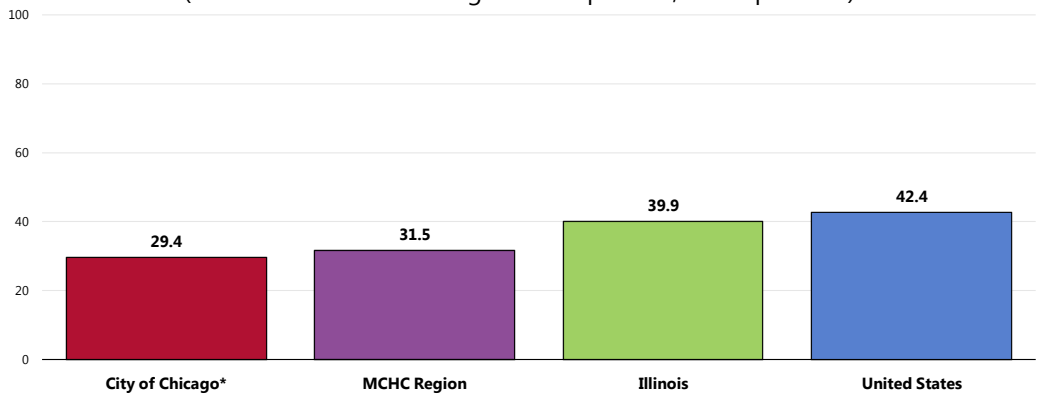
Chronic Lower Respiratory Disease Deaths (CLRD)

Between 2006 and 2008, there was an annual average age-adjusted CLRD mortality rate of 29.4 deaths per 100,000 population in the City of Chicago.

- Better than the regional rate.
- Better than found statewide.
- Better than the national rate.

CLRD: Age-Adjusted Mortality

(2007-2009 Annual Average Deaths per 100,000 Population)



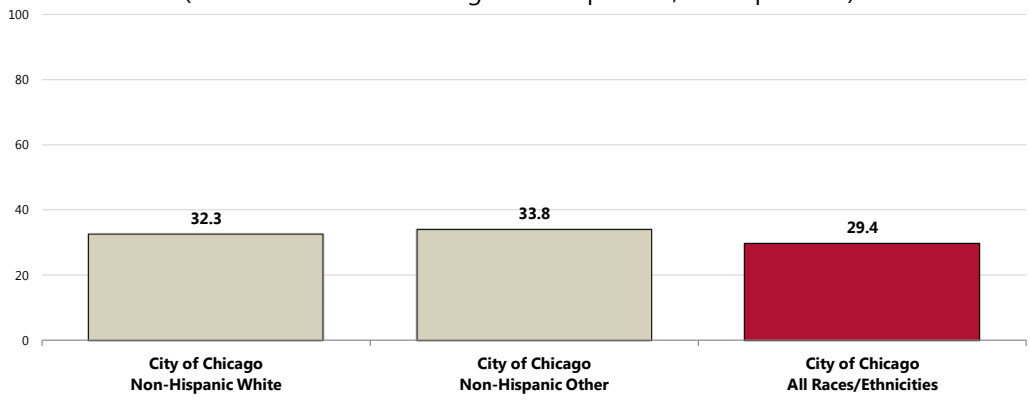
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- CLRD is chronic lower respiratory disease.
- *City of Chicago rate represents 2006-2008 data.

CLRD mortality does not appear to vary much by race in the City of Chicago.

CLRD: Age-Adjusted Mortality by Race

(2006-2008 Annual Average Deaths per 100,000 Population)



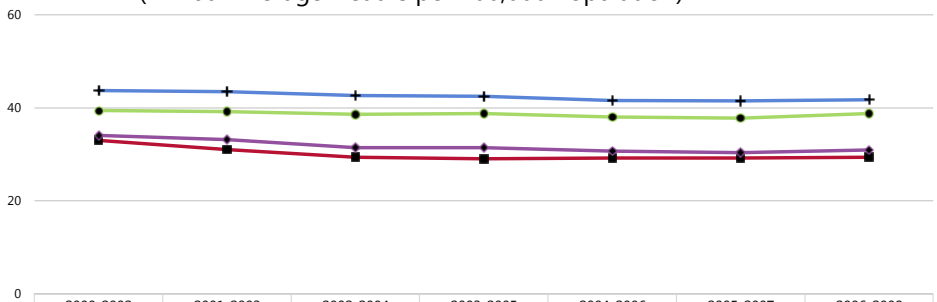
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- CLRD is chronic lower respiratory disease.

The City's CLRD mortality rate has decreased over the past decade, similar to the trends reported regionally and both statewide and nationwide.

CLRD: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
City of Chicago	33.0	31.0	29.3	29.0	29.2	29.2	29.4
MCHC Region	34.1	33.2	31.4	31.4	30.7	30.4	30.9
Illinois	39.4	39.2	38.6	38.8	38.0	37.8	38.8
United States	43.8	43.5	42.6	42.5	41.6	41.5	41.8

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- CLRD is chronic lower respiratory disease.

Pneumonia/Influenza Deaths

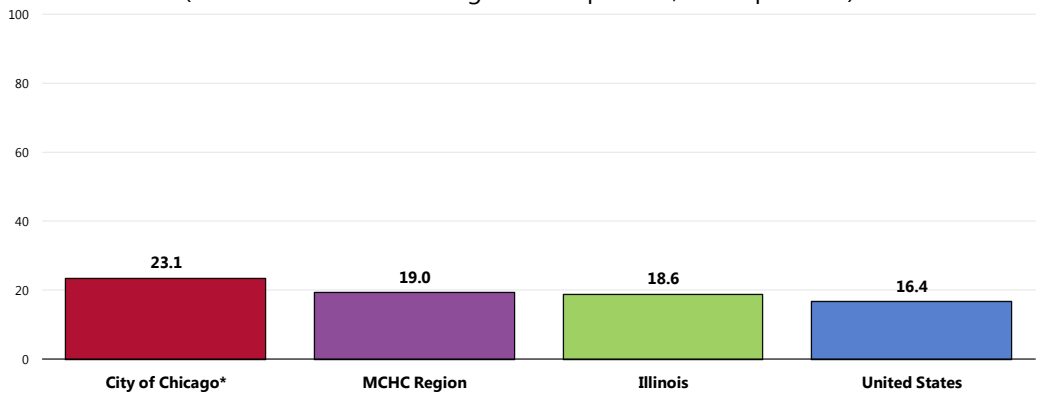
For prevalence of vaccinations for pneumonia and influenza, see also "Immunization & Infectious Disease."

Between 2006 and 2008, the City of Chicago reported an annual average age-adjusted pneumonia influenza mortality rate of 23.1 deaths per 100,000 population.

- Higher than the regional rate.
- Higher than the rate reported statewide.
- Higher than the national rate.

Pneumonia/Influenza: Age-Adjusted Mortality

(2007-2009 Annual Average Deaths per 100,000 Population)



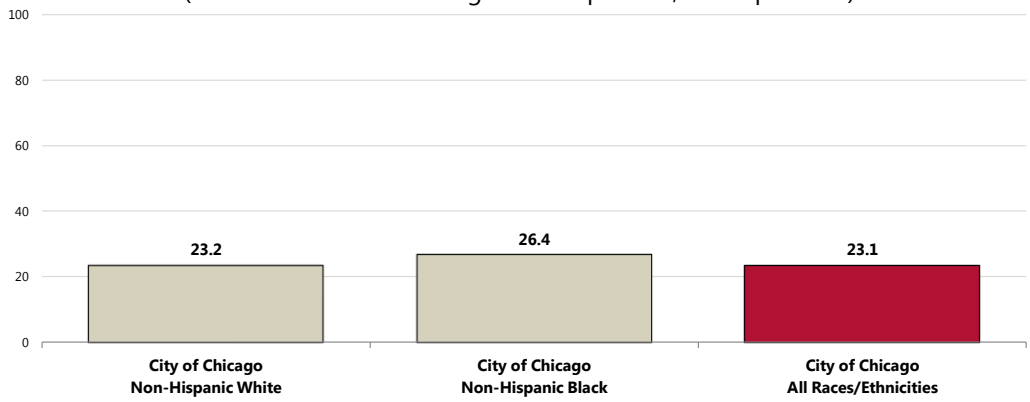
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- *City of Chicago rate represents 2006-2008 data.

The City's pneumonia/influenza mortality rate is slightly higher among Blacks than Whites.

Pneumonia/Influenza: Age-Adjusted Mortality by Race

(2006-2008 Annual Average Deaths per 100,000 Population)



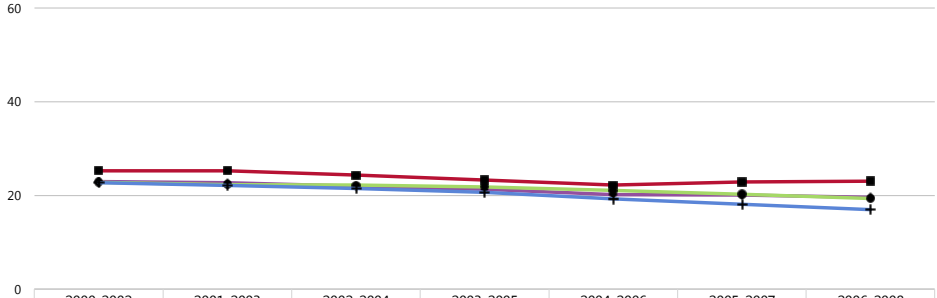
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• Local, state and national data are simple three-year averages.

City of Chicago pneumonia/influenza mortality has decreased over the past decade; a downward trend is evident across the MCHC Region, and is reported statewide and nationwide as well.

Pneumonia/Influenza: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
City of Chicago	25.3	25.3	24.3	23.3	22.2	22.9	23.1
MCHC Region	23.0	22.7	22.0	21.3	20.2	20.1	19.6
Illinois	22.8	22.3	22.2	21.8	21.1	20.3	19.4
United States	22.7	22.2	21.5	20.7	19.3	18.1	17.0

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

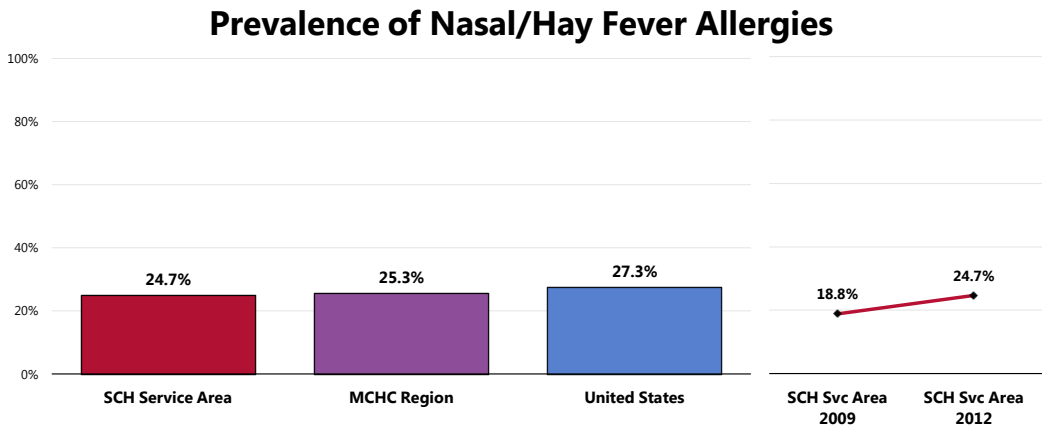
Prevalence of Respiratory Conditions

Survey respondents were next asked to indicate whether they suffer from or have been diagnosed with various respiratory conditions, including asthma, nasal/hay fever allergies, sinusitis, and/or chronic lung disease.

Nasal/Hay Fever Allergies

A total of one in four Swedish Covenant Hospital Service Area adults (24.7%) currently suffers from or have been diagnosed with nasal/hay fever allergies.

- Comparable to regional findings.
- Comparable to the US prevalence.
- Statistically unchanged since 2009.

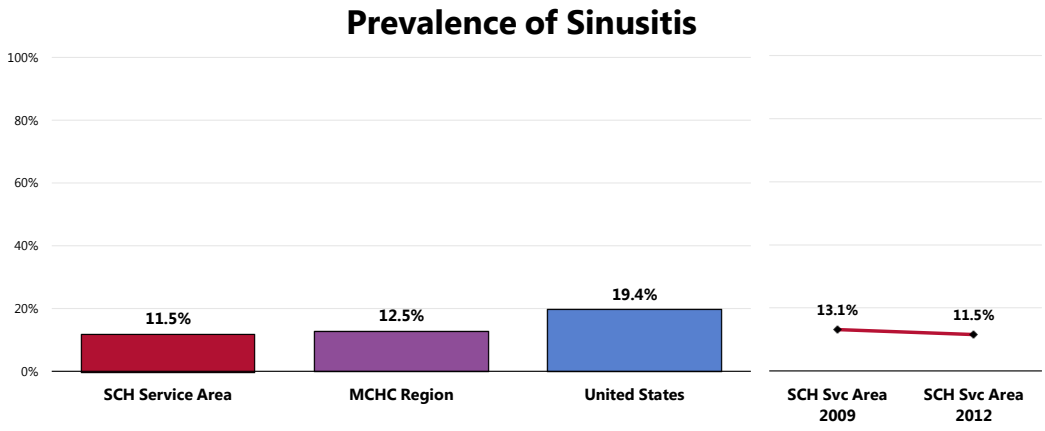


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 35]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Sinusitis

A total of 11.5% of Swedish Covenant Hospital Service Area adults suffer from sinusitis.

- Similar to findings in the MCHC Region.
- More favorable than the national prevalence.
- Statistically similar to 2009 findings.



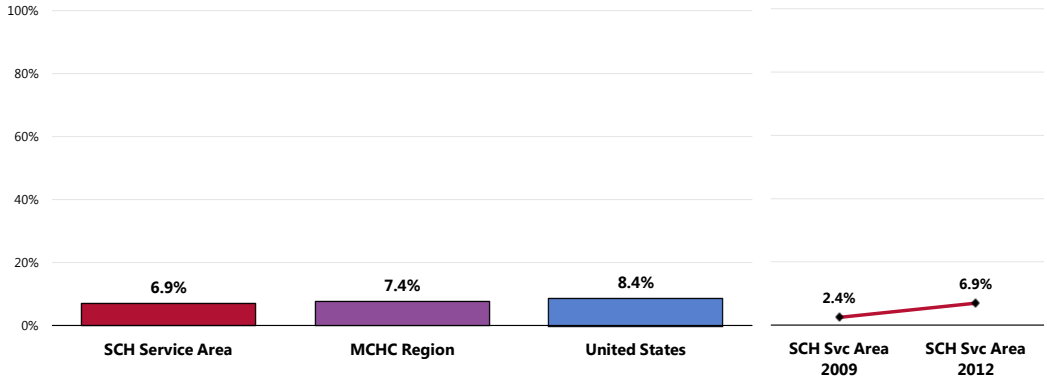
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 34]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Chronic Lung Disease

A total of 6.9% of Swedish Covenant Hospital Service Area adults suffer from chronic lung disease.

- Comparable to regional findings.
- Comparable to the national prevalence.
- Denotes a significant increase from 2009.

Prevalence of Chronic Lung Disease



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 25]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

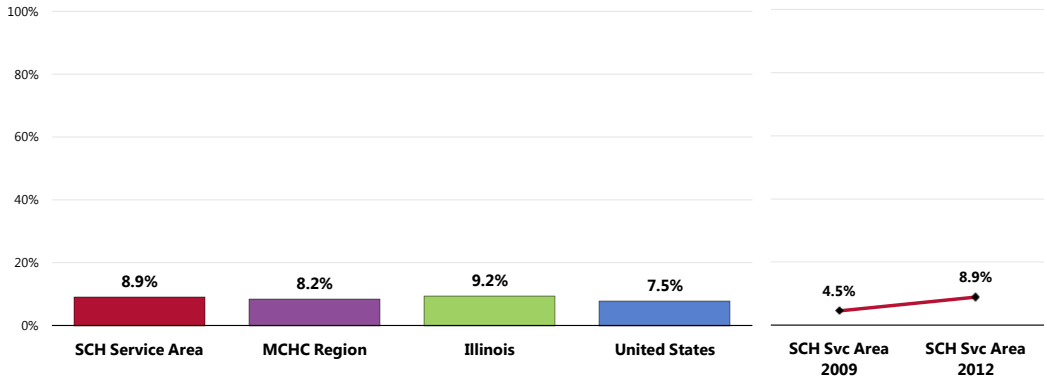
Asthma

Adults

A total of 8.9% of service area adults currently suffer from asthma.

- Similar to regional findings.
- Similar to the statewide prevalence.
- Similar to the national prevalence.
- The prevalence of asthma in adults increased significantly since 2009.

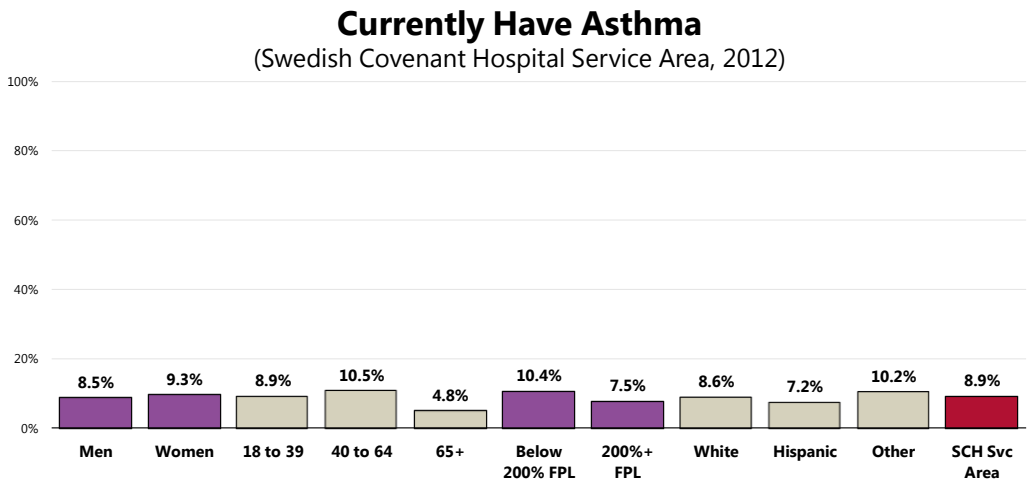
Currently Have Asthma



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 162]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.

Notes:
- Asked of all respondents.

- No statistical differences in asthma prevalence were identified when viewed by demographic characteristics.

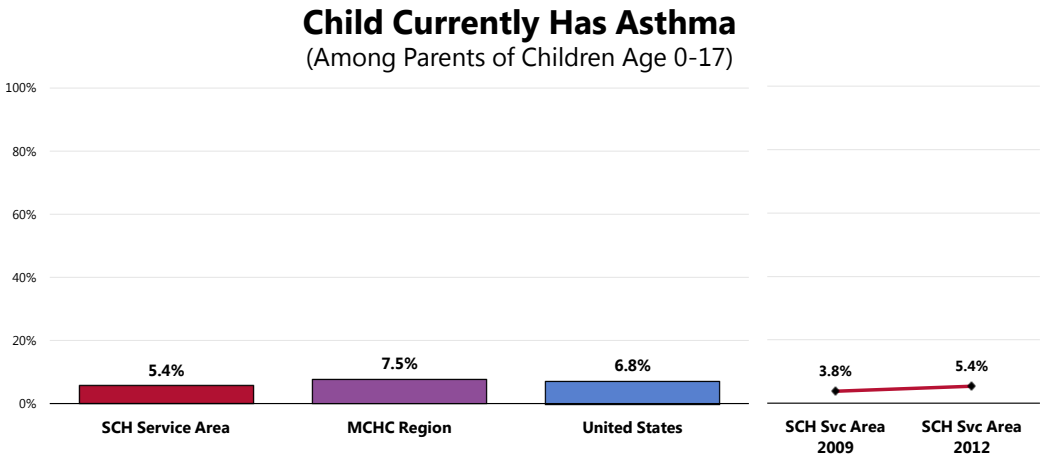


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 162]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Children

Among Swedish Covenant Hospital Service Area children under age 18, 5.4% currently have asthma.

- Similar to findings in the MCHC Region.
- Similar to national findings.
- The prevalence of children with asthma has not changed significantly over time.



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 163]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents with children 0 to 17 in the household.

Injury & Violence

Injuries and violence are widespread in society. Both unintentional injuries and those caused by acts of violence are among the top 15 killers for Americans of all ages. Many people accept them as "accidents," "acts of fate," or as "part of life." However, most events resulting in injury, disability, or death are predictable and preventable.

Injuries are the leading cause of death for Americans ages 1 to 44, and a leading cause of disability for all ages, regardless of sex, race/ethnicity, or socioeconomic status. More than 180,000 people die from injuries each year, and approximately 1 in 10 sustains a nonfatal injury serious enough to be treated in a hospital emergency department.

Beyond their immediate health consequences, injuries and violence have a significant impact on the well-being of Americans by contributing to:

- Premature death
- Disability
- Poor mental health
- High medical costs
- Lost productivity

The effects of injuries and violence extend beyond the injured person or victim of violence to family members, friends, coworkers, employers, and communities.

Numerous factors can affect the risk of unintentional injury and violence, including individual behaviors, physical environment, access to health services (ranging from pre-hospital and acute care to rehabilitation), and social environment (from parental monitoring and supervision of youth to peer group associations, neighborhoods, and communities).

Interventions addressing these social and physical factors have the potential to prevent unintentional injuries and violence. Efforts to prevent unintentional injury may focus on:

- Modifications of the environment
- Improvements in product safety
- Legislation and enforcement
- Education and behavior change
- Technology and engineering

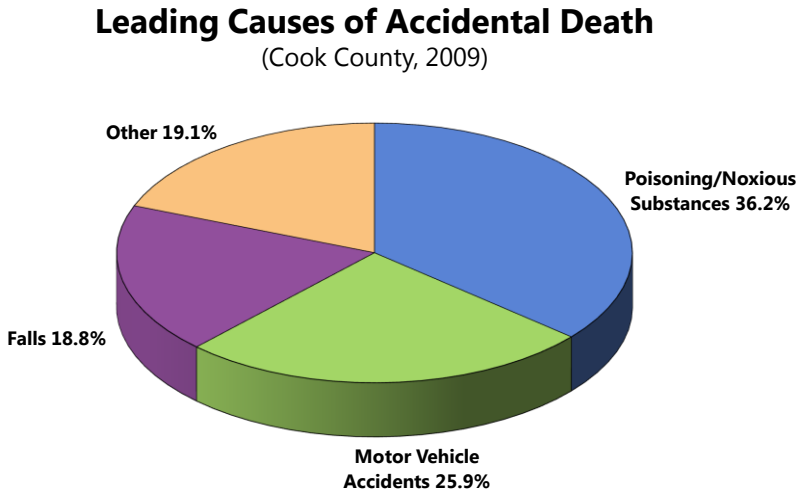
Efforts to prevent violence may focus on:

- Changing social norms about the acceptability of violence
- Improving problem-solving skills (for example, parenting, conflict resolution, coping)
- Changing policies to address the social and economic conditions that often give rise to violence

– Healthy People 2020 (www.healthypeople.gov)

Leading Causes of Accidental Death

Poisoning, motor vehicle accidents, and falls accounted for 80.9% of Cook County accidental deaths in 2009.



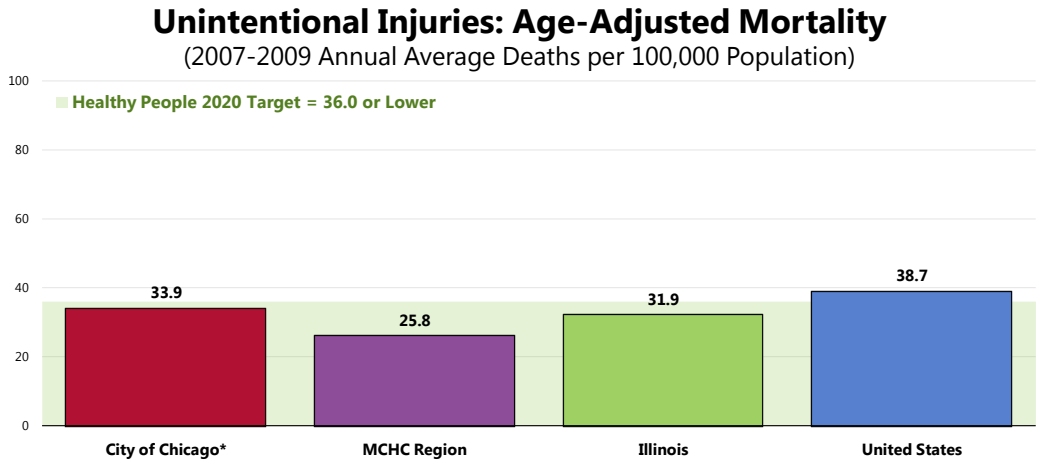
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

Between 2006 and 2008, the City of Chicago reported an annual average age-adjusted unintentional injury mortality rate of 33.9 deaths per 100,000 population.

- Much higher than the regional rate.
- Higher than the Illinois rate.
- Lower than the national rate.
- Satisfies the Healthy People 2020 target (36.0 or lower).

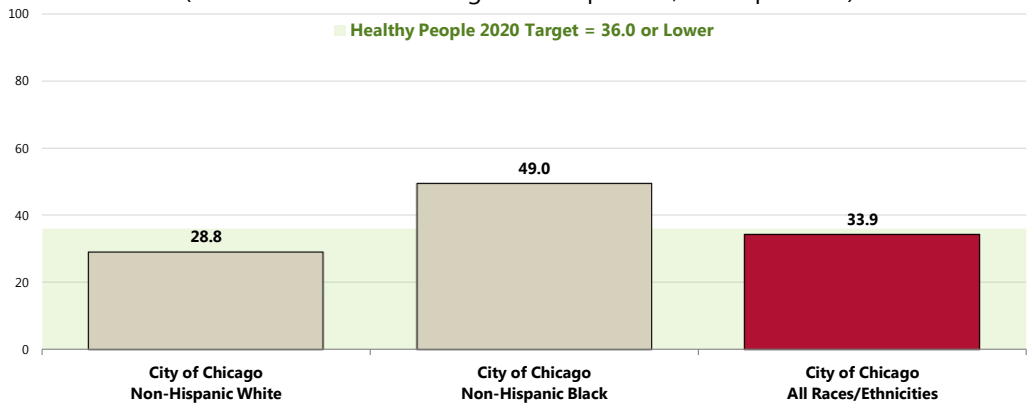


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-11]
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• Local, state and national data are simple three-year averages.
• *City of Chicago rate represents 2006-2008 data.

The mortality rate due to accidents is notably higher among Blacks than Whites in the City of Chicago.

Unintentional Injuries: Age-Adjusted Mortality by Race

(2006-2008 Annual Average Deaths per 100,000 Population)



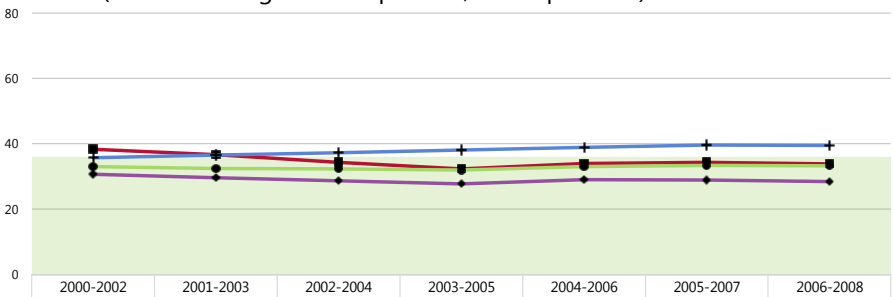
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-11]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.

The City's unintentional injury mortality rate declined early in the last decade, but has since increased slightly. Nationally, the trend has been consistently upward.

Unintentional Injuries: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2020	36.0	36.0	36.0	36.0	36.0	36.0	36.0
City of Chicago	38.3	36.7	34.3	32.3	34.0	34.3	33.9
MCHC Region	30.7	29.6	28.7	27.7	29.0	28.9	28.4
Illinois	33.0	32.4	32.3	31.9	33.0	33.4	33.3
United States	35.8	36.6	37.3	38.0	38.9	39.6	39.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-11]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.

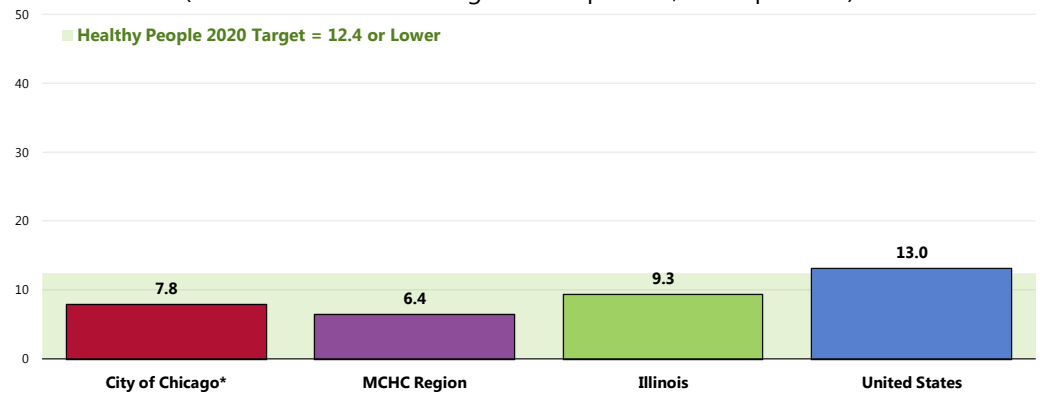
Age-Adjusted Motor-Vehicle Related Deaths

Between 2006 and 2008, there was an annual average age-adjusted motor vehicle crash mortality rate of 7.8 deaths per 100,000 population in the City of Chicago.

- Higher than the regional rate.
- Better than found statewide.
- Better than found nationally.
- Satisfies the Healthy People 2020 target (12.4 or lower).

Motor Vehicle Crashes: Age-Adjusted Mortality

(2007-2009 Annual Average Deaths per 100,000 Population)



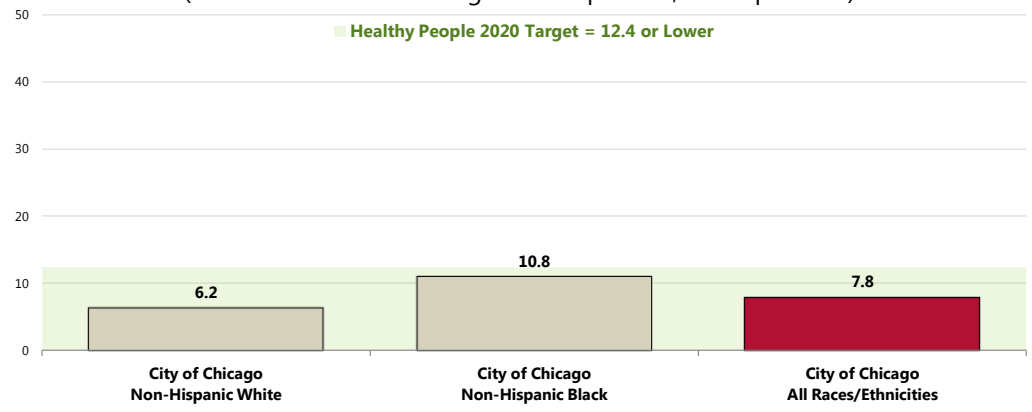
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-13.1]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- *City of Chicago rate represents 2006-2008 data.

The City's 2006-2008 motor vehicle crash mortality rate was higher among Blacks than among Whites.

Motor Vehicle Crashes: Age-Adjusted Mortality by Race

(2006-2008 Annual Average Deaths per 100,000 Population)



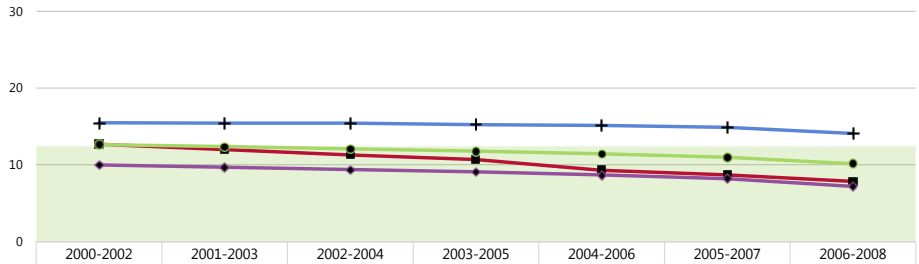
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-13.1]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.

- The motor vehicle accident mortality rate has decreased in Chicago over the past decade.

Motor Vehicle Crashes: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2020	12.4	12.4	12.4	12.4	12.4	12.4	12.4
City of Chicago	12.7	12	11.3	10.7	9.3	8.7	7.8
MCHC Region	10.0	9.7	9.4	9.1	8.7	8.2	7.2
Illinois	12.6	12.4	12.1	11.8	11.4	11.0	10.1
United States	15.5	15.4	15.4	15.2	15.1	14.9	14.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-13.1]

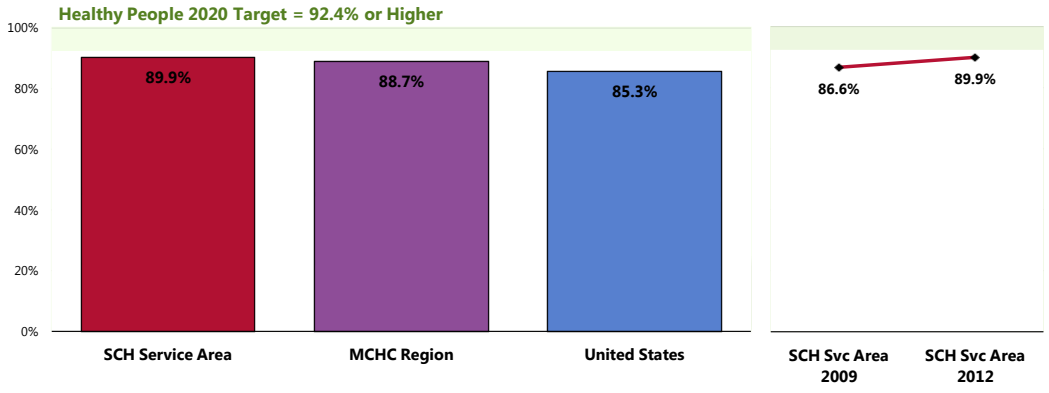
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.

Seat Belt Usage - Adults

Most Swedish Covenant Hospital Service Area adults (89.9%) report "always" wearing a seat belt when driving or riding in a vehicle.

- Similar to regional findings.
- More favorable than the percentage found nationally.
- Similar to the Healthy People 2020 target of 92.4% or higher.
- No significant change since 2009.

"Always" Wear a Seat Belt When Driving or Riding in a Vehicle



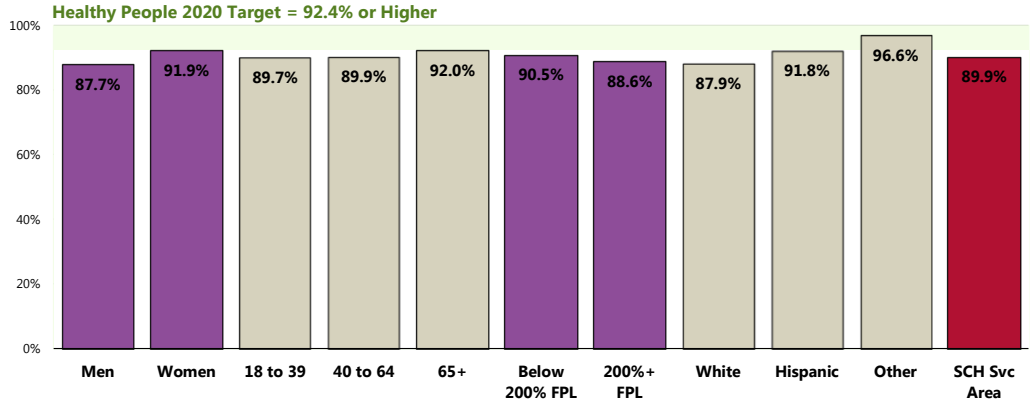
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 57]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IPV-15]

Notes:
- Asked of all respondents.

Whites in the service area are less likely to report consistent seat belt usage.

"Always" Wear a Seat Belt When Driving or Riding in a Vehicle

(Swedish Covenant Hospital Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 57]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IPV-15]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

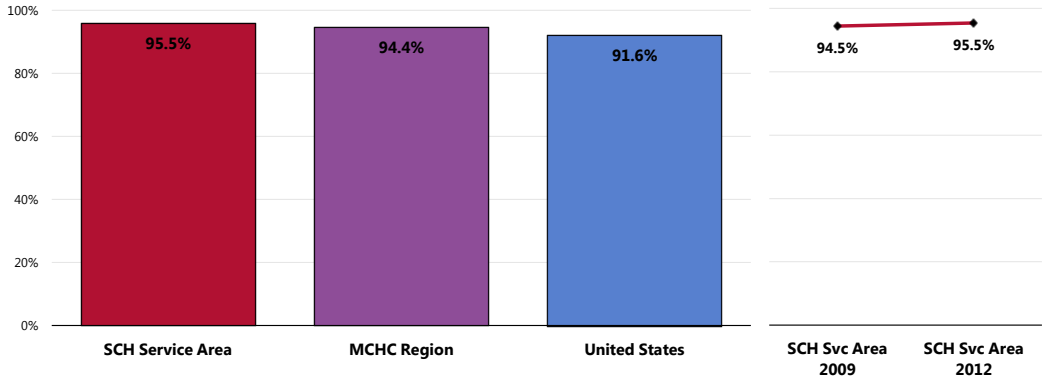
Seat Belt Usage - Children

A full 95.5% of Swedish Covenant Hospital Service Area parents report that their child (age 0 to 17) "always" wears a seat belt (or appropriate car seat for younger children) when riding in a vehicle.

- Comparable to MCHC regional findings.
- Comparable to the rate found nationally.
- Statistically unchanged since 2009.

Child "Always" Wears a Seat Belt or Appropriate Restraint When Riding in a Vehicle

(Among Parents of Children Age 0-17)



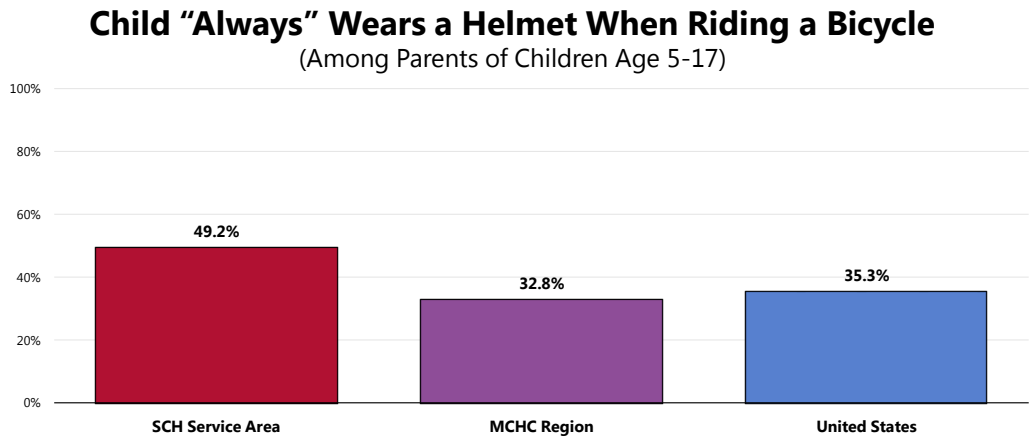
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 141]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.

Bicycle Safety

Nearly one-half (49.2%) of Swedish Covenant Hospital Service Area children age 5 to 17 are reported to "always" wear a helmet when riding a bicycle.

- More favorable than regional findings.
- More favorable than the national prevalence.



Sources: • 2012 PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 147]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents with children age 5 to 17 at home.

Firearm Safety

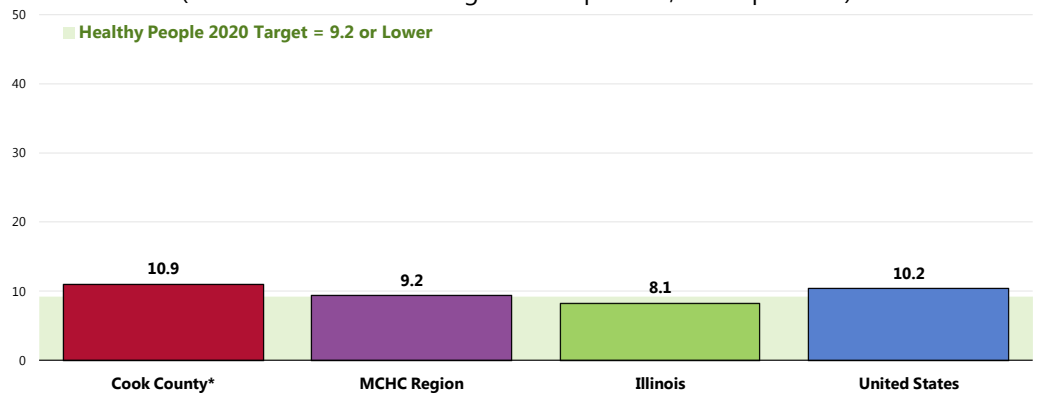
Age-Adjusted Firearm-Related Deaths

Between 2007 and 2009, there was an annual average age-adjusted rate of 10.9 firearm-related deaths per 100,000 population in Cook County (City of Chicago data not available).

- Higher than the regional rate.
- Higher than found statewide.
- Just above that found nationally.
- Fails to satisfy the Healthy People 2020 objective (9.2 or lower).

Firearms-Related Deaths: Age-Adjusted Mortality

(2007-2009 Annual Average Deaths per 100,000 Population)



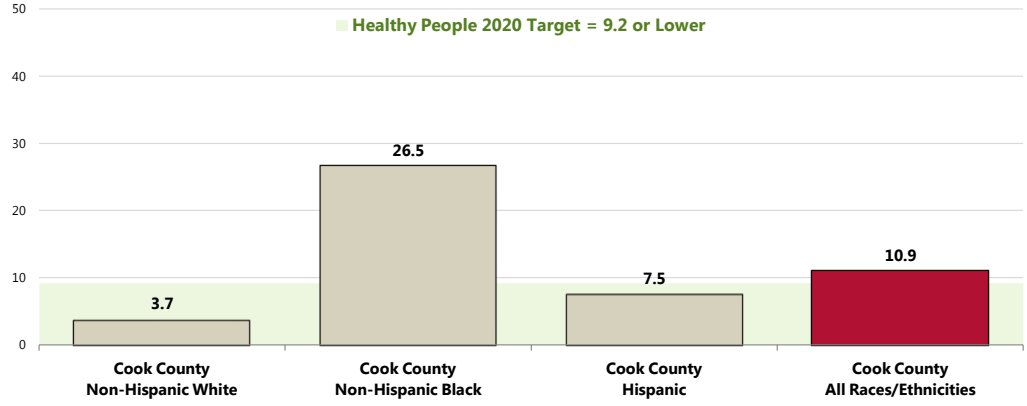
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-30]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- Local, state and national data are simple three-year averages.
- *City of Chicago data not available; Cook County data is used here.

The Cook County firearm-related mortality rate among Blacks is more than seven times higher than among Whites, and is more than three times higher than among Hispanics.

Firearms-Related Deaths: Age-Adjusted Mortality by Race

(2007-2009 Annual Average Deaths per 100,000 Population)



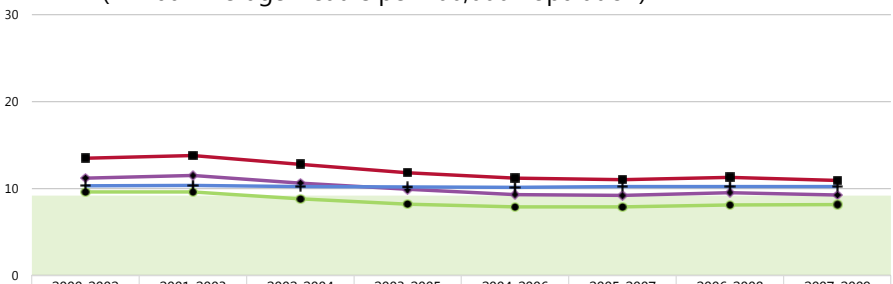
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-30]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- Local, state and national data are simple three-year averages.

The Cook County mortality rate decreased over the past decade, echoing the regional and state trends. Across the US, firearm-related mortality was more stable.

Firearms-Related Deaths: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
Healthy People 2020	9.2	9.2	9.2	9.2	9.2	9.2	9.2	9.2
Cook County	13.5	13.8	12.8	11.8	11.2	11.0	11.3	10.9
MCHC Region	11.2	11.5	10.6	9.9	9.3	9.2	9.5	9.2
Illinois	9.6	9.6	8.8	8.2	7.9	7.9	8.1	8.1
United States	10.3	10.3	10.2	10.2	10.1	10.2	10.2	10.2

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-30]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- Local, state and national data are simple three-year averages.

Survey respondents were further asked about the presence of weapons in the home:

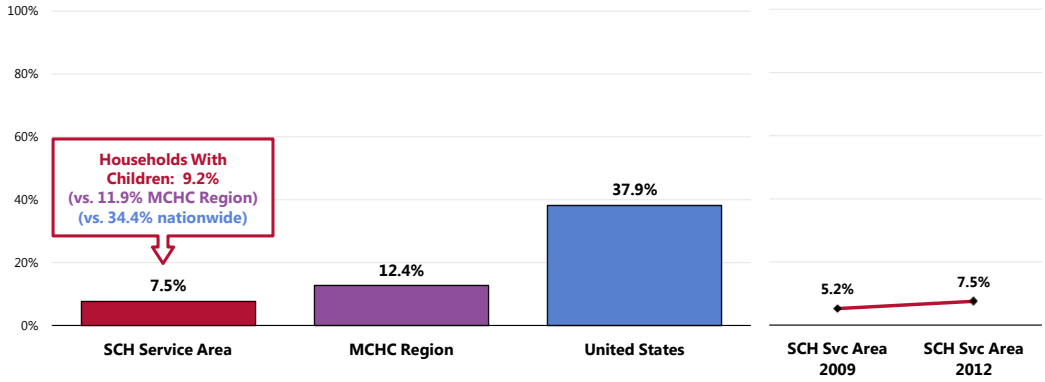
"Are there any firearms now kept in or around your home, including those kept in a garage, outdoor storage area, truck, or car? For the purposes of this inquiry, 'firearms' include pistols, shotguns, rifles, and other types of guns, but do NOT include starter pistols, BB guns, or guns that cannot fire."

Presence of Firearms in Homes

Overall, just 7.5% of Swedish Covenant Hospital Service Area adults have a firearm kept in or around their home.

- Lower than regional findings.
- Much lower than the national prevalence.
- Similar to that reported in 2009.
- Among Swedish Covenant Hospital Service Area households with children, 9.2% have a firearm kept in or around the house (more favorable than reported nationally).
- The prevalence of firearms in households with children has not changed significantly over time (not shown).

Have a Firearm Kept in or Around the Home



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 62, 164]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

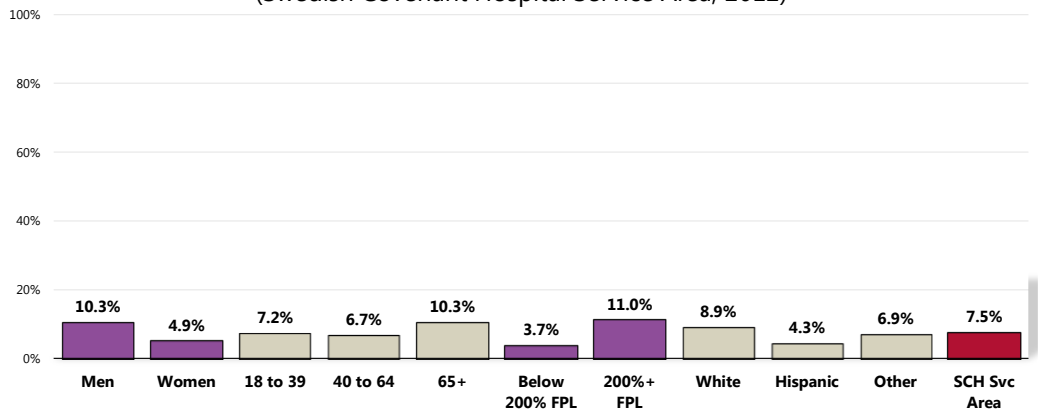
Notes:
- Asked of all respondents.
- In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.

Reports of firearms in or around the home are <u>more</u> prevalent among the following respondent groups:

- Men.
- Higher-income households.

Have a Firearm Kept in or Around the House

(Swedish Covenant Hospital Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 62]

Notes:
- Asked of all respondents.
- In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Age-Adjusted Homicide Deaths

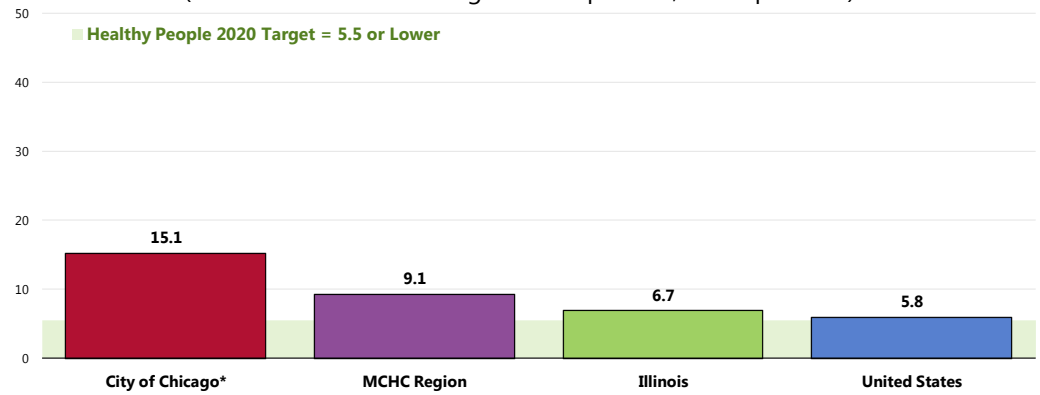
RELATED ISSUE:
See also *Suicide* in the **Mental Health & Mental Disorders** section of this report.

Between 2006 and 2008, there was an annual average age-adjusted homicide rate of 15.1 deaths per 100,000 population in the City of Chicago.

- Much higher than the regional rate.
- Much higher than the rate found statewide.
- Much higher than the national rate.
- Fails to satisfy the Healthy People 2020 target of 5.5 or lower.

Homicide: Age-Adjusted Mortality

(2007-2009 Annual Average Deaths per 100,000 Population)



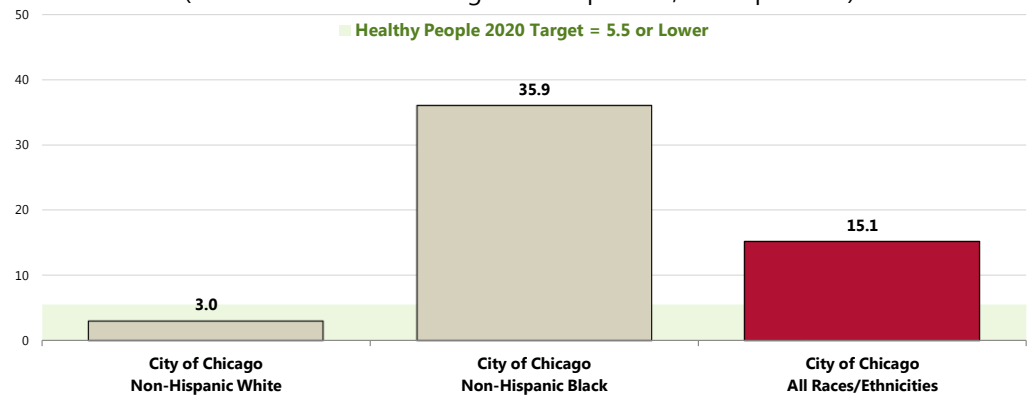
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IPV-29]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- *City of Chicago rate represents 2006-2008 data.

