Ann & Robert H. Lurie
Children's Hospital of Chicago®

2022
COMMUNITY HEALTH
Needs Assessment and 2023-2025 Implementation Strategy
for Chicago infants, children, youth and families

luriechildrens.org/chna

TABLE OF CONTENTS

EXECUTIVE SUMMARY

An essential part of Ann & Robert H. Lurie Children's Hospital of Chicago's mission is to advance health equity for all infants, children and youth. Every three years, we conduct a comprehensive Community Health Needs Assessment (CHNA) to inform our community health efforts. Based on our learnings from significant community input and an extensive analysis of key health and social metrics, we have developed a Community Health Implementation Strategy for 2023-2025 that prioritizes community health efforts for which Lurie Children's is uniquely positioned to have the most impact.

2022 CHNA Key Findings and Priority Areas

Nearly 30 percent of Chicagoans are under the age of 25 years. Eighty percent of Chicago's youth are Black, Hispanic/Latinx, Asian and other youth of color. Although it is racially and ethnically diverse, Chicago is also among the top five most segregated cities in the country. Therefore, throughout this report, we present data based on race and ethnicity, where available. We also highlight health disparities, which are rooted in social and structural inequities and were exacerbated by the interrelated pandemics of COVID-19, the youth mental health crisis and racism.

Faced with these challenges, Chicago communities have demonstrated tremendous resilience and a groundswell of grassroots leadership. Working in partnership with our communities, Lurie Children's is taking concrete steps to address the following key priority health areas:

Priority Area A: Social and structural influencers of health and access to care

- Communities emphasized that they need economic opportunity, stable housing, healthy foods, quality childcare and education, social cohesion and safe environments to be healthy.
- Communities prioritized an immediate need for holistic, integrated physical and mental healthcare and accessible, appropriate community programs and services.
- Life expectancy in Chicago dropped a full 2 years in 2020, with the most significant drop among Hispanic/Latinx and Black Chicagoans.
- Most Chicagoans under the age of 18 years have health insurance and less than 4 percent are uninsured. Despite this, inequities in cost, proximity, availability and quality of healthcare services are significant barriers to care.
- Although infant mortality overall in Chicago has been trending slightly downwards since 2000, Black infants continue to die at a rate three times higher than white infants.

Priority Area B: Chronic health conditions

- Chicago has been identified as an asthma epicenter with prevalence higher than state and national levels, specifically in the city's West and South Sides.
- One in 3 of Chicago's children and teenagers are overweight or have obesity, a number that has increased during the pandemic. Youth with obesity are more likely to experience severe asthma, type 2 diabetes, poorer disease control and overall poorer quality of life.
- Families and caregivers of youth with medical complexities report significant physical, emotional and financial challenges related to providing quality care at home.

Priority Area C: Mental and behavioral health

- In 2019, 39 percent of Chicago high school students reported experiencing symptoms of depression – a 125 percent increase since 2007. The pandemic exacerbated youth depression and anxiety, with estimates suggesting a doubling effect.
- The availability of mental and behavioral health preventative services and treatment is severely limited despite continuously rising rates of youth depression, anxiety and suicide attempts.
- In 2019, more than 30 percent of Chicago's high school students reported being offered, sold or given an illegal drug on school property.
- In 2019-2021, substance use related Emergency Department visits and hospitalizations for Black Chicago youth were up to 3 times as high as those of Hispanic/Latinx, white or Asian youth.

Priority Area D: Violence and Injury

- Firearm injuries are now the *single* leading cause of death for children and adolescents 0-19 years of age, with an 83 percent increase in youth firearm fatalities over the past decade.
- Black youth had an unprecedented 40 percent increase in firearm deaths between 2019 to 2020.
- Considered altogether, unintentional injuries remain the leading cause of death and disability for children and youth ages 0-24 years in the United States.

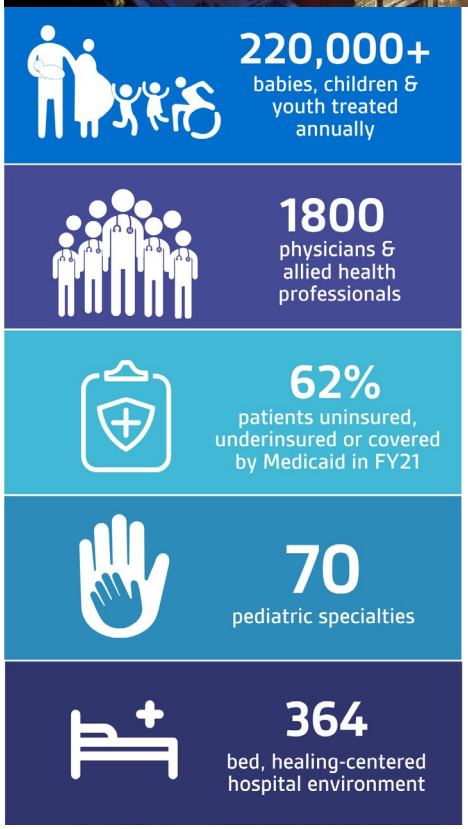
2023-2025 Community Health Implementation Strategy

Health equity is not possible when communities do not have access to the conditions and resources that enable them to live their healthiest lives. To address the priority health issues/areas we identified in our CHNA, Lurie Children's has developed an impact framework comprised of the following domains – each of which is essential to achieving health equity for youth:

- **EQUITABLE and INCLUSIVE CARE |** *Goal: Expand the availability and accessibility of physical, mental and behavioral health and social services closer to home for youth living in disinvested communities.*
- **EDUCATIONAL and ECONOMIC OPPORTUNITY |** *Goal: Foster educational and economic opportunities to help infants, children, youth and their families and communities thrive.*
- **SAFE and NURTURING SPACES |** *Goal: Cultivate safe, supportive and nurturing physical and social environments for youth where they live, learn and play.*

Across the three domains, we have identified 13 distinct strategies that address each of the priority areas listed above. This framework moves us towards an impact-focused, asset-based and inclusive approach to address the priority health issues of the populations we serve more holistically and comprehensively. Each of these domains and their associated goals are interconnected; for example, safe and nurturing learning environments are essential building blocks for future academic achievements and economic success.