The homicide rate is dramatically higher among Blacks than Whites in the City of Chicago.

Homicide: Age-Adjusted Mortality by Race

(2006-2008 Annual Average Deaths per 100,000 Population)



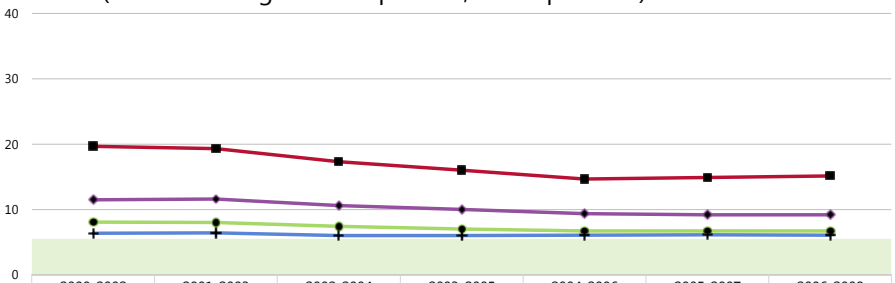
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IPV-29]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.

The City's homicide rate decreased over the past decade, following the downward trends reported regionally as well as statewide and nationwide.

Homicide: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2020	5.5	5.5	5.5	5.5	5.5	5.5	5.5
City of Chicago	19.7	19.3	17.3	16	14.7	14.9	15.1
MCHC Regioin	11.5	11.6	10.6	10	9.4	9.2	9.2
Illinois	8.1	8.0	7.4	7.0	6.7	6.7	6.7
United States	6.4	6.4	6.0	6.0	6.1	6.1	6.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IPV-29]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.

Violent Crime

Violent Crime Rates

Between 2007 and 2009, Cook County reported an annual average violent crime rate of 785.3 offenses per 100,000 population.

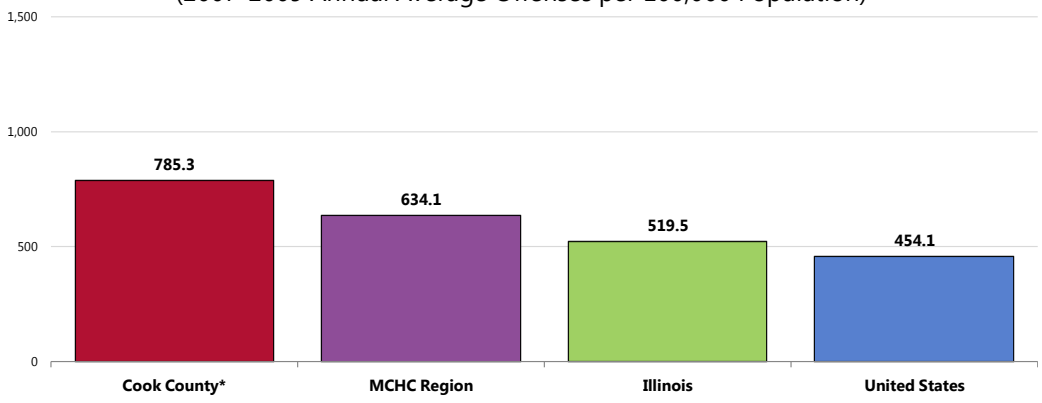
- Worse than the regional rate.
- Worse than the Illinois rate for the same period.
- Worse than the national rate.

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.

Violent Crime Rates

(2007-2009 Annual Average Offenses per 100,000 Population)



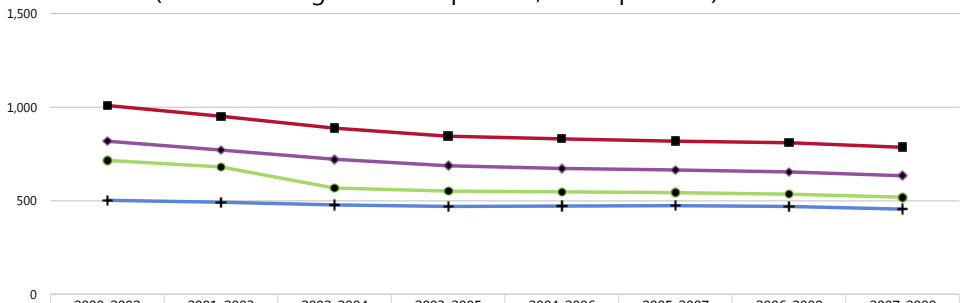
Sources:
- Illinois State Police
- US Department of Justice, Federal Bureau of Investigation

Notes:
- Rates are offenses per 100,000 population among agencies reporting.
- *City of Chicago data is unavailable; Cook County data is used here.

- The crime rate has declined in recent years, echoing the regional, state and national trends.

Violent Crime Rates

(Annual Average Offenses per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
Cook County	1009.3	950.7	888.8	845.4	829.7	818.3	810.4	785.3
MCHC Region	817.6	771.0	721.7	686.8	673.0	663.4	655.0	634.1
Illinois	715.2	681.7	568.0	551.4	546.5	542.3	534.3	519.5
United States	501.8	491.6	477.8	469.3	470.5	473.4	469.9	454.1

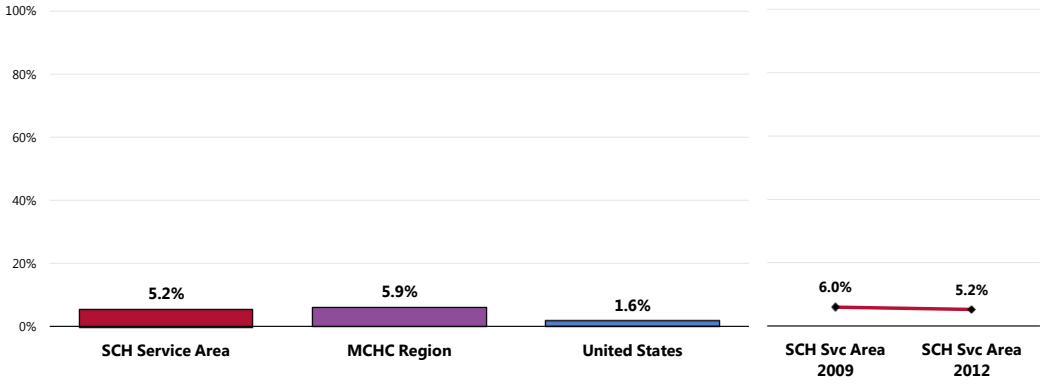
Sources: • Illinois State Police
• US Department of Justice, Federal Bureau of Investigation
Notes: • Rates are offenses per 100,000 population among agencies reporting.

Self-Reported Violence

A total of 5.2% of Swedish Covenant Hospital Service Area adults acknowledge being the victim of a violent crime in the past five years.

- Comparable to findings in the MCHC Region.
- Less favorable than is found nationally.
- Comparable to findings of the 2009 study.

Victim of a Violent Crime in the Past Five Years

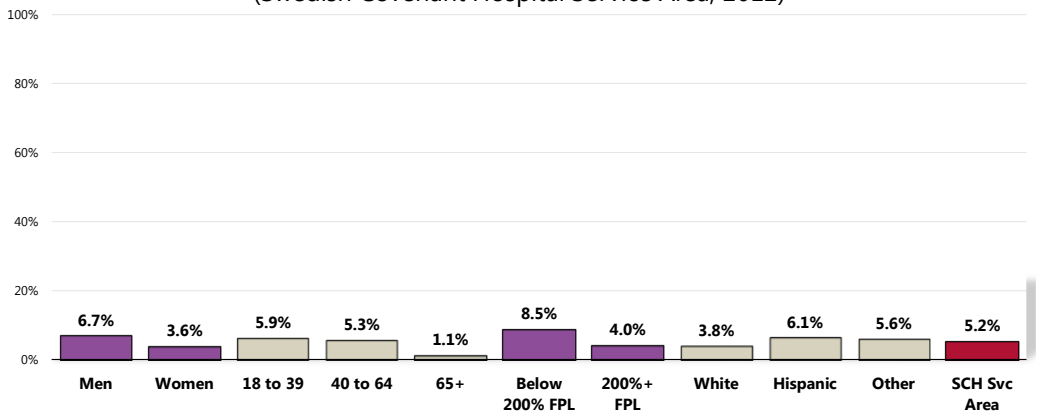


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 59]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

- Reports of violence are notably higher among residents under age 65.

Victim of a Violent Crime in the Past Five Years

(Swedish Covenant Hospital Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 59]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

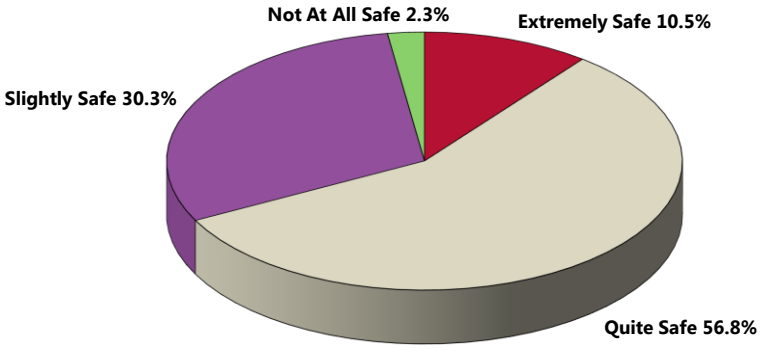
Perceived Neighborhood Safety

While most service area residents (67.3%) consider their neighborhood to be "extremely" or "quite" safe from crime, many do not.

- 30.3% gave "slightly safe" ratings of their neighborhoods.

Perceptions of Neighborhood's Safety From Crime

(Swedish Covenant Hospital Service Area, 2012)



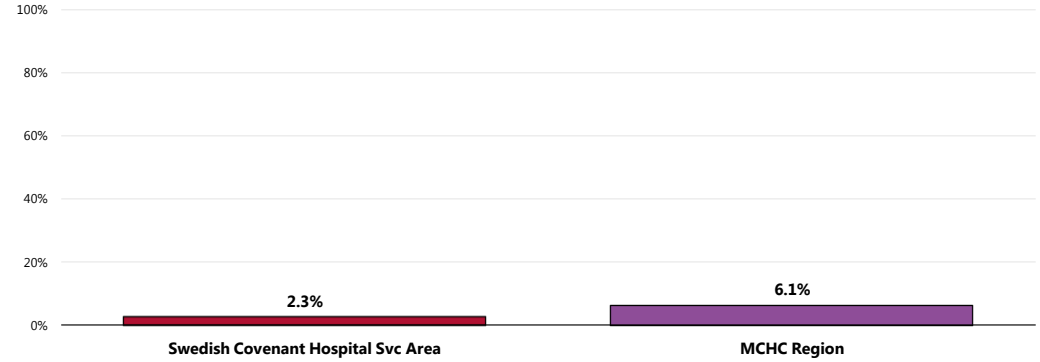
Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 58]

Notes:
- Asked of all respondents.

A total of 2.3% of respondents consider their neighborhood to be "not at all safe" from crime.

- More favorable than the regional findings.

Perceive Neighborhood to be "Not At All Safe" From Crime

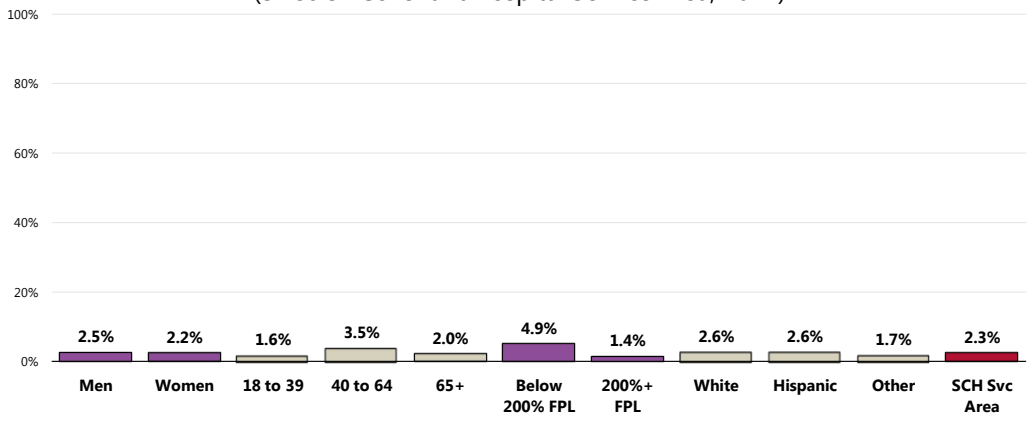


Sources: • 2012 PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 58]
Notes: • Reflects the total sample of respondents.

- No population segment is statistically more or less likely to worry about crime in their own neighborhood.

Perceive Neighborhood to be "Not At All Safe" From Crime

(Swedish Covenant Hospital Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 58]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

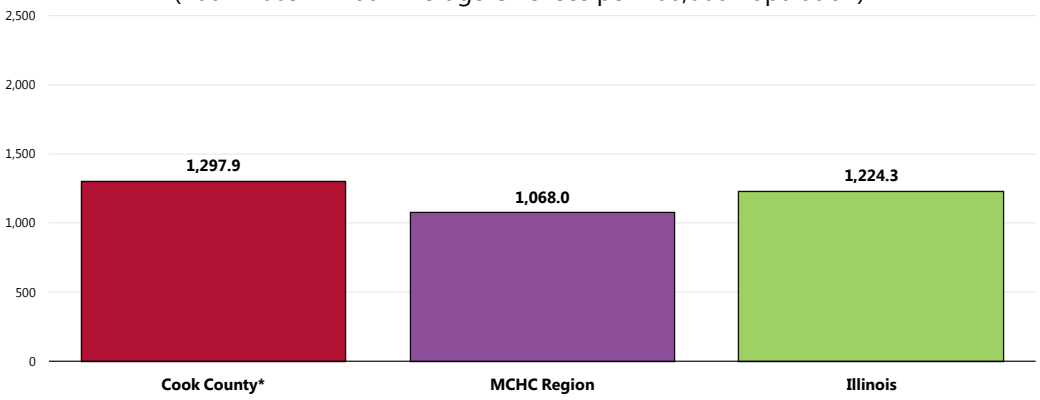
Between 2007 and 2009, there was an annual average domestic violence rate of 1,297.9 offenses per 100,000 population in Cook County.

- Higher than the regional rate.
- Higher than the Illinois rate.

Keep in mind that these data only reflect those incidents reported to law enforcement (offenses).

Domestic Violence Rates

(2007-2009 Annual Average Offenses per 100,000 Population)

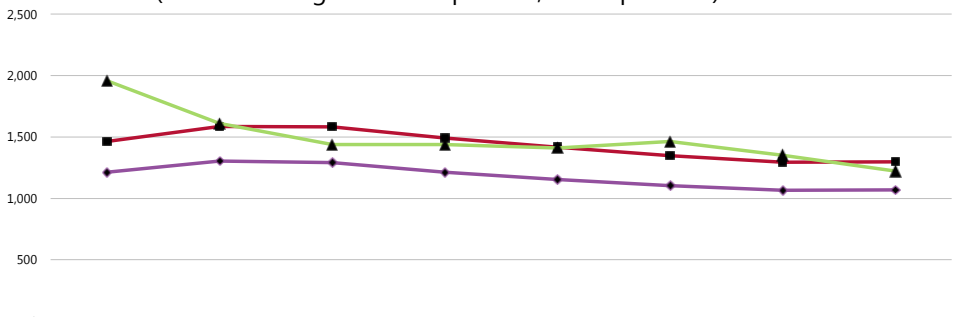


Sources: • Illinois State Police
Notes: • Rates are domestic calls for assistance per 100,000 population.
• *City of Chicago data not available; Cook County data is shown here.

The reported domestic violence rate decreased overall in Cook County in the past decade. In Illinois, domestic violence reports decreased in recent years as well.

Domestic Violence Rates

(Annual Average Offenses per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
Cook County	1462.5	1586.2	1581.9	1491.4	1416.8	1348.0	1294.0	1297.9
MCHC Region	1213.2	1303.0	1292.3	1214.4	1154.9	1102.8	1064.8	1068.0
Illinois	1957.9	1609.4	1437.3	1439.4	1412.1	1462.5	1350.3	1224.3

Sources: • Illinois State Police
Notes: • Rates are domestic calls for assistance per 100,000 population.

Self-Reported Family Violence

Respondents were told:

"By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with would also be considered an intimate partner."

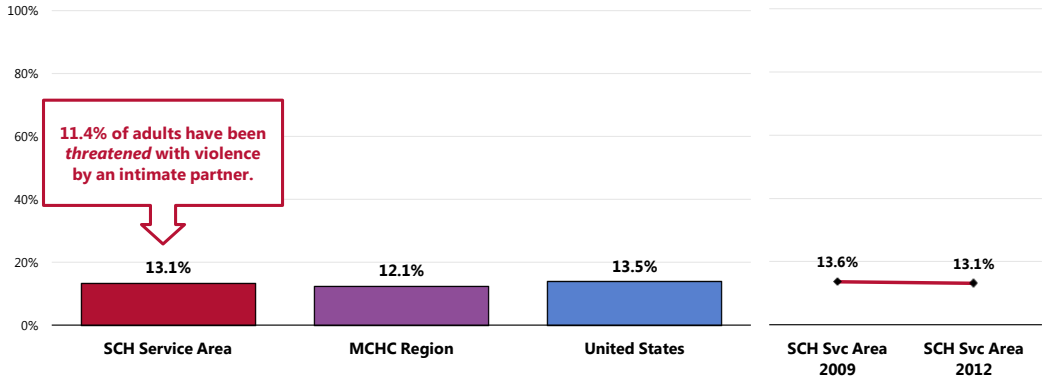
A total of 11.4% of Swedish Covenant Hospital Service Area adults report that they have ever been threatened with physical violence by an intimate partner.

- Similar to MCHC regional findings.
- Similar to US findings.
- Statistically unchanged since 2009.

A total of 13.1% of respondents acknowledge that they have ever been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner.

- Comparable to regional findings.
- Comparable to national findings.
- Comparable to the 2009 findings.

Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 60-61]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

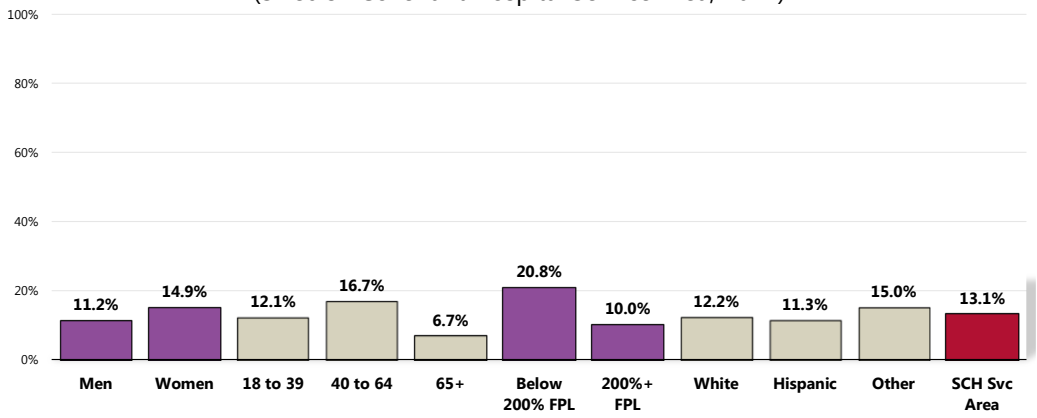
Notes:
- Asked of all respondents.

Reports of domestic violence are also notably higher among:

- Adults between the ages of 40 and 64.
- Those with lower incomes.

Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner

(Swedish Covenant Hospital Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 61]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Child Abuse Rates

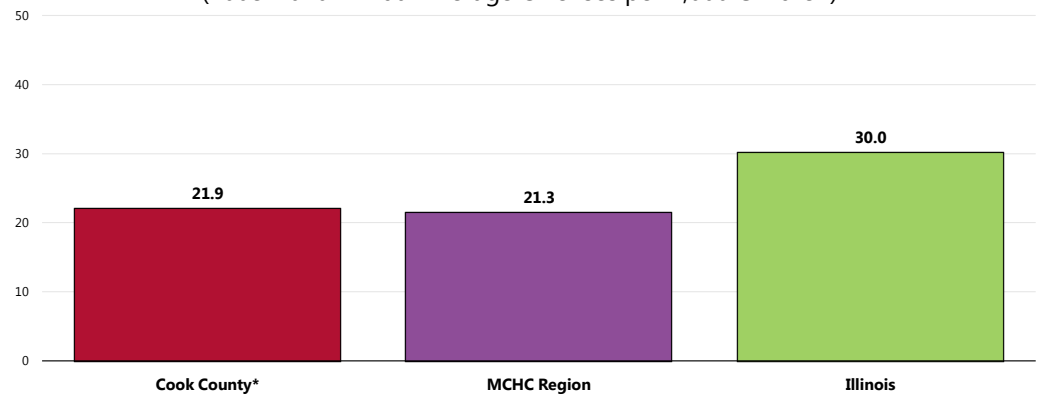
Keep in mind that these data only reflect those incidents reported to law enforcement.

Between 2008 and 2010, there was an annual average child abuse offense rate of 21.9 per 1,000 children in Cook County (City of Chicago data not available).

- Similar to the regional rate.
- More favorable than the Illinois rate for the same period.

Reported Child Abuse Rates

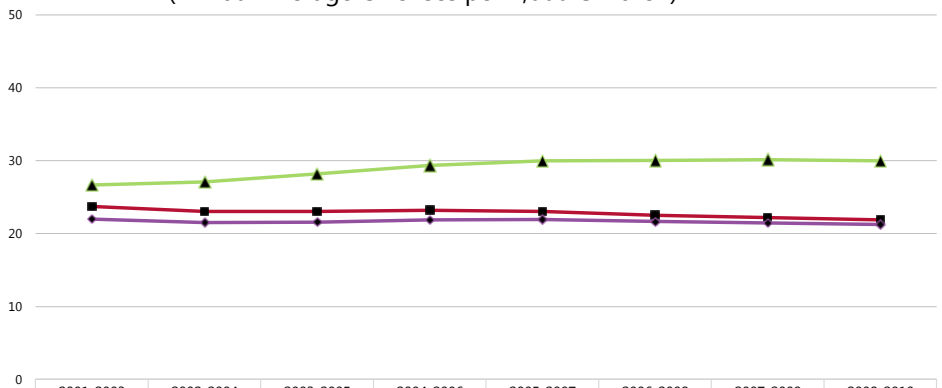
(2008-2010 Annual Average Offenses per 1,000 Children)



Sources: • Illinois State Police
Notes: • Rates are reports of child abuse per 1,000 children.
• *City of Chicago data unavailable; Cook County data is shown here.

- The reported Cook County child abuse rate has decreased slightly in the past decade. In contrast, rates increased across Illinois.

Reported Child Abuse Rates
(Annual Average Offenses per 1,000 Children)



	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010
Cook County	23.7	23.1	23.0	23.2	23.1	22.5	22.2	21.9
MCHC Region	22.0	21.5	21.6	21.9	21.9	21.7	21.5	21.3
Illinois	26.7	27.1	28.2	29.3	30.0	30.0	30.1	30.0

Sources: • Illinois State Police
Notes: • Rates are reports of child abuse per 1,000 children.

Related Focus Group Findings: Violence

Many focus group participants are concerned with violence in the community, with discussion centered on the following issues:

- Impact of violence
- Gang violence
- Domestic violence
    - Shelters
    - Support groups

According to group participants, **violence** is pervasive in Cook County and in some North Chicago neighborhoods. Attendees cite the poor economic climate and substance abuse as drivers of the violence. The violence is not severe enough in North Chicago to warrant outside assistance, but attendees worry about the availability of guns and the level of gun violence.

> *"Nobody can get a handle on the lack of respect for life and the happenstance way in which they just pull out guns and start shooting at you. It makes no sense. So it's almost like when it happens on the north side, we know it's happening but we don't talk about it as much because the south and the west side is so, so infested with gang violence, but it's still happening." — Community Leader (SCH Service Area)*

Focus group participants spoke about the **gang violence** that occurs in the community, agreeing that reasons behind the increase in gang violence include a lack of leadership in gangs and unsupervised, inactive youth.

> *"It's much different than it used to be. Whatever organizations exist out there, gang organizations, have no discipline anymore. So the leadership can say whatever they want, but the guys out on the street do whatever they want and it's insane." North Chicago Community Leader*

Violence **impacts both mental and physical health**. Some residents in North Chicago communities fear leaving their homes or having their children walk to school. In addition, the mental health repercussions of trauma are countless; one participant recalls a recent experience:

> *"So it's very, very random and it scares the hell out of everybody from parents to the kids themselves 'cause they're walking to and from school, so talk about mental health and stress. It's not just when your best friend gets shot and you get shot, but it's the fear, the incident itself, but then the fear that you're living with every single day walking to and from school." North Chicago Community Leader*

Participants also expressed concern about the level of **domestic violence** in the community, which may be under-reported due to stigma or fear of deportation if addressed by law enforcement. The capacity of **domestic violence shelters** has been threatened due to budget cuts, so although shelters exist in the community, distance becomes a barrier. Shelters also can have wait lists, limiting immediate accessibility.

Attendees believe that agencies need to work on breaking the cycle of domestic violence occurring in some families. Local agencies also must combat cultural beliefs and the internalization and normalization some women experience as victims of domestic abuse. These agencies must figure out ways to help residents realize the severity of a volatile home life:

> *"When you talk about shelters, well first the individuals would need to know and understand that this isn't the norm because it's really like business as usual, you hear these stories and it's so matter of fact, business as usual, that why would you think to go to a shelter if it's business as usual to have this going on?" — Cook County Community Leader*

In addition, participants would like the community to offer more **support groups** and therapy to these women. Therapy in multiple languages is essential because of the diverse community.

Diabetes

Diabetes mellitus occurs when the body cannot produce or respond appropriately to insulin. Insulin is a hormone that the body needs to absorb and use glucose (sugar) as fuel for the body's cells. Without a properly functioning insulin signaling system, blood glucose levels become elevated and other metabolic abnormalities occur, leading to the development of serious, disabling complications. Many forms of diabetes exist; the three common types are Type 1, Type 2, and gestational diabetes.

Effective therapy can prevent or delay diabetic complications. However, almost 25% of Americans with diabetes mellitus are undiagnosed, and another 57 million Americans have blood glucose levels that greatly increase their risk of developing diabetes mellitus in the next several years. Few people receive effective preventative care, which makes diabetes mellitus an immense and complex public health challenge.

Diabetes mellitus affects an estimated 23.6 million people in the United States and is the 7th leading cause of death. Diabetes mellitus:

- Lowers life expectancy by up to 15 years.
- Increases the risk of heart disease by 2 to 4 times.
- Is the leading cause of kidney failure, lower limb amputations, and adult-onset blindness.

In addition to these human costs, the estimated total financial cost of diabetes mellitus in the US in 2007 was $174 billion, which includes the costs of medical care, disability, and premature death.

The rate of diabetes mellitus continues to increase both in the United States and throughout the world. Due to the steady rise in the number of persons with diabetes mellitus, and possibly earlier onset of type 2 diabetes mellitus, there is growing concern about the possibility that the increase in the number of persons with diabetes mellitus and the complexity of their care might overwhelm existing healthcare systems.

People from minority populations are more frequently affected by type 2 diabetes. Minority groups constitute 25% of all adult patients with diabetes in the US and represent the majority of children and adolescents with type 2 diabetes.

Lifestyle change has been proven effective in preventing or delaying the onset of type 2 diabetes in high-risk individuals.

– Healthy People 2020 (www.healthypeople.gov)

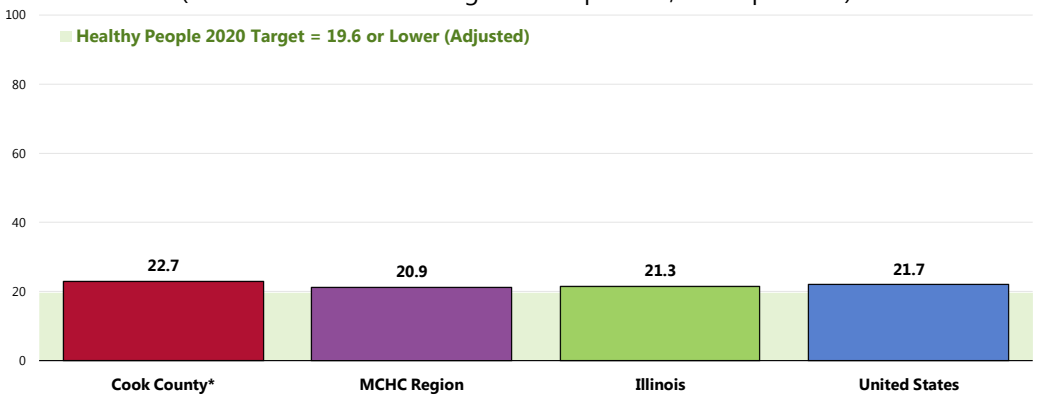
Age-Adjusted Diabetes Deaths

Between 2007 and 2009, Cook County reported an annual average age-adjusted diabetes mortality rate of 22.7 deaths per 100,000 population.

- Higher than the regional rate.
- Higher than the state rate.
- Comparable to the national rate.
- Fails to satisfy the Healthy People 2020 target (19.6 or lower).

Diabetes: Age-Adjusted Mortality

(2007-2009 Annual Average Deaths per 100,000 Population)



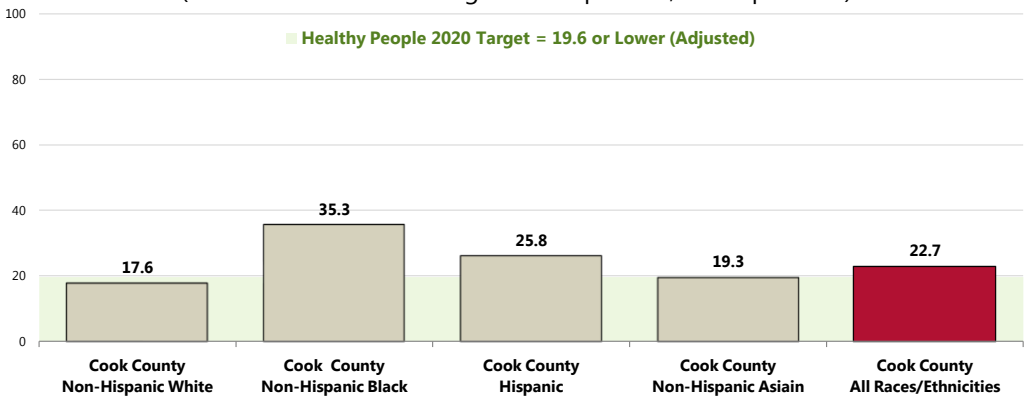
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective D-3]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.
- *City of Chicago data unavailable; Cook County data is used here.

The Cook County diabetes mortality rate is notably higher among Blacks and Hispanics when compared with Whites and Asians.

Diabetes: Age-Adjusted Mortality by Race

(2007-2009 Annual Average Deaths per 100,000 Population)



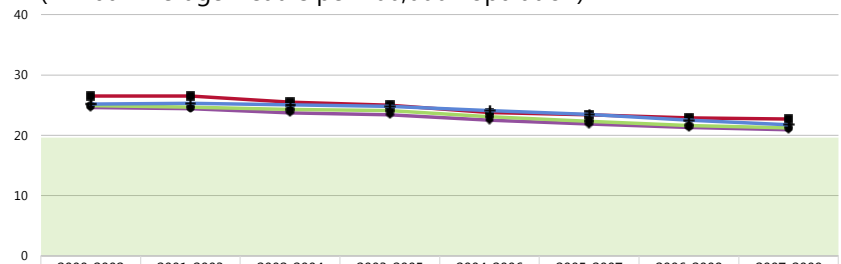
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective D-3]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

- Diabetes mortality decreased over the past decade for Cook County, echoing the regional, state and national trends.

Diabetes: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
HP2020 (Adjusted)	19.6	19.6	19.6	19.6	19.6	19.6	19.6	19.6
Cook County	26.5	26.5	25.5	25.0	23.8	23.4	22.9	22.7
MCHC Region	24.6	24.4	23.7	23.4	22.5	21.9	21.3	20.9
Illinois	24.9	24.7	24.3	24.1	23.1	22.3	21.6	21.3
United States	25.2	25.3	25.1	24.8	24.1	23.5	22.5	21.7

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective D-3]

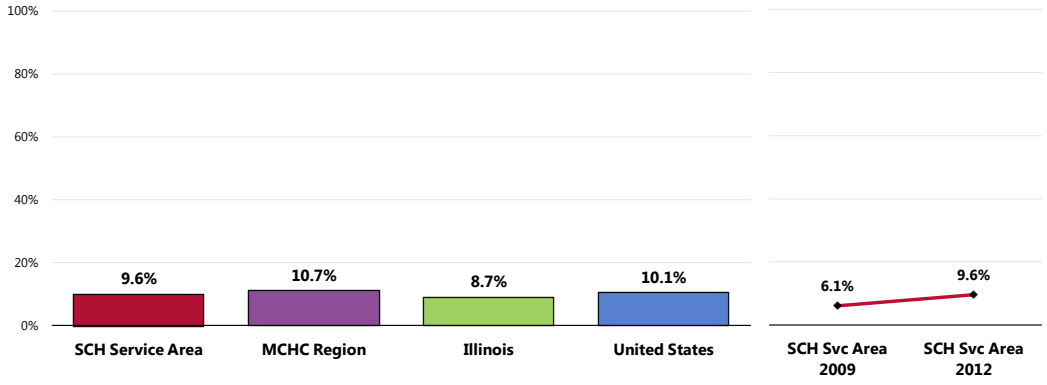
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

Prevalence of Diabetes

A total of 9.6% of Swedish Covenant Hospital Service Area adults report having been diagnosed with diabetes.

- Similar to the regional proportion.
- Similar to the proportion statewide.
- Similar to the national proportion.
- Statistically unchanged since 2009.

Prevalence of Diabetes

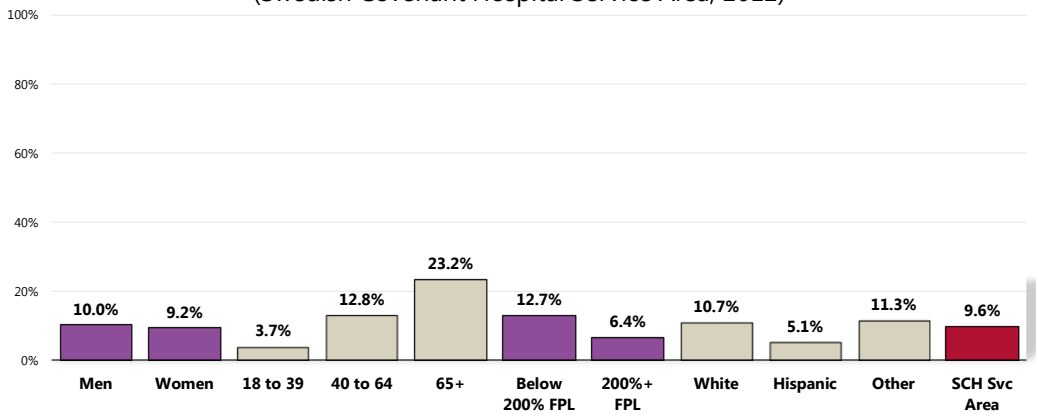


Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 47]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.

Notes:
- Asked of all respondents.
- Local and national data exclude gestation diabetes (occurring only during pregnancy).

- A higher prevalence of diabetes is reported among respondents age 40+ in the service area; note the positive correlation between diabetes and age (with 23.2% of seniors having diabetes).

Prevalence of Diabetes
(Swedish Covenant Hospital Service Area, 2012)

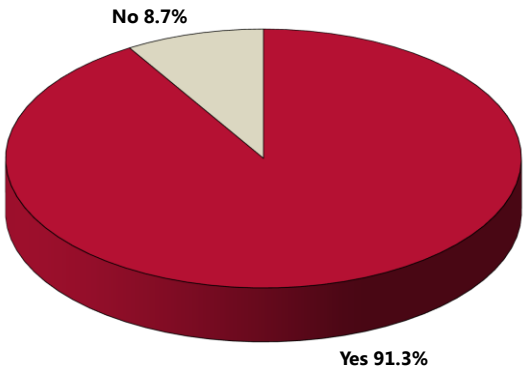


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 47]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.
• Excludes gestation diabetes (occurring only during pregnancy).

Diabetes Treatment

Among adults with diabetes, the vast majority (91.3%) are currently taking insulin or some type of medication to manage their condition.

Taking Insulin or Other Medication for Diabetes
(Among Swedish Covenant Hospital Service Area Diabetics)

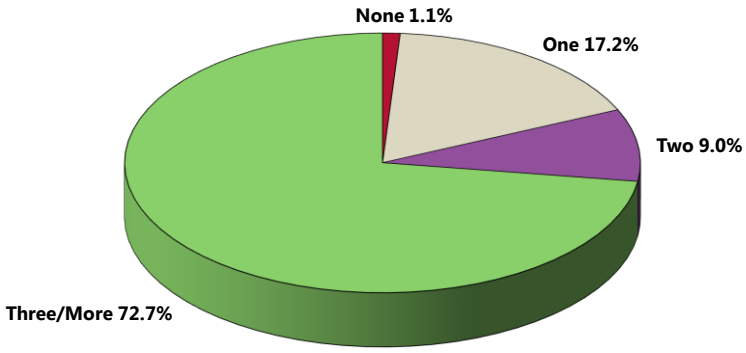


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 48]
Notes: • Asked of all diabetic respondents.

Note also that more than 7 in 10 service area diabetics (72.7%) had 3+ medical visits in the past year related to their diabetes.

Number of Medical Visits Due to Diabetes in the Past Year

(Among Swedish Covenant Hospital Service Area Diabetics)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 49]
Notes: • Asked of all diabetic respondents.

Alzheimer's Disease

Dementia is the loss of cognitive functioning—thinking, remembering, and reasoning—to such an extent that it interferes with a person's daily life. Dementia is not a disease itself, but rather a set of symptoms. Memory loss is a common symptom of dementia, although memory loss by itself does not mean a person has dementia. Alzheimer's disease is the most common cause of dementia, accounting for the majority of all diagnosed cases.

Alzheimer's disease is the 6th leading cause of death among adults age 18 years and older. Estimates vary, but experts suggest that up to 5.1 million Americans age 65 years and older have Alzheimer's disease. These numbers are predicted to more than double by 2050 unless more effective ways to treat and prevent Alzheimer's disease are found.

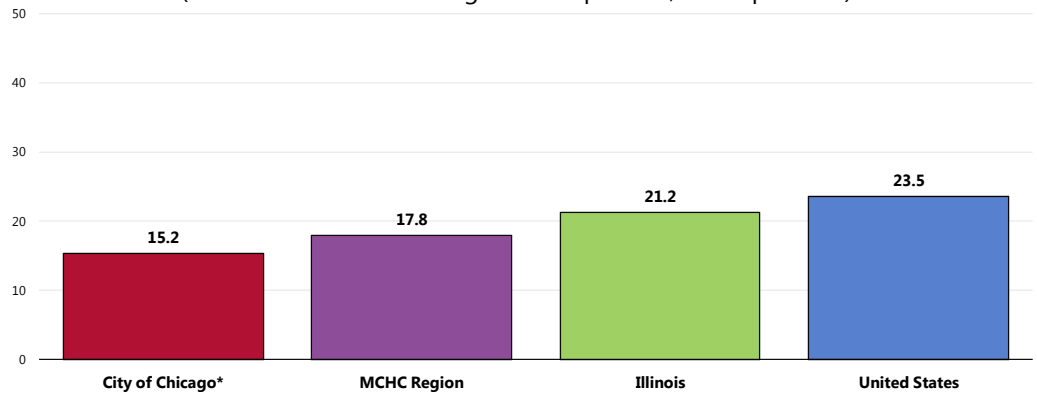
– Healthy People 2020 (www.healthypeople.gov)

Between 2006 and 2008, the City of Chicago experienced an annual average age-adjusted Alzheimer's disease mortality rate of 15.2 deaths per 100,000 population.

- More favorable than the regional rate.
- More favorable than the statewide rate.
- More favorable than the national rate.

Alzheimer's Disease: Age-Adjusted Mortality

(2007-2009 Annual Average Deaths per 100,000 Population)



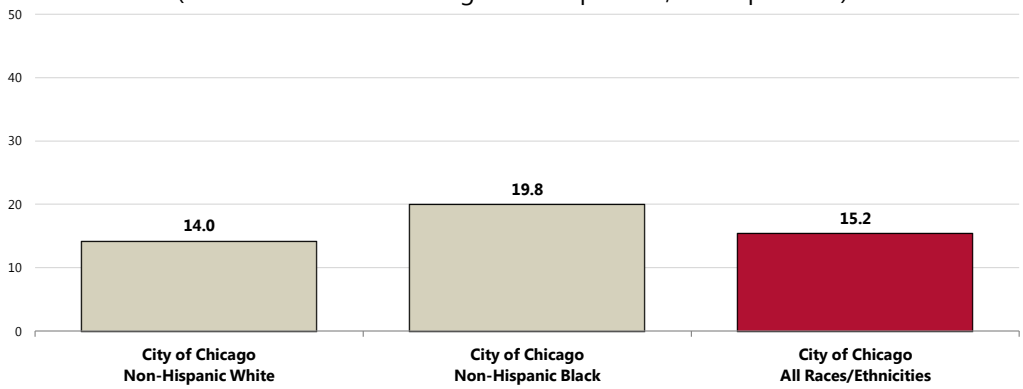
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- *City of Chicago rate represents 2006-2008 data.

The City's Alzheimer's disease mortality rate appears higher among Blacks than Whites.

Alzheimer's Disease: Age-Adjusted Mortality by Race

(2006-2008 Annual Average Deaths per 100,000 Population)



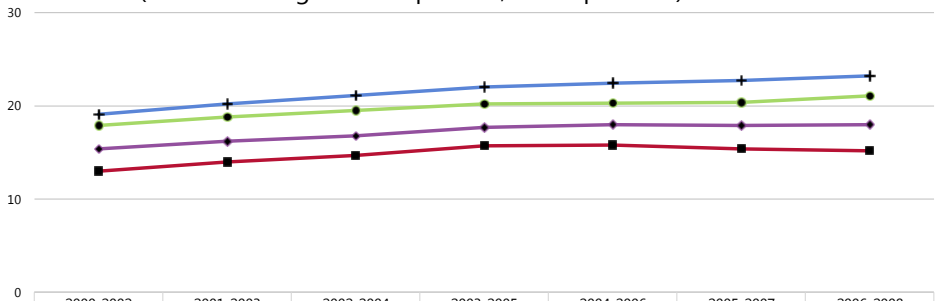
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• Local, state and national data are simple three-year averages.

Alzheimer's disease mortality rate in the City of Chicago generally increased over the past decade, echoing the regional, state and national trends.

Alzheimer's Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
City of Chicago	13.0	14.0	14.7	15.7	15.8	15.4	15.2
MCHC Region	15.4	16.2	16.8	17.7	18.0	17.9	18.0
Illinois	17.9	18.8	19.5	20.2	20.3	20.4	21.1
United States	19.1	20.2	21.1	22.0	22.4	22.7	23.2

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

Kidney Disease

Chronic kidney disease and end-stage renal disease are significant public health problems in the United States and a major source of suffering and poor quality of life for those afflicted. They are responsible for premature death and exact a high economic price from both the private and public sectors. Nearly 25% of the Medicare budget is used to treat people with chronic kidney disease and end-stage renal disease.

Genetic determinants have a large influence on the development and progression of chronic kidney disease. It is not possible to alter a person's biology and genetic determinants; however, environmental influences and individual behaviors also have a significant influence on the development and progression of chronic kidney disease. As a result, some populations are disproportionately affected. Successful behavior modification is expected to have a positive influence on the disease.

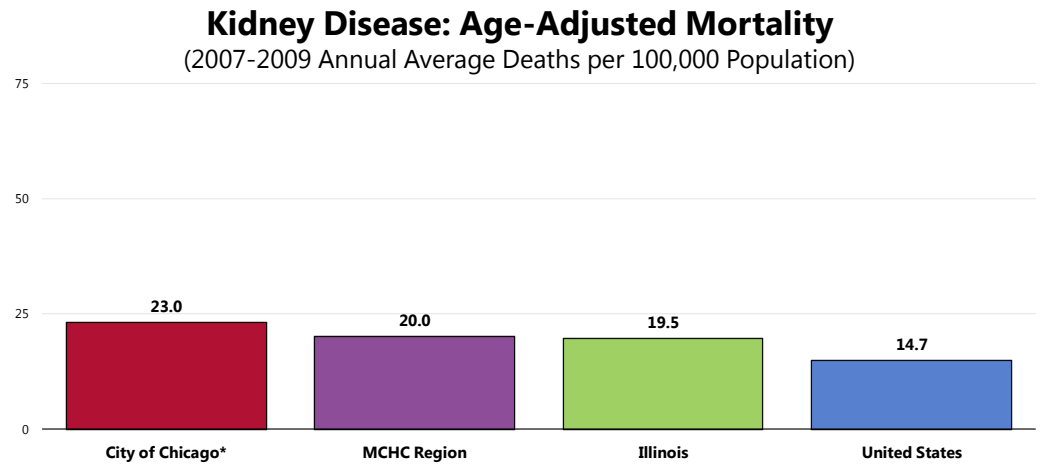
Diabetes is the most common cause of kidney failure. The results of the Diabetes Prevention Program (DPP) funded by the national Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) show that moderate exercise, a healthier diet, and weight reduction can prevent development of type 2 diabetes in persons at risk.

– Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Kidney Disease Deaths

Between 2006 and 2008 there was an annual average age-adjusted kidney disease mortality rate of 23.0 deaths per 100,000 population in the City of Chicago.

- Worse than the regional rate.
- Worse than the rate found statewide.
- Worse than the national rate.



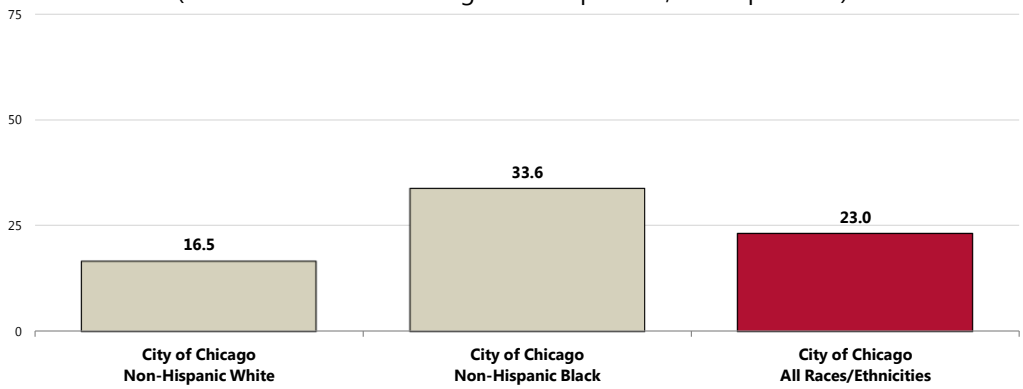
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- *City of Chicago rate represents 2006-2008 data.

The kidney disease mortality rate in the City of Chicago is twice as high among Blacks as among Whites.

Kidney Disease: Age-Adjusted Mortality by Race

(2006-2008 Annual Average Deaths per 100,000 Population)



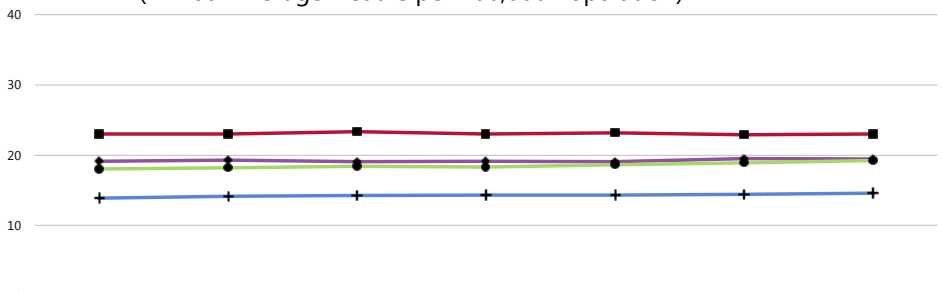
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
• Local, state and national data are simple three-year averages.

The City's kidney disease mortality rate was stable over the past decade, while regional, state and national mortality rates increased.

Kidney Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
City of Chicago	23.0	23.0	23.3	23.0	23.2	22.9	23.0
MCHC Region	19.1	19.3	19.1	19.1	19.1	19.5	19.5
Illinois	18.0	18.2	18.4	18.3	18.6	18.9	19.2
United States	13.9	14.2	14.3	14.3	14.3	14.4	14.6

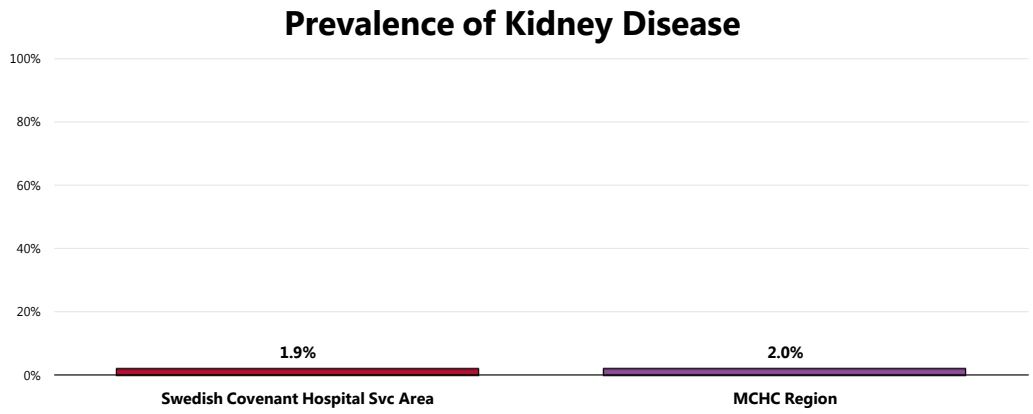
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

Prevalence of Kidney Disease

Among survey respondents, 1.9% currently suffers from kidney disease.

- Similar to the MCHC regional findings.



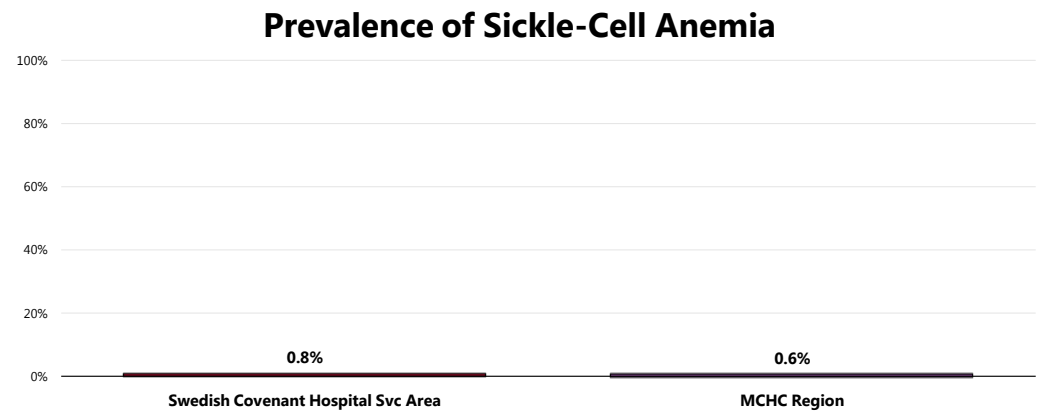
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 39]

Notes:
- Reflects the total sample of respondents.
- Does not include kidney stones, bladder infections or incontinence.

Sickle-Cell Anemia

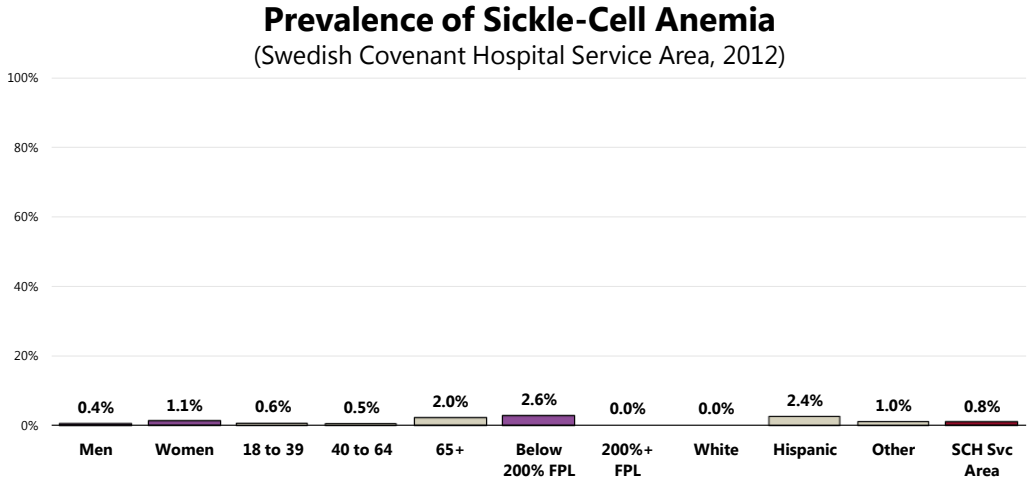
Just 0.8% of survey respondents report having been diagnosed with sickle-cell anemia.

- Similar to the MCHC regional findings.



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 40]
Notes: • Reflects the total sample of respondents.

- Prevalence of sickle-cell anemia is statistically similar between demographic groups.



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 40]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Potentially Disabling Conditions

There are more than 100 types of arthritis. Arthritis commonly occurs with other chronic conditions, such as diabetes, heart disease, and obesity. Interventions to treat the pain and reduce the functional limitations from arthritis are important, and may also enable people with these other chronic conditions to be more physically active. Arthritis affects 1 in 5 adults and continues to be the most common cause of disability. It costs more than $128 billion per year. All of the human and economic costs are projected to increase over time as the population ages. There are interventions that can reduce arthritis pain and functional limitations, but they remain underused. These include: increased physical activity; self-management education; and weight loss among overweight/obese adults.

Osteoporosis is a disease marked by reduced bone strength leading to an increased risk of fractures (broken bones). In the United States, an estimated 5.3 million people age 50 years and older have osteoporosis. Most of these people are women, but about 0.8 million are men. Just over 34 million more people, including 12 million men, have low bone mass, which puts them at increased risk for developing osteoporosis. Half of all women and as many as 1 in 4 men age 50 years and older will have an osteoporosis-related fracture in their lifetime.

RELATED ISSUE:
See also *Activity Limitations* in the **General Health Status** section of this report.

Chronic back pain is common, costly, and potentially disabling. About 80% of Americans experience low back pain in their lifetime. It is estimated that each year:

- 15%-20% of the population develop protracted back pain.
- 2-8% have chronic back pain (pain that lasts more than 3 months).
- 3-4% of the population is temporarily disabled due to back pain.
- 1% of the working-age population is disabled completely and permanently as a result of low back pain.

Americans spend at least $50 billion each year on low back pain. Low back pain is the:

- 2nd leading cause of lost work time (after the common cold).
- 3rd most common reason to undergo a surgical procedure.
- 5th most frequent cause of hospitalization.

Arthritis, osteoporosis, and chronic back conditions all have major effects on quality of life, the ability to work, and basic activities of daily living.

– Healthy People 2020 (www.healthypeople.gov)

Arthritis, Osteoporosis, & Chronic Pain

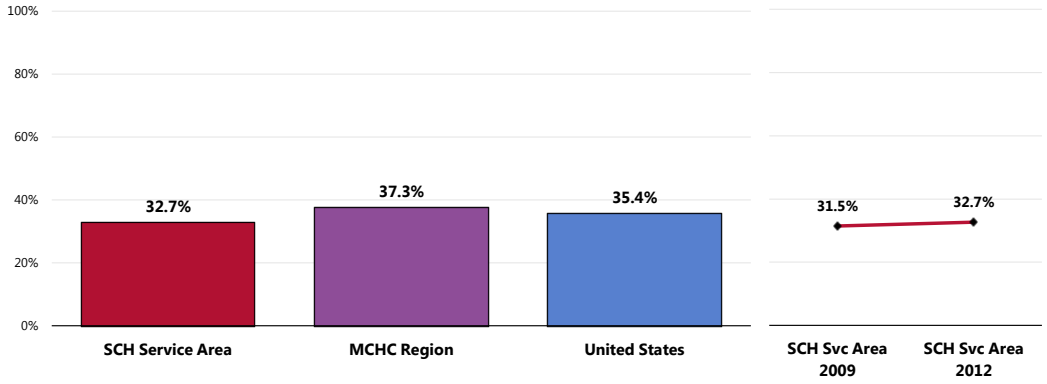
Prevalence of Arthritis/Rheumatism

Nearly one-third (32.7%) of Swedish Covenant Hospital Service Area adults age 50 and older reports suffering from arthritis or rheumatism.

- Comparable to regional findings.
- Comparable to national findings.
- The current prevalence of arthritis/rheumatism is comparable to that reported in 2009.

Prevalence of Arthritis/Rheumatism

(Among Adults 50+)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 168]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects respondents 50 and older.

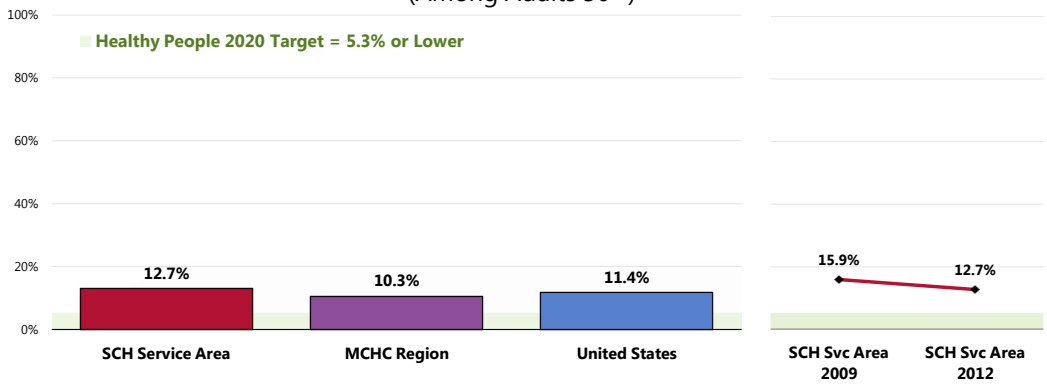
Prevalence of Osteoporosis

A total of 12.7% of survey respondents age 50 and older have osteoporosis.

- Similar to regional findings.
- Similar to that found nationwide.
- Fails to satisfy the Healthy People 2020 target of 5.3% or lower.
- Statistically unchanged over time.

Prevalence of Osteoporosis

(Among Adults 50+)



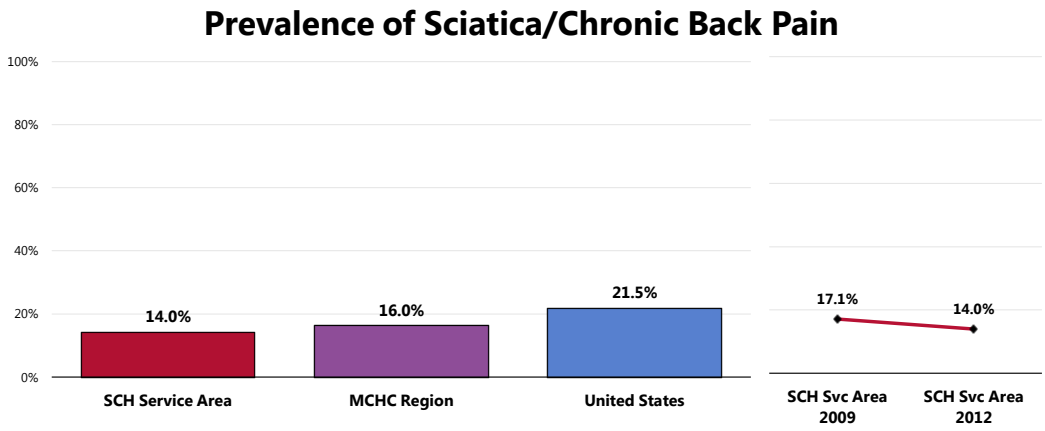
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 169]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AOCBC-10]

Notes:
- Reflects respondents 50 and older.

Prevalence of Sciatica/Chronic Back Pain

A total of 14.0% of survey respondents suffer from chronic back pain or sciatica.

- Comparable to regional findings.
- More favorable than is found nationwide.
- Statistically comparable to the 2009 findings.

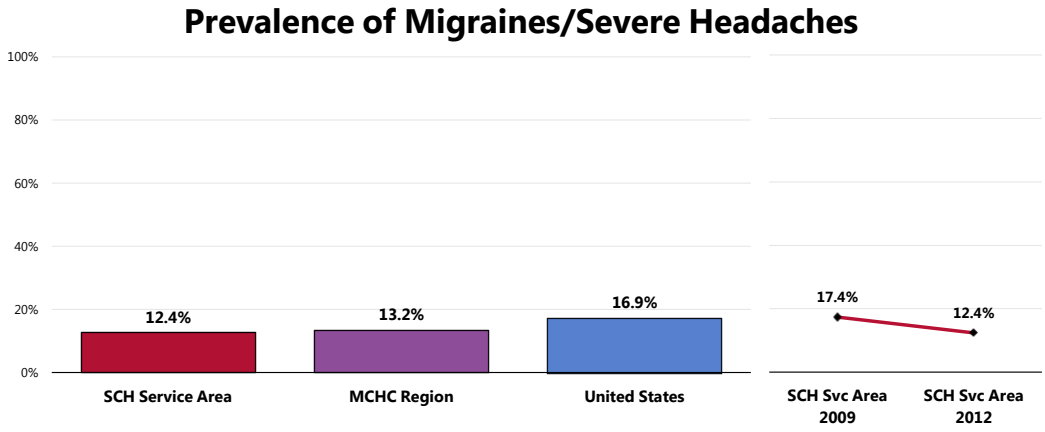


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 29]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Prevalence of Migraines/Severe Headaches

A total of 12.4% of survey respondents report suffering from migraines or severe headaches.

- Similar to findings in the MCHC Region.
- More favorable than is found nationally.
- Statistically similar to what was reported in the Swedish Covenant Hospital Service Area in 2009.

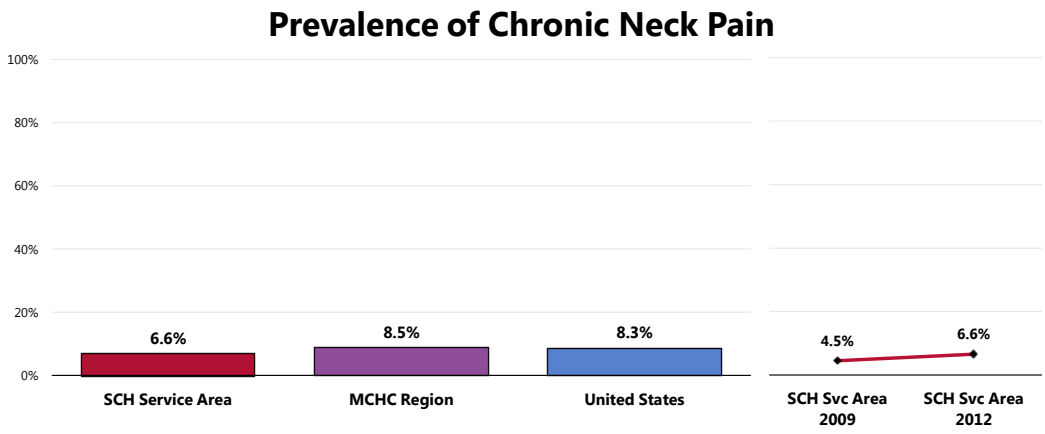


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 36]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Prevalence of Chronic Neck Pain

A total of 6.6% of survey respondents currently suffer from chronic neck pain.

- Similar to regional findings.
- Similar to the percentage found nationwide.
- Statistically unchanged since 2009.



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 37]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Vision & Hearing Impairment

Vision is an essential part of everyday life, influencing how Americans of all ages learn, communicate, work, play, and interact with the world. Yet millions of Americans live with visual impairment, and many more remain at risk for eye disease and preventable eye injury.

The eyes are an important, but often overlooked, part of overall health. Despite the preventable nature of some vision impairments, many people do not receive recommended screenings and exams. A visit to an eye care professional for a comprehensive dilated eye exam can help to detect common vision problems and eye diseases, including diabetic retinopathy, glaucoma, cataract, and age-related macular degeneration.

These common vision problems often have no early warning signs. If a problem is detected, an eye care professional can prescribe corrective eyewear, medicine, or surgery to minimize vision loss and help a person see his or her best.

Healthy vision can help to ensure a healthy and active lifestyle well into a person's later years. Educating and engaging families, communities, and the nation is critical to ensuring that people have the information, resources, and tools needed for good eye health.

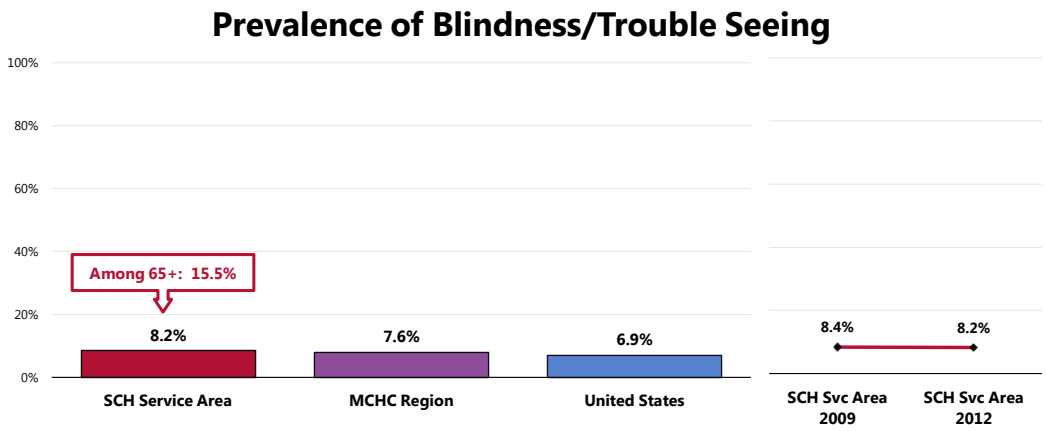
– Healthy People 2020 (www.healthypeople.gov)

Vision Trouble

RELATED ISSUE: See also *Vision Care* in the **Access to Health Services** section of this report.

A total of 8.2% of Swedish Covenant Hospital Service Area adults are blind, or have trouble seeing even when wearing corrective lenses.

- Comparable to the rate found regionally.
- Comparable to the percentage found nationwide.
- Nearly identical to the rate found in 2009.
- Among area adults age 65 and older, 15.5% have vision trouble.



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 26]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Hearing Trouble

An impaired ability to communicate with others or maintain good balance can lead many people to feel socially isolated, have unmet health needs, have limited success in school or on the job. Communication and other sensory processes contribute to our overall health and well-being. Protecting these processes is critical, particularly for people whose age, race, ethnicity, gender, occupation, genetic background, or health status places them at increased risk.

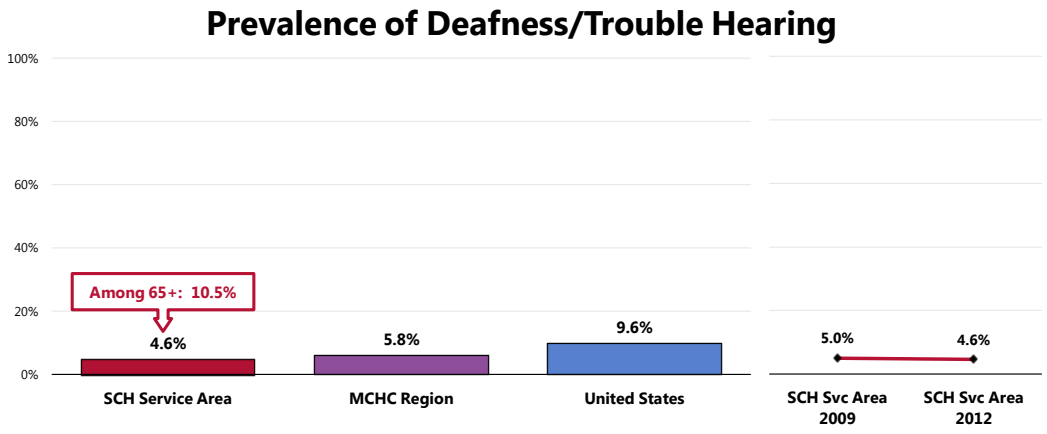
Many factors influence the numbers of Americans who are diagnosed and treated for hearing and other sensory or communication disorders, such a social determinants (social and economic standings, age of diagnosis, cost and stigma of wearing a hearing aid, and unhealthy lifestyle choices). In addition, biological causes of hearing loss and other sensory or communication disorders include: genetics; viral or bacterial infections; sensitivity to certain drugs or medications; injury; and aging.

As the nation's population ages and survival rates for medically fragile infants and for people with severe injuries and acquired diseases improve, the prevalence of sensory and communication disorders is expected to rise.

– Healthy People 2020 (www.healthypeople.gov)

In all, 4.6% of Swedish Covenant Hospital Service Area adults report being deaf or having difficulty hearing.

- Similar to MCHC regional findings.
- More favorable than national findings.
- Unchanged over time.
- Among area adults age 65+, 10.5% have partial or complete hearing loss.



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 27]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

INFECTIOUS DISEASE

Influenza & Pneumonia Vaccination

Acute respiratory infections, including pneumonia and influenza, are the 8th leading cause of death in the nation, accounting for 56,000 deaths annually. Pneumonia mortality in children fell by 97% in the last century, but respiratory infectious diseases continue to be leading causes of pediatric hospitalization and outpatient visits in the US. On average, influenza leads to more than 200,000 hospitalizations and 36,000 deaths each year. The 2009 H1N1 influenza pandemic caused an estimated 270,000 hospitalizations and 12,270 deaths (1,270 of which were of people younger than age 18) between April 2009 and March 2010.

– Healthy People 2020 (www.healthypeople.gov)

Flu Vaccinations

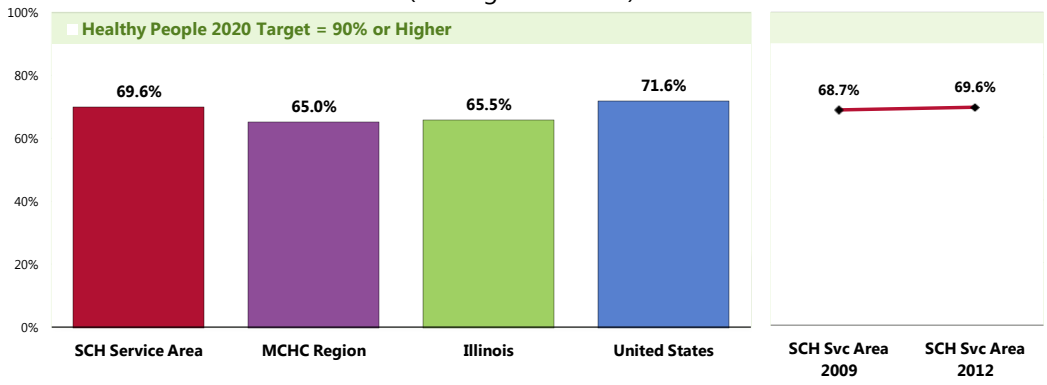
FluMist® is a vaccine that is sprayed into the nose to help protect against influenza; it is an alternative to traditional flu shots.

Among Swedish Covenant Hospital Service Area seniors, 69.6% received a flu shot (or FluMist®) within the past year.

- Comparable to findings from the MCHC Region.
- Comparable to the Illinois findings.
- Comparable to the national findings.
- Fails to satisfy the Healthy People 2020 target (90% or higher).
- Statistically unchanged since 2009.

Have Had a Flu Vaccination in the Past Year

(Among Adults 65+)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 170]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-12.7]

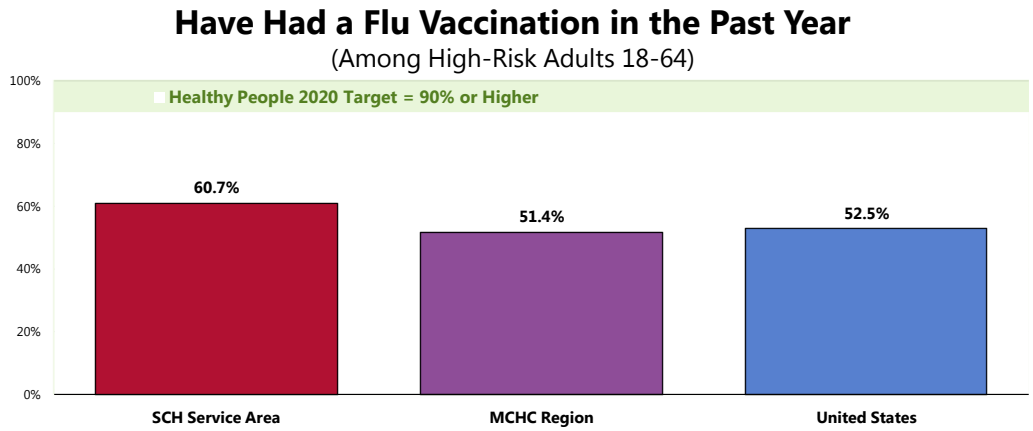
Notes:
- Reflects respondents 65 and older.
- Includes FluMist as a form of vaccination.

High-Risk Adults

"High-risk" includes adults who report having been diagnosed with heart disease, diabetes or respiratory disease.

A total of 60.7% of high-risk adults age 18 to 64 received a flu vaccination (flu shot or FluMist®) within the past year.

- Similar to regional findings.
- Similar to national findings.
- Fails to satisfy the Healthy People 2020 target (90% or higher).



Sources:
- 2012 PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 171]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-12.6]

Notes:
- Reflects high-risk respondents age 18-64.
- "High-Risk" includes adults age 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.
- Includes FluMist as a form of vaccination.

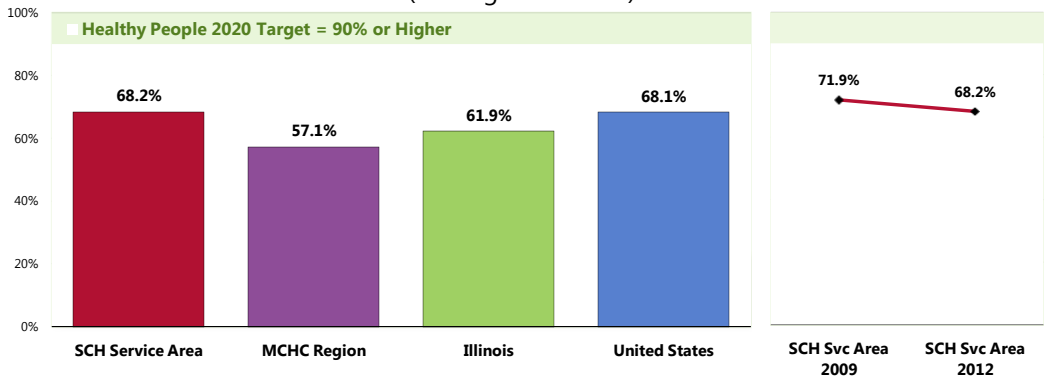
Pneumonia Vaccination

Among adults age 65 and older, 68.2% have received a pneumonia vaccination at some point in their lives.

- Comparable to MCHC regional findings.
- Comparable to the Illinois findings.
- Nearly identical to the national findings.
- Fails to satisfy the Healthy People 2020 target of 90% or higher.
- Statistically unchanged over time.

Have Ever Had a Pneumonia Vaccine

(Among Adults 65+)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 172]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-13.1]

Notes:
- Reflects respondents 65 and older.

High-Risk Adults

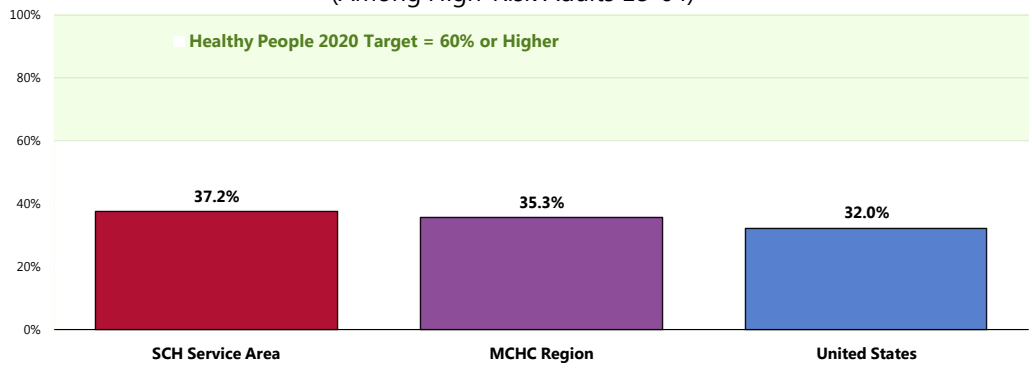
"High-risk" includes adults who report having been diagnosed with heart disease, diabetes or respiratory disease.

A total of 37.2% of high-risk adults age 18 to 64 have ever received a pneumonia vaccination.

- Similar to the MCHC regional findings.
- Similar to US findings.
- Fails to satisfy the Healthy People 2020 target (60% or higher).

Have Ever Had a Pneumonia Vaccine

(Among High-Risk Adults 18-64)



Sources:
- 2012 PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 173]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-13.2]

Notes:
- Asked of all high-risk respondents under 65.
- "High-Risk" includes adults age 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.

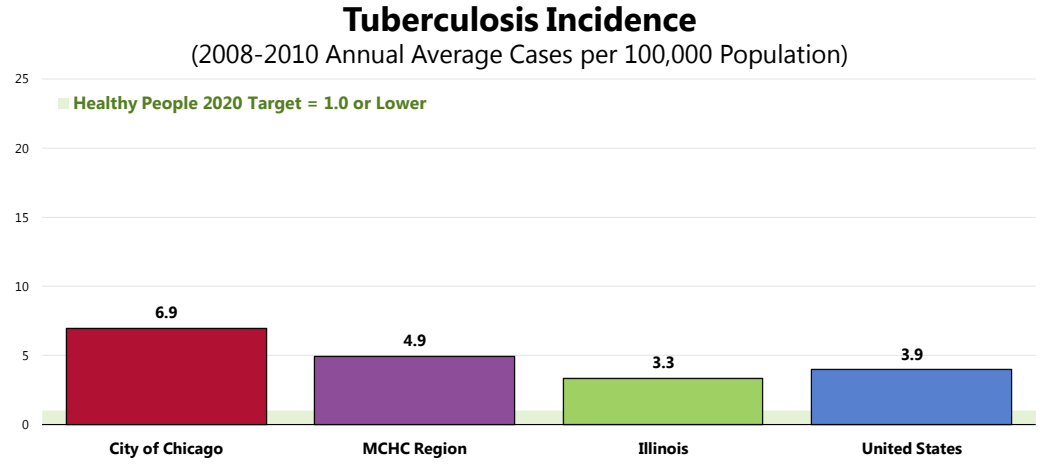
Tuberculosis

Viral hepatitis and tuberculosis (TB) can be prevented, yet healthcare systems often do not make the best use of their available resources to support prevention efforts. Because the US healthcare system focuses on treatment of illnesses, rather than health promotion, patients do not always receive information about prevention and healthy lifestyles. This includes advancing effective and evidence-based viral hepatitis and TB prevention priorities and interventions.

– Healthy People 2020 (www.healthypeople.gov)

Between 2008 and 2010, the annual average tuberculosis incidence rate (new cases per year) was 6.9 cases per 100,000 population in the City of Chicago.

- Above the regional incidence rate.
- Well above the Illinois incidence rate.
- Above the national incidence rate.
- Fails to satisfy the Healthy People 2020 target (1.0 or lower).



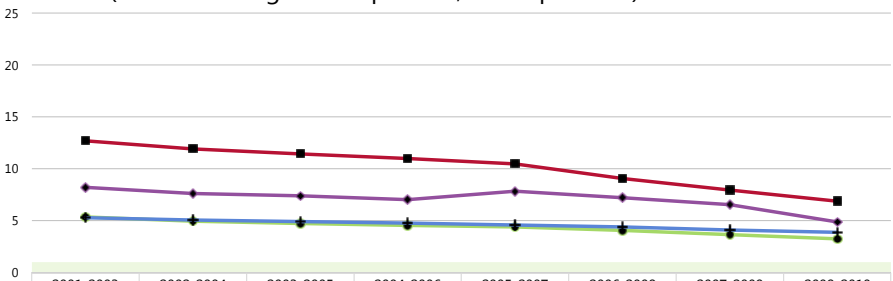
Sources:
- Illinois Department of Public Health
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-29]
- Centers for Disease Control and Prevention, Division of Public Health Surveillance and Informatics. Epidemiology Program Office.

Notes:
- Rates are annual average new cases per 100,000 population.

The City's tuberculosis incidence has decreased considerably in recent years. Downward trends in tuberculosis incidence are also evident across the region, as well as statewide and nationwide.

Tuberculosis Incidence

(Annual Average Cases per 100,000 Population)



	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010
Healthy People 2020	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
City of Chicago	12.7	11.9	11.4	11.0	10.5	9.1	7.9	6.9
MCHC Region	8.2	7.6	7.4	7.0	7.9	7.2	6.6	4.9
Illinois	5.4	5.0	4.7	4.6	4.4	4.1	3.7	3.3
United States	5.3	5.1	4.9	4.8	4.6	4.4	4.1	3.9

Sources:
- Illinois Department of Public Health
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-29]
- Centers for Disease Control and Prevention, Division of Public Health Surveillance and Informatics. Epidemiology Program Office.

Notes:
- Rates are annual average new cases per 100,000 population.

HIV

The HIV epidemic in the United States continues to be a major public health crisis. An estimated 1.1 million Americans are living with HIV, and 1 in 5 people with HIV do not know they have it. HIV continues to spread, leading to about 56,000 new HIV infections each year.

HIV is a preventable disease, and effective HIV prevention interventions have been proven to reduce HIV transmission. People who get tested for HIV and learn that they are infected can make significant behavior changes to improve their health and reduce the risk of transmitting HIV to their sex or drug-using partners. More than 50% of new HIV infections occur as a result of the 21% of people who have HIV but do not know it.

In the era of increasingly effective treatments for HIV, people with HIV are living longer, healthier, and more productive lives. Deaths from HIV infection have greatly declined in the United States since the 1990s. As the number of people living with HIV grows, it will be more important than ever to increase national HIV prevention and healthcare programs.

There are gender, race, and ethnicity disparities in new HIV infections:

- Nearly 75% of new HIV infections occur in men.
- More than half occur in gay and bisexual men, regardless of race or ethnicity.
- 45% of new HIV infections occur in African Americans, 35% in whites, and 17% in Hispanics.

Improving access to quality healthcare for populations disproportionately affected by HIV, such as persons of color and gay and bisexual men, is a fundamental public health strategy for HIV prevention. People getting care for HIV can receive:

- Antiretroviral therapy
- Screening and treatment for other diseases (such as sexually transmitted infections)
- HIV prevention interventions
- Mental health services
- Other health services

As the number of people living with HIV increases and more people become aware of their HIV status, prevention strategies that are targeted specifically for HIV-infected people are becoming more important. Prevention work with people living with HIV focuses on:

- Linking to and staying in treatment.
- Increasing the availability of ongoing HIV prevention interventions.
- Providing prevention services for their partners.

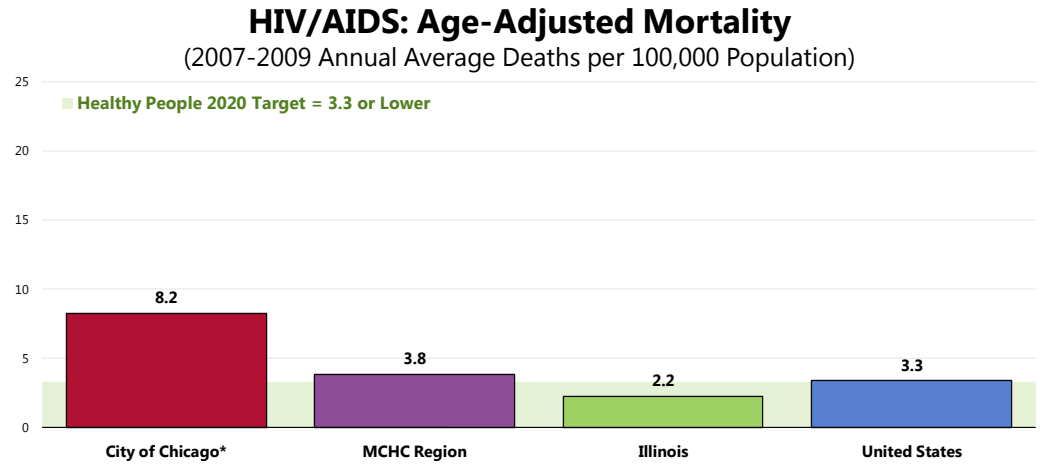
Public perception in the US about the seriousness of the HIV epidemic has declined in recent years. There is evidence that risky behaviors may be increasing among uninfected people, especially gay and bisexual men. Ongoing media and social campaigns for the general public and HIV prevention interventions for uninfected persons who engage in risky behaviors are critical.

– Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted HIV/AIDS Deaths

Between 2007 and 2009, there was an annual average age-adjusted HIV/AIDS mortality rate of 8.2 deaths per 100,000 population in the City of Chicago.

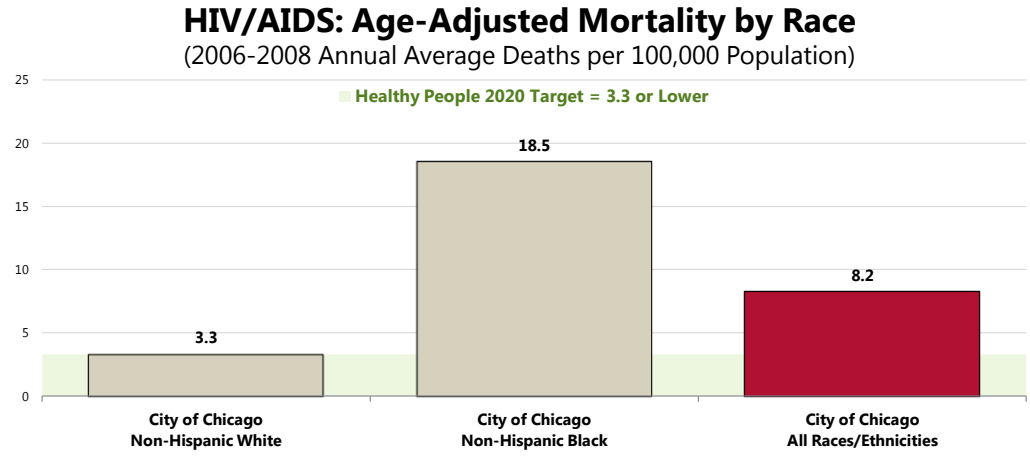
- More than twice the regional death rate.
- Much higher than found statewide.
- Much higher than the rate reported nationally.
- Fails to satisfy the Healthy People 2020 target (3.3 or lower).



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HIV-12]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- *City of Chicago rate represents 2006-2008 data.

The HIV/AIDS mortality rate among the City of Chicago Black population is more than five times the rate among Whites.



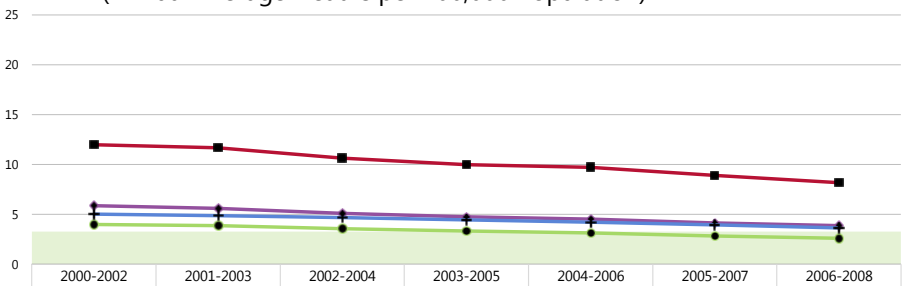
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HIV-12]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

- HIV mortality has decreased in recent years in the City of Chicago. This decreasing trend is noted across the region, state and nation as well.

HIV/AIDS: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2020	3.3	3.3	3.3	3.3	3.3	3.3	3.3
City of Chicago	12.0	11.7	10.7	10.0	9.7	8.9	8.2
MCHC Region	5.9	5.6	5.1	4.8	4.5	4.2	3.9
Illinois	4.0	3.9	3.6	3.3	3.2	2.8	2.6
United States	5.0	4.9	4.7	4.5	4.2	4.0	3.7

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HIV-12]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.

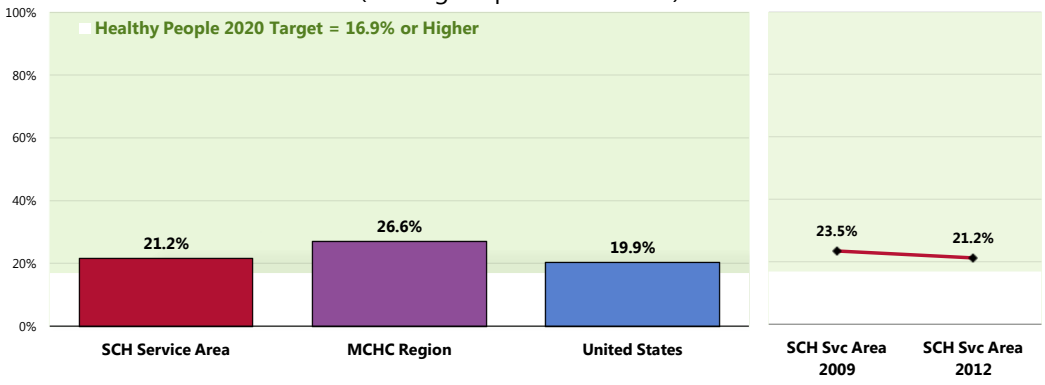
HIV Testing

Among Swedish Covenant Hospital Service Area adults age 18-44, 21.2% report that they have been tested for human immunodeficiency virus (HIV) in the past year.

- Similar to regional findings.
- Similar to the proportion found nationwide.
- Similar to the Healthy People 2020 target of 16.9% or higher.
- Testing has remained stable since 2009.

Tested for HIV in the Past Year

(Among Respondents 18-44)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 176]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HIV-14.1]

Notes:
- Reflects respondents age 18 to 44.
- Note that the Healthy People 2020 objective is for ages 15-44.

Sexually Transmitted Diseases

STDs refer to more than 25 infectious organisms that are transmitted primarily through sexual activity. Despite their burdens, costs, and complications, and the fact that they are largely preventable, STDs remain a significant public health problem in the United States. This problem is largely unrecognized by the public, policymakers, and health care professionals. STDs cause many harmful, often irreversible, and costly clinical complications, such as: reproductive health problems; fetal and perinatal health problems; cancer; and facilitation of the sexual transmission of HIV infection.

The Centers for Disease Control and Prevention (CDC) estimates that there are approximately 19 million new STD infections each year—almost half of them among young people ages 15 to 24. Because many cases of STDs go undiagnosed—and some common viral infections, such as human papillomavirus (HPV) and genital herpes, are not reported to CDC at all—the reported cases of chlamydia, gonorrhea, and syphilis represent only a fraction of the true burden of STDs in the US. Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women. CDC estimates that undiagnosed and untreated STDs cause at least 24,000 women in the United States each year to become infertile. Several factors contribute to the spread of STDs.

Biological Factors. STDs are acquired during unprotected sex with an infected partner. Biological factors that affect the spread of STDs include:

- **Asymptomatic nature of STDs**. The majority of STDs either do not produce any symptoms or signs, or they produce symptoms so mild that they are unnoticed; consequently, many infected persons do not know that they need medical care.
- **Gender disparities**. Women suffer more frequent and more serious STD complications than men do. Among the most serious STD complications are pelvic inflammatory disease, ectopic pregnancy (pregnancy outside of the uterus), infertility, and chronic pelvic pain.
- **Age disparities**. Compared to older adults, sexually active adolescents ages 15 to 19 and young adults ages 20 to 24 are at higher risk for getting STDs.
- **Lag time between infection and complications**. Often, a long interval, sometimes years, occurs between acquiring an STD and recognizing a clinically significant health problem.

Social, Economic and Behavioral Factors. The spread of STDs is directly affected by social, economic, and behavioral factors. Such factors may cause serious obstacles to STD prevention due to their influence on social and sexual networks, access to and provision of care, willingness to seek care, and social norms regarding sex and sexuality. Among certain vulnerable populations, historical experience with segregation and discrimination exacerbates the influence of these factors. Social, economic, and behavioral factors that affect the spread of STDs include:

- **Racial and ethnic disparities**. Certain racial and ethnic groups (mainly African American, Hispanic, and American Indian/Alaska Native populations) have high rates of STDs, compared with rates for whites.
- **Poverty and marginalization**. STDs disproportionately affect disenfranchised people and people in social networks where high-risk sexual behavior is common, and either access to care or health-seeking behavior is compromised.
- **Access to health care**. Access to high-quality health care is essential for early detection, treatment, and behavior-change counseling for STDs. Groups with the highest rates of STDs are often the same groups for whom access to or use of health services is most limited.
- **Substance abuse**. Many studies document the association of substance abuse with STDs. The introduction of new illicit substances into communities often can alter sexual behavior drastically in high-risk sexual networks, leading to the epidemic spread of STDs.
- **Sexuality and secrecy**. Perhaps the most important social factors contributing to the spread of STDs in the United States are the stigma associated with STDs and the general discomfort of discussing intimate aspects of life, especially those related to sex. These social factors separate the United States from industrialized countries with low rates of STDs.
- **Sexual networks**. Sexual networks refer to groups of people who can be considered "linked" by sequential or concurrent sexual partners. A person may have only 1 sex partner, but if that partner is a member of a risky sexual network, then the person is at higher risk for STDs than a similar individual from a nonrisky network.

– Healthy People 2020 (www.healthypeople.gov)

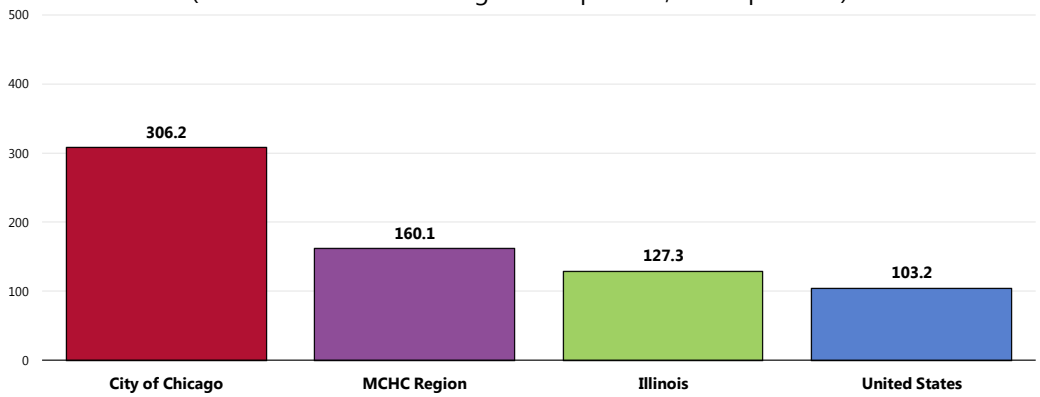
Gonorrhea

Between 2008 and 2010, the annual average gonorrhea incidence rate was 306.2 cases per 100,000 population in the City of Chicago.

- Notably higher than the regional incidence rate.
- Notably higher than the Illinois incidence rate.
- Notably higher than the national incidence rate.

Gonorrhea Incidence

(2008-2010 Annual Average Cases per 100,000 Population)

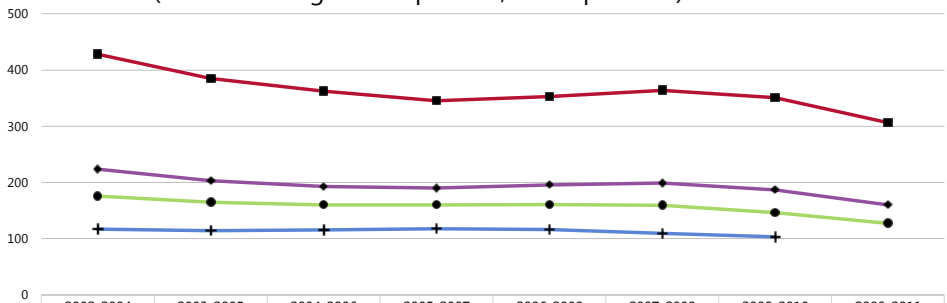


Sources: • Illinois Department of Public Health.
• Centers for Disease Control and Prevention, National Center for Health Statistics.
Notes: • Rates are annual average new cases per 100,000 population.

The City's gonorrhea incidence rate has decreased over the past decade, echoing the decreasing trends reported regionally, statewide and nationwide.

Gonorrhea Incidence

(Annual Average Cases per 100,000 Population)



	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011
City of Chicago	427.9	384.9	362.2	345.5	352.7	363.9	350.9	306.2
MCHC	223.6	203.0	192.9	189.8	195.3	198.7	186.3	160.1
Illinois	175.8	164.7	159.9	159.8	160.9	159.5	145.9	127.3
United States	116.5	114.1	115.6	117.4	116.1	108.9	103.2	

Sources: • Illinois Department of Public Health
• Centers for Disease Control and Prevention, National Center for Health Statistics.
Notes: • Rates are annual average new cases per 100,000 population.

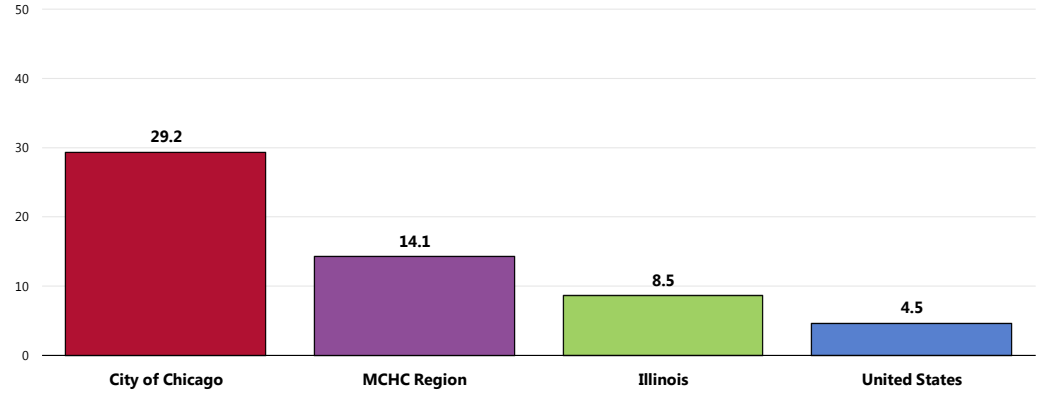
Syphilis

Between 2008 and 2010, the City's annual average primary/secondary syphilis incidence rate was 29.2 cases per 100,000 population.

- More than twice the regional incidence rate.
- Much higher than the Illinois incidence rate.
- Much higher than the national incidence rate.

Primary/Secondary Syphilis Incidence

(2008-2010 Annual Average Cases per 100,000 Population)

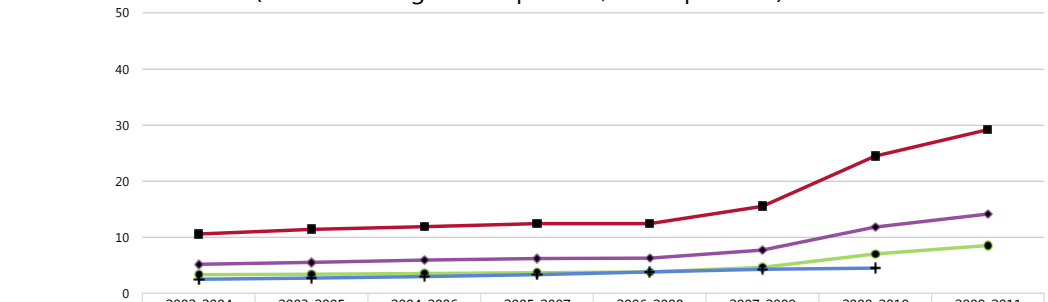


Sources: • Illinois Department of Public Health.
• Centers for Disease Control and Prevention, National Center for Health Statistics.
Notes: • Rates are annual average new cases per 100,000 population.

Syphilis incidence has increased considerably in the City of Chicago in recent years, mirroring the regional and state trends. The national rate increased as well, although less notably.

Primary/Secondary Syphilis Incidence

(Annual Average Cases per 100,000 Population)



	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011
City of Chicago	10.6	11.4	11.9	12.4	12.4	15.5	24.5	29.2
MCHC Region	5.2	5.5	5.9	6.2	6.3	7.7	11.8	14.1
Illinois	3.3	3.4	3.5	3.7	3.8	4.6	7.0	8.5
United States	2.5	2.7	3.0	3.3	3.8	4.3	4.5	

Sources: • Illinois Department of Public Health
• Centers for Disease Control and Prevention, National Center for Health Statistics.
Notes: • Rates are annual average new cases per 100,000 population.

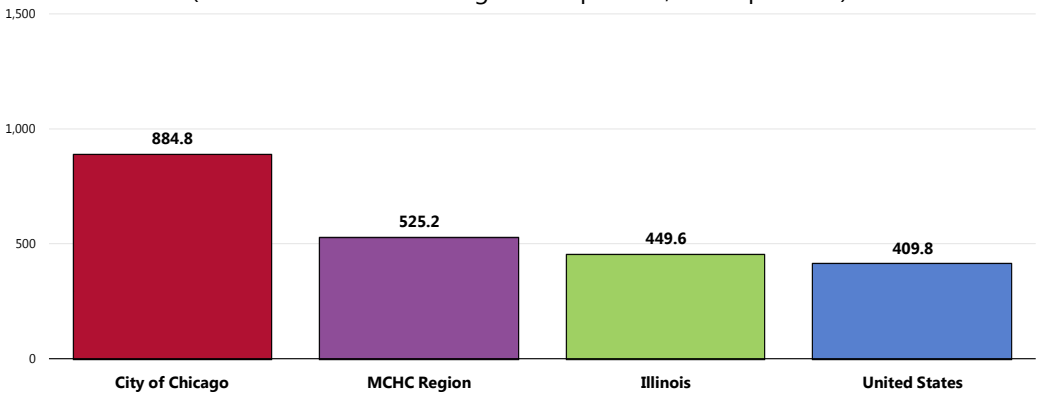
Chlamydia

Between 2008 and 2010, the annual average chlamydia incidence rate was 884.8 cases per 100,000 population in the City of Chicago.

- Worse than the regional rate.
- Worse than the Illinois incidence rate.
- More than twice the national incidence rate.

Chlamydia Incidence

(2008-2010 Annual Average Cases per 100,000 Population)



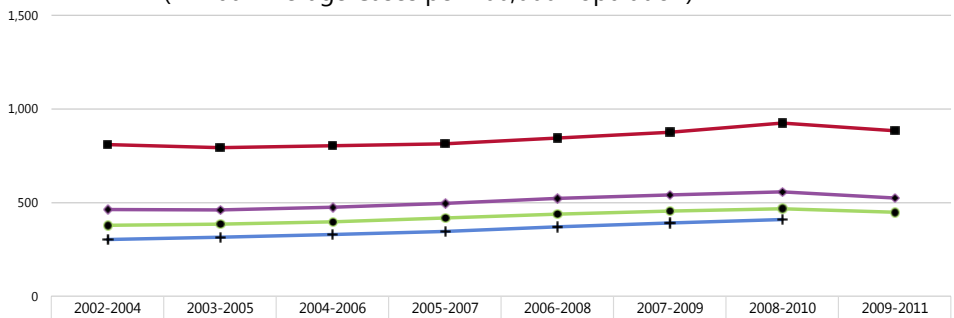
Sources:
- Illinois Department of Public Health.
- Centers for Disease Control and Prevention, National Center for Health Statistics.