The 2023-2025 Community Health Implementation Strategy will be facilitated, monitored and supported by the Patrick M. Magoon Institute for Healthy Communities, in collaboration with clinical divisions across Lurie Children's and community partners across Chicago.



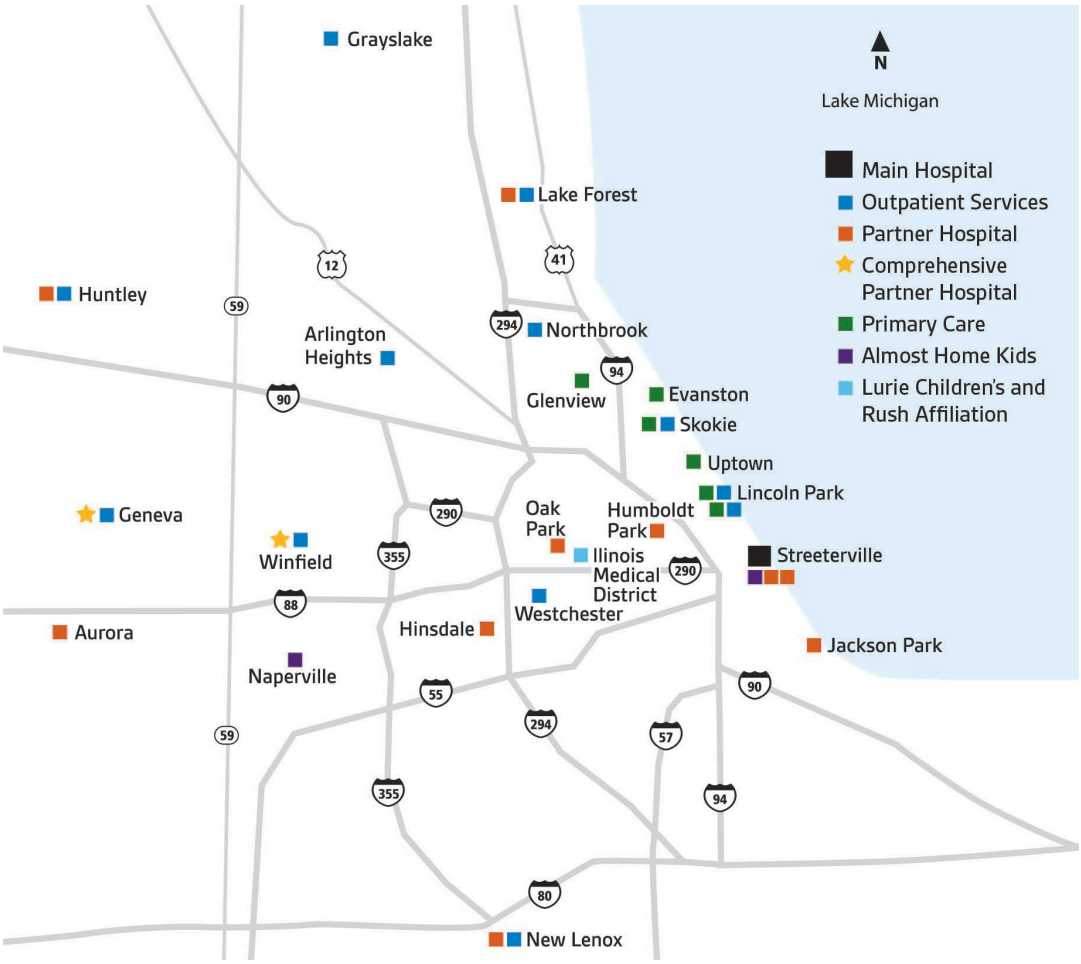
INTRODUCTION

About Lurie Children's

As the largest pediatric provider in the region and the top ranked children's hospital in Illinois, Ann & Robert H. Lurie Children's Hospital of Chicago (Lurie Children's) delivers exceptional family-centered care, conducts high-impact research, educates the next generation of pediatric providers and staunchly advocates for policies and practices that protect infants, children, adolescents and young adults.

Across Chicago and Illinois (Figure 1), we have 13 outpatient services locations, five primary care locations and 13 partner hospitals providing pediatric and adolescent care.

Figure 1. Lurie Children's locations across the Chicago metropolitan area.



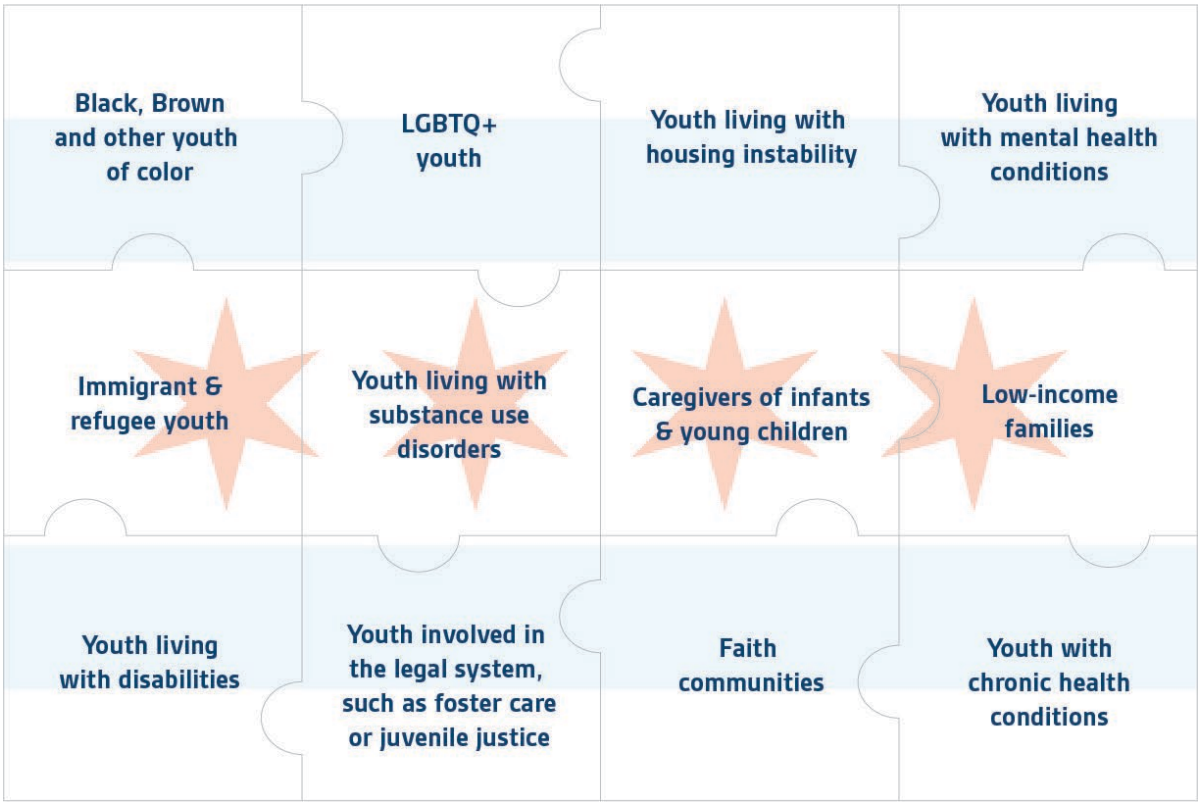
Purpose of Community Health Needs Assessment and Implementation Strategy