Notes:
- Rates are annual average new cases per 100,000 population.

Chlamydia incidence has increased in the City of Chicago over the past decade; the same is true regionally, statewide and nationwide.

Chlamydia Incidence

(Annual Average Cases per 100,000 Population)



	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011
City of Chicago	809.4	793.5	803.1	813.6	844.0	876.5	925.6	884.8
MCHC Region	463.9	460.5	474.7	495.8	522.9	542.1	557.8	525.2
Illinois	379.8	385.1	397.8	418.1	438.7	454.6	466.5	449.6
United States	302.5	315.9	330.1	347.1	370.0	390.3	409.8	

Sources:
- Illinois Department of Public Health
- Centers for Disease Control and Prevention, National Center for Health Statistics.

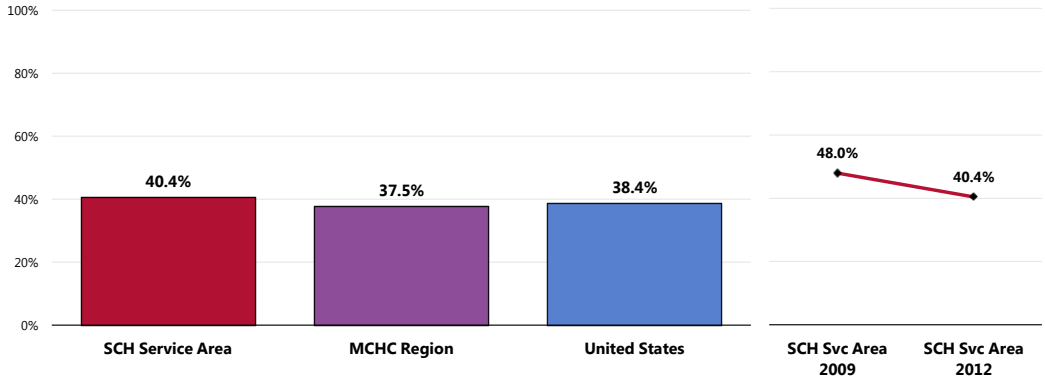
Notes:
- Rates are annual average new cases per 100,000 population.

Hepatitis B Vaccination

Based on survey data, 40.4% of residents have received the hepatitis B vaccine.

- Comparable to regional findings.
- Comparable to what is reported nationwide.
- Statistically unchanged since 2009.

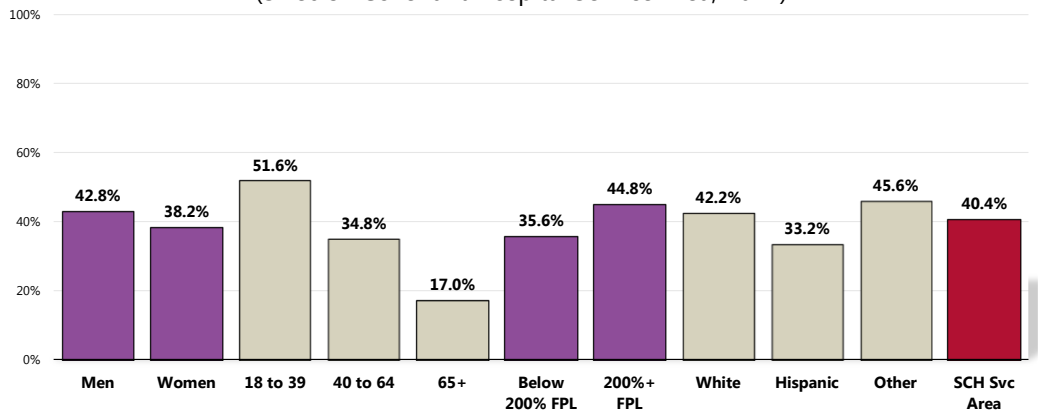
Have Ever Received the Hepatitis B Vaccination



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 82]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Note the negative correlation between age and hepatitis B vaccination.

Have Ever Received the Hepatitis B Vaccination
(Swedish Covenant Hospital Service Area, 2012)



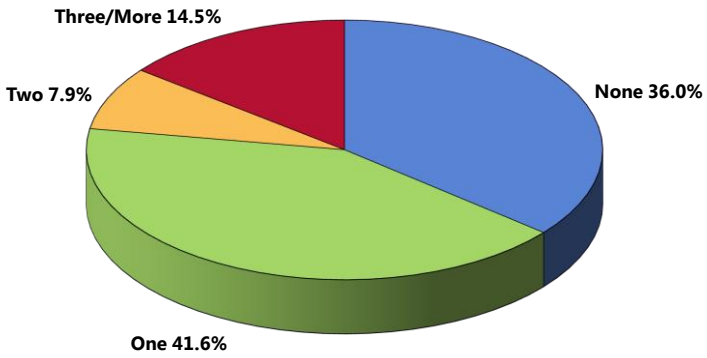
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 82]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Sexual Partners

Among unmarried Swedish Covenant Hospital Service Area adults under age 65, the vast majority cites having one (41.6%) or no (36.0%) sexual partners in the past 12 months.

Number of Sexual Partners in Past 12 Months

(Among Unmarried Adults 18-64; Swedish Covenant Hospital Service Area, 2012)



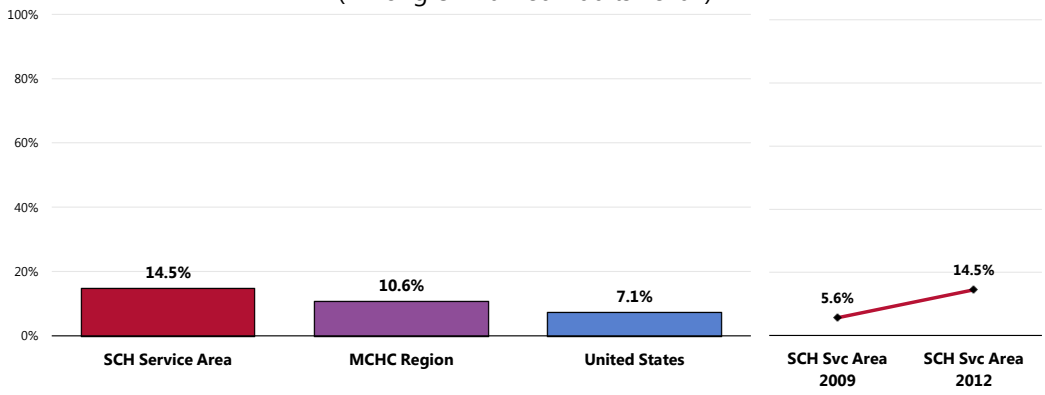
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 103]
Notes: • Asked of all unmarried respondents under the age of 65.

However, 14.5% report three or more sexual partners in the past year.

- Similar to findings in the MCHC Region.
- Twice what is found nationally.
- Marks a significant increase from 2009.

Had Three or More Sexual Partners in the Past Year

(Among Unmarried Adults 18-64)

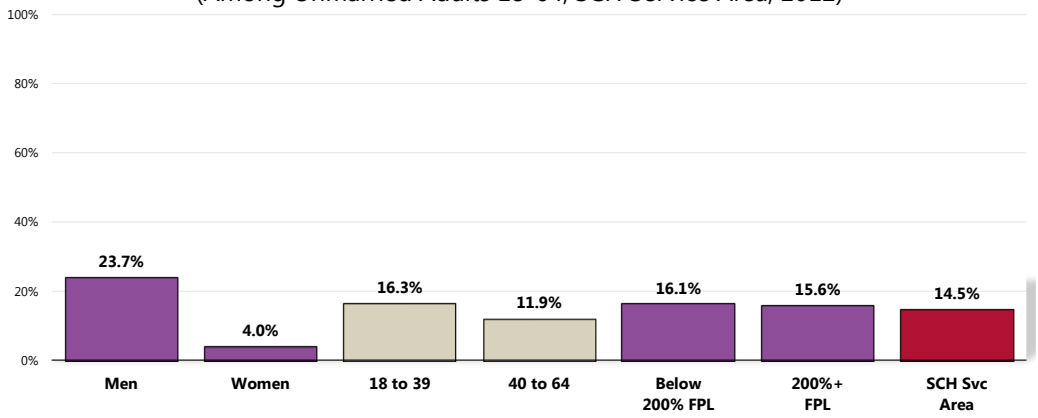


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 103]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all unmarried respondents under the age of 65.

- Unmarried men under 65 and unmarried adults under 40 are more likely to report having 3+ sexual partners in the past year.

Had Three or More Sexual Partners in the Past Year

(Among Unmarried Adults 18-64; SCH Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 103]

Notes:
- Asked of all unmarried respondents under the age of 65.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

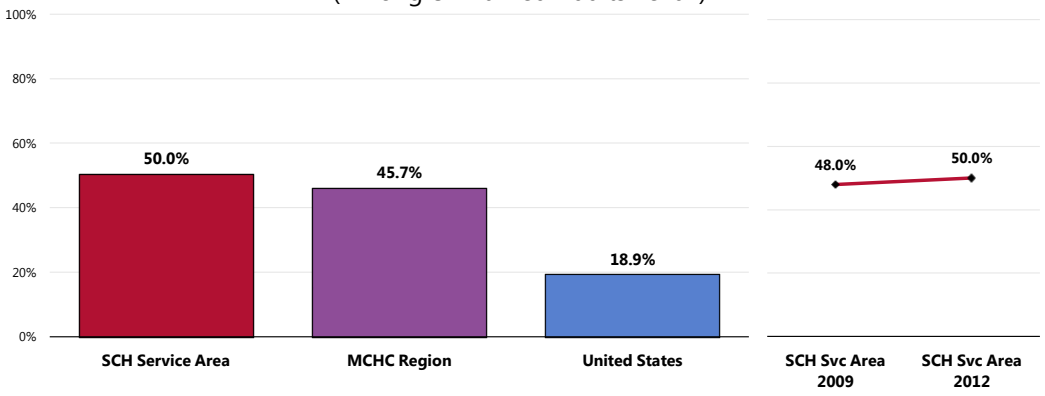
Condom Use

Among Swedish Covenant Hospital Service Area adults who are under age 65 and unmarried, one-half (50.0%) reports that a condom was used during their last sexual intercourse.

- Similar to regional findings.
- Much higher than is found nationally.
- Statistically unchanged since 2009.

Condom Was Used During Last Sexual Intercourse

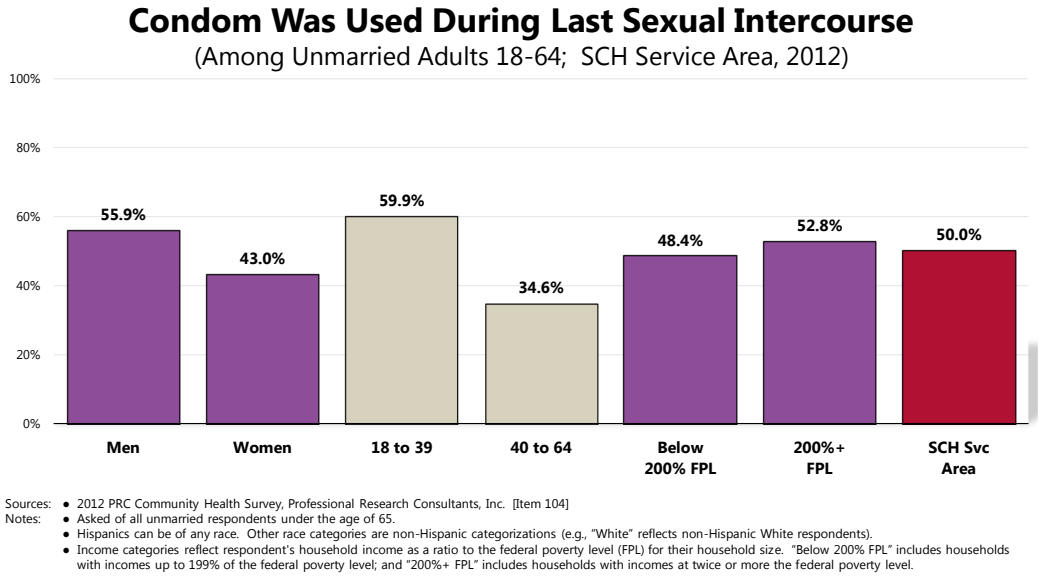
(Among Unmarried Adults 18-64)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 104]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all unmarried respondents under the age of 65.

- Among unmarried adults under 65, women and residents aged 40 to 64 are less likely to report condom use.



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 104]
Notes: • Asked of all unmarried respondents under the age of 65.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Related Focus Group Findings: Sexually Transmitted Infections

Many focus group participants discussed sexually transmitted infections. The main issues included:

- High level of STIs, including HIV/AIDS
- Senior citizens
- Education

Focus group participants worry about the levels of **sexually transmitted infections (STIs)** in the community, especially **HIV/AIDS**. Residents of all ages transmit and receive STIs, not just young people; however, this reality not often discussed.

Attendees agree that **senior citizens** represent a hidden demographic that is effected by STIs and HIV transmission. Focus group members believe that local agencies need to collaborate with medical doctors to increase the **education** and decrease the stigma surrounding sex. Seniors may not practice safe sex methods because they can no longer get pregnant and do not realize the possibility of contracting an STI; education can target these misconceptions. Agencies must figure out ways to communicate with the aging population; one participant explains the concern for seniors in the community:

> *"It's funny 'cause I'm always on the board of TPAN, which is Test Positive Aware Network. Trying to do a real connection with the HIV community and the aging community, and there's no way people want to talk about seniors having sex. I mean it's really interesting. The aging population hardly wants to talk about it. Seniors themselves hardly want to talk about it." — Community Leader (SCH Service Area)*

BIRTHS

Prenatal Care

Improving the well-being of mothers, infants, and children is an important public health goal for the US. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the healthcare system. The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy) and inter-conception (between pregnancies) care. Moreover, healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential. Many factors can affect pregnancy and childbirth, including pre-conception health status, age, access to appropriate healthcare, and poverty.

Infant and child health are similarly influenced by socio-demographic factors, such as family income, but are also linked to the physical and mental health of parents and caregivers. There are racial and ethnic disparities in mortality and morbidity for mothers and children, particularly for African Americans. These differences are likely the result of many factors, including social determinants (such as racial and ethnic disparities in infant mortality; family income; educational attainment among household members; and health insurance coverage) and physical determinants (i.e., the health, nutrition, and behaviors of the mother during pregnancy and early childhood).

– Healthy People 2020 (www.healthypeople.gov)

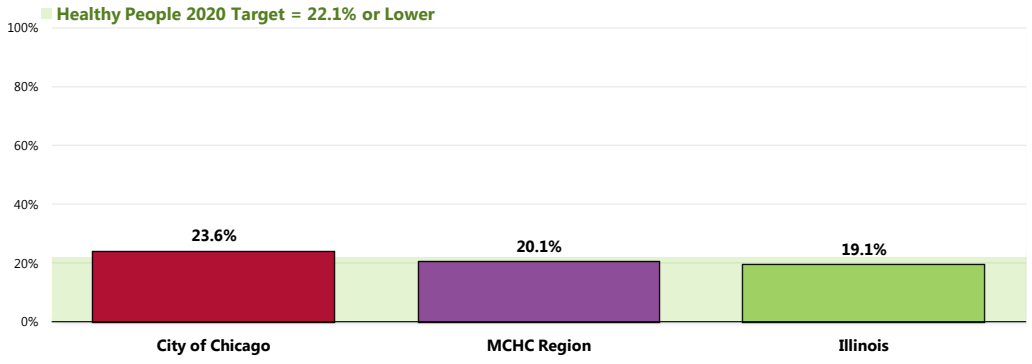
Early and continuous prenatal care is the best assurance of infant health.

Between 2007 and 2009, 23.6% of all City of Chicago births did not receive prenatal care in the first trimester of pregnancy.

- Less favorable than the regional proportion.
- Less favorable than the Illinois proportion.
- Fails to satisfy the Healthy People 2020 target (22.1% or lower).

Lack of Prenatal Care in the First Trimester

(Percentage of Live Births, 2007-2009)



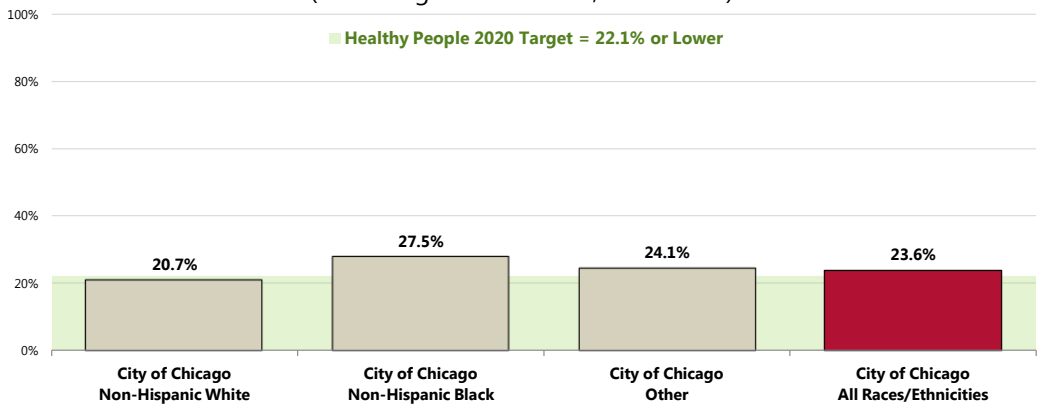
Sources:
- Illinois Department of Public Health.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-10.1]

Note:
- Numbers are a percentage of all live births within each population.

Lack of prenatal care is higher among City of Chicago Blacks than among Whites and Hispanics.

Lack of Prenatal Care in the First Trimester

(Percentage of Live Births, 2007-2009)

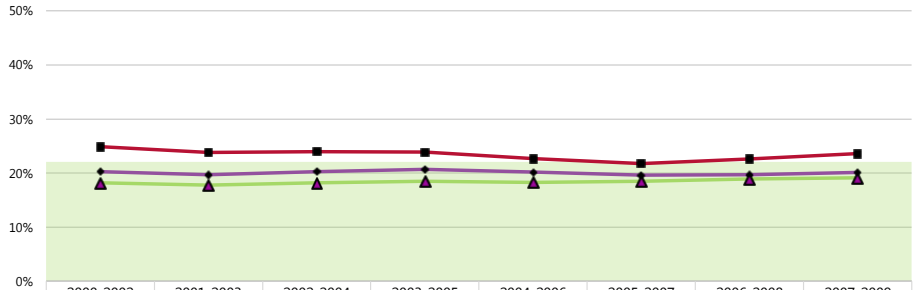


Sources: ● Illinois Department of Public Health.
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-10.1]
Note: ● Numbers are a percentage of all live births within each population.

Receipt of prenatal care improved slightly for the City of Chicago during much of the past decade; however, lack of prenatal care proportions increased in the most recent reporting periods.

Lack of Prenatal Care in the First Trimester

(Percentage of Live Births)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
Healthy People 2020	22.1%	22.1%	22.1%	22.1%	22.1%	22.1%	22.1%	22.1%
City of Chicago	24.9%	23.8%	24.0%	23.9%	22.7%	21.8%	22.6%	23.6%
MCHC Region	20.3%	19.7%	20.3%	20.7%	20.2%	19.6%	19.7%	20.1%
Illinois	18.2%	17.8%	18.2%	18.5%	18.3%	18.5%	18.9%	19.1%

Sources: ● Illinois Department of Public Health
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-10.1]
Note: ● Numbers are a percentage of all live births within each population.

Birth Outcomes & Risks

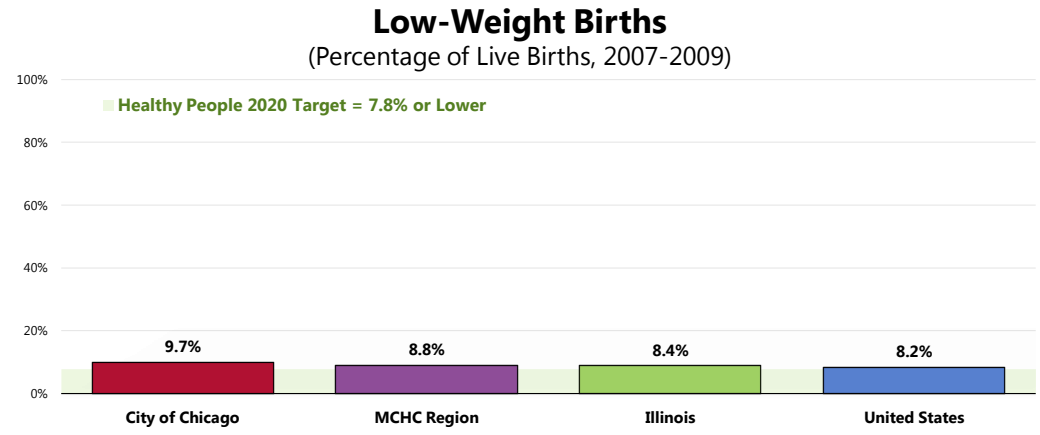
Low-Weight Births

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.

Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable.

A total of 9.7% of 2007-2009 City of Chicago births were low-weight.

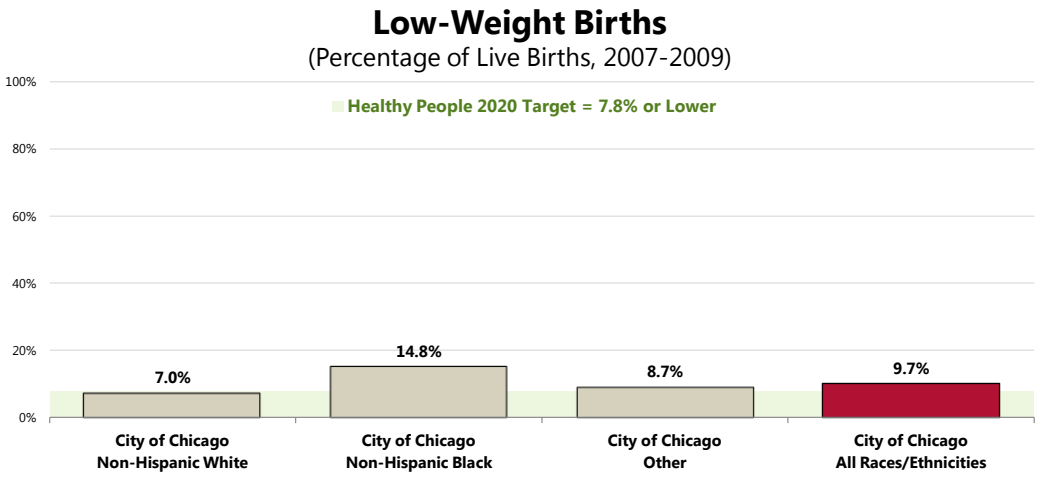
- Higher than the regional proportion.
- Higher than the Illinois proportion.
- Higher than the national proportion.
- Fails to satisfy the Healthy People 2020 target (7.8% or lower).



Sources:
- Illinois Department of Public Health.
- Centers for Disease Control and Prevention, National Vital Statistics System.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-8.1]

Note:
- Numbers are a percentage of all live births within each population.
- Defined as an infant born weighing less than 5.5 pounds (2,500 grams) regardless of gestational age.

Low-weight births are notably more prevalent among Blacks in the City of Chicago.



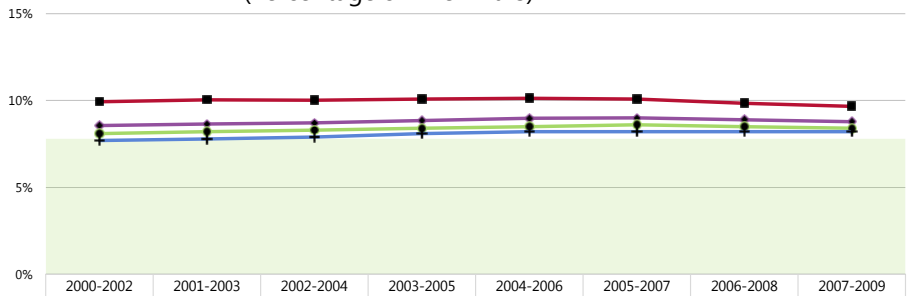
Sources:
- Illinois Department of Public Health.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-8.1]

Note:
- Numbers are a percentage of all live births within each population.

The City's proportion of low-weight births has been relatively stable over the past decade.

Low-Weight Births

(Percentage of Live Births)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
Healthy People 2020	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
City of Chicago	9.9%	10.0%	10.0%	10.1%	10.1%	10.1%	9.8%	9.7%
MCHC Region	8.6%	8.6%	8.7%	8.8%	9.0%	9.0%	8.9%	8.8%
Illinois	8.1%	8.2%	8.3%	8.4%	8.5%	8.6%	8.5%	8.4%
United States	7.7%	7.8%	7.9%	8.1%	8.2%	8.2%	8.2%	8.2%

Sources:
- Illinois Department of Public Health
- Centers for Disease Control and Prevention, National Vital Statistics System.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-8.1]

Note:
- Numbers are a percentage of all live births within each population.
- Defined as an infant born weighing less than 5.5 pounds (2,500 grams) regardless of gestational age.

Infant Mortality

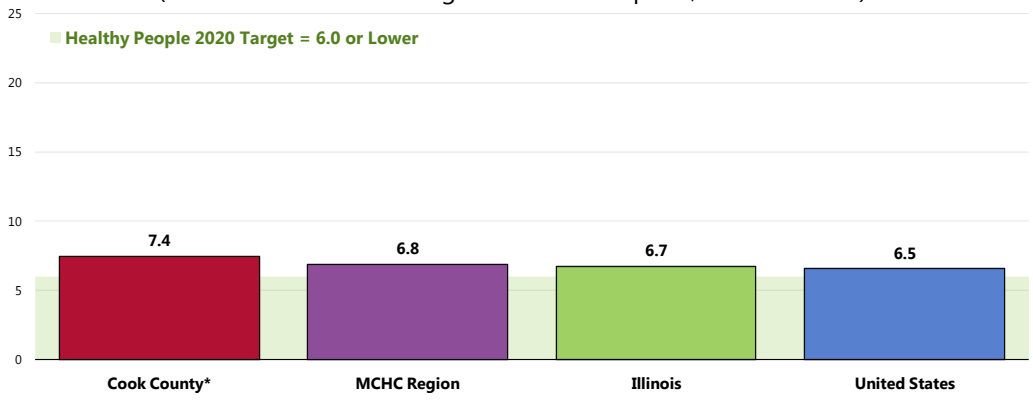
Infant mortality rates reflect deaths of children less than one year old per 1,000 live births.

Between 2007 and 2009, Cook County reported an annual average of 7.4 infant deaths per 1,000 live births.

- Worse than the regional rate.
- More favorable than the Illinois rate.
- More favorable than the national rate.
- Comparable to the Healthy People 2020 target of 6.0 per 1,000 live births.

Infant Mortality Rate

(2007-2009 Annual Average Infant Deaths per 1,000 Live Births)



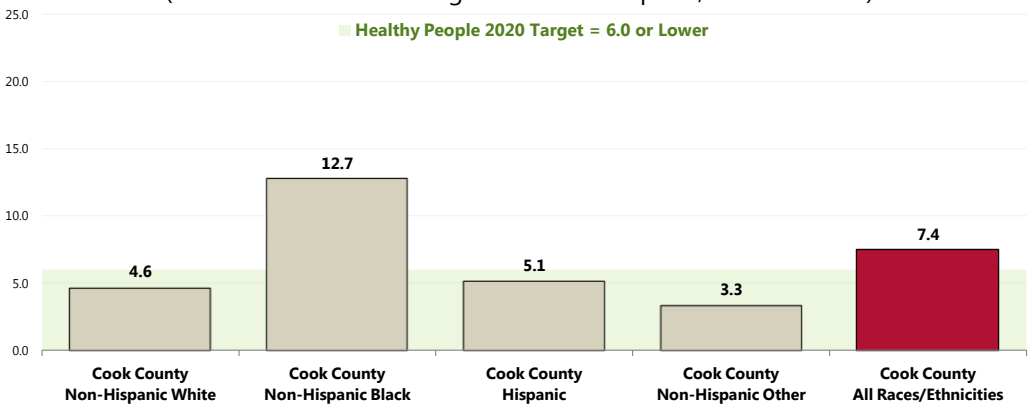
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-1.3]

Notes:
- Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.
- *Cook County data is used here; City of Chicago data is unavailable.

The infant mortality rate is notably higher among births to Black mothers when compared with Whites, Hispanics and Asians in the county.

Infant Mortality Rate

(2007-2009 Annual Average Infant Deaths per 1,000 Live Births)



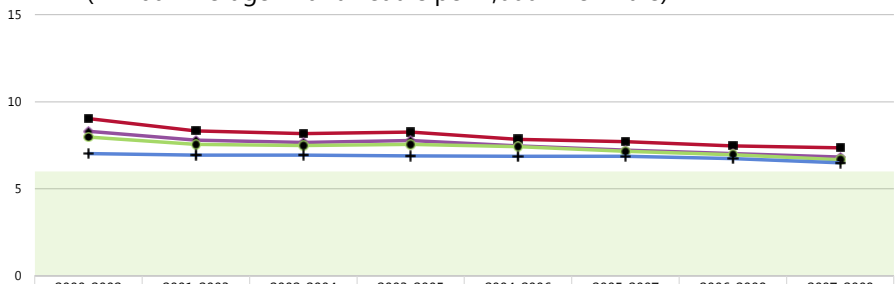
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-1.3]

Notes:
- Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.

The Cook County infant mortality rate trended downward over the past decade, echoing the trends reported regionally and for Illinois and the US overall.

Infant Mortality Rate

(Annual Average Infant Deaths per 1,000 Live Births)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
Healthy People 2020	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0
Cook County	9.0	8.3	8.2	8.3	7.8	7.7	7.5	7.4
MCHC Region	8.3	7.8	7.7	7.8	7.5	7.2	7.0	6.8
Illinois	8.0	7.6	7.5	7.6	7.4	7.2	7.0	6.7
United States	7.0	6.9	6.9	6.9	6.9	6.9	6.7	6.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-1.3]

Notes:
- Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.

Family Planning

Family planning is one of the 10 great public health achievements of the 20th century. The availability of family planning services allows individuals to achieve desired birth spacing and family size and contributes to improved health outcomes for infants, children, and women. Family planning services include contraceptive and broader reproductive health services (patient education and counseling), breast and pelvic examinations, breast and cervical cancer screening, sexually transmitted infection (STI) and HIV prevention education/counseling/testing/referral, and pregnancy diagnosis and counseling. For many women, a family planning clinic is their entry point into the healthcare system and is considered to be their usual source of care. This is especially true for women with incomes below the poverty level, women who are uninsured, Hispanic women, and Black women.

Unintended pregnancies (those reported by women as being mistimed or unwanted) are associated with many negative health and economic outcomes. In 2001, almost one-half of all pregnancies in the US were unintended. For women, negative outcomes associated with unintended pregnancy include:

- Delays in initiating prenatal care
- Reduced likelihood of breastfeeding
- Poor maternal mental health
- Lower mother-child relationship quality
- Increased risk of physical violence during pregnancy

Children born as a result of an unintended pregnancy are more likely to experience poor mental and physical health during childhood and poor educational and behavioral outcomes.

– Healthy People 2020 (www.healthypeople.gov)

Births to Unwed Mothers

According to the CDC, an unintended pregnancy is a pregnancy that is either mistimed or unwanted at the time of conception. It is a core concept in understanding the fertility of populations and the unmet need for contraception. Unintended pregnancy is associated with an increased risk of morbidity for women, and with health behaviors during pregnancy that are associated with adverse effects. For example, women with an unintended pregnancy may delay prenatal care, which may affect the health of the infant. Women of all ages may have unintended pregnancies, but some groups, such as teens, are at a higher risk.

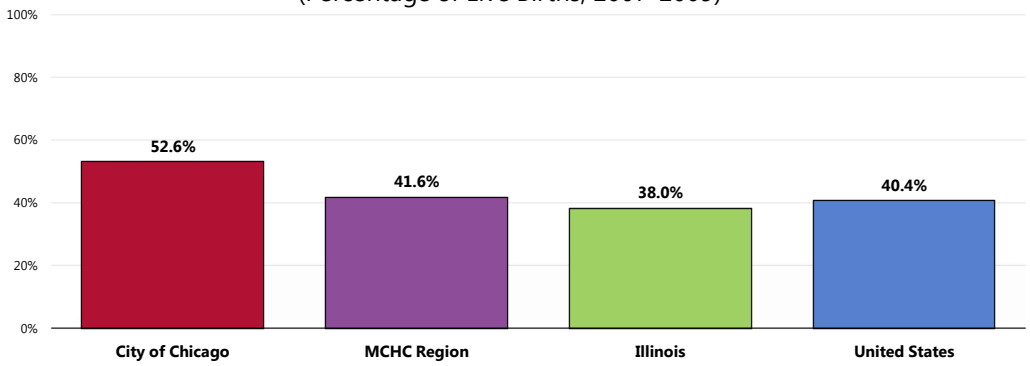
Because it is impossible to measure the true incidence of unintended pregnancy in the US, the following indicator looks at births occurring among unmarried mothers as a proxy measure for pregnancies that are not intended (knowing that this is not always the case).

More than one-half (52.6%) of 2007-2009 City of Chicago births were to unwed mothers.

- Higher than the regional percentage.
- Higher than the percentage reported statewide.
- Higher than that found nationally.

Births to Unwed Mothers

(Percentage of Live Births, 2007-2009)

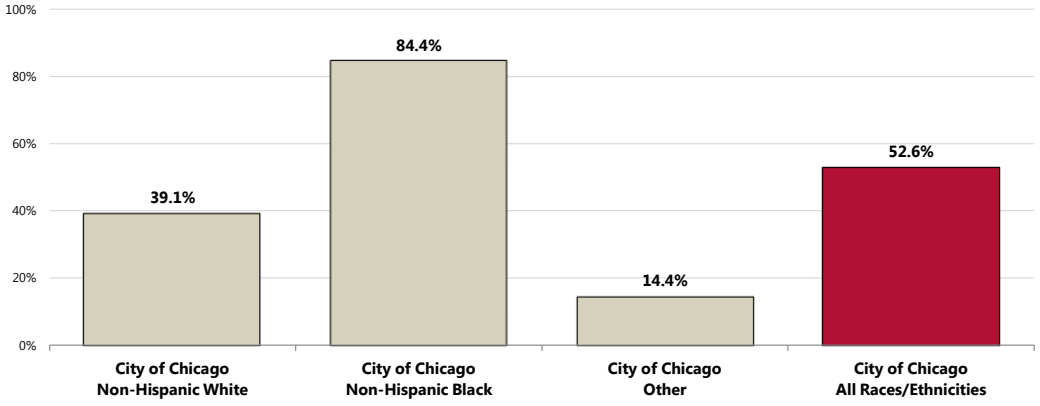


Sources: • Illinois Department of Public Health.
• Centers for Disease Control and Prevention, National Vital Statistics System.
Note: • Numbers are a percentage of all live births within each population.

Note the high prevalence (84.4%) of births to unwed mothers in the City's Black population.

Births to Unwed Mothers

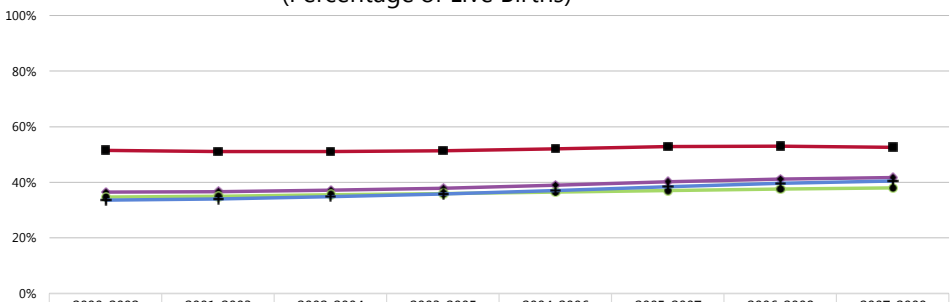
(Percentage of Live Births, 2007-2009)



Sources: • Illinois Department of Public Health.
Note: • Numbers are a percentage of all live births within each population.

- The percentage of births to unwed mothers in the City of Chicago has increased slightly over the past decade; regional, state and national percentages have increased as well.

Births to Unwed Mothers
(Percentage of Live Births)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
City of Chicago	51.5%	51.1%	51.1%	51.3%	52.0%	52.8%	53.0%	52.6%
MCHC Region	36.5%	36.6%	37.1%	37.8%	38.9%	40.1%	41.2%	41.6%
Illinois	34.7%	35.0%	35.5%	35.9%	36.4%	37.1%	37.6%	38.0%
United States	33.6%	34.0%	34.8%	35.8%	37.1%	38.4%	39.6%	40.4%

Sources: • Illinois Department of Public Health
• Centers for Disease Control and Prevention, National Vital Statistics System.
Note: • Numbers are a percentage of all live births within each population.

Births to Teen Mothers

The negative outcomes associated with unintended pregnancies are compounded for adolescents. Teen mothers:

- Are less likely to graduate from high school or attain a GED by the time they reach age 30.
- Earn an average of approximately $3,500 less per year, when compared with those who delay childbearing.
- Receive nearly twice as much Federal aid for nearly twice as long.

Similarly, early fatherhood is associated with lower educational attainment and lower income. Children of teen parents are more likely to have lower cognitive attainment and exhibit more behavior problems. Sons of teen mothers are more likely to be incarcerated, and daughters are more likely to become adolescent mothers.

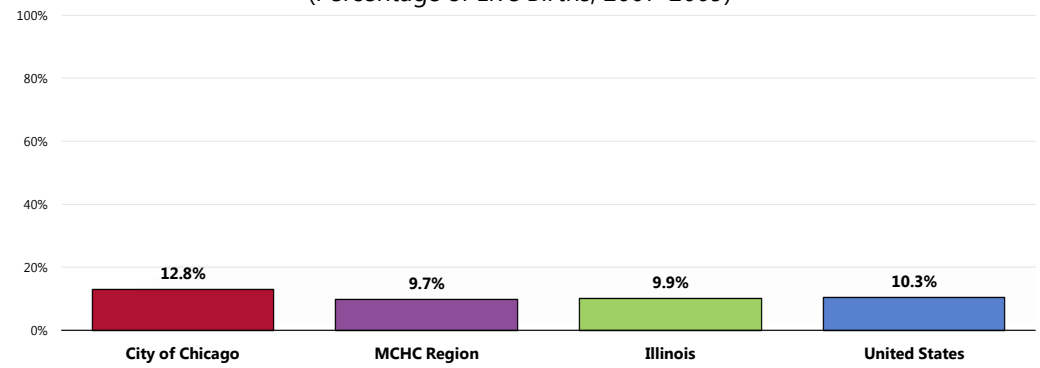
– Healthy People 2020 (www.healthypeople.gov)

A total of 12.8% of 2007-2009 city births were to teen mothers (under age 20).

- Worse than the regional proportion.
- Worse than the Illinois proportion.
- Worse than the national proportion.

Births to Teen Mothers (Under Age 20)

(Percentage of Live Births, 2007-2009)

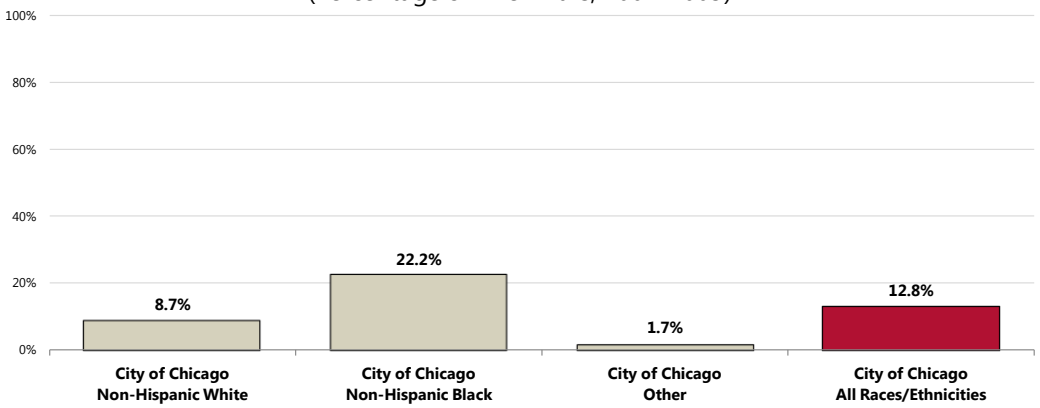


Sources: • Illinois Department of Public Health.
• Centers for Disease Control and Prevention, National Vital Statistics System.
Note: • Numbers are a percentage of all live births within each population.

Teen births are notably more prevalent among Black mothers in the City of Chicago.

Births to Teen Mothers

(Percentage of Live Births, 2007-2009)

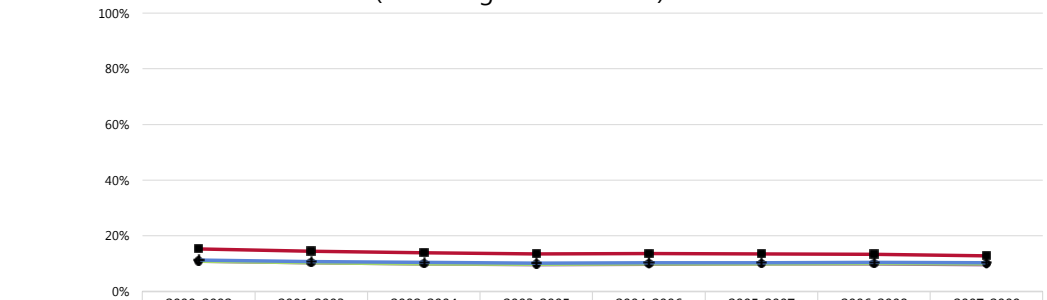


Sources: • Illinois Department of Public Health.
Note: • Numbers are a percentage of all live births within each population.

The percentage of births to teen mothers decreased over the past decade.

Births to Teen Mothers

(Percentage of Live Births)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
City of Chicago	15.3%	14.4%	13.9%	13.5%	13.6%	13.5%	13.4%	12.8%
MCHC Region	10.9%	10.3%	9.9%	9.7%	9.8%	9.9%	9.9%	9.7%
Illinois	10.9%	10.3%	10.0%	9.8%	9.9%	9.9%	10.0%	9.9%
United States	11.3%	10.8%	10.4%	10.2%	10.3%	10.3%	10.4%	10.3%

Sources:
- Illinois Department of Public Health
- Centers for Disease Control and Prevention, National Vital Statistics System.

Note:
- Numbers are a percentage of all live births within each population.

MODIFIABLE HEALTH RISKS

Actual Causes Of Death

A 1999 study (an update to a landmark 1993 study), estimated that as many as 40% of premature deaths in the United States are attributed to behavioral factors. This study found that behavior patterns represent the single-most prominent domain of influence over health prospects in the United States. The daily choices we make with respect to diet, physical activity, and sex; the substance abuse and addictions to which we fall prey; our approach to safety; and our coping strategies in confronting stress are all important determinants of health.

The most prominent contributors to mortality in the United States in 2000 were tobacco (an estimated 435,000 deaths), diet and activity patterns (400,000), alcohol (85,000), microbial agents (75,000), toxic agents (55,000), motor vehicles (43,000), firearms (29,000), sexual behavior (20,000), and illicit use of drugs (17,000). Socioeconomic status and access to medical care are also important contributors, but difficult to quantify independent of the other factors cited. Because the studies reviewed used different approaches to derive estimates, the stated numbers should be viewed as first approximations.

These analyses show that smoking remains the leading cause of mortality. However, poor diet and physical inactivity may soon overtake tobacco as the leading cause of death. These findings, along with escalating healthcare costs and aging population, argue persuasively that the need to establish a more preventive orientation in the US healthcare and public health systems has become more urgent.

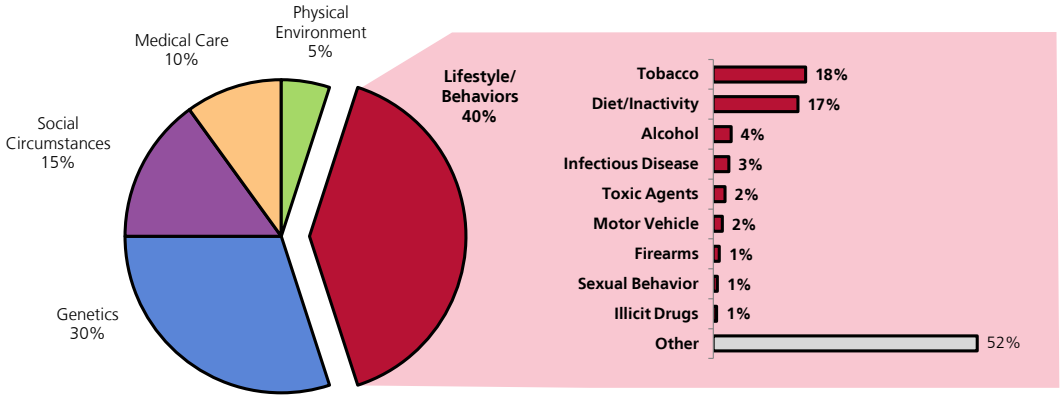
– Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, Phd, MSc; Julie L. Gerberding, MD, MPH. "Actual Causes of Death in the United States." JAMA, 291(2004):1238-1245.

While causes of death are typically described as the diseases or injuries immediately precipitating the end of life, a few important studies have shown that the actual causes of premature death (reflecting underlying risk factors) are often preventable.

Leading Causes of Death	Underlying Risk Factors (Actual Causes of Death)	
Cardiovascular disease	Tobacco use Elevated serum cholesterol High blood pressure	Obesity Diabetes Sedentary lifestyle
Cancer	Tobacco use Improper diet	Alcohol Occupational/environmental exposures
Cerebrovascular disease	High blood pressure Tobacco use	Elevated serum cholesterol
Accidental injuries	Safety belt noncompliance Alcohol/substance abuse Reckless driving	Occupational hazards Stress/fatigue
Chronic lung disease	Tobacco use	Occupational/environmental exposures

Source: National Center for Health Statistics/US Department of Health and Human Services, Health United States: 1987. DHHS Pub. No. (PHS) 88–1232.

Factors Contributing to Premature Deaths in the United States



Sources: "The Case For More Active Policy Attention to Health Promotion"; (McGinnis, Williams-Russo, Knickman) Health Affairs, Vol. 21, No. 2, March/April 2002. "Actual Causes of Death in the United States"; (Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, Phd, MSc; Julie L. Gerberding, MD, MPH) JAMA, 291(2000):1238-1245.

Nutrition

Strong science exists supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, healthcare organizations, and communities.

The goal of promoting healthful diets and healthy weight encompasses increasing household food security and eliminating hunger.

Americans with a healthful diet:

- Consume a variety of nutrient-dense foods within and across the food groups, especially whole grains, fruits, vegetables, low-fat or fat-free milk or milk products, and lean meats and other protein sources.
- Limit the intake of saturated and trans fats, cholesterol, added sugars, sodium (salt), and alcohol.
- Limit caloric intake to meet caloric needs.

Diet and body weight are related to health status. Good nutrition is important to the growth and development of children. A healthful diet also helps Americans reduce their risks for many health conditions, including: overweight and obesity; malnutrition; iron-deficiency anemia; heart disease; high blood pressure; dyslipidemia (poor lipid profiles); type 2 diabetes; osteoporosis; oral disease; constipation; diverticular disease; and some cancers.

Diet reflects the variety of foods and beverages consumed over time and in settings such as worksites, schools, restaurants, and the home. Interventions to support a healthier diet can help ensure that:

- Individuals have the knowledge and skills to make healthier choices.
- Healthier options are available and affordable.

Social Determinants of Diet. Demographic characteristics of those with a more healthful diet vary with the nutrient or food studied. However, most Americans need to improve some aspect of their diet.

Social factors thought to influence diet include:

- Knowledge and attitudes
- Skills
- Social support
- Societal and cultural norms
- Food and agricultural policies
- Food assistance programs
- Economic price systems

Physical Determinants of Diet. Access to and availability of healthier foods can help people follow healthful diets. For example, better access to retail venues that sell healthier options may have a positive impact on a person's diet; these venues may be less available in low-income or rural neighborhoods.

The places where people eat appear to influence their diet. For example, foods eaten away from home often have more calories and are of lower nutritional quality than foods prepared at home.

Marketing also influences people's—particularly children's—food choices.

– Healthy People 2020 (www.healthypeople.gov)

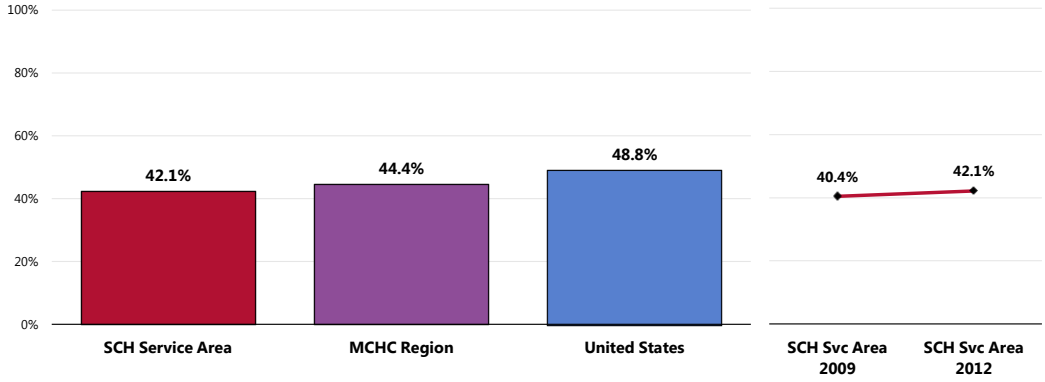
Daily Recommendation of Fruits/Vegetables

To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

A total of 42.1% of Swedish Covenant Hospital Service Area adults report eating five or more servings of fruits and/or vegetables per day.

- Similar to regional findings.
- Less favorable than national findings.
- Fruit/vegetable consumption has not changed significantly since 2009.

Consume Five or More Servings of Fruits/Vegetables Per Day



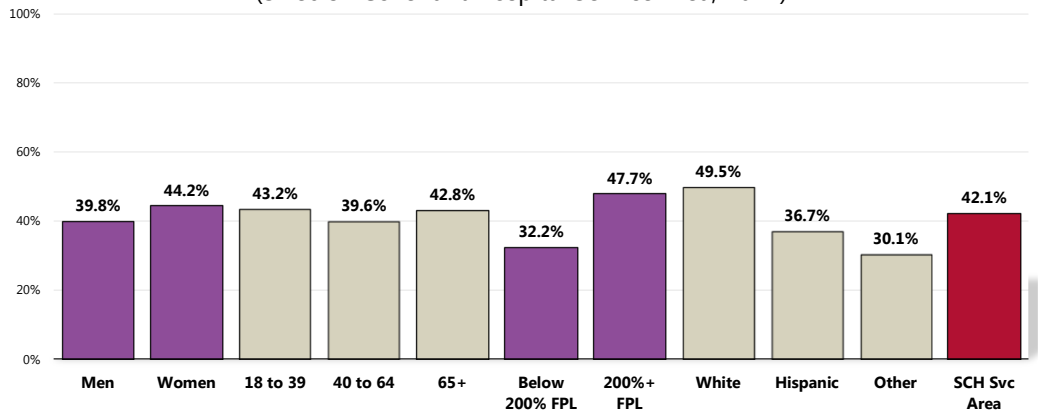
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 178]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- For this issue, respondents were asked to recall their food intake on the previous day.

- Lower-income adults are <u>less</u> likely to get the recommended servings of daily fruits/vegetables, as are non-Whites.