For 140 years, Lurie Children's mission has been to enhance the health and wellbeing of infants, children and youth. Recognizing the connection between community wellbeing and individual health, our experts have partnered closely with community-based organizations and leaders for decades to improve community health for youth and families. By linking clinical care with grassroots expertise, we are better able to develop evidence-based and community-informed health initiatives that reach youth and families where they live, learn and grow.

In accordance with the Affordable Care Act, Lurie Children's has completed a comprehensive Community Health Needs Assessment (CHNA) every three years since 2013. The CHNA is a systematic, data-driven, community-informed approach to identifying priority health needs in our service area and developing our community health strategy. Lurie Children's implements our community health strategy, including preventive care and population health initiatives, through the leadership, programs and activities of the Patrick M. Magoon Institute for Healthy Communities – the hub for all Lurie Children's community-focused initiatives.

To better understand the current health needs of the communities we serve and identify health priorities, Lurie Children's partnered with 30+ hospitals and health systems, seven local health departments and 100+ community-based organizations in Cook County, Illinois, through the Alliance for Health Equity, a membership collaborative led by the Illinois Public Health Institute (IPHI). Alliance for Health Equity partners collected primary data through community input surveys and focus groups with an emphasis on gathering input from communities that have been historically marginalized and systemically excluded from assessment and decision-making processes and who face an unequal burden of health inequities. Survey participants were 10 years old or older and focus group participants were 14 years old or older and represented a diverse range of ethnic, racial, religious, and socioeconomic backgrounds (Figure 2).

Figure 2. Examples of the communities and populations whose voices we sought to amplify in our community input survey and focus groups.



The resulting Collaborative CHNA Report, which provides data regarding the health status, behaviors and needs of Chicago and Cook County's adult and pediatric populations, is available here. Lurie Children's report presents the CHNA's findings that are specific to our service area as a pediatric hospital. It provides an overview of the current state of community health in Chicago and our community health priority areas of focus for fiscal year 2023-2025.

Advancing Health Equity

Overview of Health Inequities

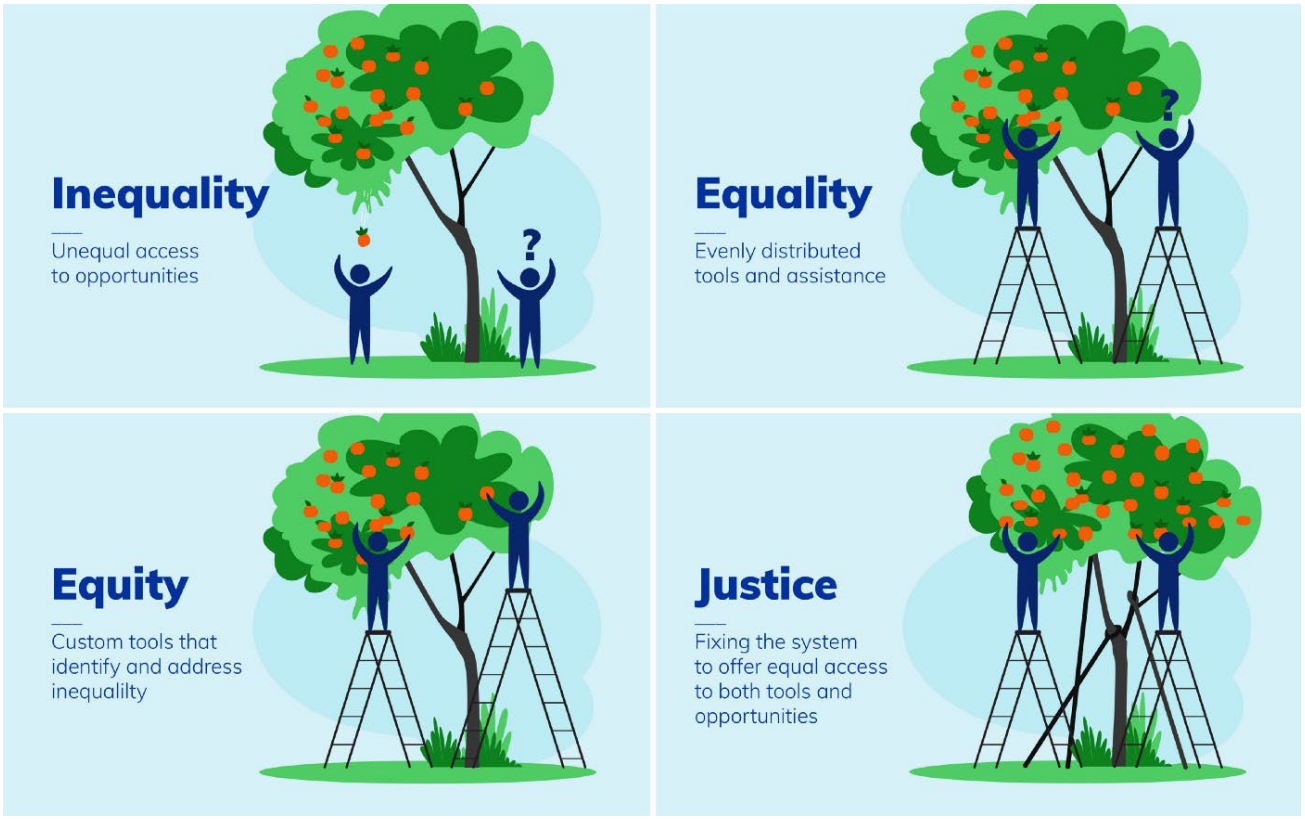
Health inequities are the differences in the burden of disease, mortality or distribution of risk or protective factors between different populations. [1] [2] Health inequities can exist across many dimensions such as race, ethnicity, gender, sexual orientation, age, disability status, socioeconomic status and geographic location. [1] [2] There are four overarching concepts that demonstrate the necessity of addressing health inequities:

1. **Inequities are unjust.** Health inequities result from the unjust distribution of the underlying influencers of health such as education, safe housing, access to healthcare and employment.
2. **Inequities affect everyone.** Conditions that lead to health disparities are detrimental to all members of society and lead to loss of income, lives and potential.
3. **Inequities are avoidable.** Many health inequities stem directly from government policies such as tax policy, business regulation, public benefits and healthcare funding and can therefore be addressed through policy interventions.
4. **Interventions to reduce health inequities are cost-effective.** Evidence-informed public health programs to reduce or prevent health inequities can be extremely cost effective particularly when compared to the financial burden of persistent disparities. [1] [2] [3]

Advancing Health Equity and Justice

Health equity is reached when race, ethnicity, gender, disability status and the other facets of our humanity no longer determine an individual or community's socioeconomic and health outcomes. [4] It is important to note that equality and equity are different. Health inequities involve more than simply unequal access to the resources needed to maintain or improve health. [4 5] True health justice will only be achieved when systems exist that offer equal access to both tools and opportunities (Figure 3).

Figure 3. Health equity involves more than providing equal access to resources needed to maintain or improve health. [170 169] (Adapted by Medium from Equity Series, Ruth, 2019)



Health Equity Priority Populations

Throughout this report, we present data based on race and ethnicity, where available and through mapping to focus on the geographic locations with the greatest health disparities. We also highlight health disparities among various groups that have experienced historic and ongoing discrimination and marginalization.

These are some of the same groups whose voices we sought to amplify in our community input. There are numerous examples of how different youth populations are impacted by systemic racism and discrimination and thus are highlighted in this report and are identified as priority populations for the subsequent strategies to address priority health issues:

- The most recent data from the Centers for Disease Control and Prevention illustrate substantial health disparities among the estimated 2.6 million LGBTQ+ youth nationwide. Many LGBTQ+ youth thrive during adolescence, but stigma, discrimination and other factors put them at increased risk for negative health and life outcomes. [6]
- Immigrants, particularly those who are undocumented, and refugees consistently experience poverty, food insecurity, housing instability, lack of educational opportunities and obstacles to accessing healthcare. [7] As with noncitizen adults, noncitizen infants, children and adolescents are more likely to lack health insurance coverage compared to their citizen counterparts. [8]
- Youth involved in the legal system, including foster care and the juvenile justice system, often face instability that can have significant effects on their physical, mental and emotional health and limit access to quality and comprehensive healthcare tailored to their unique needs. [9]
- Children with disabilities face significant barriers accessing care, including stigma, lack of financial resources, inaccessible facilities and lack of transportation. For those children with disabilities living in poverty, the additional financial burden often means poorer health outcomes. Children living with disabilities who are unable to navigate school can be deprived of an education. [10]
- Schools with primarily Black and Hispanic/Latinx students are more likely to be in areas with environmental risks such as air, water and noise pollution, and receive limited funding from the local income tax base. [11]
- Living in impoverished communities in childhood and adolescence has been shown to be a significant predictor of risk for chronic health issues, such as cardiovascular disease, diabetes and depression, in adulthood. [12]