Consume Five or More Servings of Fruits/Vegetables Per Day

(Swedish Covenant Hospital Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 178]

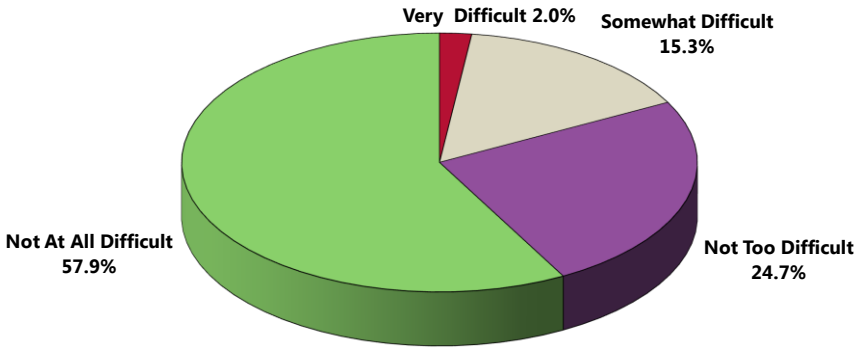
Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.
- For this issue, respondents were asked to recall their food intake on the previous day.

Affordability of Fresh Produce

Most service area adults do not find it difficult to find fresh, affordable produce in their community, with 57.9% of respondents reporting it is "not at all difficult" and 24.7% indicating that it is "not too difficult."

Ease of Obtaining Affordable, Fresh Produce

(Swedish Covenant Hospital Service Area, 2012)

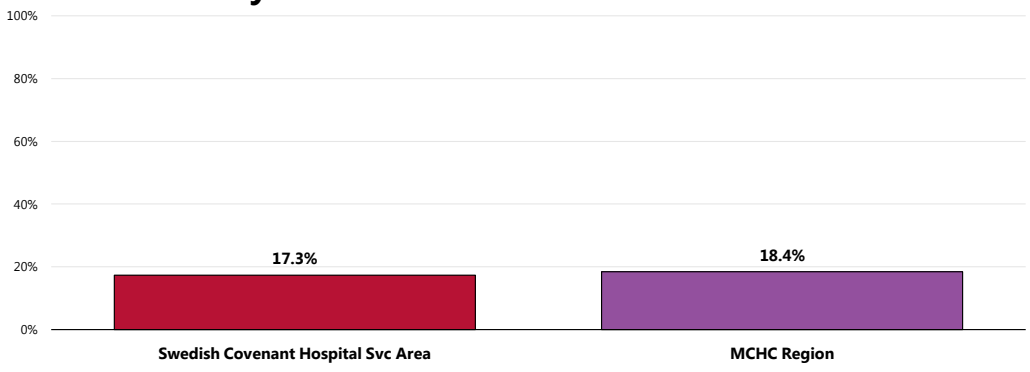


Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 109]
Notes: • Asked of all respondents.

On the other hand, a total of 17.3% of service area adults find it "somewhat" or "very" difficult to find affordable fresh fruits and vegetables in the area.

- Comparable to MCHC regional findings.

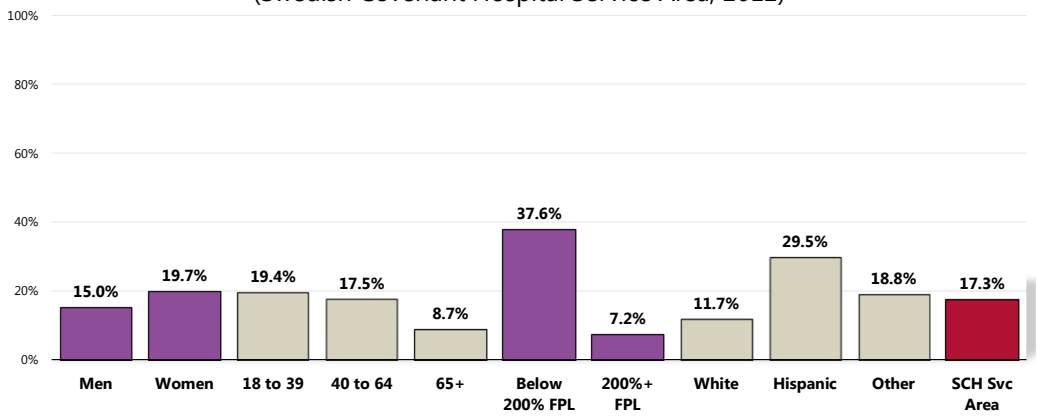
Find It "Very" or "Somewhat" Difficult to Buy Fresh Produce at an Affordable Price



Sources: • 2012 PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 109]
Notes: • Asked of all respondents.

- Adults under age 65 are more likely to report difficulty finding affordable fresh produce, as are low income residents (especially) and non-Whites.

Find It "Very" or "Somewhat" Difficult to Buy Fresh Produce at an Affordable Price
(Swedish Covenant Hospital Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 109]

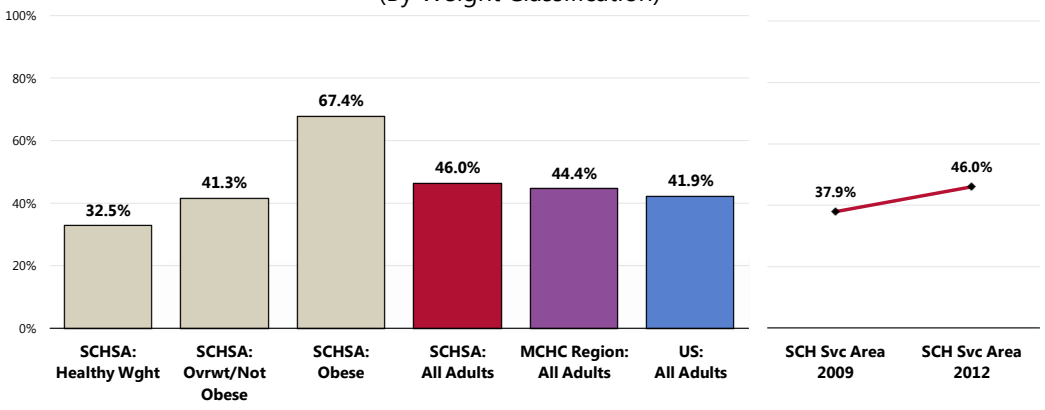
Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Health Advice About Diet & Nutrition

A total of 46.0% of survey respondents acknowledge that a physician counseled them about diet and nutrition in the past year.

- Comparable to regional findings.
- Comparable to national findings.
- Statistically unchanged since 2009.
- Note: Among obese respondents, 67.4% report receiving diet/nutrition advice (meaning that nearly one-third did not).

Have Received Advice About Diet and Nutrition in the Past Year From a Physician, Nurse, or Other Health Professional
(By Weight Classification)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 18]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Related Focus Group Findings: Nutrition

Many focus group participants discussed nutrition in the community. The main findings include:

- Basic nutrition needs not being met
- Poor eating habits
    - Convenience
    - Misconception surrounding cost
    - Unhealthy ethnic diets
- Nutrition education
- Local organizations work to increase availability of nutritious foods

Focus group attendees believe that many residents within Cook County cannot meet their own **basic nutritional needs**. The environment in which these individuals live does not support their ability to make healthy choices, like eating nutritious foods or participating in physical activity:

> *"I think we call too many things 'lifestyle' that really are 'environment.' I'm not talking about belching smokestacks although that's one piece of it but if you're living in a high crime neighborhood, how can I blame you for not getting out and exercising or not getting your kids out and exercising; it doesn't seem very productive. If you're living in a food desert -- I have students in West Garfield all the time and they are astonished by how few food choices there are for people to take advantage of in that neighborhood that are affordable, that are fresh." — Cook County Community Leader*

Attendees stress the importance of meeting people where they live, work and play in order to make the most impact. In addition, agencies must recognize the hardships which residents face daily, as one participant explains:

> *"I think the problem is also small rewards. Like everybody knows pretty much that smoking isn't good for you, but a cigarette is a reward and it's within people's reach, more or less. And food is a reward, God knows, and it's within people's reach. And so you have to think small because if you think big you aren't going to meet these people where they really live. I serve a low income population and probably most of them are below the poverty line…So I can hardly begrudge them a cigarette or food if they're obese because that's it. They aren't going to go on vacation." — Cook County Community Leader*

Many residents living in Cook County and North Chicago possess **poor eating habits**. The American culture involves overeating, pre-packaged meals and fast food. In addition, minority residents may come from a country of origin where eating is a 'right of honor,' as one participant explains:

> *"They come from other countries. Kids will starve. So to them, to the Hispanic community, eating is a right of honor because when they were kids they saw there was no food…Don't leave anything on your plate." — Key Informant Representing Hispanic Residents*

In addition, the advertising which local children encounter on a daily basis for things like fast food and snack food is hard to compete against, so many community members frequent fast food establishments. Fast food has limited nutritional value but represents a **convenient option** for working families; it also tastes good, so kids want it. An attendee describes the dilemma:

> *"A family goes to McDonald's and they can feed an entire family for $10.00 as opposed to going to Jewel and buying broccoli and the meats and everything and preparing them at home for $25.00, they're going to go to McDonald's." — Swedish Covenant Hospital Representative*

Low income residents may not be able to afford fresh food. Residents **perceive healthy foods to cost more**, as a participant recalls:

> *"And the misconception that healthy things cost more. Yes, McDonald's is convenient, but for your $4 happy meal, you could probably buy a lot of fruits and vegetables." — North Chicago Community Leader*

According to focus group members, many **ethnic diets are unhealthy**. Representatives of Asian Indian agencies recognize that many types of their traditional foods lack nutritional value:

> *"The South Asian diet is very high in refined carbohydrates and fats and sweets, and there are also a lot of vegetarians, so the health messages are like eat more vegetables, but they're already doing that and they still have diabetes." — Key Informant Representing Asian Indian Residents*

Focus group attendees think that **nutritional education** should occur regularly, as many people do not know how to cook 'healthy meals.' Learning how to read labels, understand nutritional facts, and participate in cooking classes would benefit the entire community, ensuring that residents know how to cook healthy meals for their families.

Group participants agree that an educational class should also be a requirement for residents receiving Supplemental Nutrition Assistance Program (SNAP) benefits since current recipients are allowed to purchase anything they like, including soda and junk food. Some residents simply may not know how to cook nutritious meals, or know what other foods could be substituted to make the meal healthier. Many children grow up in households with parents who do not know how to cook, so the children aren't taught, as one participant describes:

> *"And if you grew up with parents who, basically single moms who didn't know how to good food choices, and then that continues on. Where is that break? And where is that education about healthy food choices?" — North Chicago Community Leader*

Participants believe it is important to show these communities exactly how to prepare healthier options, as a participant explains:

> *"So we have people that are nutritionists and they teach you how to make chips, and not fry them. This is a great organization that came and teaches our parents how to make posole in a healthy way. Instead of making pork, you make it chicken, stuff like that." — Key Informant Representing Hispanic Residents*

Another participant describes how the Polish community needs outreach in order to improve their cooking methods:

> *"I think that Poles do a lot of home cooking. Going out to the restaurant is so – they do, but maybe not necessarily so adventurous, to some extent. I think we have a lot of the behaviors from Poland. Our kitchen is not necessarily the lightest. We always joke that vegetables are potatoes and cabbage in our diet." — Key Informant Representing Polish Residents*

Focus group attendees believe that healthy eating needs to begin early in life and that schools can play an important part in educating youth. School curriculums need to include education about nutrition and diet, and schools must provide nutritious food options in the cafeteria to reinforce the education.

> *"I'm sure it varies by school and principal, etc. and leadership, but I do think that it's got to start very young and there has to be buy-in by the family members. Even if the parents buy in it's still a challenge because once the kids leave home, I live in Oak Park, and even the Oak Park kids you see their morning breakfast of Cheetos and a Coke." North Chicago Community Leader*

Currently, several **local organizations work toward increasing availability of nutritious foods**, and many community gardening initiatives have begun in North Chicago. The Women, Infant and Children (WIC) program provides education and has provided coupons for participants to buy foods at local farmers markets in the past, and many senior citizens receive food vouchers. Additionally, many local ethnic grocery stores have fresh produce available at a less expensive price than chain grocery stores, as one participant recalls:

> *"There are a number of these ethnic fruit and vegetable stores that also may sell meat and not quite full-service, but pretty close. You know where the fruits and vegetables are quite reasonable, less expensive than in the main – the chain grocery stores." — North Chicago Community Leader*

Physical Activity

Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Among adults and older adults, physical activity can lower the risk of: early death; coronary heart disease; stroke; high blood pressure; type 2 diabetes; breast and colon cancer; falls; and depression. Among children and adolescents, physical activity can: improve bone health; improve cardiorespiratory and muscular fitness; decrease levels of body fat; and reduce symptoms of depression. For people who are inactive, even small increases in physical activity are associated with health benefits.

Personal, social, economic, and environmental factors all play a role in physical activity levels among youth, adults, and older adults. Understanding the barriers to and facilitators of physical activity is important to ensure the effectiveness of interventions and other actions to improve levels of physical activity.

Factors **positively** associated with adult physical activity include: postsecondary education; higher income; enjoyment of exercise; expectation of benefits; belief in ability to exercise (self-efficacy); history of activity in adulthood; social support from peers, family, or spouse; access to and satisfaction with facilities; enjoyable scenery; and safe neighborhoods.

Factors **negatively** associated with adult physical activity include: advancing age; low income; lack of time; low motivation; rural residency; perception of great effort needed for exercise; overweight or obesity; perception of poor health; and being disabled. Older adults may have additional factors that keep them from being physically active, including lack of social support, lack of transportation to facilities, fear of injury, and cost of programs.

Among children ages 4 to 12, the following factors have a positive association with physical activity:

- Gender (boys)
- Belief in ability to be active (self-efficacy)
- Parental support

Among adolescents ages 13 to 18, the following factors have a positive association with physical activity:

- Parental education
- Gender (boys)
- Personal goals
- Physical education/school sports
- Belief in ability to be active (self-efficacy)
- Support of friends and family

Environmental influences positively associated with physical activity among children and adolescents include:

- Presence of sidewalks
- Having a destination/walking to a particular place
- Access to public transportation
- Low traffic density
- Access to neighborhood or school play area and/or recreational equipment

People with disabilities may be less likely to participate in physical activity due to physical, emotional, and psychological barriers. Barriers may include the inaccessibility of facilities and the lack of staff trained in working with people with disabilities.

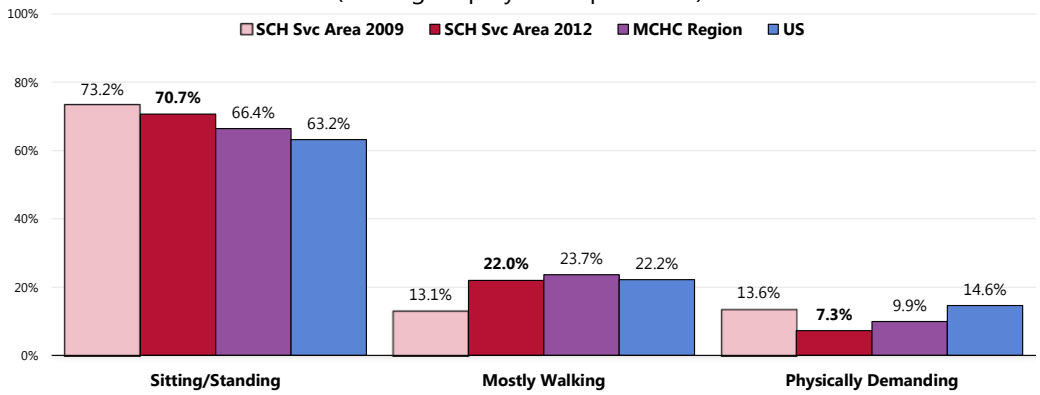
– Healthy People 2020 (www.healthypeople.gov)

Level of Activity at Work

A majority of employed respondents reports low levels of physical activity at work.

- Just over 7 in 10 employed respondents (70.7%) report that their job entails mostly sitting or standing, similar to the regional figure but higher than the US percentage.
- 22.0% report that their job entails mostly walking (similar to that reported both regionally and nationally).
- 7.3% report that their work is physically demanding (similar to the regional prevalence, and lower than what is reported nationally).
- Over time, the only significant change is the increase in reports of work requiring "mostly walking" among employed respondents.

Primary Level of Physical Activity At Work
(Among Employed Respondents)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 110]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of those respondents who are employed for wages.

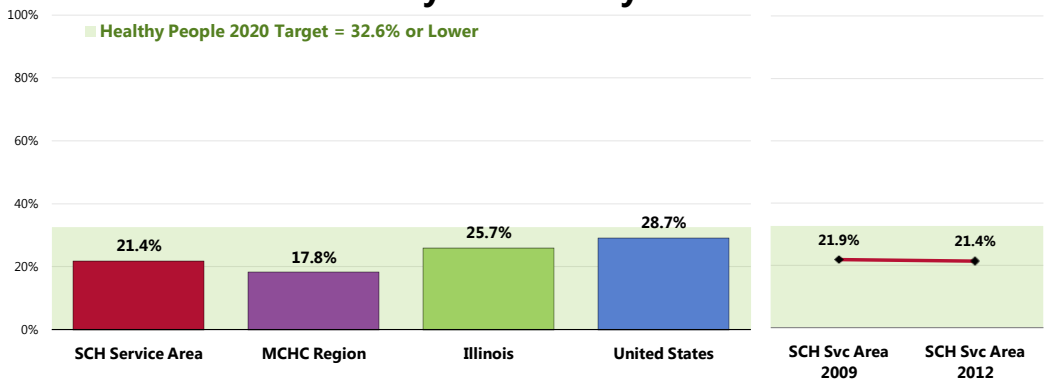
Leisure-Time Physical Activity

Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

21.4% of area adults had no leisure-time physical activity in the past month.

- Similar to the regional findings.
- More favorable than statewide findings.
- More favorable than national findings.
- Satisfies the Healthy People 2020 target (32.6% or lower).
- Statistically unchanged since 2009.

No Leisure-Time Physical Activity in the Past Month



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 111]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-1]

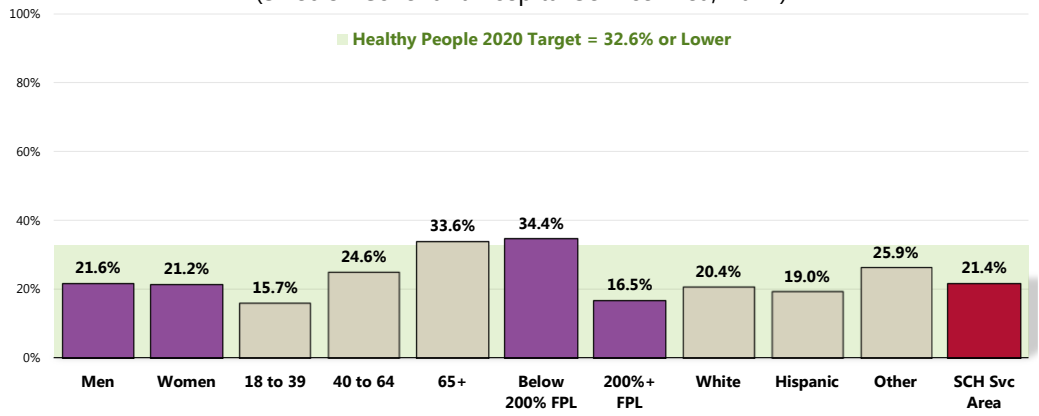
Notes:
- Asked of all respondents.

Lack of leisure-time physical activity in the area is higher among:

- Community members age 40 or older (particularly those age 65+).
- Lower-income residents.

No Leisure-Time Physical Activity in the Past Month

(Swedish Covenant Hospital Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 111]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-1]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Activity Levels

Adults (age 18–64) should do 2 hours and 30 minutes a week of moderate-intensity, or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity aerobic physical activity, or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. Aerobic activity should be performed in episodes of at least 10 minutes, preferably spread throughout the week.

Additional health benefits are provided by increasing to 5 hours (300 minutes) a week of moderate-intensity aerobic physical activity, or 2 hours and 30 minutes a week of vigorous-intensity physical activity, or an equivalent combination of both.

Older adults (age 65 and older) should follow the adult guidelines. If this is not possible due to limiting chronic conditions, older adults should be as physically active as their abilities allow. They should avoid inactivity. Older adults should do exercises that maintain or improve balance if they are at risk of falling.

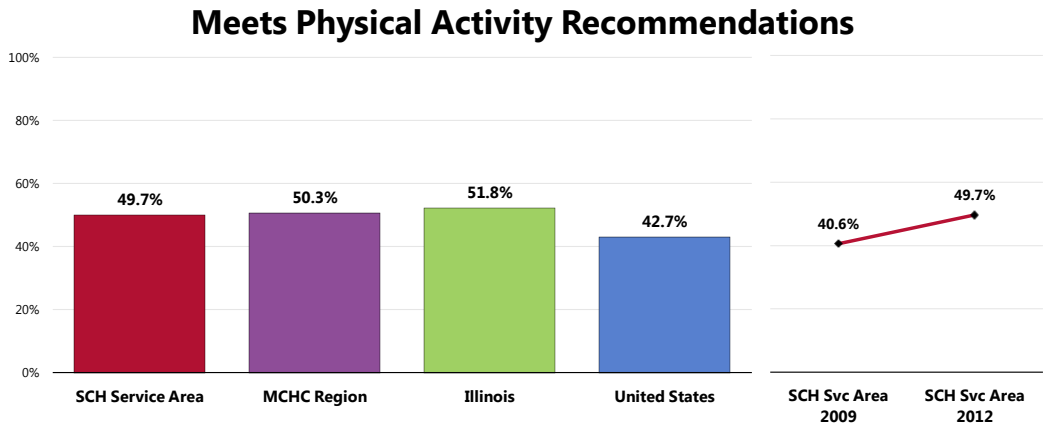
For all individuals, some activity is better than none. Physical activity is safe for almost everyone, and the health benefits of physical activity far outweigh the risks.

– 2008 Physical Activity Guidelines for Americans, U.S. Department of Health and Human Services. www.health.gov/PAGuidelines

Recommended Levels of Physical Activity

A total of 49.7% of Swedish Covenant Hospital Service Area adults participate in regular, sustained moderate or vigorous physical activity (meeting physical activity recommendations).

- Similar to findings in the MCHC Region.
- Similar to statewide findings.
- More favorable than national findings.
- Marks a significant increase since 2009.



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 181]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2009 Illinois data.

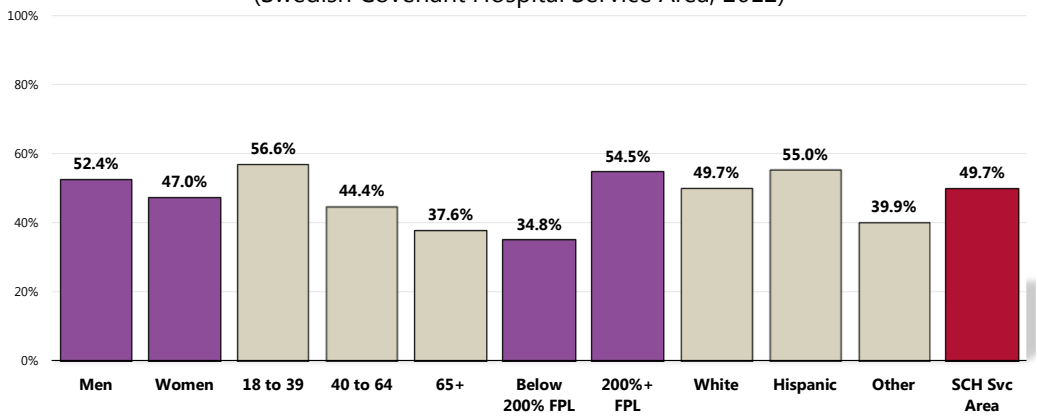
Notes:
- Asked of all respondents.
- In this case the term "meets physical activity recommendations" refers to participation in moderate physical activity (exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate) at least 5 times a week for 30 minutes at a time, and/or vigorous physical activity (activities that cause heavy sweating or large increases in breathing or heart rate) at least 3 times a week for 20 minutes at a time.

Those less likely to meet physical activity requirements include:

- Respondents age 40+, especially those age 65+.
- Those with lower incomes.

Meets Physical Activity Recommendations

(Swedish Covenant Hospital Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 181]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.
- In this case the term "meets physical activity recommendations" refers to participation in moderate physical activity (exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate) at least 5 times a week for 30 minutes at a time, and/or vigorous physical activity (activities that cause heavy sweating or large increases in breathing or heart rate) at least 3 times a week for 20 minutes at a time.

Moderate & Vigorous Physical Activity

The individual indicators of moderate and vigorous physical activity are shown here.

In the past month:

A total of 29.2% of adults participated in moderate physical activity (5 times a week, 30 minutes at a time).

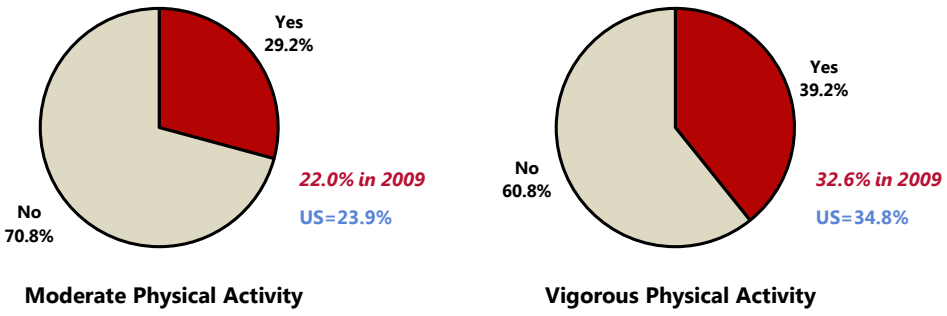
- Similar to regional findings (not shown).
- More favorable than the national level.
- Statistically unchanged since 2009.

A total of 39.2% participated in vigorous physical activity (3 times a week, 20 minutes at a time).

- Nearly identical to regional findings (not shown).
- More favorable than the statewide figure (not shown).
- Comparable to the nationwide figure.
- Unchanged since 2009.

Moderate & Vigorous Physical Activity

(Swedish Covenant Hospital Service Area, 2012)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 183-184]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

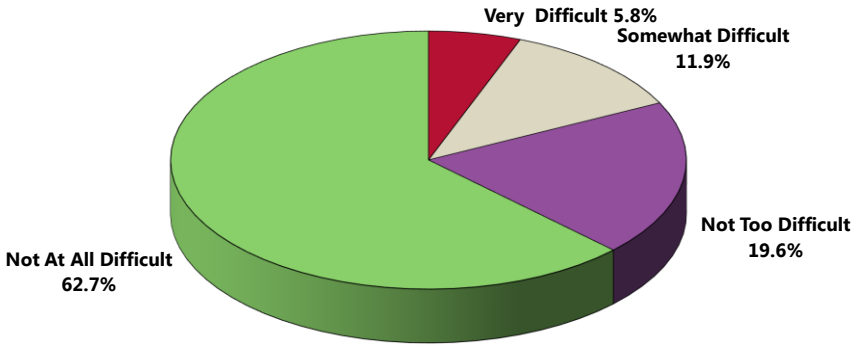
Notes:
- Asked of all respondents.
- Moderate Physical Activity: Takes part in exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate at least 5 times per week for at least 30 minutes per time.
- Vigorous Physical Activity: Takes part in activities that cause heavy sweating or large increases in breathing or heart rate at least 3 times per week for at least 20 minutes per time.

Accessing Safe and Affordable Places for Exercise

Most area adults do not find it difficult to access safe and affordable places for exercise, with 62.7% considering it "not at all difficult" and 19.6% reporting that it is "not too difficult."

Ease of Access to Safe and Affordable Fitness Facilities

(Swedish Covenant Hospital Service Area, 2012)

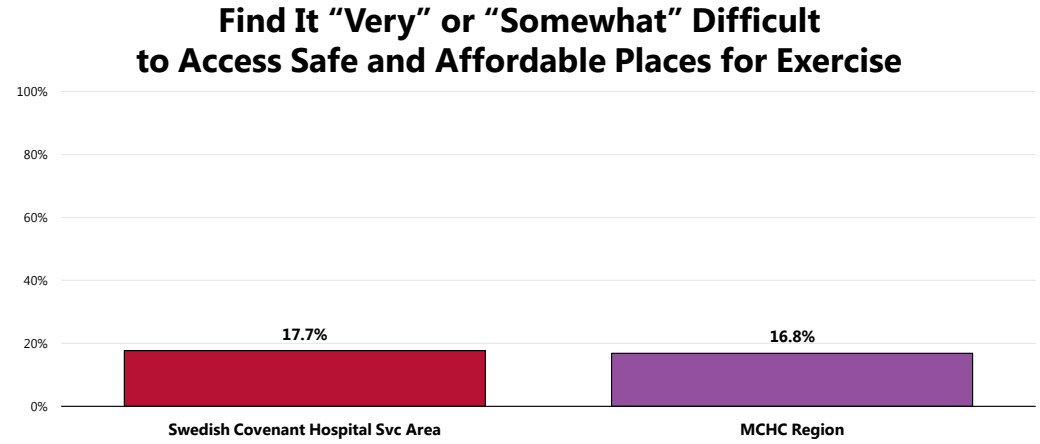


Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 114]

Notes:
- Asked of all respondents.

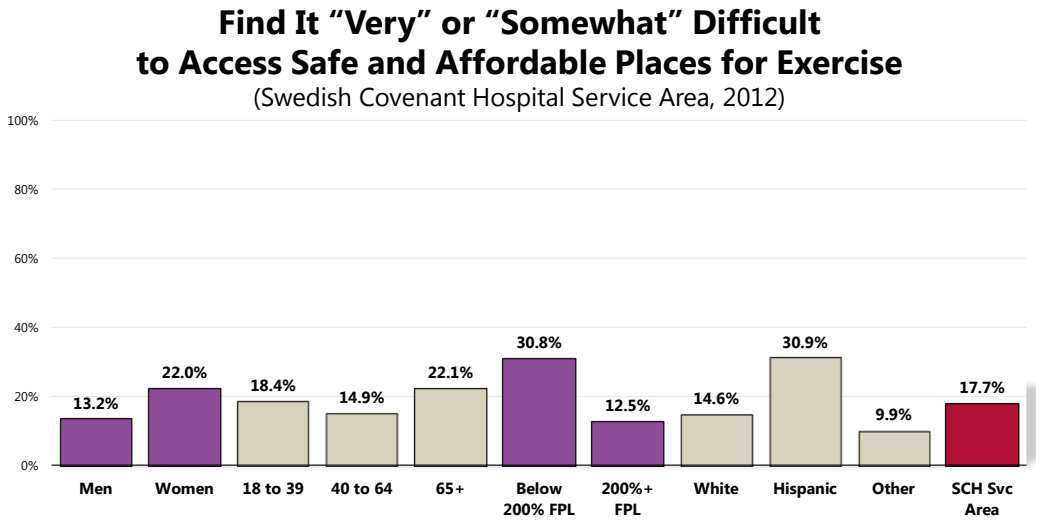
In contrast, a total of 17.7% of community members find it "somewhat" or "very" difficult to access safe and affordable places for exercise.

- Comparable to findings in the MCHC Region.



Sources: • 2012 PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 114]
Notes: • Asked of all respondents.
• Examples include a park, gym, YMCA or recreation center.

- Swedish Covenant Hospital Service Area women are more likely to report that finding safe and affordable places for exercise is difficult, as are residents living in the lower income category and Hispanics.



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 114]
Notes: • Asked of all respondents.
• Examples include a park, gym, YMCA or recreation center.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

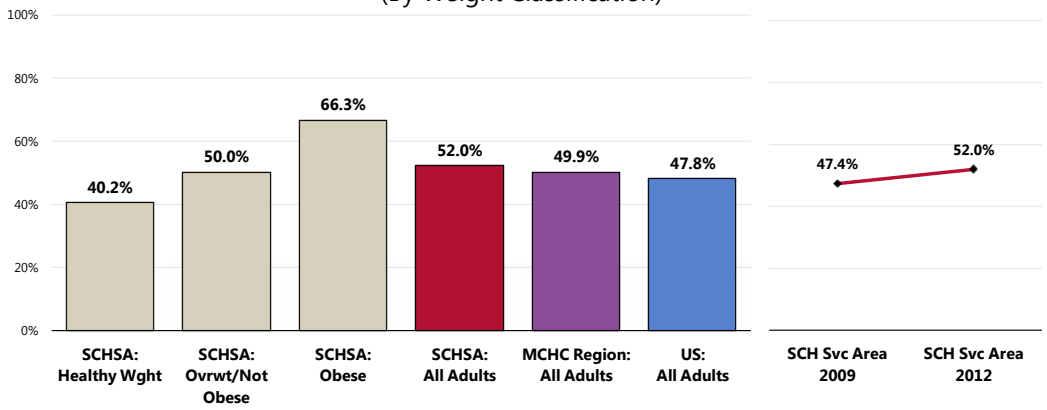
Health Advice About Physical Activity & Exercise

A total of 52.0% of Swedish Covenant Hospital Service Area adults report that their physician has asked about or given advice to them about physical activity in the past year.

- Similar to regional findings.
- Similar to the national average.
- Unchanged from the 2009 survey findings.
- Note: 66.3% of obese Swedish Covenant Hospital Service Area respondents say that they have talked with their doctor about physical activity/exercise in the past year.

Have Received Advice About Exercise in the Past Year From a Physician, Nurse, or Other Health Professional

(By Weight Classification)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 19]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Children's Screen Time

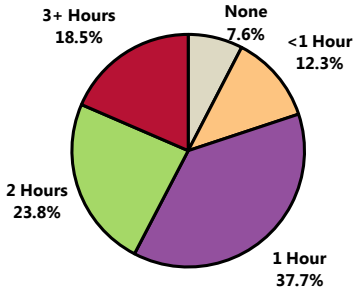
Television Watching & Other Screen Time

Among children aged 5 through 17, 18.5% are reported to watch three or more hours of television per day; 18.7% are reported to spend three or more hours on other types of screen time for entertainment (video games, Internet, etc.).

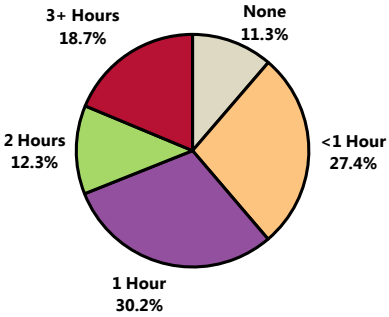
- Both figures are comparable to regional findings.
- The percentage of children spending 3+ hours on other types of screen time is less favorable than is found nationally.

Children's Screen Time

(Among Parents of Children Ages 5-17; Swedish Covenant Hospital Service Area, 2012)



Hours per Day of Television



Hours per Day of Other Screen Time
(i.e., video games, computer/Internet entertainment)

Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 148-149, 185-186]
Notes: • Asked of respondents with a child aged 5 to 17 in the household.

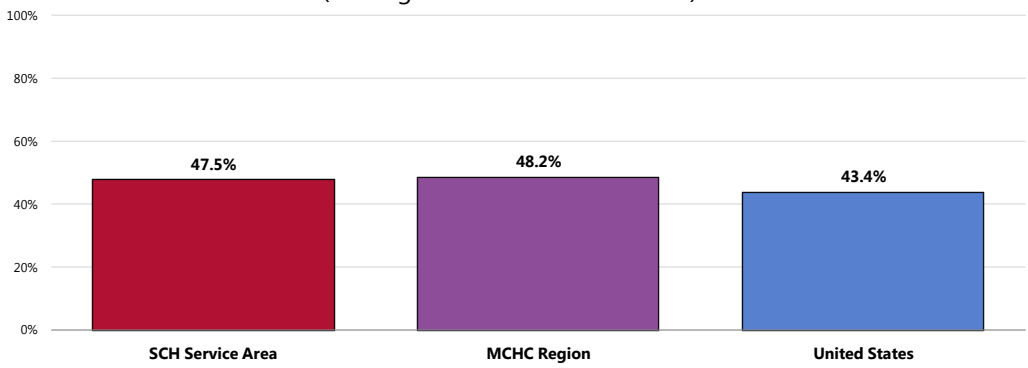
Total Screen Time

When combined, 47.5% of Swedish Covenant Hospital Service Area children aged 5 to 17 spend three or more hours on screen time (whether television or computer, Internet, video games, etc.) per day.

- Similar to regional findings.
- Similar to that found nationally.

Children With Three or More Hours per School Day of Total Screen Time [TV, Computer, Video Games, Etc. for Entertainment]

(Among Parents of Children 5-17)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 187]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents with children 5-17 at home.
• For this issue, respondents with children who are not in school were asked about "weekdays," while parents of children in school were asked about typical "school days."
• "Three or more hours" includes reported screen time of 180 minutes or more per day.

Related Focus Group Findings: Physical Activity

Many focus group participants discussed physical activity in the community, with discussion centered on:

- Many opportunities for physical activity
- Personal choice
- Cost, convenience, interest, language and cultural barriers
- Safety concerns

Participants believe that residents have **many opportunities to participate in physical activity** in the community. For active residents there are many local parks, lakes and bike paths in the community, facilitating physical activity. In addition, resources like the Galter LifeCenter and local park districts provide excellent programs for youth, and senior centers provide exercise classes and other organized activities for their members.

> *"When you live in a city such as Chicago, there are so many interesting things to do, whether in our neighborhood just walking over to River Park and walking through the pathways under the trees. There are a ton of sports there. We live so close to the lake. And for those patients who can get up and take a bus or walk, there's really a plethora of opportunities." — Swedish Covenant Hospital Representative*

Although residents have access to physical activity spaces, many community members do not make the **personal choice** to exercise. One focus group attendee believes that agencies must continue to stress the importance of physical activity. Agencies should consider reworking the language and messaging surrounding exercise in order to help people overcome their mental roadblocks:

> *"When you hear you got to work out three times a week for an hour, people are like, 'I can't do that.' But just walking to the grocery store instead of taking the bus the four blocks. Those kinds of things too are important messages." — North Chicago Community Leader*

Participants believe that **cost, convenience, interest, language and culture** may act as barriers to physical activity. Many residents live very sedentary lifestyles and children spend more time than ever before watching television or playing video games. Group attendees believe that community members do not walk anymore, as driving represents the obvious choice. Local anti-loitering legislation may also limit adolescents' ability to be outside. A participant describes the new reality:

> *"What parents tell their kids to do when they get home from school, 'Go in the house. I don't want you outside running around the streets,' so they turn on the TV. Playgrounds aren't open after school often because they have to hire custodians and everything.'" North Chicago Community Leader*

Other ethnic minority populations historically do not exercise. For example, Asian Indian residents have a different perspective on physical activity and consider their daily activities to be exercise. An attendee explains:

> *"I think in South Asians I think our definition of exercise is so different. It's not going to the gym and getting on a treadmill and running for 30 minutes every day or most days of the week. We think of exercise as daily kinds of things that happen within our daily life as in prayer and housework and we consider that our physical activity and use that in place of actual exercise." — Key Informant Representing Asian Indian Residents*

Generally, local residents do not have **safety concerns** for outdoor activity, especially during daylight; however, some participants voice apprehension, specifically for some low income neighborhoods.

> *"I think it depends on the neighborhood you're in, too. A little bit east and north of the neighborhood can get somewhat difficult to walk 'cause there's a little bit more violence there and certainly if you're from the south side of Chicago, it's not something that is safe to do at all times of the day. For Chicago, it depends on where you're at.'" — Swedish Covenant Hospital Representative*

Weight Status

Because weight is influenced by energy (calories) consumed and expended, interventions to improve weight can support changes in diet or physical activity. They can help change individuals' knowledge and skills, reduce exposure to foods low in nutritional value and high in calories, or increase opportunities for physical activity. Interventions can help prevent unhealthy weight gain or facilitate weight loss among obese people. They can be delivered in multiple settings, including healthcare settings, worksites, or schools.

The social and physical factors affecting diet and physical activity (see Physical Activity topic area) may also have an impact on weight. Obesity is a problem throughout the population. However, among adults, the prevalence is highest for middle-aged people and for non-Hispanic black and Mexican American women. Among children and adolescents, the prevalence of obesity is highest among older and Mexican American children and non-Hispanic black girls. The association of income with obesity varies by age, gender, and race/ethnicity.

– Healthy People 2020 (www.healthypeople.gov)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

– Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Classification of Overweight and Obesity by BMI	BMI (kg/m^2)
Underweight	<18.5
Normal	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

Healthy Weight

"Healthy weight "means neither underweight, nor overweight (BMI = 18.5-24.9).

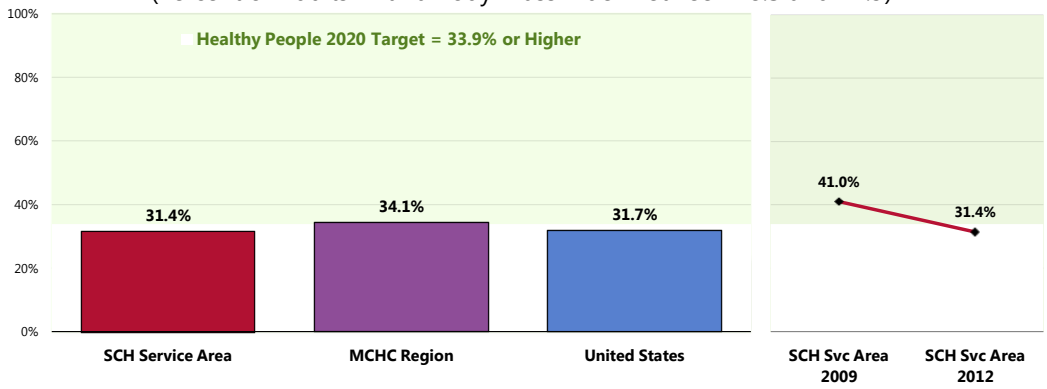
Based on self-reported heights and weights, 31.4% of Swedish Covenant Hospital Service Area adults are at a healthy weight.

- Comparable to MCHC regional findings.
- Nearly identical to national findings.
- Comparable to the Healthy People 2020 target (33.9% or higher).

Represents a significant decrease since 2009.

Healthy Weight

(Percent of Adults With a Body Mass Index Between 18.5 and 24.9)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 189]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Based on reported heights and weights, asked of all respondents.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-8]
- The definition of healthy weight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), between 18.5 and 24.9.

Overweight Status

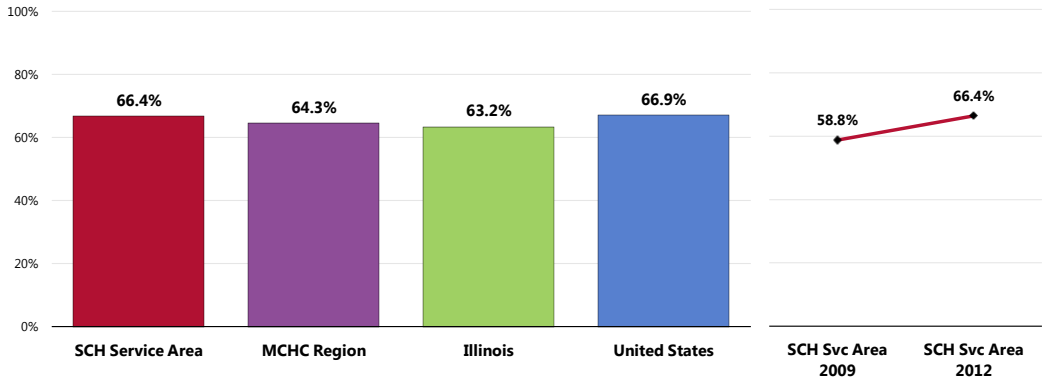
Here, "overweight" includes those respondents with a BMI value ≥25.

A total of 66.4% of Swedish Covenant Hospital Service Area adults are overweight.

- Comparable to findings from the MCHC Region.
- Comparable to the Illinois prevalence.
- Comparable to the US overweight prevalence.
- Statistically unchanged since 2009.

Prevalence of Total Overweight

(Percent of Overweight or/Obese Adults; Body Mass Index of 25.0 or Higher)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 189]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

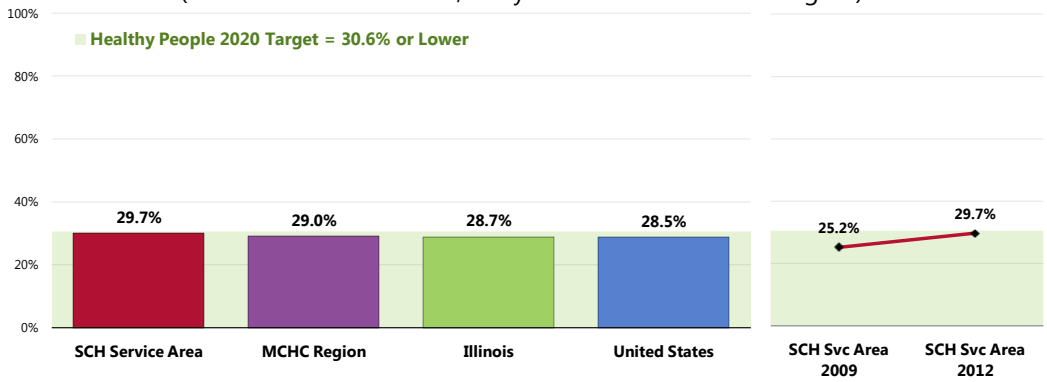
"Obese" (also included in overweight prevalence discussed previously) includes respondents with a BMI value ≥30.

Further, 29.7% of Swedish Covenant Hospital Service Area adults are obese.

- Similar to regional findings.
- Similar to Illinois findings.
- Similar to US findings.
- Similar to the Healthy People 2020 target (30.6% or lower).
- Similar to the obesity rate reported in 2009.

Prevalence of Obesity

(Percent of Obese Adults; Body Mass Index of 30.0 or Higher)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 189]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-9]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.

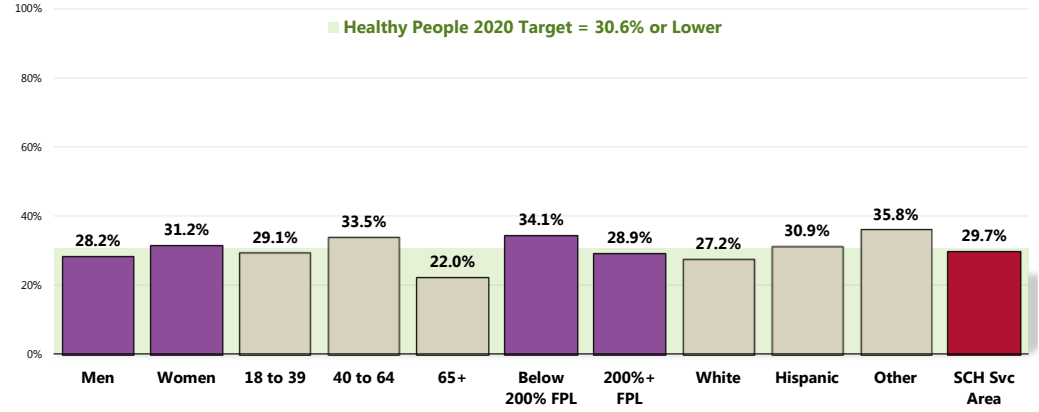
Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Obesity is notably more prevalent among:

- Respondents between the ages of 40 and 64.

Prevalence of Obesity

(Percent of Obese Adults; BMI of 30.0 or Higher; SCH Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 189]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-9]

Notes:
- Based on reported heights and weights, asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

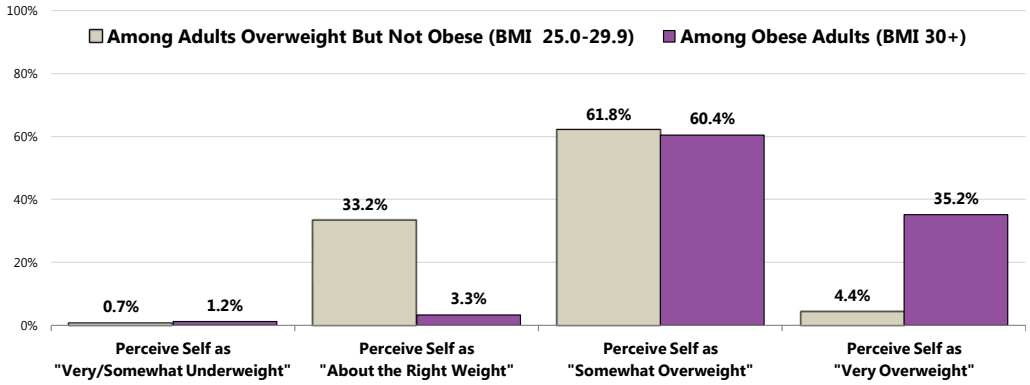
Actual vs. Perceived Body Weight

A total of 3.3% of obese adults and 33.2% of overweight (but not obese) adults feel that their current weight is "about right."

- 61.8% of overweight (but not obese) adults see themselves as "somewhat overweight."
- 35.2% of obese adults classify themselves as "very overweight."

Actual vs. Perceived Weight Status

(Among Adults Who Are Overweight/Obese Based on BMI; SCH Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 119]

Notes:
- BMI is based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

Relationship of Overweight With Other Health Issues

The correlation between overweight and various health issues cannot be disputed.

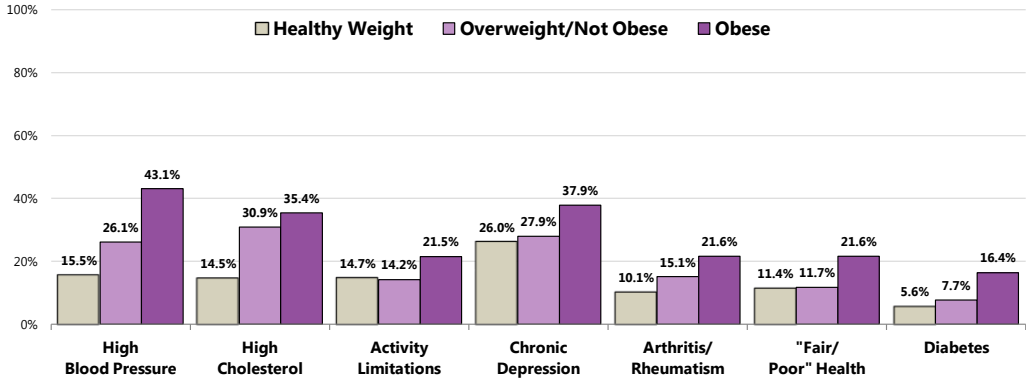
Obese (and often overweight) adults are more likely to report a number of adverse health conditions.

Among these are:

- Hypertension (high blood pressure).
- High cholesterol.
- Activity limitations.
- Chronic depression.
- Arthritis/rheumatism.
- "Fair" or "poor" physical health.
- Diabetes.

Relationship of Overweight With Other Health Issues

(By Weight Classification; Swedish Covenant Hospital Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 5, 28, 47, 121, 125, 152, 153]
Notes: • Based on reported heights and weights, asked of all respondents.

Weight Management

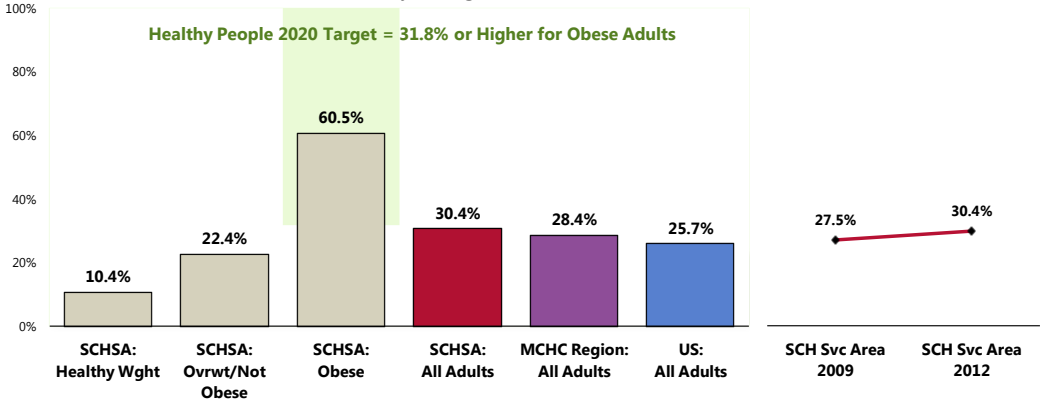
Health Advice

A total of 30.4% of adults have been given advice about their weight by a doctor, nurse or other health professional in the past year.