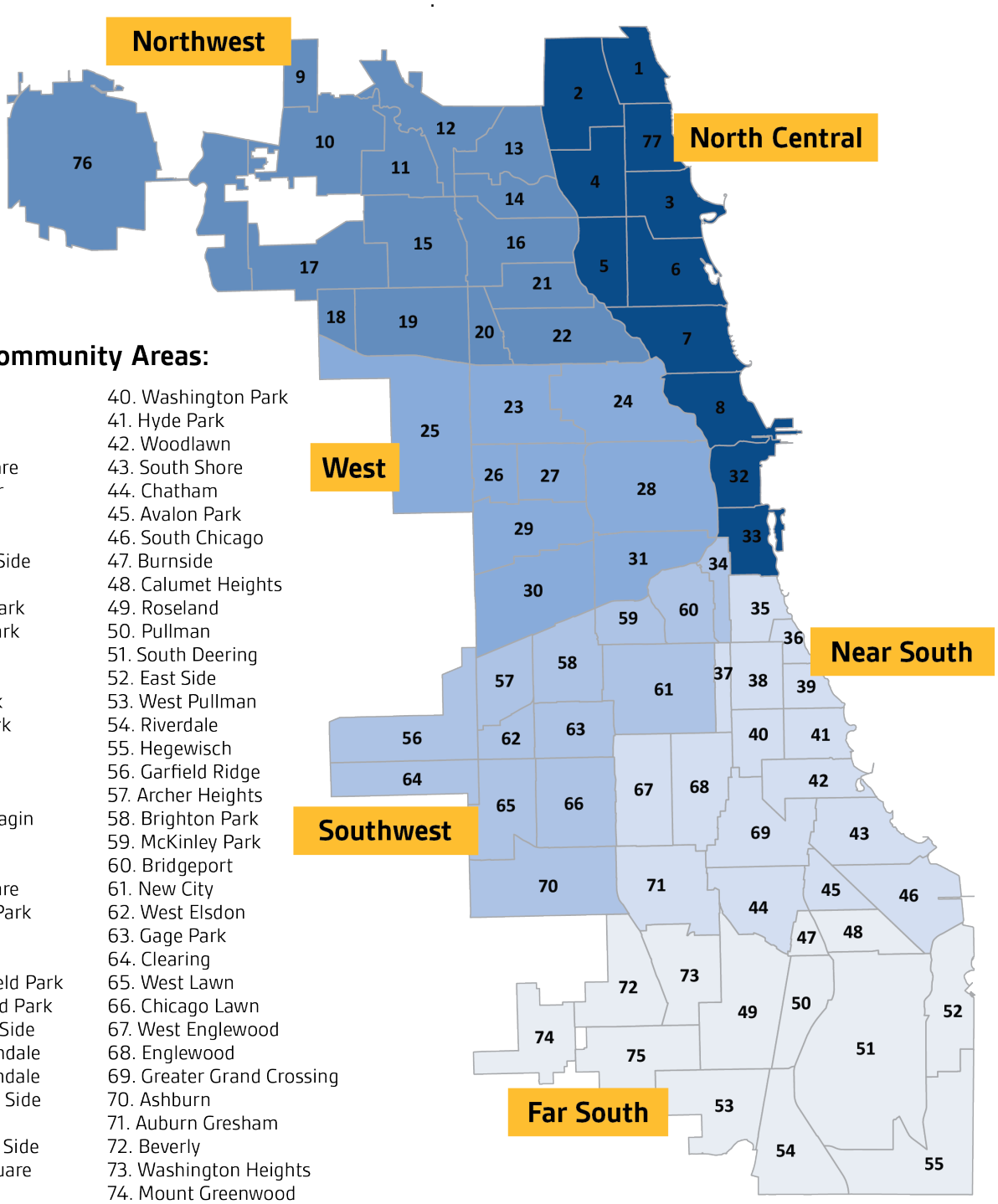
COMMUNITY HEALTH NEEDS ASSESSMENT

Lurie Children's Community

For the purposes of the assessment, we define our service area as the city of Chicago (Figure 4) and our priority population as infants, children, adolescents and young adults ages 0-24 years old.

Lurie Children's patients and families live in every state in the United States and over 50 countries across the world. However, the highest volume of patients is from our very own community, with over 40 percent living in Chicago. Of those, 38 percent live in neighborhoods that have experienced historic disinvestment.

Figure 4. City of Chicago's 77 community areas.



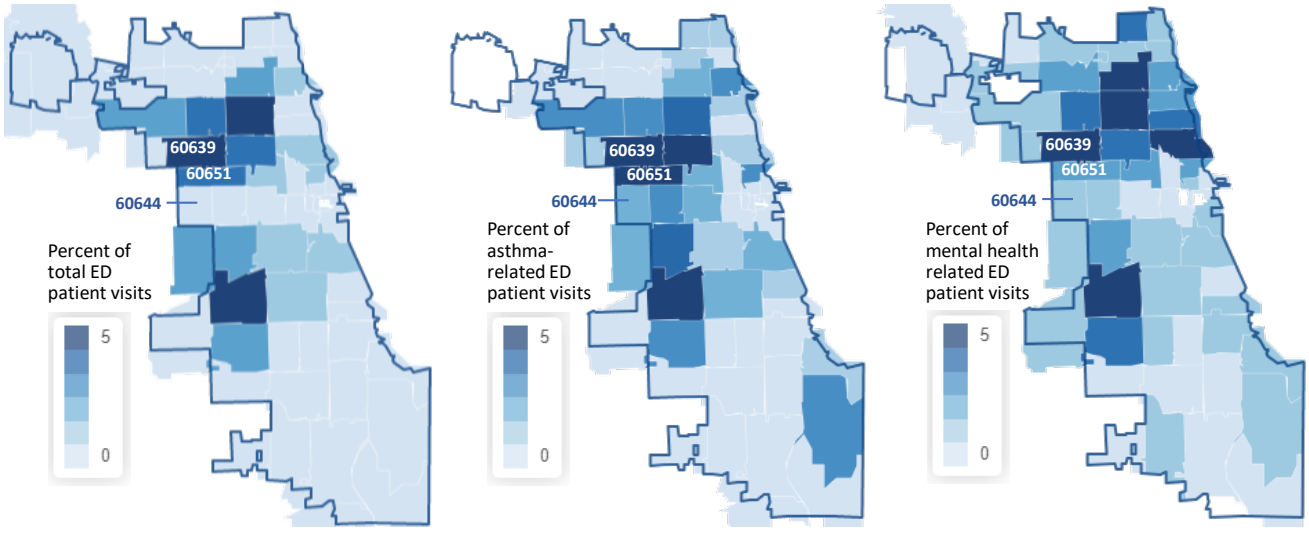
Chicago Community Areas:

1. Rogers Park
2. West Ridge
3. Uptown
4. Lincoln Square
5. North Center
6. Lake View
7. Lincoln Park
8. Near North Side
9. Edison Park
10. Norwood Park
11. Jefferson Park
12. Forest Glen
13. North Park
14. Albany Park
15. Portage Park
16. Irving Park
17. Dunning
18. Montclare
19. Belmont Cragin
20. Hermosa
21. Avondale
22. Logan Square
23. Humboldt Park
24. West Town
25. Austin
26. West Garfield Park
27. East Garfield Park
28. Near West Side
29. North Lawndale
30. South Lawndale
31. Lower West Side
32. (The) Loop
33. Near South Side
34. Armour Square
35. Douglas
36. Oakland
37. Fuller Park
38. Grand Boulevard
39. Kenwood
40. Washington Park
41. Hyde Park
42. Woodlawn
43. South Shore
44. Chatham
45. Avalon Park
46. South Chicago
47. Burnside
48. Calumet Heights
49. Roseland
50. Pullman
51. South Deering
52. East Side
53. West Pullman
54. Riverdale
55. Hegewisch
56. Garfield Ridge
57. Archer Heights
58. Brighton Park
59. McKinley Park
60. Bridgeport
61. New City
62. West Elsdon
63. Gage Park
64. Clearing
65. West Lawn
66. Chicago Lawn
67. West Englewood
68. Englewood
69. Greater Grand Crossing
70. Ashburn
71. Auburn Gresham
72. Beverly
73. Washington Heights
74. Mount Greenwood
75. Morgan Park
76. O'Hare
77. Edgewater

Annually, Lurie Children's provides healthcare services, from primary care to subspecialty care, to over 150,000 youth from birth to 18 years of age. We also serve over 10,000 young adults (ages 18-24) as they transition to adult care. In FY21, 36 percent of Chicago patients 0 to 24 years of age identified their race as white, 15 percent identified as Black, 6 percent identified as Asian and 42 percent identified as other or unknown. Additionally, 36 percent of those same patients identified their ethnicity as Hispanic/Latinx.

Within Chicago, our community health efforts focus on communities experiencing disinvestment and populations that have been historically marginalized, particularly those communities from which we serve a high volume of patients. In 2019, using Lurie Children's deidentified patient data, including emergency department (ED) visits, asthma, potential child maltreatment referrals and mental health care waitlists, we identified ZIP code 60639, which includes the Chicago community areas of Austin, Belmont Cragin and Hermosa, as the neighborhoods that accounted for our largest patient volumes at that time. The percent of ED patient volumes remain consistently higher in these communities (Figure 5). We launched an intensive and collaborative initiative focused on these communities to expand care, services and programming in 2019. This long-term commitment continues and has expanded to surrounding ZIP codes included in those communities.

Figure 5. Percent of Lurie Children's Emergency Department patient volumes by ZIP code, total (left), asthma-related (middle) and mental health related (right) among patients 0 to 25 years. (Lurie Children's, 2021)

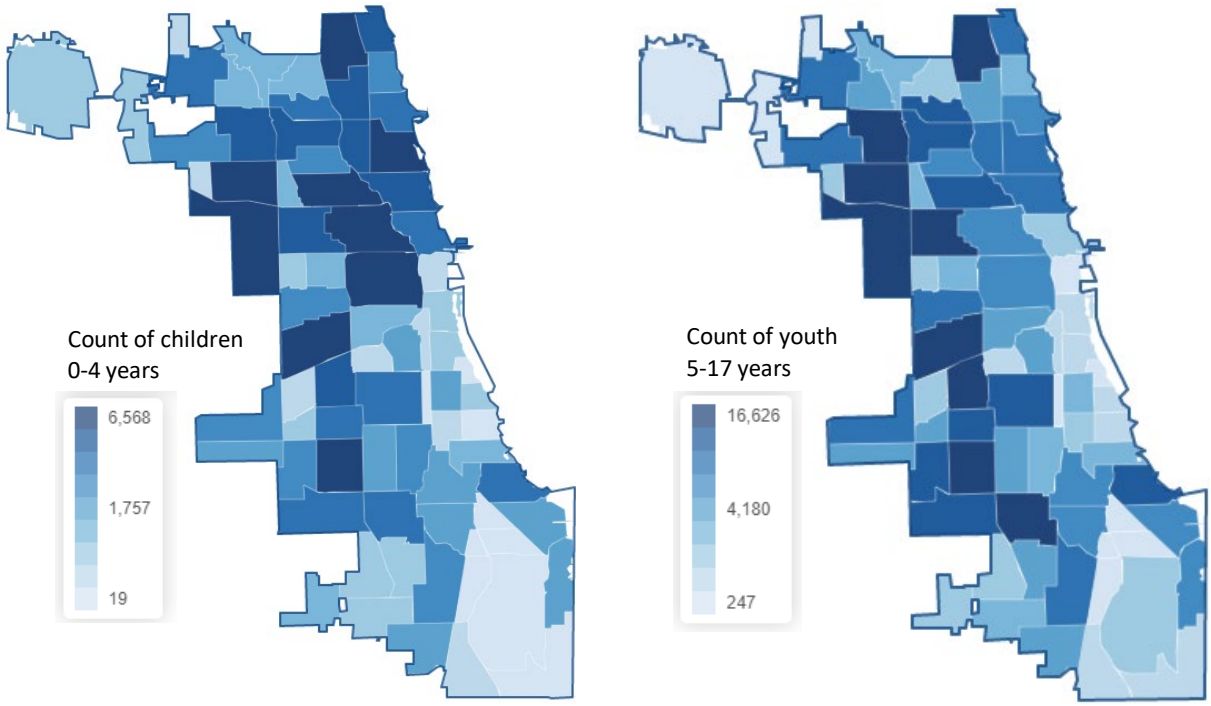


Note: Darkest blue comprise 5 percent or more of ED visits

Chicago's Youth

Chicago is home to 2.7 million people, 20 percent of whom are under the age of 18 and nearly 10 percent are young adults ages 18-24. [13] In Figure 6, the community areas in the darkest blue are home to nearly 30 percent of Chicago's youth with over 150,000 youth living in 10 community areas: Austin, West Ridge, Belmont Cragin, South Lawndale (Little Village), Humboldt Park, Chicago Lawn, Portage Park, Logan Square, Brighton Park and Lake View.

Figure 6. Count of pediatric and adolescent population 0-4 years (left) and 5-17 years (right) by Chicago community area. (American Community Survey, 2016-2020, 5-year estimates)