- Comparable to findings in the MCHC Region.
- Comparable to the national findings.
- Statistically unchanged from that reported in 2009.
- Note that 60.5% of <u>obese</u> adults have been given advice about their weight by a health professional in the past year, which is better than the US percentage (not shown).
  - Meets the Healthy People 2020 target of 31.8% or higher.

Have Received Advice About Weight in the Past Year From a Physician, Nurse, or Other Health Professional

(By Weight Classification)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 118, 191-192]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-6.2]
Notes: • Asked of all respondents.

Weight Control

Individuals who are at a healthy weight are less likely to:

- Develop chronic disease risk factors, such as high blood pressure and dyslipidemia.
- Develop chronic diseases, such as type 2 diabetes, heart disease, osteoarthritis, and some cancers.
- Experience complications during pregnancy.
- Die at an earlier age.

All Americans should avoid unhealthy weight gain, and those whose weight is too high may also need to lose weight.

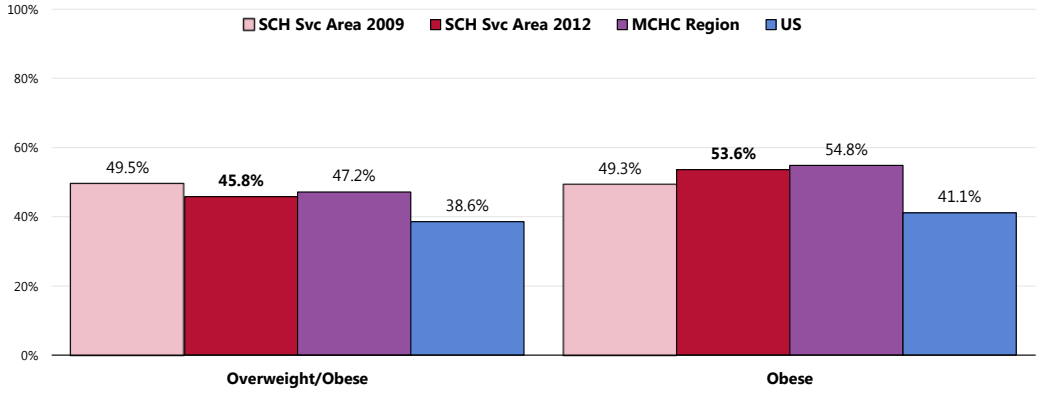
– Healthy People 2020 (www.healthypeople.gov)

A total of 45.8% of Swedish Covenant Hospital Service Area adults who are overweight say that they are both modifying their diet and increasing their physical activity to try to lose weight.

- Similar to regional findings.
- Better than national findings.
- Statistically similar to that reported among overweight adults in 2009.
- Note: 53.6% of <u>obese</u> Swedish Covenant Hospital Service Area adults report that they are trying to lose weight through a combination of diet and exercise, similar to the regional prevalence, better than what is found nationally, and unchanged over time.

Trying to Lose Weight by Both Modifying Diet and Increasing Physical Activity

(By Weight Classification)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 190]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Based on reported heights and weights, asked of all respondents.

Childhood Overweight & Obesity

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

- Underweight ..... <5th percentile
- Healthy Weight..... ≥5th and <85th percentile
- Overweight ..... ≥85th and <95th percentile
- Obese..... ≥95th percentile

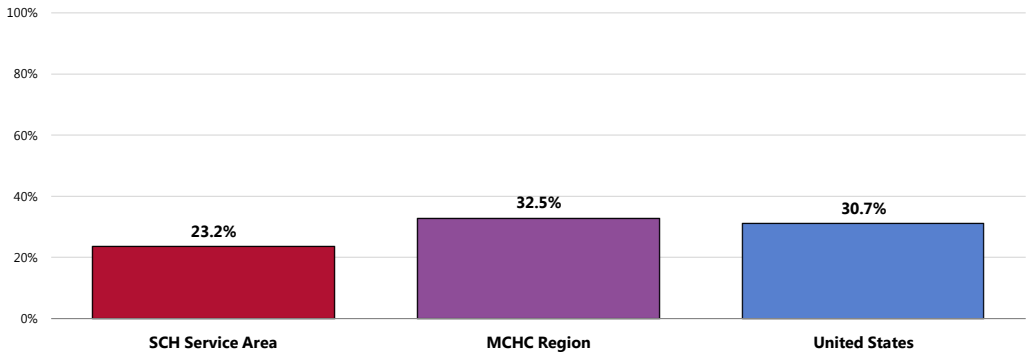
– Centers for Disease Control and Prevention.

Based on the heights/weights reported by surveyed parents, 23.2% of service area children age 5 to 17 are overweight or obese (≥85th percentile).

- More favorable than regional findings.
- Comparable to the US prevalence.

Child Total Overweight Prevalence

(Children 5-17 Who Are Overweight/Obese; BMI in the 85th Percentile or Higher)



Sources:
- 2012 PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 193]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

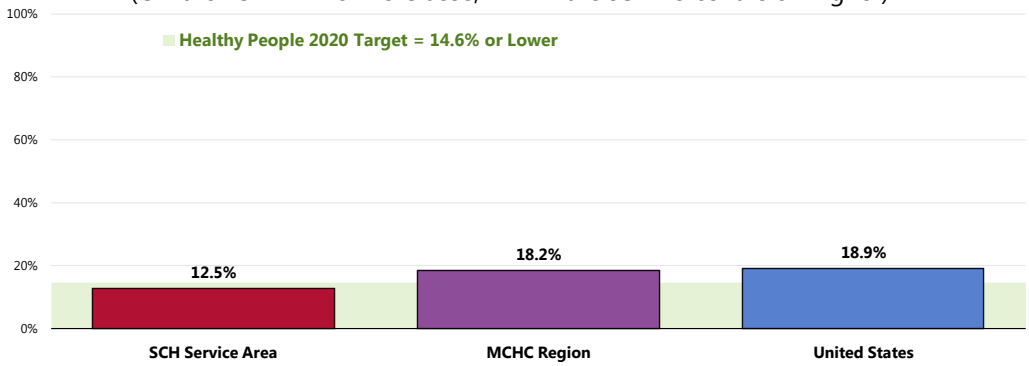
Notes:
- Asked of all respondents with children age 5-17 at home.
- Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

Further, 12.5% of Swedish Covenant Hospital Service Area children age 5 to 17 are obese (≥95th percentile).

- Similar to regional findings.
- Similar to the national percentage.
- Similar to the Healthy People 2020 target (14.6% or lower for children age 2-19).

Child Obesity Prevalence

(Children 5-17 Who Are Obese; BMI in the 95th Percentile or Higher)



Sources:
- 2012 PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 193]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-10.4]

Notes:
- Asked of all respondents with children age 5-17 at home.
- Obesity among children is determined by children's Body Mass Index status equal to or above the 95th percentile of US growth charts by gender and age.

Substance Abuse

In 2005, an estimated 22 million Americans struggled with a drug or alcohol problem. Almost 95% of people with substance use problems are considered unaware of their problem. Of those who recognize their problem, 273,000 have made an unsuccessful effort to obtain treatment. These estimates highlight the importance of increasing prevention efforts and improving access to treatment for substance abuse and co-occurring disorders.

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include:

- Teenage pregnancy
- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Other sexually transmitted diseases (STDs)
- Domestic violence
- Child abuse
- Motor vehicle crashes
- Physical fights
- Crime
- Homicide
- Suicide

The field has made progress in addressing substance abuse, particularly among youth. According to data from the national Institute of Drug Abuse (NIDA) Monitoring the Future (MTF) survey, which is an ongoing study of the behaviors and values of America's youth between 2004 and 2009, a drop in drug use (including amphetamines, methamphetamine, cocaine, hallucinogens, and LSD) was reported among students in 8th, 10th, and 12th grades. Note that, despite a decreasing trend in marijuana use which began in the mid-1990s, the trend has stalled in recent years among these youth. Use of alcohol among students in these three grades also decreased during this time.

Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. Social attitudes and political and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues. In addition to the considerable health implications, substance abuse has been a flash-point in the criminal justice system and a major focal point in discussions about social values: people argue over whether substance abuse is a disease with genetic and biological foundations or a matter of personal choice.

Advances in research have led to the development of evidence-based strategies to effectively address substance abuse. Improvements in brain-imaging technologies and the development of medications that assist in treatment have gradually shifted the research community's perspective on substance abuse. There is now a deeper understanding of substance abuse as a disorder that develops in adolescence and, for some individuals, will develop into a chronic illness that will require lifelong monitoring and care.

Improved evaluation of community-level prevention has enhanced researchers' understanding of environmental and social factors that contribute to the initiation and abuse of alcohol and illicit drugs, leading to a more sophisticated understanding of how to implement evidence-based strategies in specific social and cultural settings.

A stronger emphasis on evaluation has expanded evidence-based practices for drug and alcohol treatment. Improvements have focused on the development of better clinical interventions through research and increasing the skills and qualifications of treatment providers.

– Healthy People 2020 (www.healthypeople.gov)

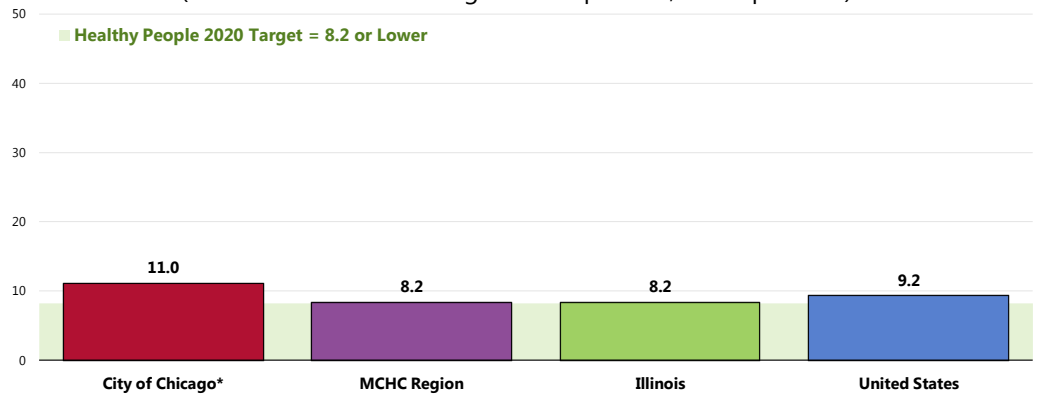
Age-Adjusted Cirrhosis/Liver Disease Deaths

Between 2006 and 2008, the City of Chicago reported an annual average age-adjusted cirrhosis/liver disease mortality rate of 11.0 deaths per 100,000 population.

- Higher than the regional rate.
- Higher than the statewide rate.
- Higher than the national rate.
- Fails to satisfy the Healthy People 2020 target (8.2 or lower).

Cirrhosis/Liver Disease: Age-Adjusted Mortality

(2007-2009 Annual Average Deaths per 100,000 Population)



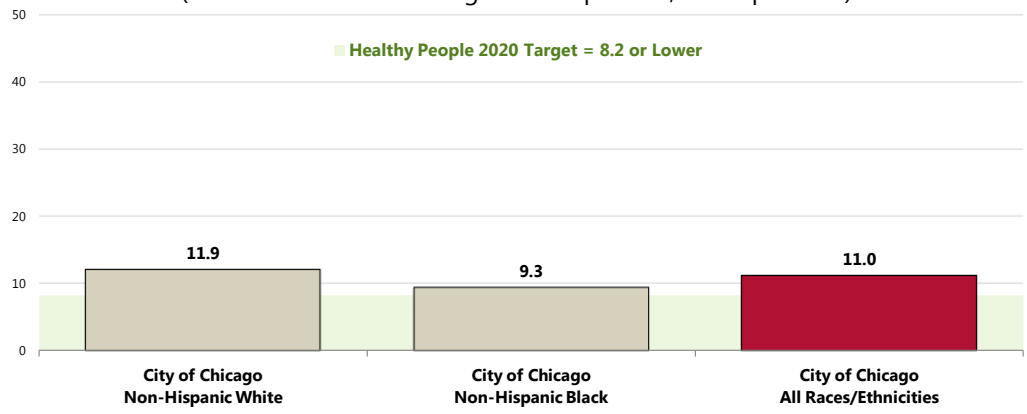
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-11]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.
- *City of Chicago rate represents 2006-2008 data.

The City's cirrhosis mortality rate appears to be higher among Whites than Blacks.

Cirrhosis/Liver Disease: Age-Adjusted Mortality by Race

(2006-2008 Annual Average Deaths per 100,000 Population)



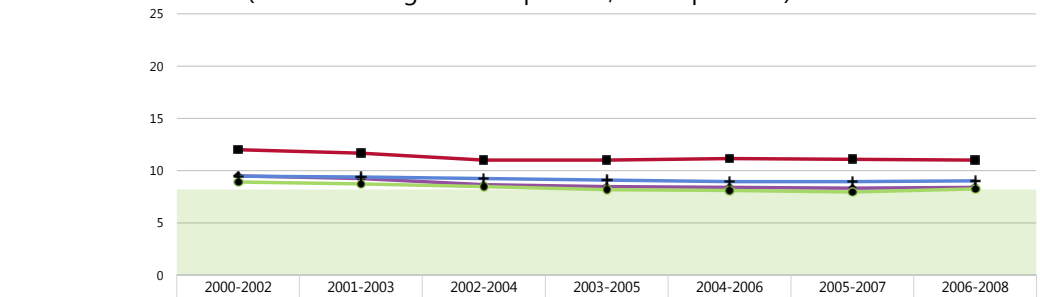
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-11]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple three-year averages.

- The mortality rate decreased slightly over the past decade, echoing the regional, state and national trends.

Cirrhosis/Liver Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008
Healthy People 2020	8.2	8.2	8.2	8.2	8.2	8.2	8.2
City of Chicago	12.0	11.7	11.0	11.0	11.2	11.1	11.0
MCHC Region	9.5	9.2	8.7	8.5	8.4	8.3	8.4
Illinois	8.9	8.7	8.5	8.2	8.1	8.0	8.2
United States	9.5	9.4	9.2	9.1	8.9	9.0	9.0

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-11]

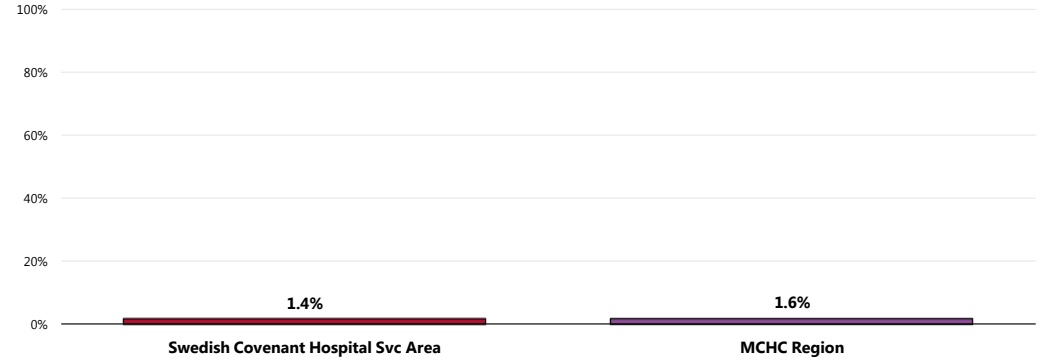
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

Prevalence of Liver Disease

Among service area residents, 1.4% has been diagnosed with liver disease.

- Statistically similar to MCHC regional data.

Prevalence of Liver Disease



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 38]

Notes:
- Reflects the total sample of respondents.

High-Risk Alcohol Use

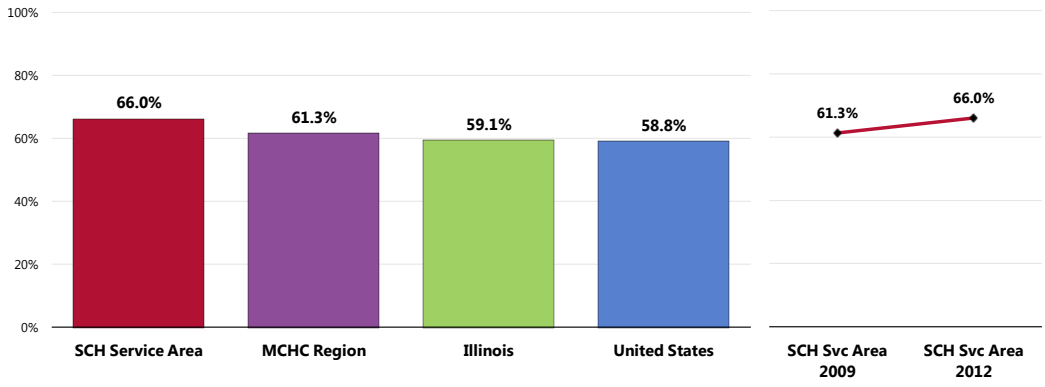
Current Drinking

"Current drinkers" include survey respondents who had at least one drink of alcohol in the month preceding the interview. For the purposes of this study, a "drink" is considered one can or bottle of beer, one glass of wine, one can or bottle of wine cooler, one cocktail, or one shot of liquor.

A total of 66.0% of area adults had at least one drink of alcohol in the past month (current drinkers).

- Less favorable than regional findings.
- Less favorable than the statewide proportion.
- Less favorable than the national proportion.
- Statistically unchanged since 2009.

Current Drinkers

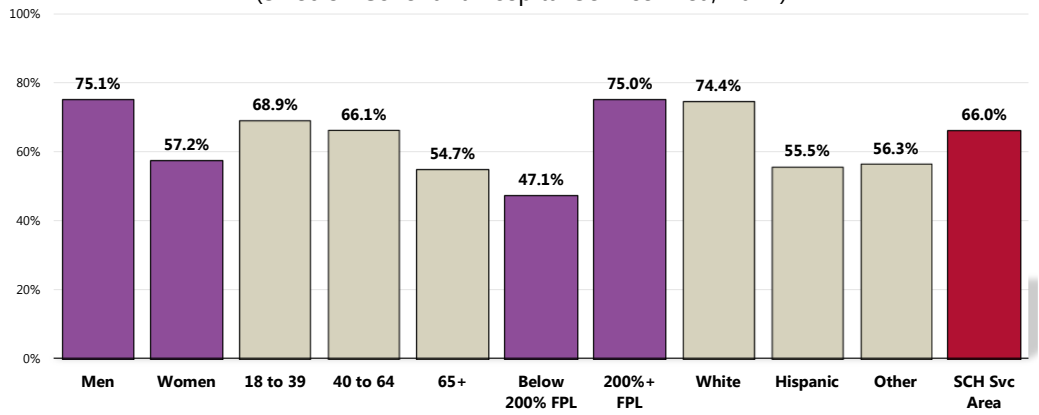


Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 198]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Current drinkers had at least one alcoholic drink in the past month.

Current drinking is more prevalent among men, young adults (age 18-39), higher-income respondents and Whites.

Current Drinkers
(Swedish Covenant Hospital Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 198]

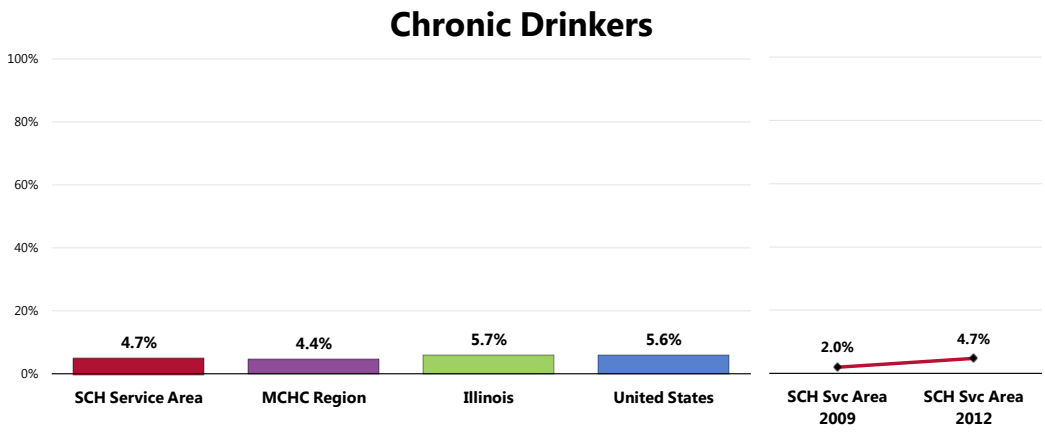
Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.
- Current drinkers had at least one alcoholic drink in the past month.

"Chronic drinkers" include survey respondents reporting 60 or more drinks of alcohol in the month preceding the interview.

RELATED ISSUE: See also *Stress* in the **Mental Health & Mental Disorders** section of this report.

A total of 4.7% of area adults averaged two or more drinks of alcohol per day in the past month (chronic drinkers).

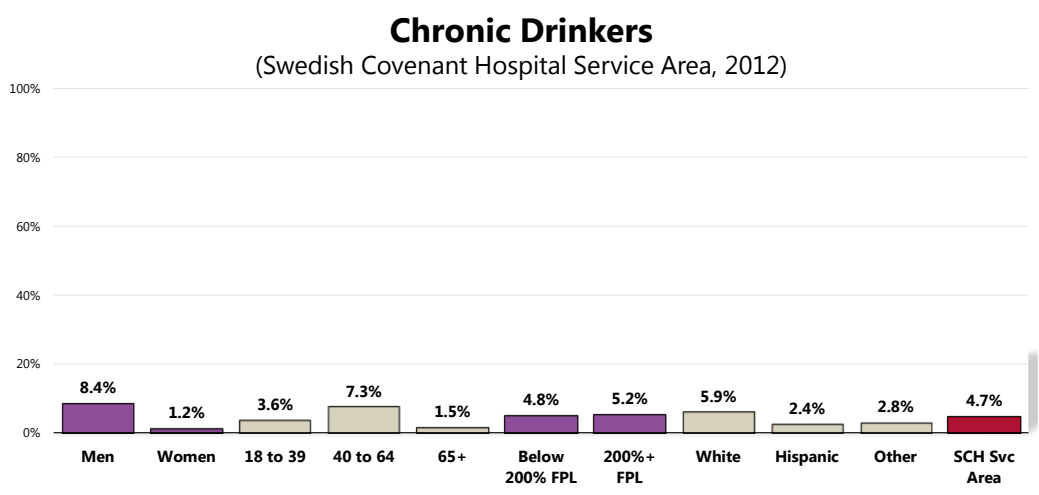
- Similar to the MCHC regional findings.
- Similar to the statewide proportion.
- Similar to the national proportion.
- Statistically unchanged over time.



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 199]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Chronic drinkers are defined as having 60+ alcoholic drinks in the past month.
- *The state definition for chronic drinkers is males consuming 2+ drinks per day and females consuming 1+ drink per day.

Chronic drinking is more prevalent among men and those age 40 to 64.



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 199]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.
- Chronic drinkers are defined as those having 60+ alcoholic drinks in the past month.

"Binge drinkers" include:

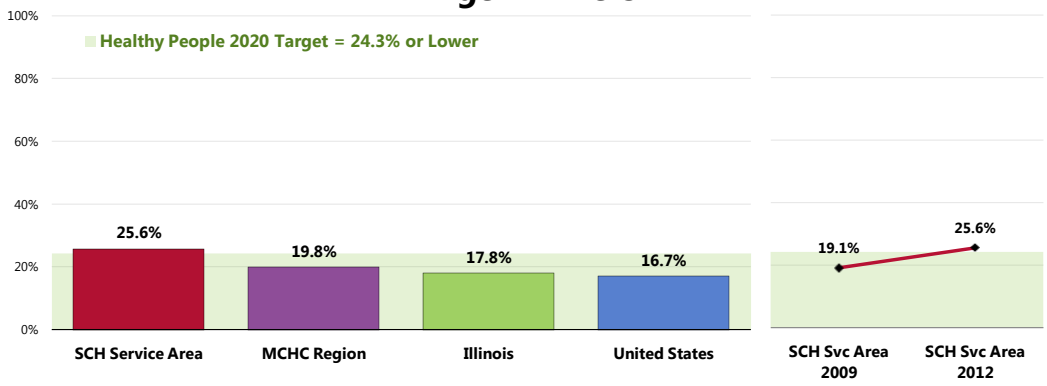
1) MEN who report drinking 5 or more alcoholic drinks on any single occasion during the past month; and

2) WOMEN who report drinking 4 or more alcoholic drinks on any single occasion during the past month.

A total of 25.6% of Swedish Covenant Hospital Service Area adults are binge drinkers.

- Less favorable than what is found regionally.
- Less favorable than Illinois findings.
- Less favorable than national findings.
- Similar to the Healthy People 2020 target (24.3% or lower).
- Statistically similar to the 2009 percentage.

Binge Drinkers



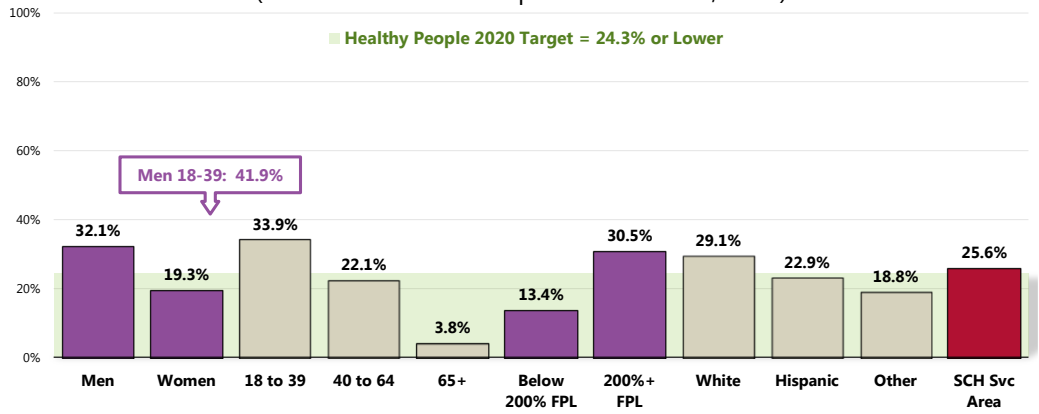
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 200]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-14.3]

Notes:
- Asked of all respondents.
- Binge drinkers are defined as men having 5+ alcoholic drinks on any one occasion or women consuming 4+ drinks on any one occasion.

Binge drinking is more prevalent among:

- Men (especially those under age 40).
- Adults under age 40.
- Higher-income respondents.

Binge Drinkers
(Swedish Covenant Hospital Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 200]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-14.3]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.
- Binge drinkers are defined as men having 5+ alcoholic drinks on any one occasion or women consuming 4+ drinks on any one occasion

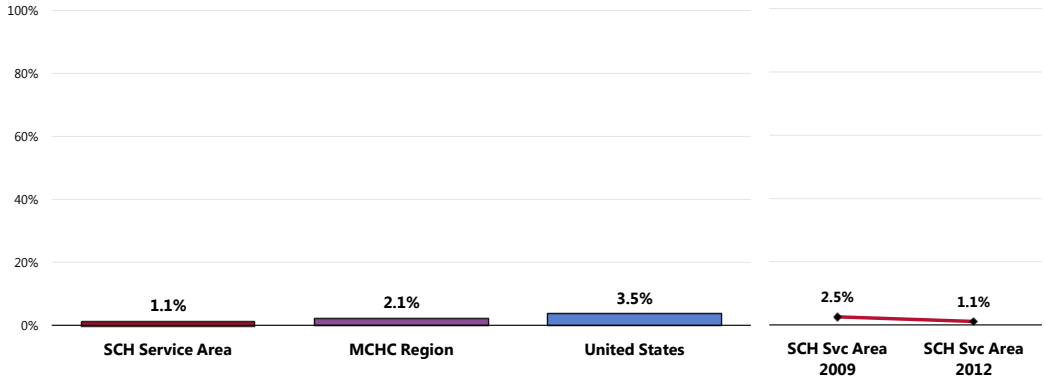
Drinking & Driving

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that the actual incidence of drinking and driving in the community is likely higher.

A total of 1.1% of Swedish Covenant Hospital Service Area adults acknowledge having driven a vehicle in the past month after they had perhaps too much to drink.

- Similar to the MCHC regional findings.
- Better than the national findings.
- The drinking and driving prevalence has not changed significantly over time.

Have Driven in the Past Month After Perhaps Having Too Much to Drink

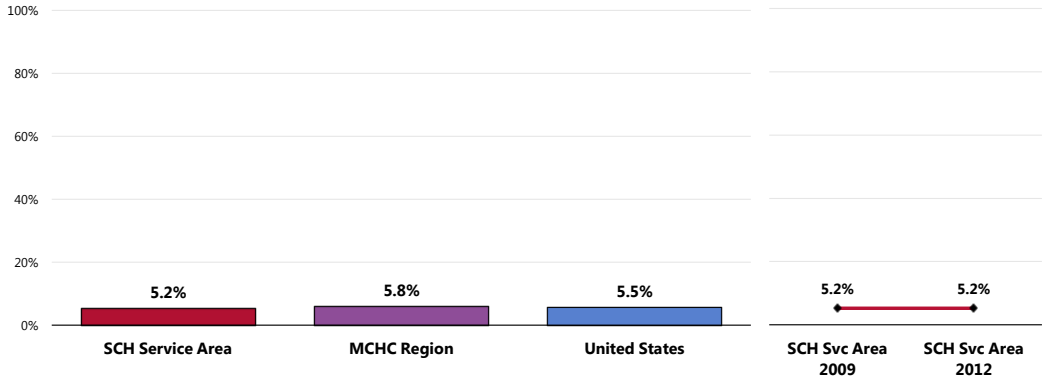


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 75]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

A total of 5.2% of Swedish Covenant Hospital Service Area adults acknowledge either drinking and driving or riding with a drunk driver in the past month.

- Comparable to regional findings.
- Comparable to national findings.
- Unchanged over time in the service area.

Have Driven Drunk OR Ridden With a Driver in the Past Month Who Had Too Much to Drink



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 201]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

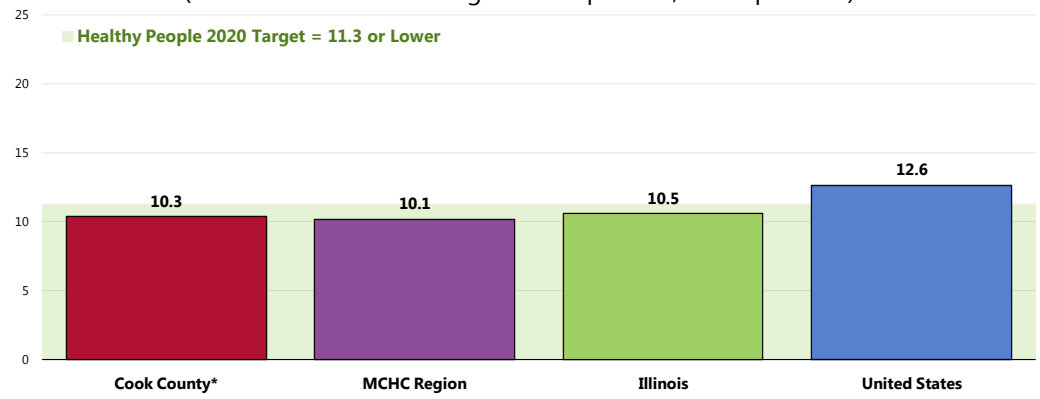
Age-Adjusted Drug-Induced Deaths

Between 2007 and 2009, there was an annual average age-adjusted drug-induced mortality rate of 10.3 deaths per 100,000 population in Cook County.

- Similar to the regional rate.
- Similar to the statewide rate.
- Better than the national rate.
- Satisfies the Healthy People 2020 target (11.3 or lower).

Drug-Induced Deaths: Age-Adjusted Mortality

(2007-2009 Annual Average Deaths per 100,000 Population)



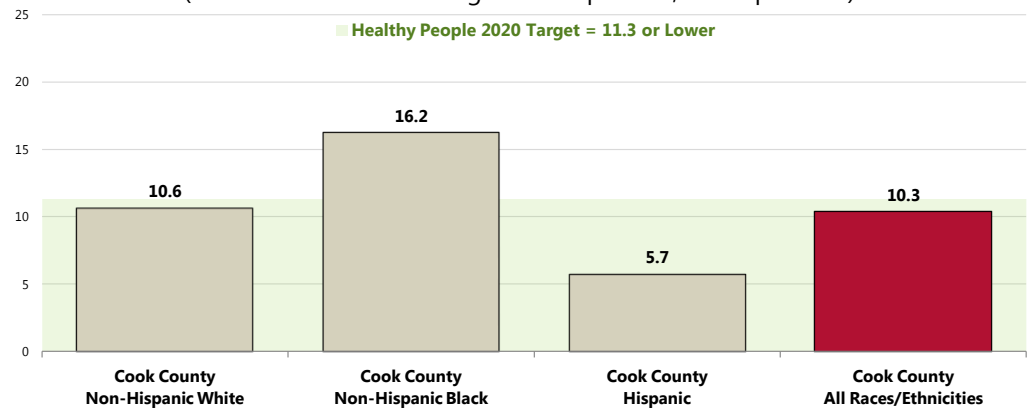
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-12]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- Local, state and national data are simple three-year averages.
- *City of Chicago data unavailable; Cook County data is used here.

The drug-induced mortality rate appears to be higher among the county's Black population when compared with Whites and Hispanics.

Drug-Induced Deaths: Age-Adjusted Mortality by Race

(2007-2009 Annual Average Deaths per 100,000 Population)



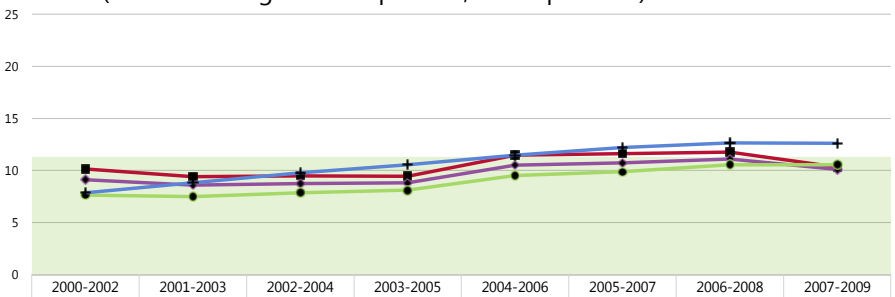
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-12]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- County, state and national data are simple three-year averages.

- The drug-induced mortality rate has fluctuated in Cook County over the past decade, but the general trend is upward. Statewide and nationwide, rates have clearly increased.

Drug-Induced Deaths: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
Healthy People 2020	11.3	11.3	11.3	11.3	11.3	11.3	11.3	11.3
Cook County	10.1	9.4	9.5	9.4	11.5	11.6	11.8	10.3
MCHC	9.1	8.6	8.7	8.8	10.5	10.7	11.1	10.1
Illinois	7.6	7.5	7.9	8.1	9.5	9.9	10.5	10.5
United States	7.9	8.8	9.8	10.5	11.5	12.2	12.6	12.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2012.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-12]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Illicit Drug Use

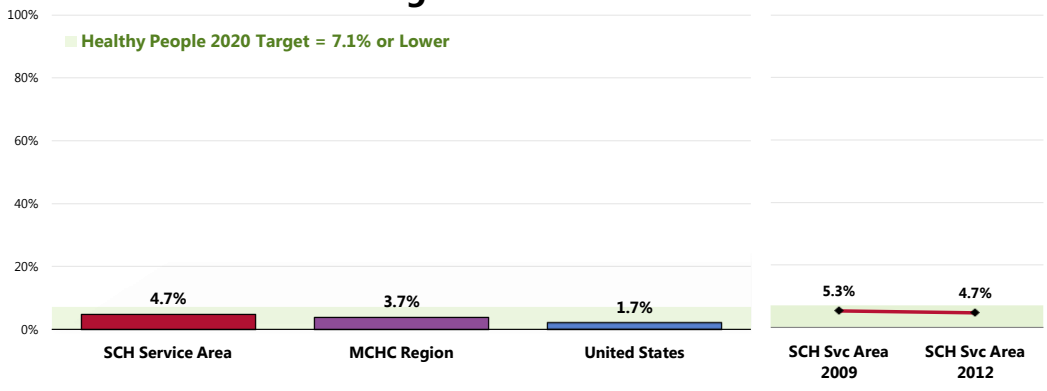
A total of 4.7% of Swedish Covenant Hospital Service Area adults acknowledge using an illicit drug in the past month.

For the purposes of this survey, "illicit drug use" includes use of illegal substances or of prescription drugs taken without a physician's order.

- Similar to the MCHC regional findings.
- Less favorable than the proportion found nationally.
- Satisfies the Healthy People 2020 target of 7.1% or lower.
- Statistically unchanged over time.

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

Illicit Drug Use in the Past Month



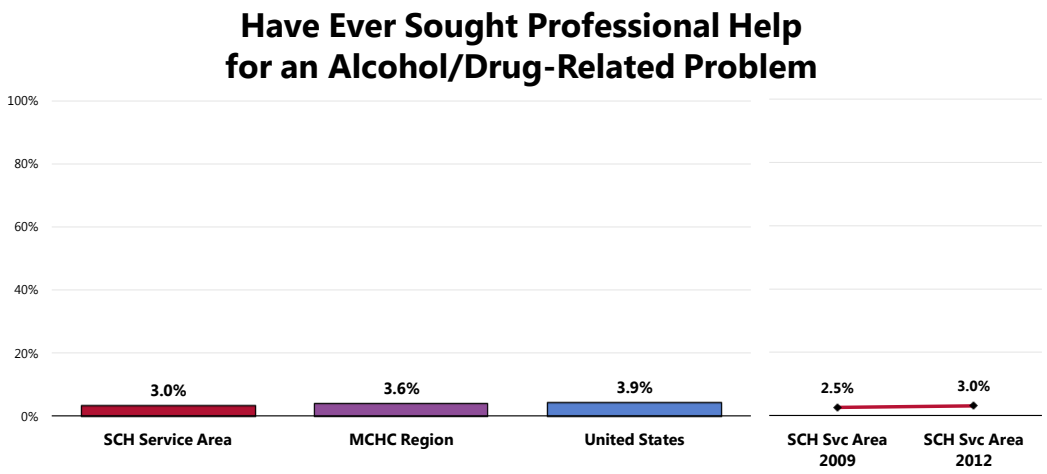
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 77]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-13.3]

Notes:
- Asked of all respondents.

Alcohol & Drug Treatment

A total of 3.0% of Swedish Covenant Hospital Service Area adults report that they have sought professional help for an alcohol or drug problem at some point in their lives.

- Similar to regional findings.
- Similar to national findings.
- Statistically unchanged over time.



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 78]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Related Focus Group Findings: Substance Abuse

The focus group participants are concerned with substance abuse in the community, including worries about:

- Prevalence of substance abuse
- Limited treatment facilities
- Prevention
- Stigma

A number of focus group participants expressed concern with the **prevalence of substance abuse** in the community, especially prescription drugs, alcohol, cocaine and heroin. Attendees believe that alcohol use occurs more frequently among the higher income populations, and drug use more often among the low income and minority populations, but that substance abuse takes place within every demographic. Participants agree that there has been an increase in substance use among adults over age 50 in recent years and worry about the level of alcoholism in adults.

> *"Just living there (Albany Park) you see a lot of people under the influence walking on the street, drinking on the sidewalk, some people driving their car with a beer in their hand. So I would say alcoholism is big. I'm sure drugs are more prevalent around certain youth populations, but I think for adults alcoholism is a big one in our neighborhood." North Chicago Community Leader*

In addition, respondents perceive a recent increase in heroin use:

> *"I used to see heroin addicts a lot. I do drug use. And then it went out of favor, but now because it's smokeable, we're seeing an increase in heroin." — North Chicago Community Leader*

Focus group attendees worry because of **limited treatment facilities** and lack of capacity to handle substance abuse referrals. In North Chicago, finding treatment facilities that will accept under- or uninsured populations remains very difficult, although there are several substance abuse treatment facilities throughout Cook County which anyone can enter regardless of insurance status.

Hospital social workers can provide links to community-based programming, but limited funding equates to a small number of available programs. Individuals may be placed on a waiting list, effectively postponing recovery. In addition, some minority groups' limited English proficiency may hinder their ability to participate in the programs. A participant expresses his concerns with the current system:

> *"We know about AA groups but because of the access to those services in Polish are limited, and then if you have a problem with substance abuse where do you go and seek assistance if you have limited English?" — Key Informant Representing Polish Residents*

Participants agree that not enough **prevention** occurs in the community and that education on substance abuse needs to begin early. Some minority-based, faith-based organizations have begun to address substance abuse in their parishes, but attendees feel that more organizations need to begin the conversation with their parishioners. Additionally, the **stigma** attached to substance abuse affects local agencies' ability to make an impact on the community:

> *"If you're not insured or have poor economic mobility, you have very good programs like Gateway and Haymarket. Those programs do a very good job…But there is still a problem, a bias and a lack of education as to brain diseases, the whole spectrum." — Cook County Community Leader*

Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. Each year, approximately 443,000 Americans die from tobacco-related illnesses. For every person who dies from tobacco use, 20 more people suffer with at least one serious tobacco-related illness. In addition, tobacco use costs the US $193 billion annually in direct medical expenses and lost productivity.

Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General's report on tobacco was released in 1964.

Tobacco use causes:

- Cancer
- Heart disease
- Lung diseases (including emphysema, bronchitis, and chronic airway obstruction)
- Premature birth, low birth weight, stillbirth, and infant death

There is no risk-free level of exposure to secondhand smoke. Secondhand smoke causes heart disease and lung cancer in adults and a number of health problems in infants and children, including: severe asthma attacks; respiratory infections; ear infections; and sudden infant death syndrome (SIDS).

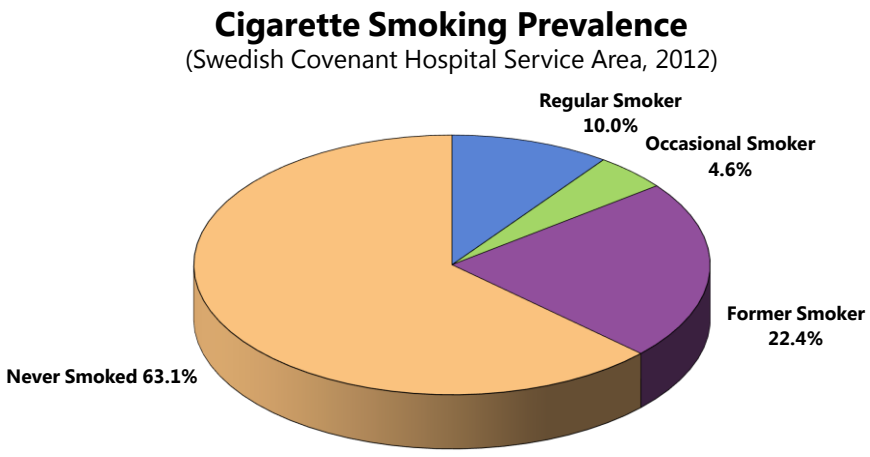
Smokeless tobacco causes a number of serious oral health problems, including cancer of the mouth and gums, periodontitis, and tooth loss. Cigar use causes cancer of the larynx, mouth, esophagus, and lung.

– Healthy People 2020 (www.healthypeople.gov)

Cigarette Smoking

Cigarette Smoking Prevalence

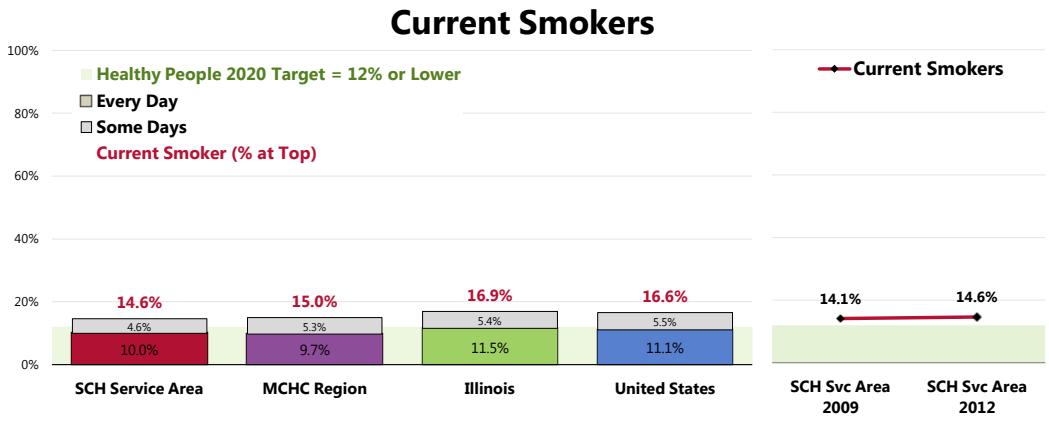
A total of 14.6% of Swedish Covenant Hospital Service Area adults currently smoke cigarettes, either regularly (10.0% every day) or occasionally (4.6% on some days).



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 194]
Notes: • Asked of all respondents.

- Similar to findings in the MCHC Region.
- Similar to statewide findings.
- Similar to national findings.

- Similar to the Healthy People 2020 target (12% or lower).
- The current smoking prevalence is statistically unchanged since 2009.

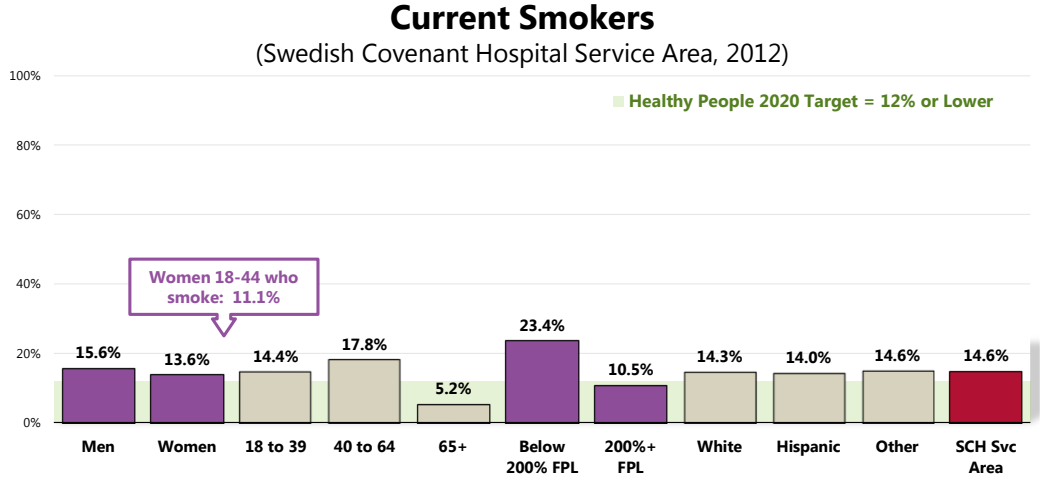


Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 194]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.1]

Notes:
- Asked of all respondents.
- Includes regular and occasional smokers (everyday and some days).

Cigarette smoking is more prevalent among:

- Adults between ages 40 and 64.
- Lower-income residents.
- 11.1% of women of child-bearing age (ages 18 to 44) currently smoke. This is notable given that tobacco use increases the risk of infertility, as well as the risks for miscarriage, stillbirth and low birthweight for women who smoke during pregnancy.



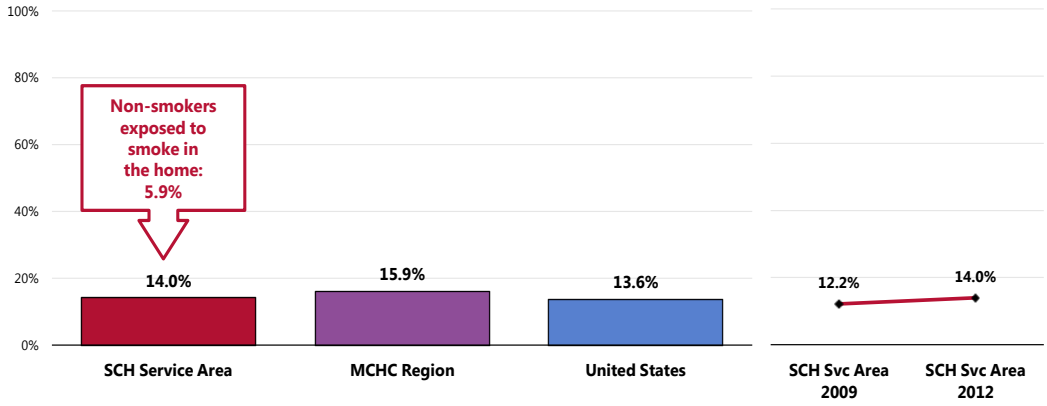
Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 194-195]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.1]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.
- Includes regular and occasion smokers (everyday and some days).

A total of 14.0% of Swedish Covenant Hospital Service Area adults (including smokers and non-smokers) report that a member of their household has smoked cigarettes in the home an average of 4+ times per week over the past month.

- Similar to regional findings.
- Similar to national findings.
- Similar to the 2009 findings.
- Note that 5.9% of Swedish Covenant Hospital Service Area non-smokers are exposed to cigarette smoke at home.

Member of Household Smokes at Home



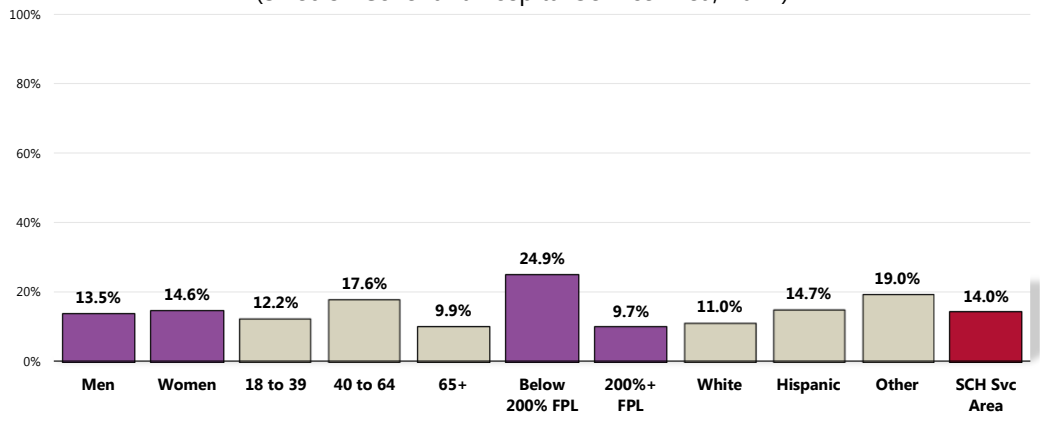
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 69, 196]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

- Notably higher among residents with lower incomes.

Member of Household Smokes At Home

(Swedish Covenant Hospital Service Area, 2012)

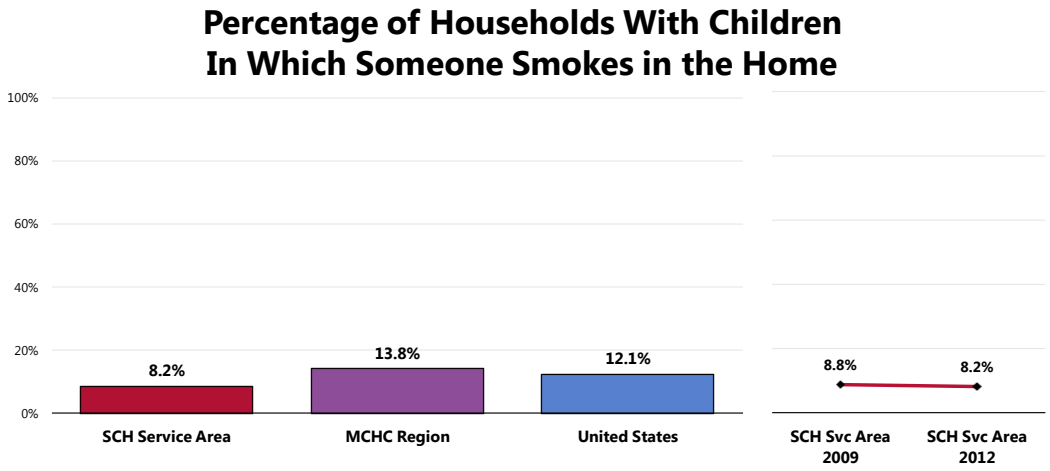


Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 69]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Among households with children, 8.2% have someone who smokes cigarettes in the home.