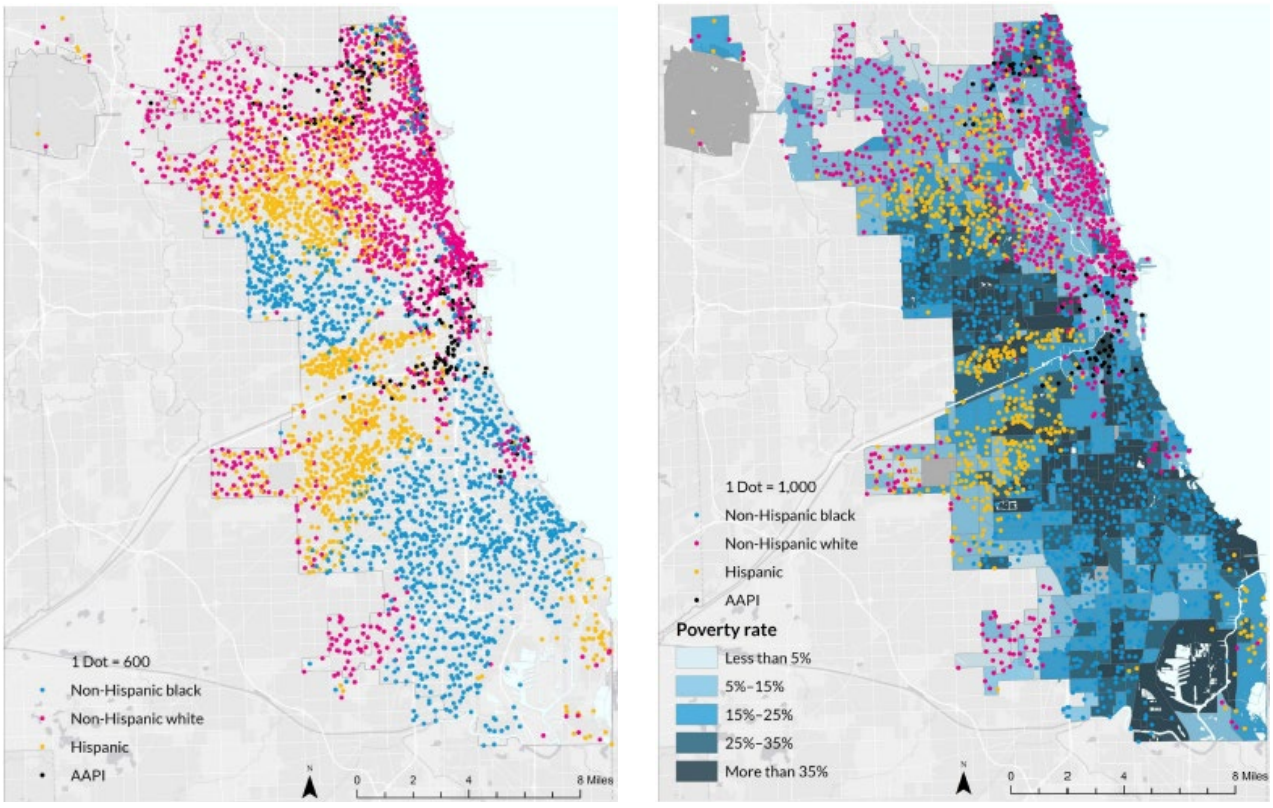
There are over one million households in Chicago, over half of which are families with an average family size of three people. Of those families, one in four include youth under the age of 18. [13] There are many types of families across Chicago. Married couples are heads of households with youth at almost twice the rate of single parent households (13 percent of total households compared to 7 percent). Over 10 percent of children and adolescents live in multigenerational homes, about one and half times higher than Illinois (7 percent) and the U.S. (8 percent). [14] Of those Chicago households, over 17,000 grandparents are responsible for the care of their grandchildren. [14]

Race and Ethnicity

Race and ethnicity are social constructs that have profound effects on the lives of individuals and communities. Racial and ethnic health inequities have persisted over time in the United States [2] and are directly linked to racism. Racism structures opportunity and assigns value based on how a person looks resulting in conditions that unfairly advantage some and unfairly disadvantage others. [15] Racism and other forms of discrimination diminish the overall health of our nation by denying some people the opportunity to attain their highest level of health. [15] In addition, racism can be traumatic to the individuals and communities that are routinely exposed to it, thus causing and exacerbating health inequities.

Chicago is one of the country's most diverse cities. Our population is split into almost equal thirds of Black, Hispanic/Latinx and white residents and more than 35 percent of Chicagoans speak a language other than English at home, with Spanish, Polish, Arabic, Tagalog and Chinese being the most popular. [14] However, Chicago's high levels of diversity do not equate to low segregation; in fact, Chicago is among the most segregated cities in the United States, with rates similar to cities like Detroit, Cleveland, Milwaukee, Philadelphia and Trenton. [16] Figure 7 illustrates this extreme segregation with Black and Hispanic/Latinx Chicagoans primarily residing on the West and South Sides and white Chicagoans clustered on the North Side. This figure also overlays the poverty rate, illustrating the connection between racial and ethnic segregation and poverty that results from discriminatory housing, economic and urban development practices and policies, among others. [17]

Figure 7. Population distribution of Chicagoans by race or ethnicity (left) and overlayed with poverty rates (right). (Theodos et al., 2019) [17]



The longtime racial and ethnic diversity has lent itself to the cultural richness of the city, yet the historic marginalization and systemic exclusion continues to impact Chicago's Black and Hispanic/Latinx communities in countless ways. For example:

- Due to structural and historical racism, Black and Hispanic/Latinx households disproportionately experience poverty and homelessness. In 2019, an estimated 34,125 Black Chicagoans and 14,491 Hispanic/Latinx Chicagoans experienced homelessness. In total, 81 percent (33,525) of people temporarily staying with others identified as Black and/or Hispanic/Latinx. [18]
- Racial and economic segregation are closely tied to violence. Chicago neighborhoods with high rates of poverty have consistently had homicide rates that are three to five times as high as lower-poverty neighborhoods. The most severe disparities in community violence map onto racial segregation and poverty within the city. Violence has been concentrated in predominantly Black neighborhoods of Chicago and the level of violence in Black communities in 2020 was higher than at any other point since 1965. [19]
- In Chicago neighborhoods with high rates of poverty and violence, nearly 20 percent of infants are born with low birthweight; comparable to rates of the world's poorest nations, including Ethiopia (20 percent), Chad (20 percent), Nigeria (15 percent), and Benin (15 percent). [20]
- The unemployment rate for Black workers in Chicago is 16 percent compared to 4 percent for white workers. [14] Lower-income and high unemployment impacts access to insurance, access to healthcare, access to mental health services, access to college education and contributes to chronic stress and poor health.