- More favorable than what is reported regionally.
- Similar to the US findings.
- Statistically unchanged over time.



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 197]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Smoking Cessation

Preventing tobacco use and helping tobacco users quit can improve the health and quality of life for Americans of all ages. People who stop smoking greatly reduce their risk of disease and premature death. Benefits are greater for people who stop at earlier ages, but quitting tobacco use is beneficial at any age.

Many factors influence tobacco use, disease, and mortality. Risk factors include race/ethnicity, age, education, and socioeconomic status. Significant disparities in tobacco use exist geographically; such disparities typically result from differences among states in smoke-free protections, tobacco prices, and program funding for tobacco prevention.

– Healthy People 2020 (www.healthypeople.gov)

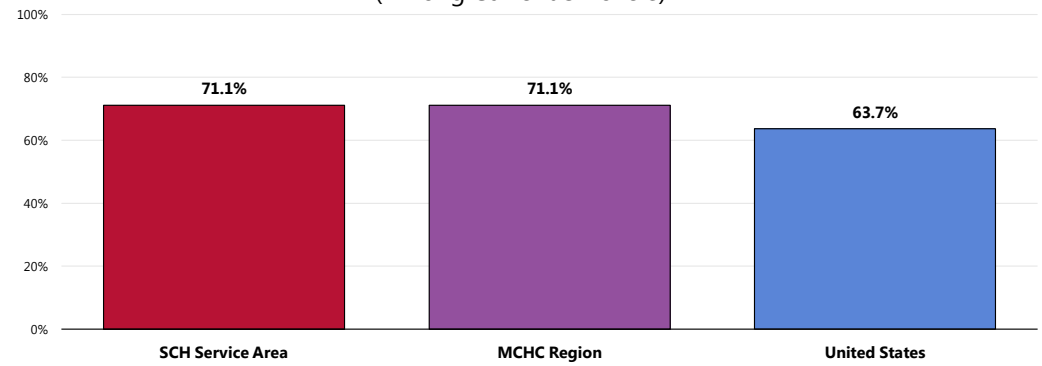
Health Advice About Smoking Cessation

A total of 71.1% of smokers say that a doctor, nurse or other health professional has recommended in the past year that they quit smoking.

- Identical to regional findings.
- Statistically similar to the national percentage.

Advised by a Healthcare Professional in the Past Year to Quit Smoking

(Among Current Smokers)



Sources:
- 2012 PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 68]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all current smokers.

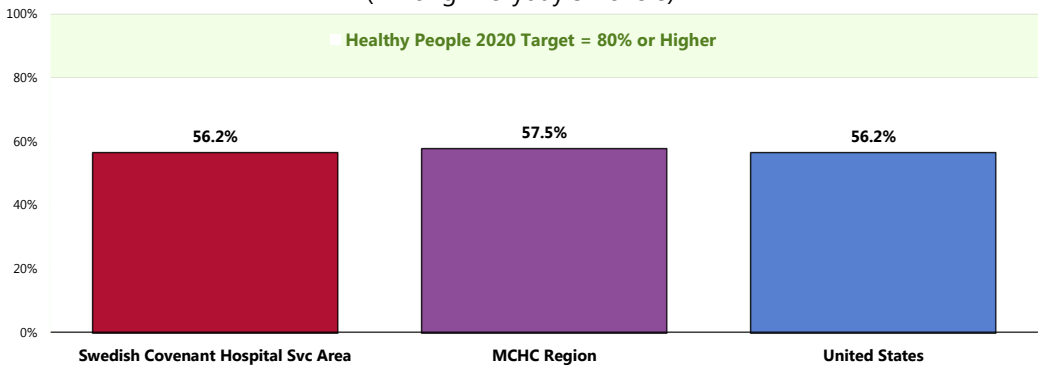
Smoking Cessation Attempts

More than one-half (56.2%) of regular smokers went without smoking for one day or longer in the past year because they were trying to quit smoking.

- Similar to the MCHC regional findings.
- Identical to the national percentage.
- Fails to satisfy the Healthy People 2020 target (80% or higher).

Have Stopped Smoking for One Day or Longer in the Past Year in an Attempt to Quit Smoking

(Among Everyday Smokers)



Sources:
- 2012 PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 67]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-4.1]

Notes:
- Asked of respondents who smoke cigarettes every day.

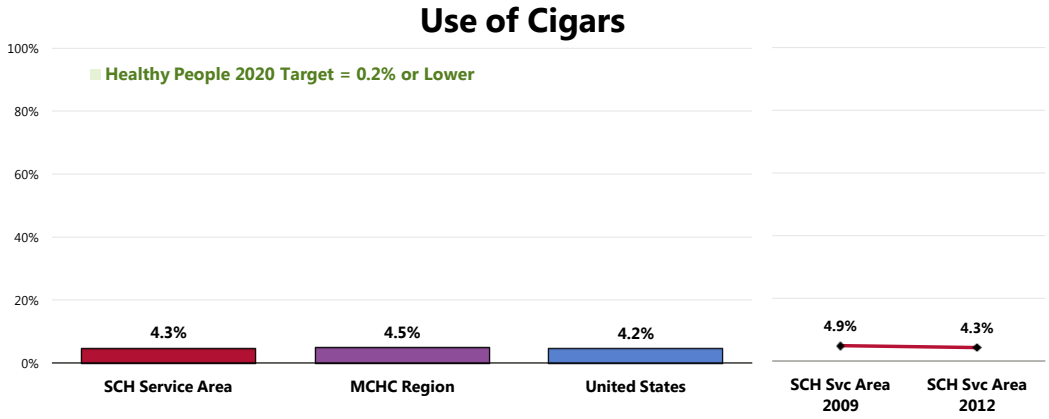
Other Tobacco Use

Cigars

Examples of smokeless tobacco include chewing tobacco, snuff, or "snus."

A total of 4.3% of area adults use cigars every day or on some days.

- Similar to regional findings.
- Nearly identical to the national percentage.
- Fails to satisfy the Healthy People 2020 target (0.2% or lower).
- Statistically unchanged since 2009.



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 71]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.3]

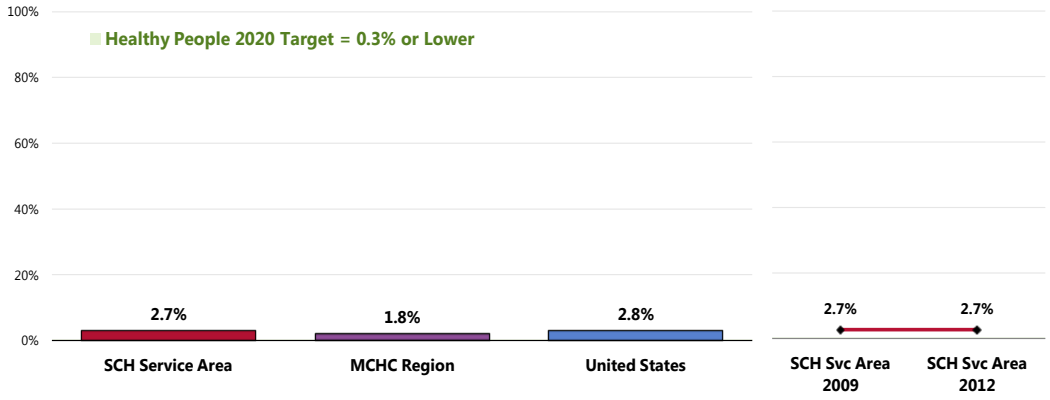
Notes:
- Asked of all respondents.

Smokeless Tobacco

A total of 2.7% of Swedish Covenant Hospital Service Area adults use some type of smokeless tobacco every day or on some days.

- Comparable to regional findings.
- Almost identical to the national percentage.
- Fails to satisfy the Healthy People 2020 target (0.3% or lower).
- Unchanged over time.

Use of Smokeless Tobacco



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 70]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.2]

Notes:
- Asked of all respondents.
- Smokeless tobacco includes chewing tobacco or snuff.

Related Focus Group Findings: Tobacco

Many focus group participants are concerned with tobacco use in the community, discussing these primary issues:

- Long-term consequences
- Higher use seen in teenagers, new immigrants, residents with mental illness, and second-generation women

Focus group participants believe that cigarette smoking continues to occur throughout the community, regardless of income level. The **long-term consequences** of smoking and chewing tobacco (as well as exposure to secondhand smoke) are detrimental to the body and these effects are what concern attendees. Members recognize the addictive nature of tobacco products, but agree that residents may not understand the health risks, as a participant describes:

> *"Because since it's a cultural, something you do when you're with friends… But that's how the habit begins. First of all someone offers it to you and then you get addicted and finally you look for where it is available." — Key Informant Representing Asian Indian Residents*

Another participant describes her experience with tobacco:

> *"It's an addiction. It starts as a social thing; especially with the youngsters…It was a social thing. It was girls in high school who taught me how to smoke. It was obviously for social purposes but then it continued as an addiction until I finally stopped and feel much better." — Key Informant Representing Polish Residents*

Certain populations are perceived as smoking cigarettes more than others, including **teenagers, new immigrants, residents with mental illness, and second-generation women**.

ACCESS TO HEALTH SERVICES

Health Insurance Coverage

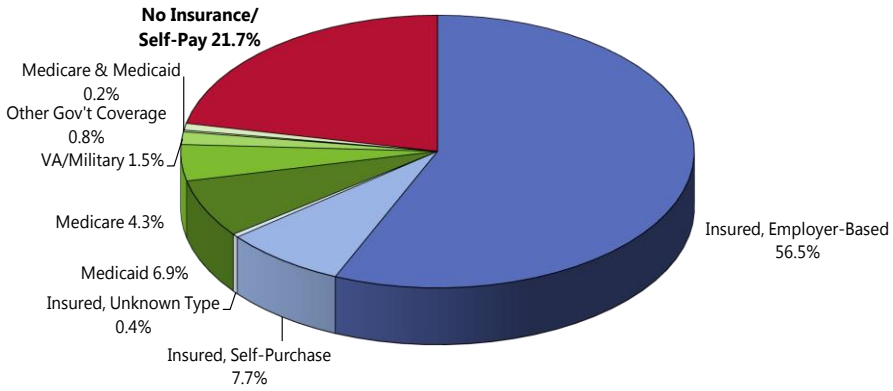
Type of Healthcare Coverage

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources.

A total of 64.6% of Swedish Covenant Hospital Service Area adults age 18 to 64 report having healthcare coverage through private insurance. Another 13.7% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, military benefits).

Healthcare Insurance Coverage

(Among Adults 18-64; Swedish Covenant Hospital Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 202]
Notes: • Reflects respondents age 18 to 64.

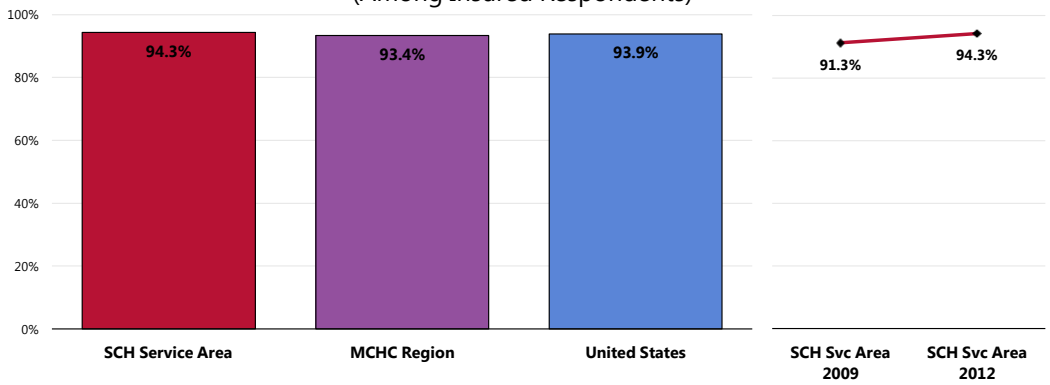
Prescription Drug Coverage

Among insured adults, 94.3% report having prescription coverage as part of their insurance plan.

- Similar to regional findings.
- Similar to the national prevalence.
- Statistically unchanged since 2009.

Health Insurance Covers Prescriptions at Least in Part

(Among Insured Respondents)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 93]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents with healthcare insurance coverage.

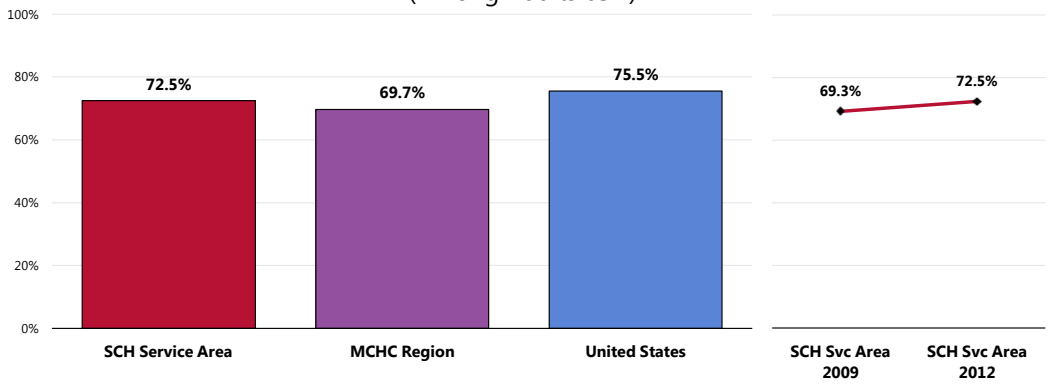
Supplemental Coverage

Among Medicare recipients, the majority (72.5%) has additional, supplemental healthcare coverage.

- Comparable to the MCHC Region's findings.
- Comparable to that reported among Medicare recipients nationwide.
- Statistically similar to the proportion reported in 2009.

Have Supplemental Coverage in Addition to Medicare

(Among Adults 65+)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 92]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of respondents age 65+.

Lack of Health Insurance Coverage

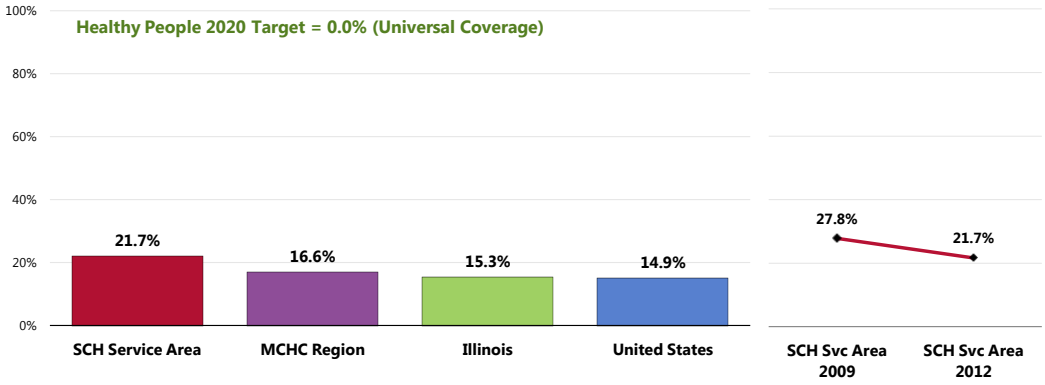
Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

Among adults age 18 to 64, 21.7% report having no insurance coverage for healthcare expenses.

- Less favorable than regional findings.
- Less favorable than the state finding.
- Less favorable than the national finding.
- The Healthy People 2020 target is universal coverage (0% uninsured).
- Statistically similar to 2009 findings.

Lack of Healthcare Insurance Coverage

(Among Adults 18-64)



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 202]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-1]

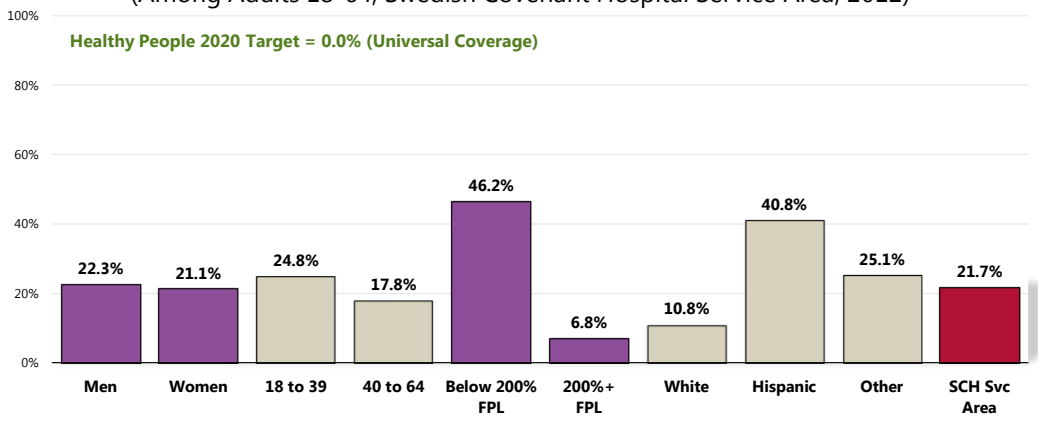
Notes:
- Asked of all respondents under the age of 65.

The following population segments are more likely to be without healthcare insurance coverage:

- Adults under age 40.
- Residents living at lower incomes (note the 46.2% uninsured prevalence among low-income adults).
- Non-Whites.

Lack of Healthcare Insurance Coverage

(Among Adults 18-64; Swedish Covenant Hospital Service Area, 2012)



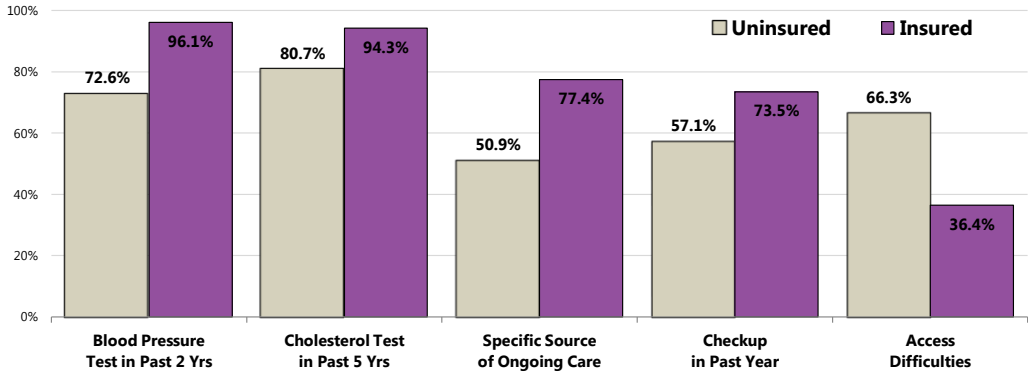
Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 202]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-1]

Notes:
- Asked of all respondents under the age of 65.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

As might be expected, uninsured adults in the Swedish Covenant Hospital Service Area are less likely to receive routine care and preventive health screenings, and are more likely to have experienced difficulties accessing healthcare.

Preventive Healthcare

(By Insured Status; Swedish Covenant Hospital Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 17, 53, 56, 203, 206]

Notes:
- Asked of all respondents.

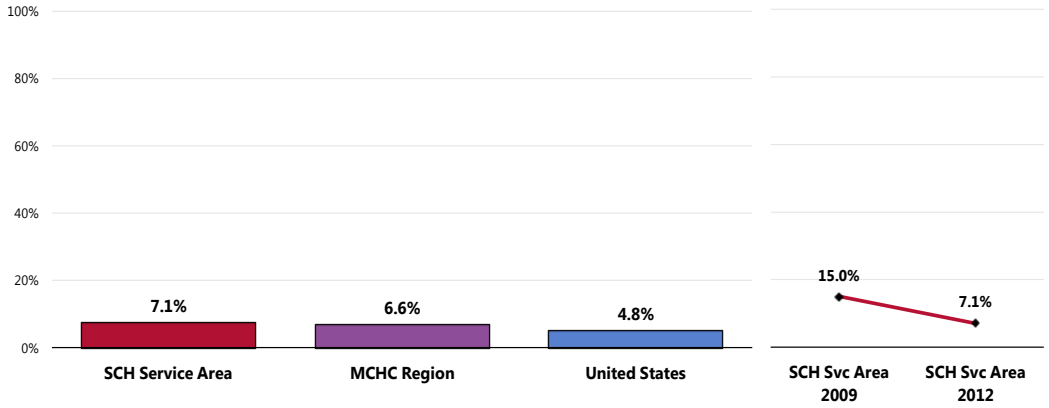
Recent Lack of Coverage (Insurance Instability)

Among currently insured adults in the service area, 7.1% report that they were without healthcare coverage at some point in the past year.

- Similar to regional findings.
- Similar to US findings.
- Marks a statistically significant improvement in insurance instability.

Went Without Healthcare Insurance Coverage At Some Point in the Past Year

(Among Insured Adults)



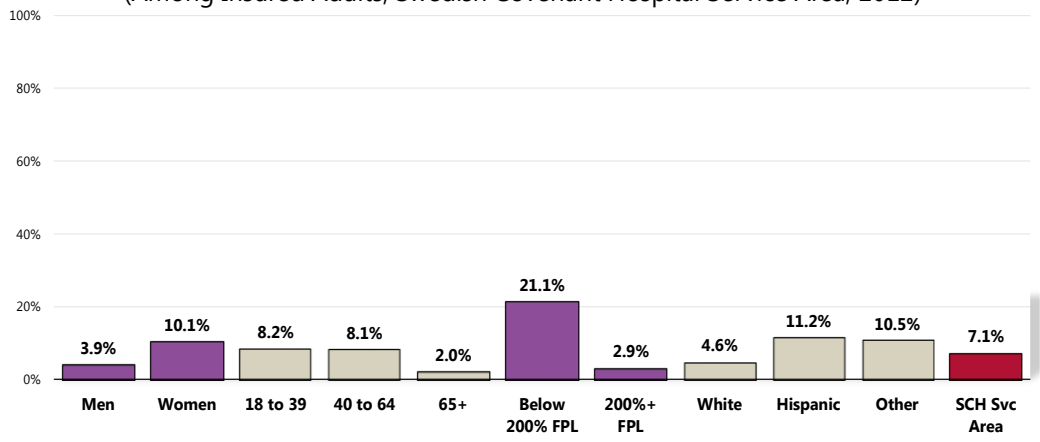
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 94]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all insured respondents.

Among insured adults, the following segments are more likely to have gone without healthcare insurance coverage at some point in the past year:

- Women.
- Adults under age 65.
- Lower-income residents (especially).

Went Without Healthcare Insurance Coverage At Some Point in the Past Year

(Among Insured Adults; Swedish Covenant Hospital Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 94]
Notes: • Asked of all insured respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Difficulties Accessing Healthcare

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It impacts: overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy.

Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires three distinct steps: 1) Gaining entry into the health care system; 2) Accessing a health care location where needed services are provided; and 3) Finding a health care provider with whom the patient can communicate and trust.

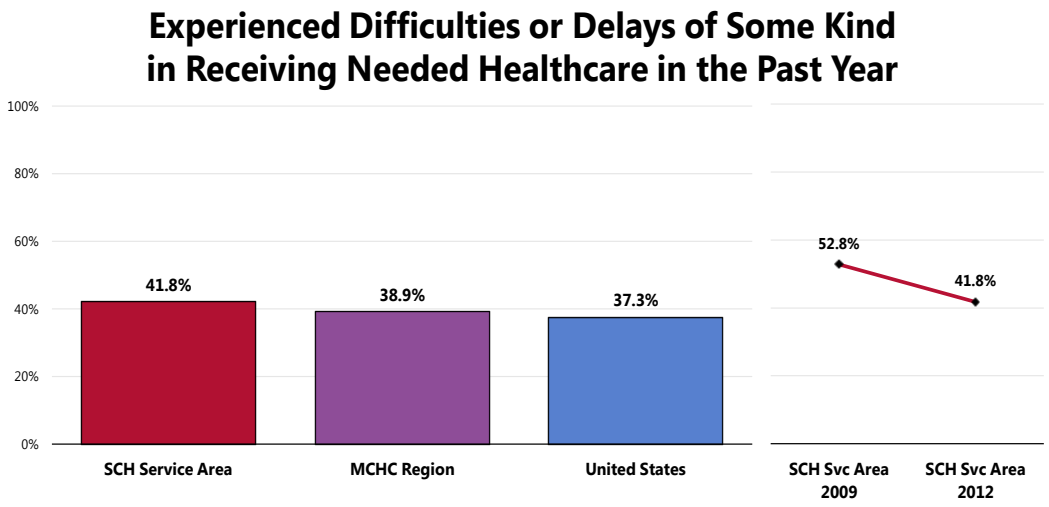
– Healthy People 2020 (www.healthypeople.gov)

Difficulties Accessing Services

This indicator reflects the percentage of the total population experiencing problems accessing healthcare in the past year, regardless of whether they needed or sought care.

A total of 41.8% of Swedish Covenant Hospital Service Area adults report some type of difficulty or delay in obtaining healthcare services in the past year.

- Comparable to MCHC regional findings.
- Comparable to national findings.
- A significant decrease from the percentage reported in 2009.



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 206]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

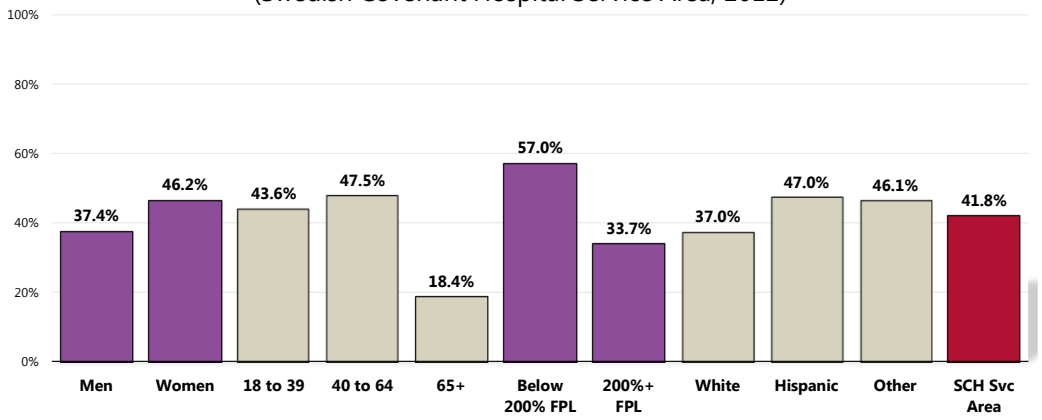
Notes:
- Asked of all respondents.
- Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.

Note that the following demographic groups more often report difficulties accessing healthcare services:

- Women.
- Adults under the age of 65.
- Lower-income residents (especially).

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year

(Swedish Covenant Hospital Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 206]

Notes:
- Asked of all respondents.
- Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Barriers to Healthcare Access

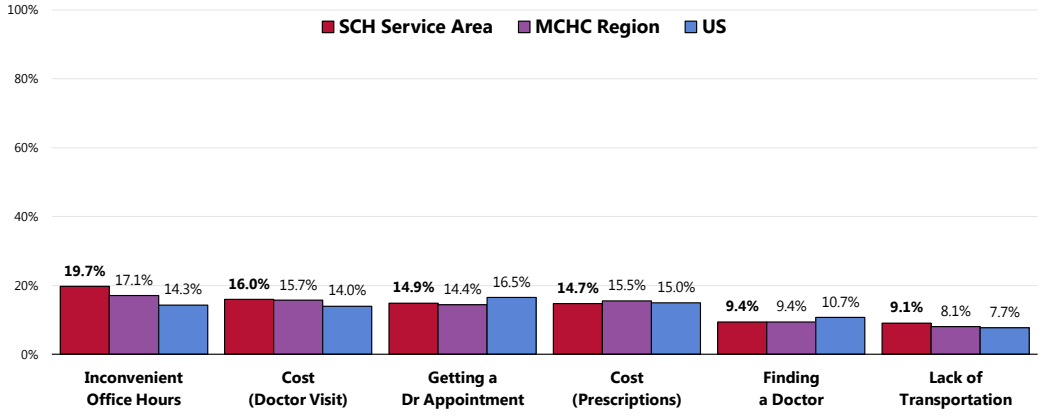
To better understand healthcare access barriers, survey participants were asked whether any of six types of barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

Again, these percentages reflect the total population, regardless of whether medical care was needed or sought.

Of the tested barriers, inconvenient office hours impacted the greatest share of Swedish Covenant Hospital Service Area adults (19.7% say that they were unable to see a physician in the past year because the office hours were not convenient).

- The proportion of service area residents impacted was statistically comparable to that reported regionally for each of the tested barriers.
- The proportion of Swedish Covenant Hospital Service Area adults impacted was statistically comparable to that found nationwide for each of the tested barriers, with the exception of inconvenient office hours (for which the area prevalence was higher).

Barriers to Access Have Prevented Medical Care in the Past Year



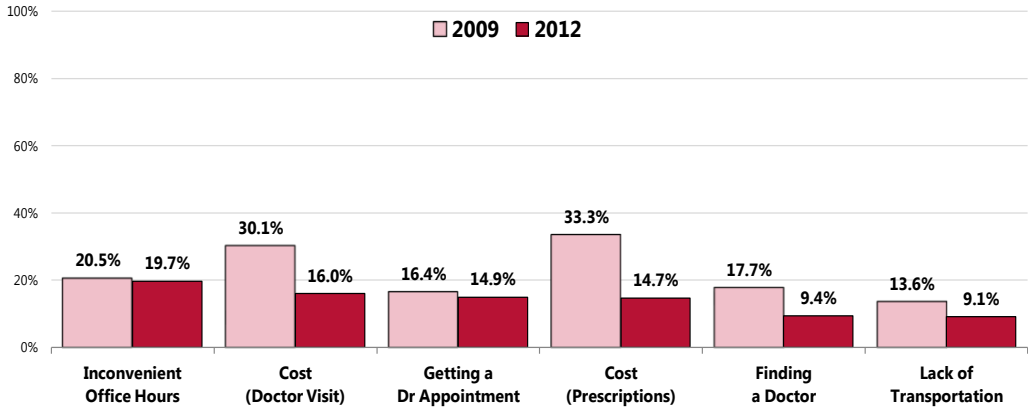
Sources:
- 2012 PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 7-12]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Compared to baseline 2009 data, the Swedish Covenant Hospital Service Area has seen a significant decrease with regard to the barriers of **prescription costs**, **costs associated with physician visits**, and **difficulties in finding physicians**.

Trend in Barriers to Healthcare Access

(Swedish Covenant Hospital Service Area, 2009-2012)

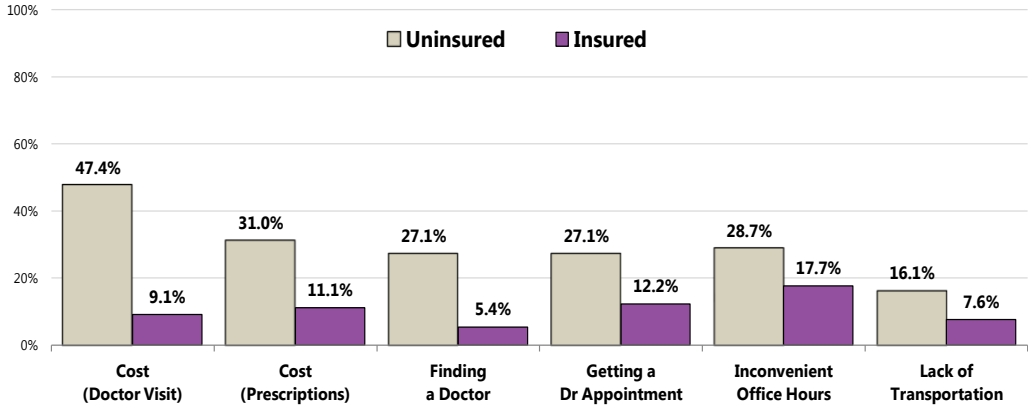


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 7-12]
Notes: • Asked of all respondents.

As might be expected, Swedish Covenant Hospital Service Area adults without health insurance are much more likely to report access barriers when compared to the insured population, particularly those related to cost.

Barriers to Healthcare Access

(By Insured Status, Adults 18+; Swedish Covenant Hospital Service Area, 2012)



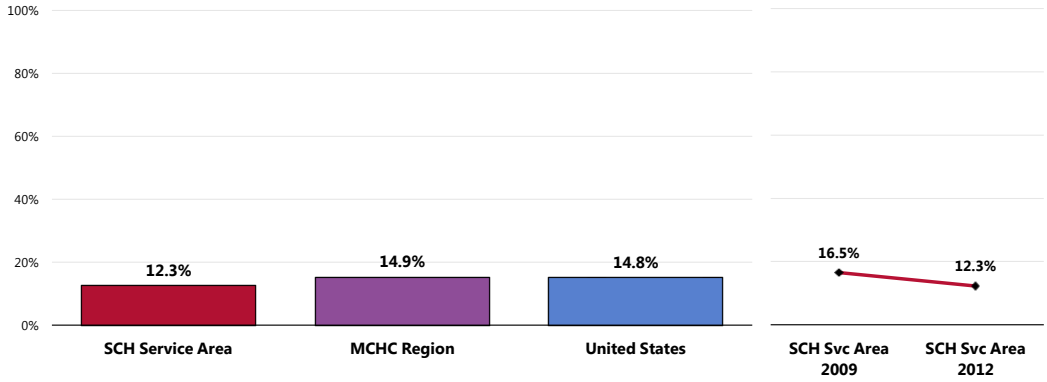
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 7-12]
Notes: • Asked of all respondents.

Prescriptions

Among all Swedish Covenant Hospital Service Area adults, 12.3% skipped or reduced medication doses in the past year in order to stretch a prescription and save money.

- Similar to regional findings.
- Similar to national findings.
- Statistically similar to 2009 findings.

Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money



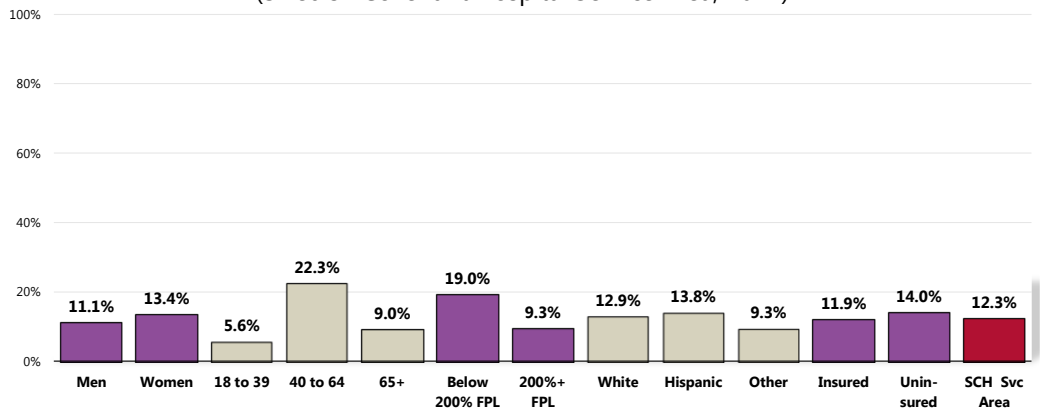
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 13]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Adults more likely to have skipped or reduced their prescription doses include:

- Adults age 40 to 64.
- Respondents with lower incomes.

Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money

(Swedish Covenant Hospital Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 13]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Accessing Healthcare for Children

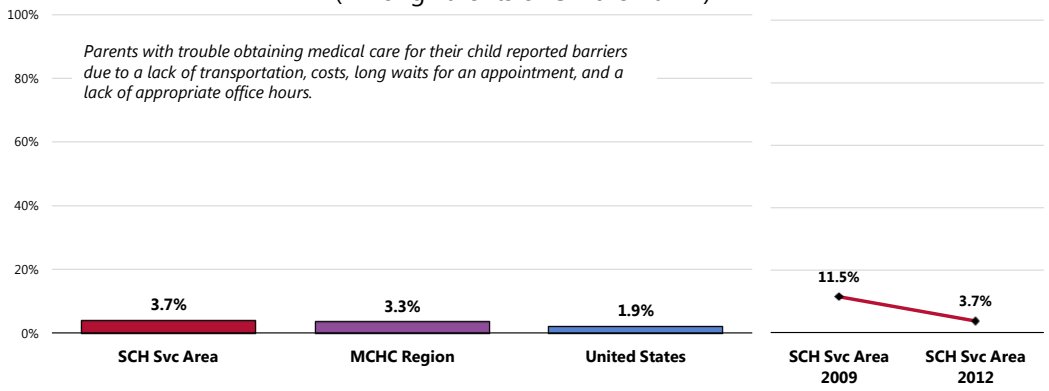
Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly-selected child in their household.

A total of 3.7% of parents say there was a time in the past year when they needed medical care for their child, but were unable to get it.

- Similar to MCHC regional findings.
- Similar to what is reported nationwide.
- Statistically unchanged since 2009.

Had Trouble Obtaining Medical Care for Child in the Past Year

(Among Parents of Children 0-17)



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 134-135]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents with children 0 to 17 in the household.

Among the parents experiencing difficulties, the majority cited a **lack of transportation or costs** as the primary reason; others cited long waits for appointments and closed offices.

Related Focus Group Findings: Access to Healthcare

Many focus group participants are concerned with access to healthcare, with discussion focused on these main issues:

- Barriers to accessing healthcare
  - Ethnically-diverse community
  - Cultural competence
  - Undocumented residents and recent immigrants
  - Interpretive services
  - Insurance status
  - Medicaid or public aid
    - Reimbursement rates
  - Uninsured and underinsured
  - Federally Qualified Health Centers
  - Hours of operation
  - Cost

        - Prescription medication
    - Transportation
    - Affordability and/or availability of childcare
- Patient navigators

Focus group participants agree that residents encounter several **barriers** when trying to **access healthcare services** in Cook County, and that many disparities exist within the community (dependent upon geography). One participant explains:

> *"Place plays a very large part in the disparity that we see between the healthy and those who aren't healthy. I'd like to suggest, and this isn't my idea, but that we actually talk about 'sick care' as what we now know as 'healthcare,' and that 'healthcare' we actually talk about 'prevention' and community programs that support a person with self-management." — Cook County Community Leader*

Attendees feel the community is also very **ethnically diverse**, creating added barriers to healthcare access. For example, certain cultural beliefs may discourage residents from accessing preventative care or treatment:

> *"I think we have so many different cultures and the diversity is so high that the barriers can be cultural, just their beliefs. Maybe fighting cancer is considered more of a taboo, a punishment for something they've done in their life so they don't want to find that out or it's just they're unaware or they don't know how to ask for services." — Swedish Covenant Hospital Representative*

In many cultures which are represented in Cook County, accessing preventative care is not a priority, and some residents may rely on home remedies or family traditions, this either knowingly or unknowingly avoiding more effective medical treatments. A — Key Informant Representing Polish Residents describes Polish cultural attitudes regarding medical care:

> *"When it comes to older people, middle aged, too, that I can think of, reliance on home remedies and whatever traditionally natural. 'You have some symptoms; you should go to a doctor.' 'Oh, no. I know what to do because my grandparents taught me and I have just written a letter or called Poland and they're sending me a package with these natural remedies that will take care of that.'" — Key Informant Representing Polish Residents*

Another participant describes how residents do not access healthcare because they receive inaccurate information from other community members:

> *"I also think that with the access issue many of our population are living with their peers' misinformation that, 'I can't sign up for a medical card because my child will be conscripted into the Army or because my immigration attorney told me that if I sign up for public benefits it's going to hurt my application for U.S. citizenship.'" — Key Informant Representing Hispanic Residents*

Some cultures may not place the same importance on each gender's health, as one attendee describes:

> *"Then I think there are important differences between men and women and how their health is valued and that should be thought about as well. For a lot of women they don't take the time necessarily to engage in prevention because they're so busy taking care of the day-to-day things." — Key Informant Representing Asian Indian Residents*

The attendees believe that both physicians and social service agencies need to possess **cultural competence** in order to make an impact on resident's health. Culturally-competent providers recognize how culture affects a patient's attitude and can tailor their message accordingly.

Other participants are concerned about **undocumented residents and recent immigrants**: undocumented residents may fear deportation or legal ramifications if they access services. They may also be unable to obtain health insurance.

Many immigrants have not had sufficient medical care in their country of origin, so needs are high when they eventually obtain care in the United States. In addition, language may become a barrier to care. Participants note that not all organizations provide translators and even for those with interpretive services for physicians, making an appointment may prove difficult.

> *"So if somebody calls Swedish Covenant and has problems communicating, it depends a lot on the person who receives that phone call and often those who don't know Polish, they hear a heavy Polish accent and they panic and they quickly assume that it's impossible to communicate. No, take a deep breath. Have a sense of humor and you'll be able to if you try. Especially in person it's very easy. So attitude and psychological barriers on sides, the limited proficient English Pole and the also very proficient English-speaking American and no other languages." — Key Informant Representing Polish Residents*

Currently there are an inadequate number of **interpretive services** in the North Chicago communities. With a large refugee population, interpreters are needed for many languages (not just Spanish). Some agencies have even begun using Skype to facilitate interpretive services. A participant explains the dilemma:

> *"In our organization we say we all speak Spanish and English so we will help you translate any documents you might need, but the problem with the doctors come in sometimes they don't have. So they bring their child to translate and women are uncomfortable." — Key Informant Representing Hispanic Residents*

Another participant explains the importance of an interpreter:

> *"We have many patients like I said that are Korean, Russian – and so, there needs to be a middle man to help with interpretation. And you know what they say, something gets lost in the interpretation, right? But we try. And it's not 100 percent effective or successful but we just – there's always plenty of room for improvement." — North Chicago Community Leader*

Focus group participants agree that access to healthcare is **insurance dependent**: if residents possess private insurance, there are many local providers available and accessible. However, the insurance system is complex and some residents may struggle with understanding coverage, referrals, or the approval process. As a participant recalls:

> *"But here, you are a patient but at the same time you are a consumer and you have certain rights and many times people are not aware of those rights. They just don't know they can appeal. They can kind of question the bill. Many times they would win but some people, they feel if the bill came… I have to pay it even if I can't afford it or even if I was told I would only pay $20.00." — Key Informant Representing Polish Residents*

Some residents may qualify for **Medicaid** or **public aid**, but finding a provider who accepts that insurance can prove difficult. Group participants discussed the decreasing number of physicians who accept Medicaid due to the low **reimbursement rate** and the opportunity for primary care physicians to receive higher returns in other states.

Focus group members report that many residents are **under-insured or uninsured**, creating additional barriers to accessing healthcare (especially specialty services). The underinsured population includes the working poor: those individuals who may qualify for employer insurance but the deductibles are too high or the monthly employee cost is too much, so they elect to go without.

> *"You have the people with lots of resources, insurance, then you have folks that don't have or they have public aid. But then you have those in the middle, the working poor, so I want to just bring that up, the difficulty with those populations whereas they have employment and maybe their place of employment even offers health insurance but they cannot afford to take that." — Cook County Community Leader*

Swedish Covenant provides discounts to uninsured community members, but participants note that minority residents may struggle to fill out the charity care applications because of limited language skills or low literacy levels; having someone to assist with this process could increase compliance.

> *"They're not filling out the charity care applications, we know that a lot of that could be taken care of with a health navigator, a person from the community who speaks the language who can help people, educate them about the clinical options, educate them about health insurance, let them know what their rights are, what their responsibilities are, and then sometimes actually sit with them and fill out the paperwork and turn it in." — Key Informant Representing Hispanic Residents*

Other residents may not be "poor" enough to qualify for services and not enough safety net programs exist in the North Chicago community.

> *"I think that there's a lot of folks who actually fall in that middle ground of not actually being poor enough to be eligible for a lot of resources, so that piece of things I think creates some certain traps." North Chicago Community Leader*

There are several school-based clinics and federally qualified health centers (FQHCs) in the community which operate on a sliding fee schedule to provide services to uninsured residents. Several options exist for the uninsured population in North Chicago, including: the Irving Park Clinic (which is free and staffed by volunteers); Healthcare for the Homeless; the ARK; the Compassionate Care Network; Asian Human Services Health Center; school health centers; and other **Federally Qualified Health Centers (FQHCs).** However, the FQHCs are overwhelmed and many have long waits. The FQHCs operate on

a sliding fee schedule starting at $30, but do not deny services based on the ability to pay. One participant explains:

> *"So some agencies (FQHCs) have more of a collection orientation upfront than others, and that's just the way some people choose to operate or not. But no one gets sent to collections that I'm aware of. There could be some FQHCs doing that; we don't. And we're not denying services at the front desk to someone who doesn't have money. We will ask them to pay, we will tell them what the charge for the visit is – that's how we do business, but no one gets thrown back out the door." — North Chicago Community Leader*

Ethnically-specific FQHCs also operate in the North Chicago community. For example, the Asian Human Services Family Health Center operates with volunteers and offers a sliding-fee payment schedule.

Additionally, participants shared concern that the **cost** of healthcare can overburden families, *even those with insurance*.

> *"Well if you don't have the money when you go to see a doctor you don't know how much it's going to cost. Because unlike everything else in the world there could be a basic price given to you but lab tests, medicine, x-rays. So you really don't know. And that causes huge difficulty. Also the uninsured pay full price, unlike everybody else." — Cook County Community Leader*

For some ethnic groups, the fear of not being able to pay the bill means these residents do not frequent medical providers. One participant describes how the Asian Indian community worries about defaulting:

> *"That is a problem at least I can say in the community, the fear that they will be charged heavily and they might not be able to repay. Because one conscious thing is at least I can vouch for the Indian community, they don't want to default any payments. They want to keep their conscience very clear." — Key Informant Representing Asian Indian Residents*

In addition, the **cost of prescription medication** can overburden families and local prescription programs have been eliminated. Residents now must travel to the county hospital for free or reduced-cost prescriptions, which can take hours via public transport, as one participant explains:

> *"So we could get my patients free drugs from Stroger delivered to us because we were part of the neighborhood. That doesn't happen anymore and we can't even write prescriptions to Cook County anymore and Cook County now has a $5 co-pay for their prescriptions and you usually have to wait at least 2 days to get your medication. So if you live up here, or in a suburb to get down there to get seen, which will take about 12 hours – then go to the pharmacy and then you have to come back." — North Chicago Community Leader*

Another participant recalls a recent conversation with a client:

> *"They tell me 'I buy the first time the medicine…I didn't buy it no more.' I said, 'How? Why? you're supposed to take it all your life as soon as you find out you were a diabetic.' And he said, 'I don't have any more money. It costs me $180.00 a month for Lipitor.' 'Have you talked to your doctor about it?' There was some medication that now came out as a generic... And he said, 'That's good, but I still cannot afford it.' So again it's not that they don't see a benefit, but they don't see a benefit at the same time." — Key Informant Representing Hispanic Residents*

Some community members may try and obtain prescription drugs or medical care from their home country in order to lower costs, as one attendee explains:

> *"I mean often when folks do travel to Poland, they tend to go and take care of their medical needs. They go to all the doctors, they get all their tests, and they come with prescriptions. They get prescriptions there and they get it filled and they just get the medications. And again, because I think it's easy to communicate with the doctor in Poland. The system is more easily manageable and it's cheaper in terms of the medications." — Key Informant Representing Polish Residents*

Additional barriers to care include providers' hours of operation, transportation and childcare. The standard **hours of operation** for most clinics in the area may limit access; participants cannot afford to take an entire day off of work and clinics close before their shift ends.

Transportation may also hinder access: the current public transit routes don't always travel past a clinic, so some residents do not have easy access to a clinic. The cost to ride the train ($2.25/ride or $5.75/day) can also limit one's ability to access the train. In addition, the train does not have many routes into the North Chicago suburbs; residents can utilize the PACE bus system, but hours of operation and limited routes hinder its utility, as one participant describes:

> *"FQHCs and community health centers are in the areas but they're overwhelmed. Also if you can't get to a clinic then there's no point. In suburban Cook County distances are fairly --public transportation is fairly poor. So you combine those two things and you can't maybe get to a FQHC even though it's relatively near but it isn't on a major route, or you're not on a major route." — Cook County Community Leader*

Affordability and/or availability of childcare can also limit a resident's ability to access healthcare. Many residents need to bring their children with them to appointments because they cannot afford childcare, so if doing this is not an option, then residents do not go to the appointment.

Participants also feel that **patient navigators** are needed to guide patients through the complex healthcare system. These individuals could help patients with any questions or concerns that arise, since many residents struggle to understand and communicate with providers, insurance companies and hospitals.

> *"I do speak English and sometimes I have no idea what people are telling me. If I'm calling my insurance, I literally am asking them to repeat three times so I can comprehend where does this fall into what I understand the healthcare system to be. So I think education, explanation of the system. You can be fluent and still not understand." — Key Informant Representing Polish Residents*

Others community members who immigrated to the United States after growing up in a country with a different healthcare system need education about navigating the US healthcare system. Some residents may not realize their medical rights, the ability to ask for second opinions, the referral process or payment procedures. As a participant describes:

> *"It's different for folks who grew up in Poland who know the Polish system. Here it's not that you have one doctor. You have to get referrals. It depends on your plan and then it depends on what doctor you want to go to, you have to call someone else… I think the whole thing with bills afterwards. All of a sudden you're going to one doctor for one checkup and you're getting three different bills from three different people." — Key Informant Representing Polish Residents*

Currently a North Chicago hospital utilizes a patient navigator to assist with day-to-day operations and customer services complaints, as a participant explains:

> *"There's a website out there and I'm not everyone here…or able to see the website. It's 'yelp' – where you see all these replies and comments by, I think there's a hospital sector there. And so everyday our patient advocate reads the comments and they're not really kind of – you can lose your appetite just reading some of those comments. And she will answer or – not be specific, but say, 'Let me give you a call.' Or, 'I'll give you a call within the next hour.' And she follows up on those." — North Chicago Community Leader*

Primary Care Services

Improving health care services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. Having a primary care provider (PCP) as the usual source of care is especially important. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Having a usual PCP is associated with:

- Greater patient trust in the provider
- Good patient-provider communication
- Increased likelihood that patients will receive appropriate care

Improving health care services includes increasing access to and use of evidence-based preventive services. Clinical preventive services are services that: **prevent** illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention); or **detect** a disease at an earlier, and often more treatable, stage (secondary prevention).

– Healthy People 2020 (www.healthypeople.gov)

Specific Source of Ongoing Care

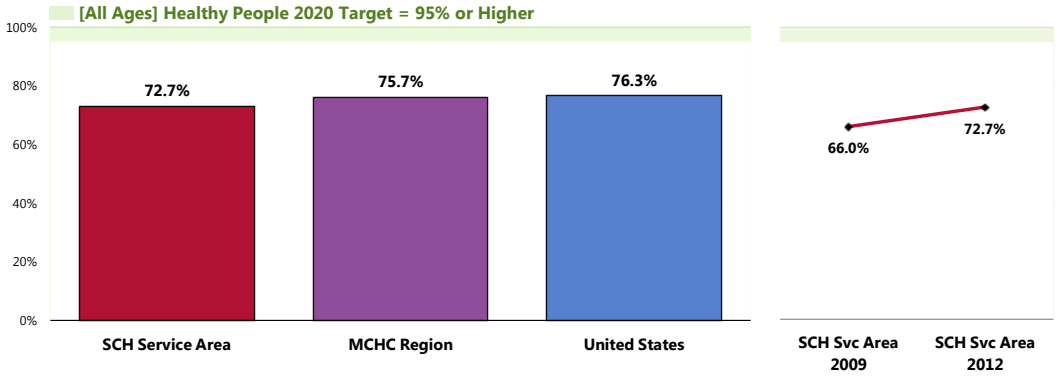
Having a specific source of ongoing care includes having a doctor's office, clinic, urgent care center, walk-in clinic, health center facility, hospital outpatient clinic, HMO or prepaid group, military/VA clinic, or some other kind of place to go if one is sick or needs advice about his or her health. This resource is also known as a "medical home."

A hospital emergency room is not considered a source of ongoing care in this instance.

A total of 72.7% of Swedish Covenant Hospital Service Area adults were determined to have a specific source of ongoing medical care (a "medical home").

- Similar to findings in the MCHC Region.
- Similar to national findings.
- Fails to satisfy the Healthy People 2010 objective (95% or higher).
- Statistically unchanged since 2009.

Have a Specific Source of Ongoing Medical Care



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 203]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-5.1]

Notes:
- Asked of all respondents.

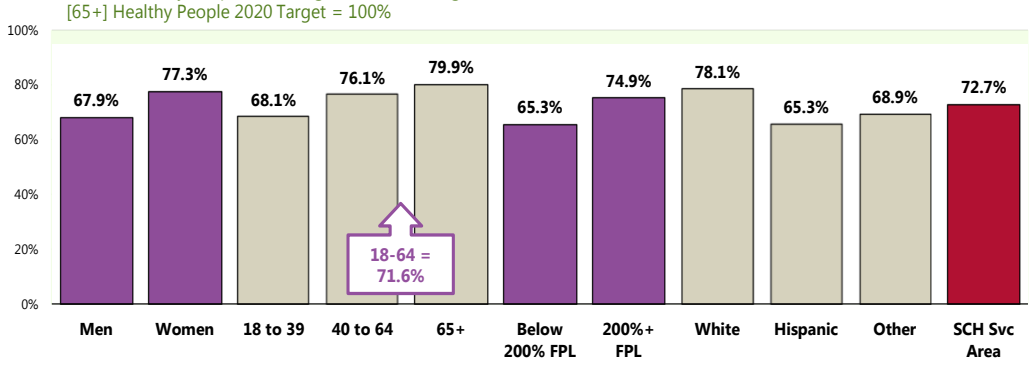
When viewed by demographic characteristics, the following population segments are <u>less likely</u> to have a specific source of care:

- Men.
- Adults under age 40.
- Lower-income adults.
- Non-Whites
- Among adults age 18-64, 71.6% have a specific source for ongoing medical care, which is similar to national findings.
  - Fails to satisfy the Healthy People 2020 target for this age group (89.4% or higher).
- Among adults 65+, 79.9% have a specific source for care, similar to the percentage reported among seniors nationally.
  - Fails to satisfy the Healthy People 2020 target of 100% for seniors.

Have a Specific Source of Ongoing Medical Care

(Swedish Covenant Hospital Service Area, 2012)

[All Ages] Healthy People 2020 Target = 95.0% or Higher
[18-64] Healthy People 2020 Target = 89.4% or Higher
[65+] Healthy People 2020 Target = 100%

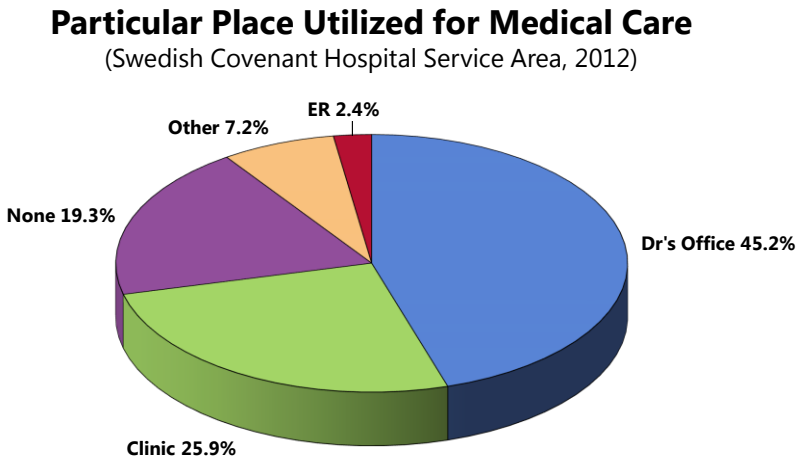


Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 203-205x]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objectives AHS-5.1, 5.3, 5.4]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Type of Place Used for Medical Care

When asked where they usually go if they are sick or need advice about their health, the greatest share of respondents (45.2%) identified a doctor's office, while 25.9% mentioned some type of clinic and 2.4% rely on an emergency room for their routine care.



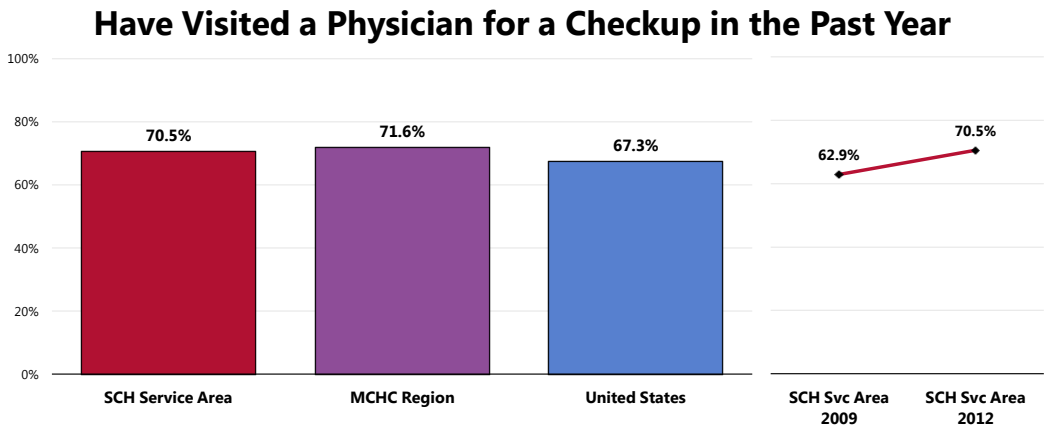
Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 15-16]
Notes: • Asked of all respondents.

Utilization of Primary Care Services

Adults

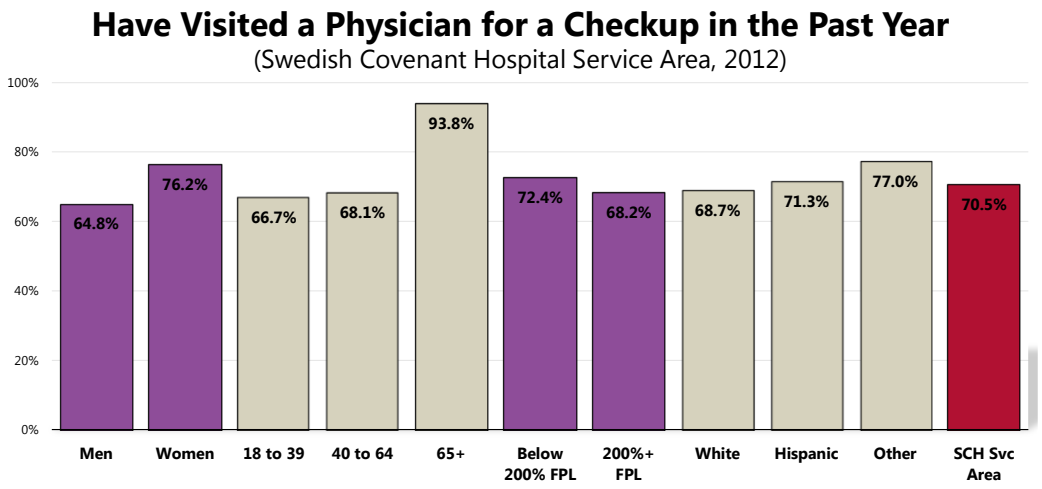
Seven in 10 adults (70.5%) visited a physician for a routine checkup in the past year.

- Comparable to regional findings.
- Comparable to national findings.
- Statistically similar to 2009 findings.



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 17]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

- Men and adults under age 65 are less likely to have received routine care in the past year.



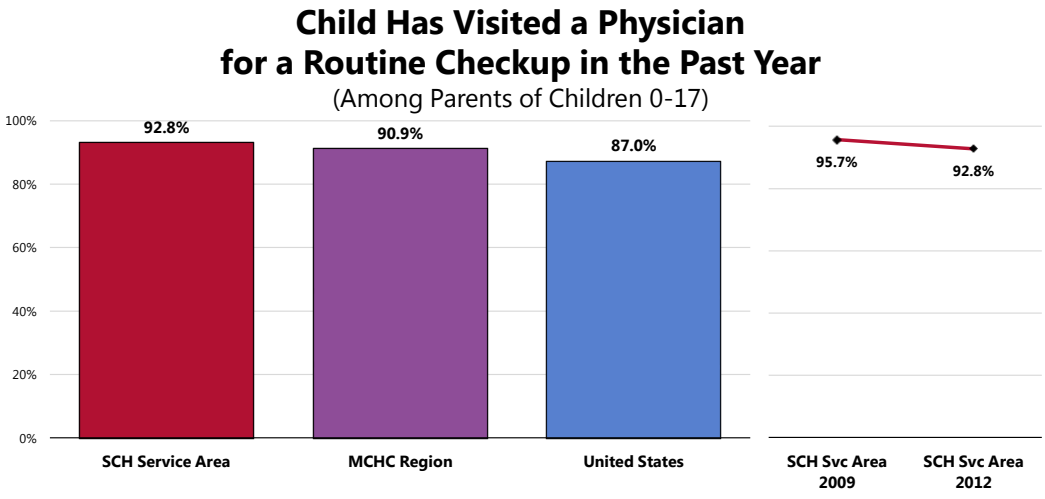
Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 17]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

Children

Among surveyed parents, 92.8% report that their child has had a routine checkup in the past year.

- Similar to MCHC regional findings.
- More favorable than national findings.
- Statistically similar to the 2009 findings.



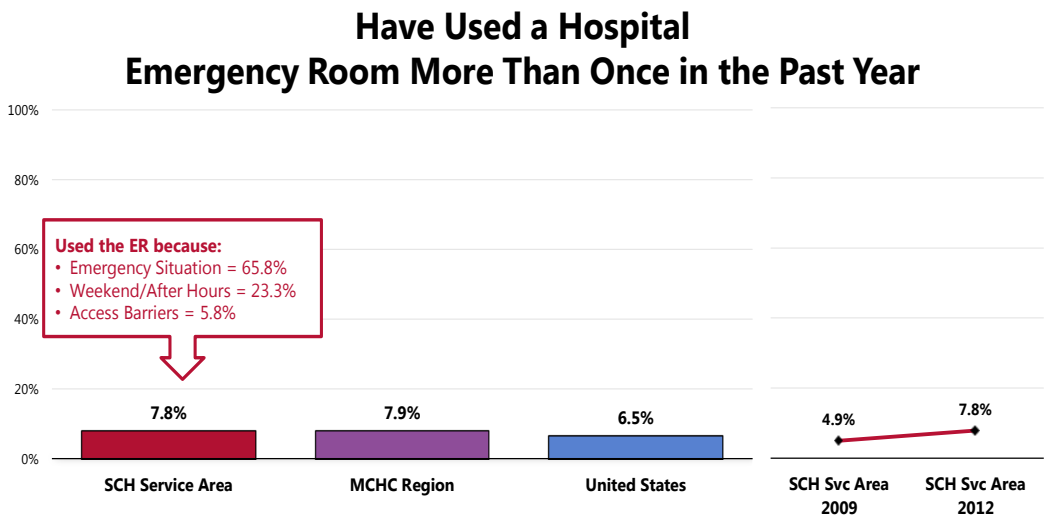
Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 136]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.

Emergency Room Utilization

A total of 7.8% of Swedish Covenant Hospital Service Area adults have gone to a hospital emergency room more than once in the past year about their own health.

- Nearly identical to regional findings.
- Comparable to national findings.
- Comparable to the findings of the 2009 study.



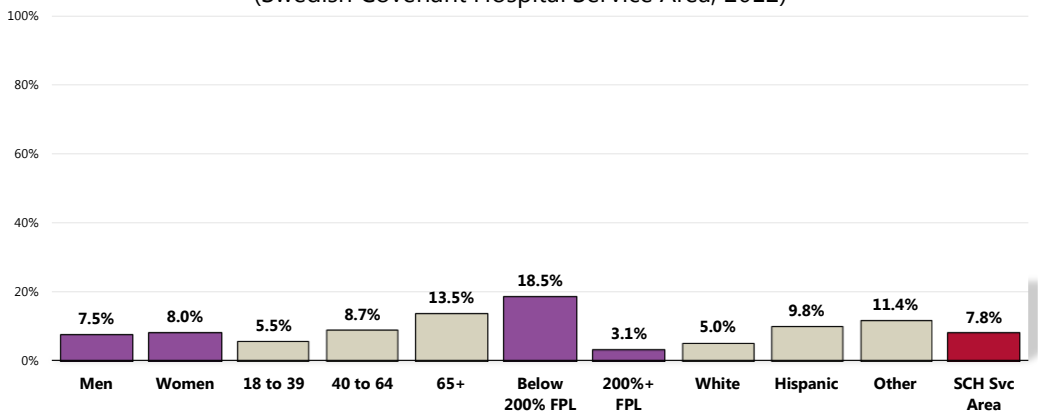
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 23-24]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Of those using a hospital ER, 65.8% say this was due to an **emergency or life-threatening situation**, while 23.3% indicated that the visit was during **after-hours or on the weekend**. Additionally, a total of 5.8% of ER patients cited some type of **access barrier**.

- Frequent ER utilization is statistically high among lower-income respondents.

Have Used a Hospital Emergency Room More Than Once in the Past Year

(Swedish Covenant Hospital Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 23]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
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Oral Health

The health of the mouth and surrounding craniofacial (skull and face) structures is central to a person's overall health and well-being. Oral and craniofacial diseases and conditions include: dental caries (tooth decay); periodontal (gum) diseases; cleft lip and palate; oral and facial pain; and oral and pharyngeal (mouth and throat) cancers.

The significant improvement in the oral health of Americans over the past 50 years is a public health success story. Most of the gains are a result of effective prevention and treatment efforts. One major success is community water fluoridation, which now benefits about 7 out of 10 Americans who get water through public water systems. However, some Americans do not have access to preventive programs. People who have the least access to preventive services and dental treatment have greater rates of oral diseases. A person's ability to access oral healthcare is associated with factors such as education level, income, race, and ethnicity.

Oral health is essential to overall health. Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions. However, oral diseases, from cavities to oral cancer, cause pain and disability for many Americans. Good self-care, such as brushing with fluoride toothpaste, daily flossing, and professional treatment, is key to good oral health. Health behaviors that can lead to poor oral health include:

- Tobacco use
- Excessive alcohol use
- Poor dietary choices

Barriers that can limit a person's use of preventive interventions and treatments include:

- Limited access to and availability of dental services
- Lack of awareness of the need for care
- Cost
- Fear of dental procedures

There are also social determinants that affect oral health. In general, people with lower levels of education and income, and people from specific racial/ethnic groups, have higher rates of disease. People with disabilities and other health conditions, like diabetes, are more likely to have poor oral health.

Community water fluoridation and school-based dental sealant programs are 2 leading evidence-based interventions to prevent tooth decay.

Major improvements have occurred in the nation's oral health, but some challenges remain and new concerns have emerged. One important emerging oral health issue is the increase of tooth decay in preschool children. A recent CDC publication reported that, over the past decade, dental caries (tooth decay) in children ages 2 to 5 have increased.

Lack of access to dental care for all ages remains a public health challenge. This issue was highlighted in a 2008 Government Accountability Office (GAO) report that described difficulties in accessing dental care for low-income children. In addition, the Institute of Medicine (IOM) has convened an expert panel to evaluate factors that influence access to dental care.

Potential strategies to address these issues include:

- Implementing and evaluating activities that have an impact on health behavior.
- Promoting interventions to reduce tooth decay, such as dental sealants and fluoride use.
- Evaluating and improving methods of monitoring oral diseases and conditions.
- Increasing the capacity of State dental health programs to provide preventive oral health services.
- Increasing the number of community health centers with an oral health component.

– Healthy People 2020 (www.healthypeople.gov)

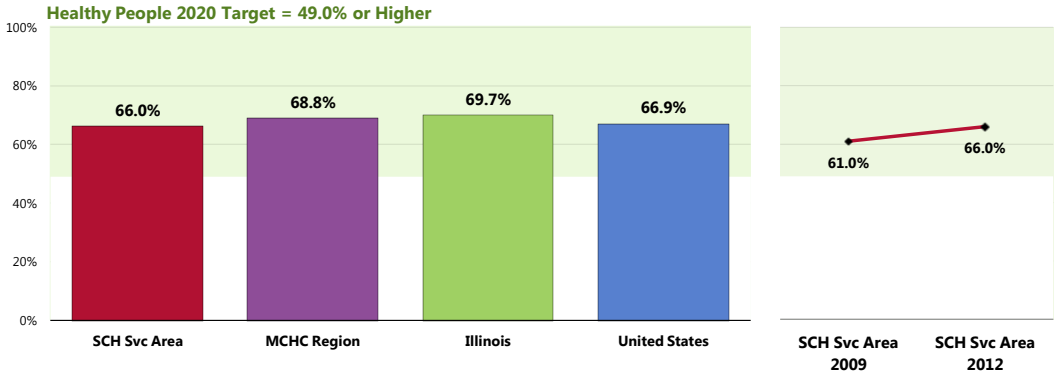
Dental Care

Adults

Two-thirds of Swedish Covenant Hospital Service Area adults (66.0%) have visited a dentist or dental clinic (for any reason) in the past year.

- Comparable to regional findings.
- Comparable to statewide findings.
- Comparable to national findings.
- Satisfies the Healthy People 2020 target (49% or higher).
- Statistically unchanged since 2009.

Have Visited a Dentist or Dental Clinic Within the Past Year



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 21]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2010 Illinois data.

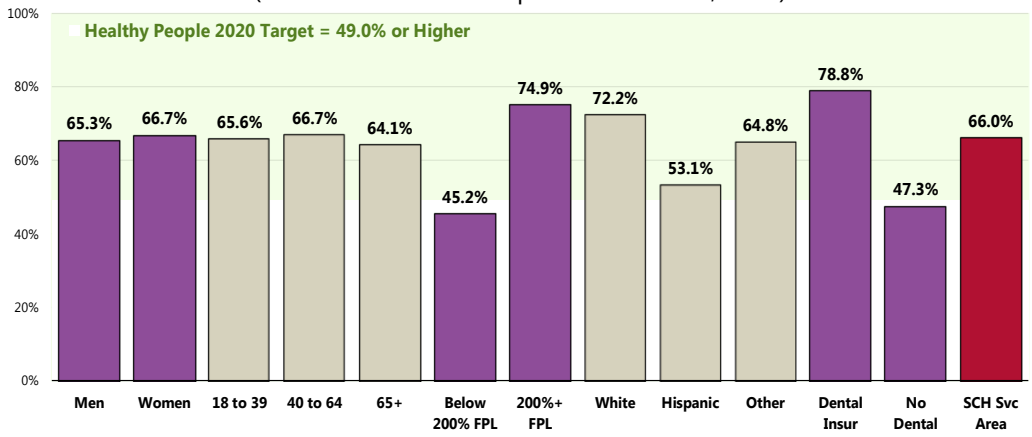
Notes:
- Asked of all respondents.

Note the following:

- Persons living in the higher income category report much higher utilization of oral health services (low-income adults fail to satisfy the Healthy People 2020 target).
- Whites are more likely than Hispanics or "Other" races to report recent dental care.
- As might be expected, persons without dental insurance report much lower utilization of oral health services than those with dental coverage.

Have Visited a Dentist or Dental Clinic Within the Past Year

(Swedish Covenant Hospital Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

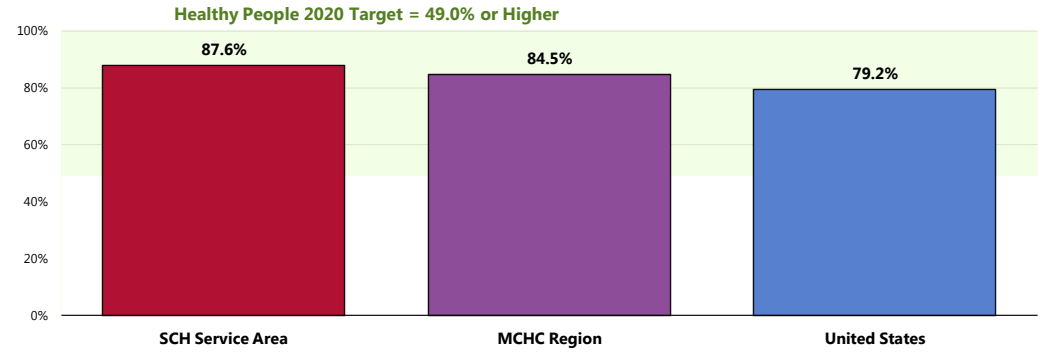
Children

A total of 87.6% of parents report that their child (age 2 to 17) has been to a dentist or dental clinic within the past year.

- Similar to MCHC regional findings.
- More favorable than national findings.
- Satisfies the Healthy People 2020 target (49% or higher).

Child Has Visited a Dentist or Dental Clinic Within the Past Year

(Among Parents of Children 2-17)



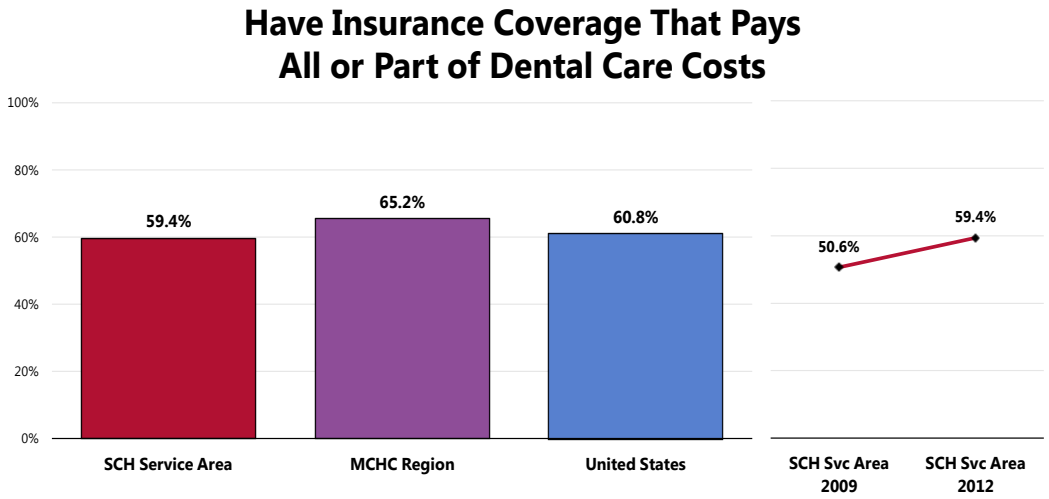
Sources:
- 2012 PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 137]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]

Notes:
- Asked of all respondents with children age 2 through 17.

Dental Insurance

A total of 59.4% of Swedish Covenant Hospital Service Area adults have dental insurance that covers all or part of their dental care costs.

- Less favorable than regional findings.
- Comparable to the US findings.
- Marks a significant increase since 2009.



Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 22]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Related Focus Group Findings: Oral Health

Many focus group participants are concerned with oral health in the community, with discussion centering around these issues:

- Regular or preventative dental care
- Uninsured
- Heartland International Health Center

Focus group participants believe that neglect of oral health can result in a significant decrease in a person's overall health. Attendees recognize the importance of **regular preventative dental care** but note that many residents face barriers in accessing dental treatment. Refugee residents may never have seen a dentist in their country of origin, so they face additional challenges to improving their oral health. One participant describes:

> *"We do see a lot of refugees coming through the dental program who have never seen a dentist in their life. And that still happens with people right here in the United States, but we've seen 23-year-olds going in for extractions and that is not cost effective or fair to them." — North Chicago Community Leader*

For those residents without **dental insurance**, many cannot afford basic care and "fall through the cracks." Only a limited number of dentists serve community members with

Medicaid insurance due to low reimbursement rates; upcoming Medicaid cuts will only cover emergency dental care.

The **Heartland International Health Center**, a federally qualified health center (FQHC), has two dentists on staff and oral health services available to the public, but the demand far surpasses the resources. In turn, waiting lists become extensive, as a participant explains:

> *"I think we are the only more consistently open resource that will theoretically take any patient, but that's a wonderful theory when we know how long our waiting lists get. So we always have to do a little bit of clinical triaging with our dental team and there's really no fair and great way to do it. But even if that worked well, which is a leap –I mean we all know Medicaid doesn't cover costs and that's particularly true in dental care, particularly as people age." — North Chicago Community Leader*

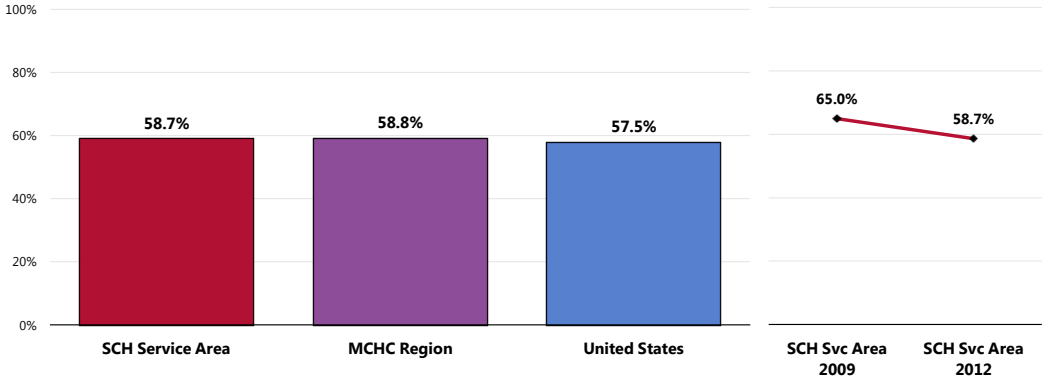
Vision Care

RELATED ISSUE:
See also *Vision & Hearing* in the **Deaths & Disease** section of this report.

A total of 58.7% of residents had an eye exam in the past two years during which their pupils were dilated.

- Nearly identical to regional findings.
- Statistically comparable to national findings.
- Comparable to the 2009 survey findings.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated



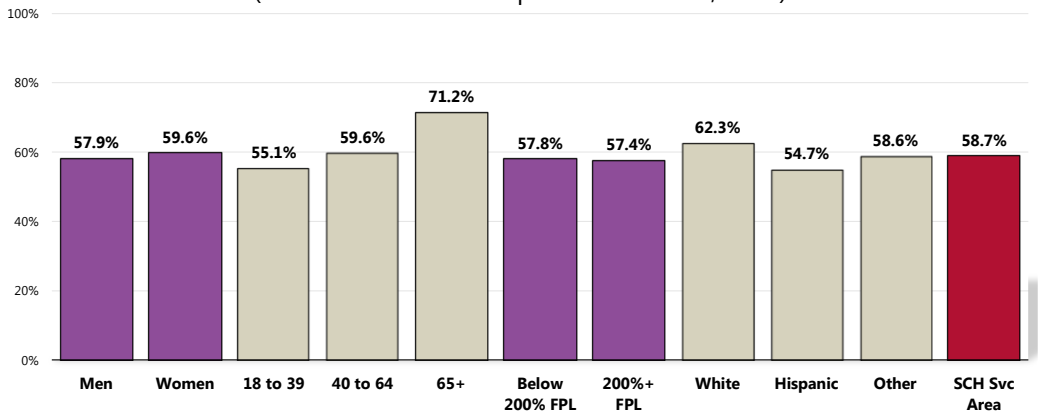
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 20]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Recent vision care in the Swedish Covenant Hospital Service Area is more often reported among:

- Residents age 40+, and especially seniors.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

(Swedish Covenant Hospital Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

HEALTH EDUCATION & OUTREACH

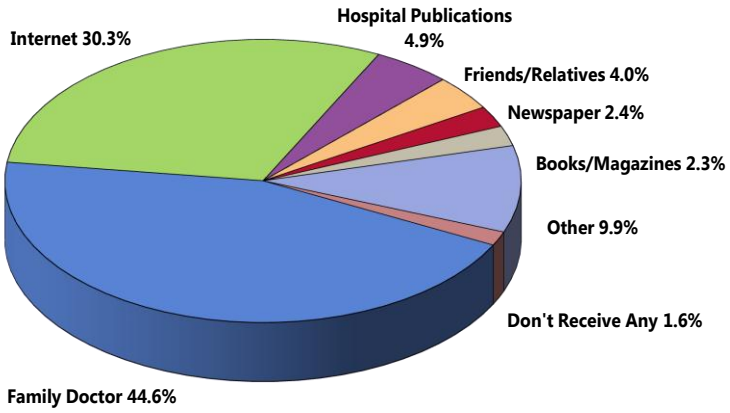
Healthcare Information Sources

Family physicians and the Internet are residents' primary sources of healthcare information.

- 44.6% of Swedish Covenant Hospital Service Area adults cited their **family physician** as their primary source of healthcare information.
- The **Internet** received the second-highest response, with 30.3%.
  - Other sources mentioned include hospital publications (4.9%), friends and relatives (4.0%), newspapers (2.4%) and books and magazines (2.3%).
- Just 1.6% of survey respondents say that they do not receive any healthcare information.

Primary Source of Healthcare Information

(Swedish Covenant Hospital Service Area, 2012)



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 127]
Notes: • Asked of all respondents.

Related Focus Group Findings: Education

Many focus group participants discussed education and prevention needs for the community, with discussing focused on:

- Prevention
- Health literacy
- Providing education where people live, work and play
- Employee wellness programs

Focus group participants agree that health education represents an important aspect of **prevention** and improving the overall health of community members. Attendees believe that Cook County residents suffer due to limited prevention programming and that prevention does not occur regularly due to minimal subsidies for those services. Agencies and providers must advocate for an upstream approach to healthcare. Focus group participants report that the current healthcare system enables people to be

'passive participants' and that this attitude must change in order to have healthy residents.

> *"Instead of finding some way to incentivize people to own some responsibility, we're almost rewarding them for not taking any responsibility by looking at all these ways that we will add more band aids to the situation. Now we'll come to your house and try to make sure you called your doctor and made an appointment and we'll drive you to the neighborhood clinic to try to convince you that you need a regular place to go for routine care so you don't end up in the emergency room. Are we really changing behaviors with some of these programs that we're exploring or are we just motivating them to continue to be passive participants in their own care?" — Swedish Covenant Hospital Representative*

Even though health education resources remain inadequate, many hospitals, schools, FQHCs, and faith-based organizations participate in education efforts. Participants believe that these organizations need to remain patient and persistent. Attendees stress that agencies cannot give up on the population; minority residents may need time to 'trust' the programs, as a participant explains:

> *"So often I see somebody try something once and if it's not well attended, so let's drop it…Poles are very suspicious of things that somebody's trying to do so the first attempt very often can be somebody's looking from a distance and asking others how was it and so on. If it's confirmed or it's repeated, then it's only a matter of time when they will find their way if they need it." — Key Informant Representing Polish Residents*

Another participant describes the mistrust which the Asian Indian community has toward health fairs:

> *"They do conduct health camps, but there again the complaint is that these health camps have been used as recruiting more patients by the organizers for the doctors rather than help the patient." — Key Informant Representing Asian Indian Residents*

Other health education programs struggle due to budget limitations. School-based clinics do their best to educate students, but funding is always a challenge:

> *"I'm going back to our school-based health centers and I think of all the wonderful work that our RNs do and that it's all prevention and education and keeping people out of the emergency departments. But nobody pays me for that. So you're constantly writing grants which are not sustainable and taking up time of mine where I could be doing something much more functional than continuing to write." — Cook County Community Leader*

Providing education where people live, work and play is critical to ensuring that education reaches the entire community. Minority populations may be transient, so identifying their movement and going to the population is critical. Agencies and providers must also recognize the diverse cultures and ethnicities in the community and provide programming in multiple languages, tailoring each message accordingly:

> *"You have individuals like this who just has walked in and probably born here and a very different style of thinking and traditions and approaches to things than my own, and my own is probably very different than a more recent immigrant from Poland like Monica. We for some reason often find common language but we don't necessarily follow the same groups or belong to the same groups…So this natural diversity, which is a beautiful thing, it may be a bit of a barrier and therefore somebody trying to approach the Polish community should be aware of it*

> *and maybe make sure that all kinds of segments of the community covered approached at the same time, or separately, but none is forgotten." — Cook County Community Leader*

A participant explains the challenge when it comes to communicating about healthy eating to the Asian Indian population, due to cultural diversity:

> *"You have vegetarian, non-vegetarian, lots of different religions, so you can't assume one kind of message is going to fit the whole population. Then I mean some of the strengths are the community is very family oriented and religion is a strength, like meditation and prayer, so those are positive things as well." — Key Informant Representing Asian Indian Residents*

Overall, **health literacy levels** remain low and urgently need to increase. Higher health literacy would help residents to realize the importance of preventative healthcare, medication management and healthy living. Health-literate residents would expect more out of their communication with physicians. In the meantime, agencies must provide materials in a variety of languages, at various reading levels, and/or through video.

> *"If there's a waiting area a friendly video translated into several languages playing over and over about education and awareness instead of written materials, which get thrown out into the trash can." — Key Informant Representing Hispanic Residents*

Participants also feel strongly that **employee wellness programs** can positively impact workers. In addition to better engagement at work, many wellness programs increase overall health and quality of life:

> *"So now there's a push to encourage employers to continue with the health prevention programs and not to look for a return on the investment per se but look for -- these are all jargon -- return on engagement, that what happens is because you offer this prevention in general your employees will feel more engaged even if they don't take advantage of the prevention services." — Cook County Community Leader*

Participation in Health Promotion Events

Educational and community-based programs play a key role in preventing disease and injury, improving health, and enhancing quality of life.

Health status and related-health behaviors are determined by influences at multiple levels: personal, organizational/institutional, environmental, and policy. Because significant and dynamic interrelationships exist among these different levels of health determinants, educational and community-based programs are most likely to succeed in improving health and wellness when they address influences at all levels and in a variety of environments/settings.

Education and community-based programs and strategies are designed to reach people outside of traditional healthcare settings. These settings may include schools, worksites, healthcare facilities, and/or communities.

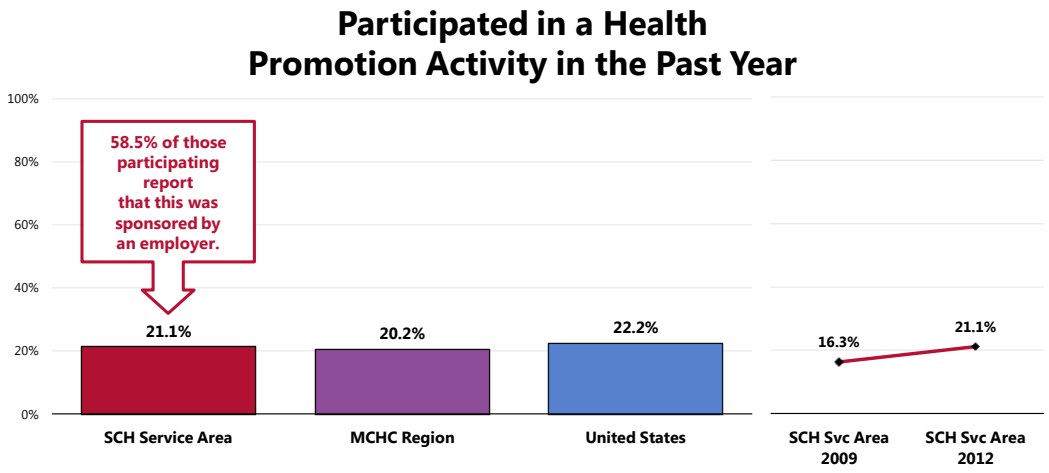
Using nontraditional settings can help encourage informal information sharing within communities through peer social interaction. Reaching out to people in different settings also allows for greater tailoring of health information and education.

Educational and community-based programs encourage and enhance health and wellness by educating communities on topics such as: chronic diseases; injury and violence prevention; mental illness/behavioral health; unintended pregnancy; oral health; tobacco use; substance abuse; nutrition; and obesity prevention.

– Healthy People 2020 (www.healthypeople.gov)

A total of 21.1% of Swedish Covenant Hospital Service Area adults participated in some type of organized health promotion activity in the past year, such as health fairs, health screenings, or seminars.

- Comparable to findings in the MCHC Region.
- Comparable to the national prevalence.
- Unchanged since the 2009 survey was conducted.
- Note that 58.5% of adults who participated in a health promotion activity in the past year indicate that it was sponsored by their employer.



Sources:
- PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 128-129]
- 2011 PRC National Health Survey, Professional Research Consultants, Inc.

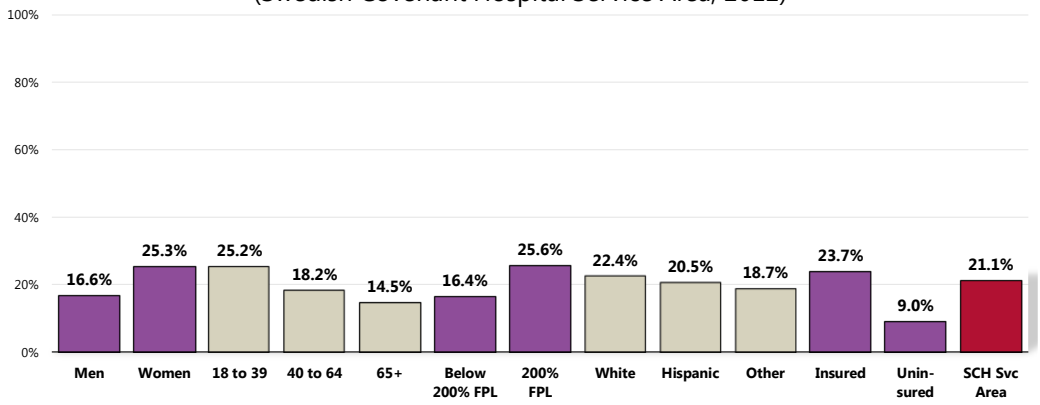
Notes:
- Asked of all respondents.

The following chart outlines participation by various demographic characteristics.

- Note that women, adults under 40, residents with higher incomes, and the insured more often report participation in health promotion activities.

Participated in a Health Promotion Activity in the Past Year

(Swedish Covenant Hospital Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 128]

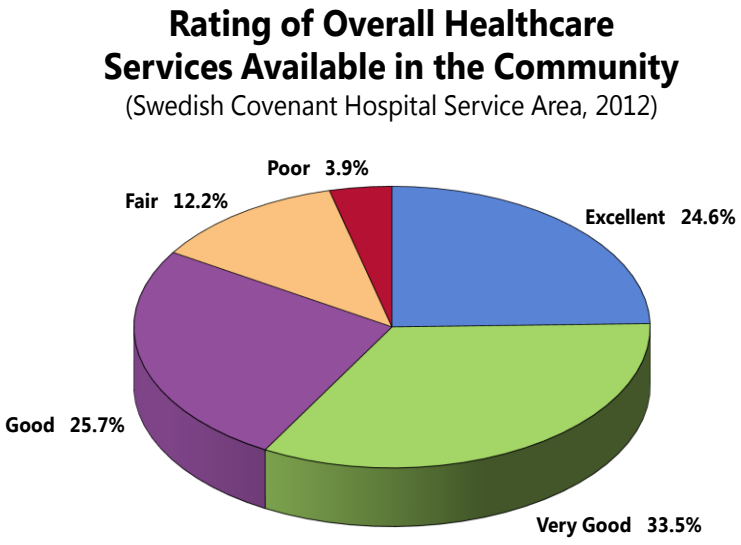
Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Below 200% FPL" includes households with incomes up to 199% of the federal poverty level; and "200%+ FPL" includes households with incomes at twice or more the federal poverty level.

LOCAL HEALTHCARE

Perceptions of Local Healthcare Services

More than one-half of Swedish Covenant Hospital Service Area adults (58.1%) rates the overall healthcare services available in their community as "excellent" or "very good."

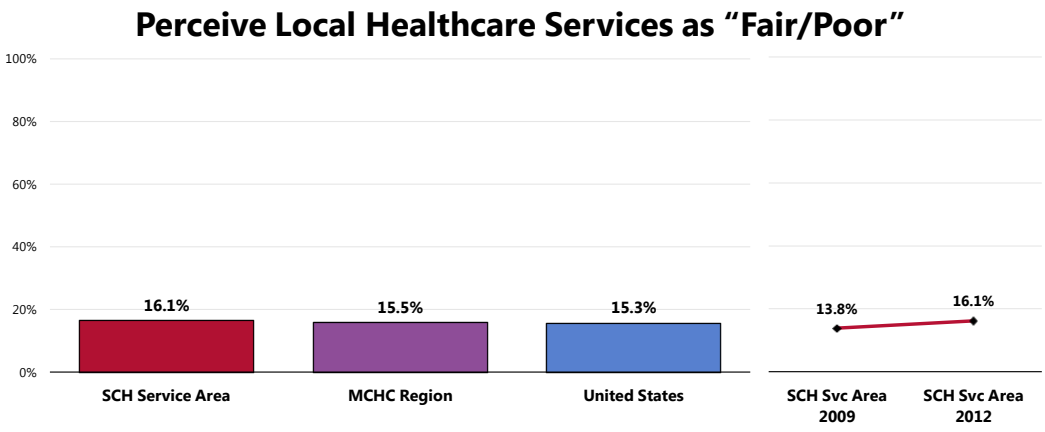
- Another 25.7% gave "good" ratings.



Sources: • 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
Notes: • Asked of all respondents.

However, 16.1% of residents characterize local healthcare services as "fair" or "poor."

- Similar to MCHC regional findings.
- Similar to the percentage reported nationally.
- Statistically similar to the 2009 findings.



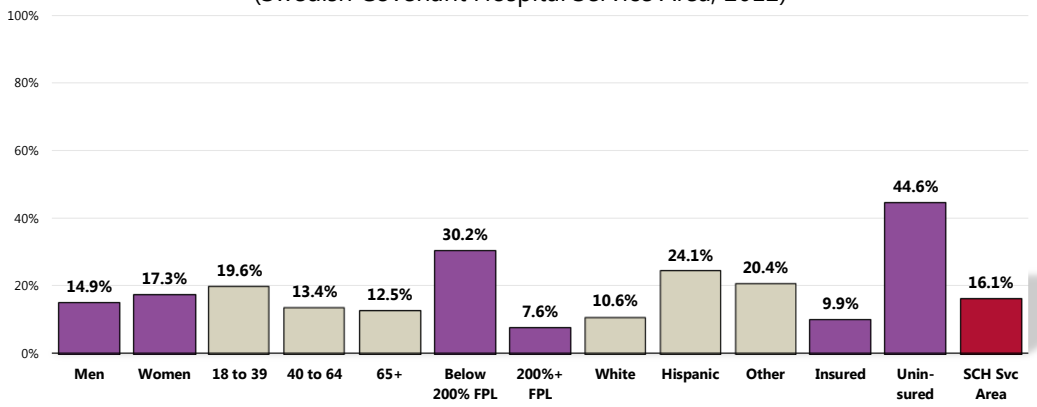
Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Item 6]
• 2011 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

The following residents are more critical of local healthcare services:

- Residents with lower incomes.
- Non-Whites.
- Uninsured adults (especially).

Perceive Local Healthcare Services as "Fair/Poor"

(Swedish Covenant Hospital Service Area, 2012)



Sources:
- 2012 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
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Other Issues

Related Focus Group Findings: Collaboration

Participants spent time discussing the varying degrees of collaboration occurring in the community between non-profit organizations, schools, healthcare providers and hospitals. The issues surrounding collaboration were:

- Cook County agencies:
    - Varying degrees of collaboration (Cook County)
    - Operation in silos
- North Chicago agencies:
    - Willingness to collaborate
    - Funding concerns
    - Desire to streamline collaborative efforts
    - Faith-based organizations
- Resource guide

Many of the focus group respondents agree that there are **varying degrees of collaboration** in **Cook County** as a whole, and that collaboration does not represent the norm. Historically, organizations in Cook County have **operated in silos** and do not communicate well (aside from non-profits). The status quo frustrates participants, believing that it is critical to connect primary care physicians with public health and for hospitals to coordinate care. However, with the reduction in state funding and with grant applications pushing coordination, attendees note that some collaborative efforts have begun:

> *"I mean I think that recent events have tended to create more pressures, opportunities in some cases to look at ways to partner and work together to address issues where it used to be one organization that could do it. As those resources are being cut back they're looking for partners to kind of continue meeting that need that's out there even if they can't do it within their own organization." — Cook County Community Leader*

Focus group participants agree that a willingness to collaborate exists among **North Chicago** organizations. Many local non-profit agencies collaborate well with one another and hold one another responsible, as one — Key Informant Representing Hispanic Residents explains:

> *"We'll (non-profits) work together for something particular… and we'll work as a team and report to each other and make ourselves accountable to each other, which make a big difference… So I think that the collaboration that I'm talking about has to be meaningful, honestly, and keep each other accountable. So that's the part of collaboration I meant, not just, 'Okay, give me a few seats for our families and thank you.' That's charity. I'm not talking about that." — Key Informant Representing Hispanic Residents*

Many local organizations operate under enormous time, turnover and financial pressures, limiting their capacity for collaboration. Participants consider informal networks and referrals to represent the most successful collaborative efforts. As one participant explains:

> *"I would say there's a great desire on behalf of most agencies. It seems to be the same agencies that you see at meetings. Resources are thin. I think that it's a lot of informal collaboration. Just thinking last night, I saw a patient at a shelter who had seen Teresa at Heartland that morning, who knew I was going to be there that night. And so we had this informal referral going around and we know, 'Oh, I know so-and-so is working here, I'm going to call them and see if there's a place over there where I can send.'" — North Chicago Community Leader*

Hospital partnerships are also crucial for many small non-profits; a participant explains how her agency relies upon its relationship with Swedish Covenant Hospital to further its mission:

> *"We're such a small organization that we can't do it all and we know we can't do it all, so partnership is key to everything that we do accomplish, and Swedish is a big part of that. We just started a new partnership at North Park Village with Korean American Community Services, Swedish Covenant Hospital, and Northeastern Illinois University and the athletic department to try to bring more services to seniors that will be beneficial to the 600 low-income seniors living at Park Village. So that's just like one recent example." North Chicago Community Leader*

Some grants requiring collaboration can act as catalysts to create or increase efforts. Attendees know that quality collaborations can be the most efficient use of resources. Participants agree that sometimes they are overburdened by the sheer number of meetings and if local organizations could **streamline their collaborative efforts**, so much more could be accomplished:

> *"For us, we kind of designate one person to go to all the meetings and then bring it all back and disseminate it to all the case managers. Because we do home visits, we're going out on the home visits. But the case managers have to be out doing the home visits; the doctors have to be seeing the patients. You know they don't have time to be out collaborating all the time unless you find that super champion that's out doing everything. But not everybody's a super person." — North Chicago Community Leader*

Attendees stress that **funding** affects agencies' ability and willingness to collaborate with other entities. Federal funds and grants may be limited in flexibility, and agencies cannot always geographically-define minority populations, hindering the ability for these agencies to easily obtain federal dollars. Focus group members recognize that low funding levels make it difficult for agencies to work together because agencies compete for the limited resources, as a participant describes:

> *"So we're looking at each other anymore not so much as partners but as competitors, and I think that does shift a little bit how we come to the table and talk about, okay, let's write this grant together and let's see how we can collaborate on that, but then if that means that we'll only get funding for two staff that means okay, you get one and I get one instead of what about the two being in my agency." North Chicago Community Leader*

Focus group attendees agree that local non-profits need to capitalize on relationships which the **faith-based organizations** have within the community. For some minority

populations, faith-based organizations already provide healthcare and support services to members, as a participant explains:

> *"I mentioned before a lot of the parishes and churches that are predominant in the Polish community, we have a lot of them. And I think that's actually the place out in the suburbs that tries to substitute for lack of nonprofit organizations or access to services. And for us, it's the churches are the places where access happens" — Key Informant Representing Polish Residents*

These established relationships between faith-based organizations and the community can create buy-in for local agencies that need to work on opening the lines of communication.

> *"In terms of partnering with congregations to share information to access, groups of people do health and wellness activities. I think congregations would be very open, a number of them would be very open to it." — North Chicago Community Leader*

Other focus group participants note that for the Asian Indian population, the sheer number and types of religions and faith-based organizations make them difficult to coordinate; local agencies must recognize these cultural divisions when working with their minority residents.

> *"Part of the reason why it's hard is unlike the African American community, the South Asian community go into the faith-based organizations as there's so many faith-based organizations and there's so many religious kind of factions to the group that it's hard to get together or get one or two faith-based organizations to kind of start representing. A lot of times there's a lot of divisions." — Key Informant Representing Asian Indian Residents*

Participants also see a need for a **resource guide**, some type of clearinghouse or system where agencies and residents can locate information about the current resources available. Group attendees believe that easy access to information and services will facilitate better access to care for the community members. One participant explains:

> *"I think a lot of it's we don't have the information at our fingertips and then it becomes a hassle to do it so we don't. In the last two years is when I finally found out about access clinics." — Cook County Community Leader*

Related Focus Group Findings: Senior Health

Many focus group participants discussed geriatric health concerns, focusing on these topics:

- Isolation
- A need for health advocates
- Cultural sensitivity

Focus group participants worry about the high levels of **isolation** which many seniors live with daily, especially during the winter months. Attendees perceive local neighborhoods to limit a senior citizen's ability to get around town because of restricted walkability options. Seniors may no longer drive, limiting their options for transportation. Some

may need to rely upon family members, but the family dynamics may have changed and seniors feel even more alone, as a participant describes:

> *"They depend heavily on their children. Then people when they don't get the attention they feel that they are neglected. Whenever everybody visits they, 'Oh, my son is not looking up to me. My daughter-in-law is treating me bad. She doesn't even speak to me.' The children have their own problems because they work eight, ten hours and then come and cook and all that and then finally are tired. They have no time for their parents and these seniors have all the time and they don't feel somebody is taking care of them." — Key Informant Representing Asian Indian Residents*

Other seniors may not ask for help because they do not want to be considered an encumbrance to their families, as a participant explains:

> *"For example, my father: he lives across the street at Covenant Home. He is 89. But for the longest time he didn't want to – for one thing, he didn't know about resources, and he didn't want to access any of them. 'Because he didn't want to be a burden.'" — North Chicago Community Leader*

Many seniors possess strong ties to their heritage and culture. Providers and social service agencies need to possess **cultural sensitivity** when working with the senior population, as one participant describes:

> *"So we have a vast, large scale of minorities. And often they're senior. There's this apathy, there's no interest I've noticed in seeking healthcare, or health and wellness. And part of that is truly cultural too. I know that in the Asian community, your orientation is to try to stay healthy. You eat more vegetables and what have you. And when you do get sick, you accept that. You know, that's your fate. And you don't resist it. You may want to seek treatment, but to an extent you don't resist the deterioration of your body or whatever. So we need that cultural sensitivity." — North Chicago Community Leader*

Focus group attendees agree that senior citizens are likely to experience a multitude of health conditions, including barriers like hearing or vision difficulties. In general, physicians do not have extra time to explain procedures or prescriptions to them; therefore, many seniors leave the office without a complete understanding of their medications. Participants agree that having a **health advocate** for this population would assist in comprehension and treatment adherence. Further, long-term use of health advocates could potentially result in lower hospitalization rates.

> *"They have a little bit of a hearing problem and the providers speak fast like me and soft, so the seniors can't hear. Nothing is given to them in writing to follow up. There isn't a chance to meet with somebody perhaps less expensive than the physician's specialist provider to really go through the visit to say, 'What just happened here and what questions do you have?' or beforehand to say what questions you have when you want to go in. I despair for the people who don't have somebody to accompany them on every visit and help them." — Cook County Community Leader*

Health advocates could also provide physicians with the 'big picture' of a senior's life. Some senior citizens may not communicate truthfully with physicians due to shame of their limited income and minimal support system. These geriatric patients may neglect to inform their physician that they cannot afford certain prescriptions, so residents self-

adjust medications, which can lead to negative health outcomes. An attendee describes a common situation:

> *"So when you go into the home, you're realizing that maybe they're taking something they're supposed to take twice a day and they're taking it once, three times a week, because they're hoping that will be enough to keep them well and it will make it last longer because they can't afford to refill it or it's clear that they're not filling their fridge or eating well because the money is going towards medication." — Swedish Covenant Hospital Representative*