Figure 8 shows the breakdown of Chicago's population by race and ethnicity. In 2020, the U.S. Census Bureau estimated that 33 percent of Chicagoans identify as non-Hispanic white, 29 percent non-Hispanic Black/African American, 29 percent Hispanic/Latinx and 7 percent Asian or Pacific Islander. The population of Chicago youth is notably different with the largest proportion of youth age 0-17 years being Hispanic/Latinx, followed by non-Hispanic Black/African American, Non-Hispanic white and Asian or Pacific Islander.

Figure 8. Race and ethnicity among all Chicagoans (left) and youth 0-17 years old (right). (American Community Survey, 5-year estimates, 2016-2020)

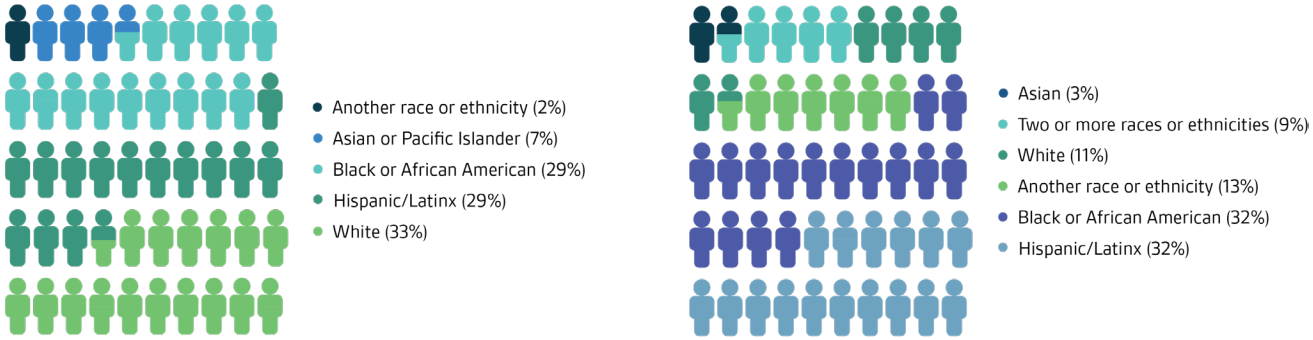
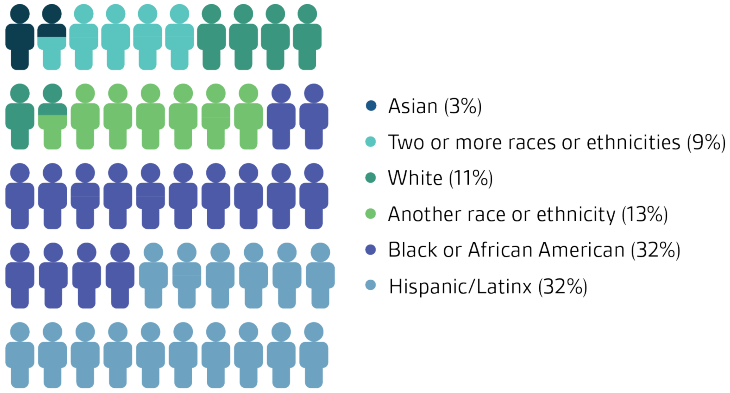


Figure 9. Race and ethnicity among Chicagoans under 18 years old with a disability. (American Community Survey, 5-years estimates, 2016-2020)



An estimated one out of every ten Chicagoans has a disability. For youth, the estimates are lower, with approximately 3 percent (17,000+) of Chicagoans under the age of 18 having a disability. Disparities exist within this group; as can be seen in Figure 9, Black and Hispanic/Latinx youth in Chicago experience disability at a rate three times higher than white youth. Over 60 percent (330,000+) of Chicago youth are enrolled in Chicago Public Schools (CPS) and more than 14 percent (48,000+) of CPS students receive special education and related services to address a variety of needs including visual and hearing impairments, cognitive impairments, learning disabilities and other disabilities. [21]

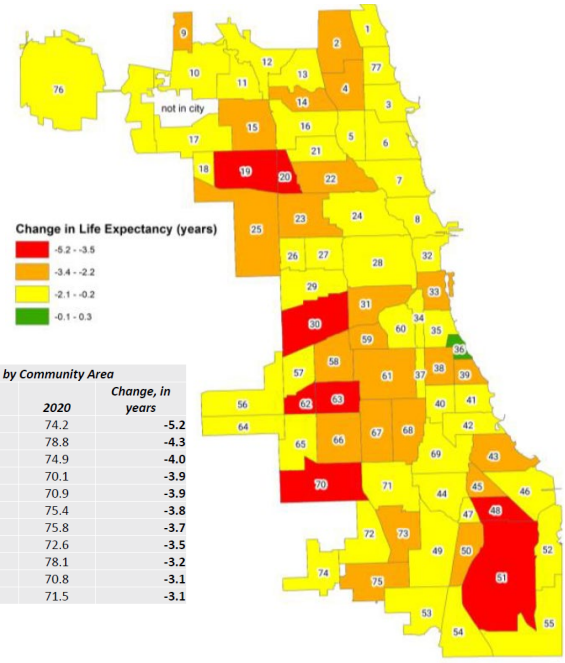
Life Expectancy

The inequitable distribution of resources across Chicago's neighborhoods results in vastly different quality of life and health outcomes for the city's Black, Hispanic/Latinx and white communities. For example, before the COVID-19 pandemic, there was a ten-year difference in life expectancy between Black Chicagoans and non-Black Chicagoans. [22] Hispanic/Latinx Chicagoans, who were once among the groups with the highest life expectancy in Chicago, have lost over seven years of their expected length of life since 2012. [22] After the first year of the COVID-19 pandemic, overall life expectancy in Chicago dropped two years (from 77 to 75), with the most significant drop from Hispanic/Latinx Chicagoans (3.2 years). [23]

Of Chicago's 77 community areas, 76 saw a decrease in life expectancy from 2019 to 2020, 12 of which – all on the South and West Sides – experienced a decrease of more than three years (Figure 10). [23] The number of community areas with a life expectancy of less than 70 years almost tripled during the first year of the pandemic, from four in 2019 to 11 in 2020. All 11 of those community areas have a predominantly Black population and very high levels of economic hardship. [22]

It is important to note that, while the pandemic significantly worsened the inequities in life expectancy, they existed well before the pandemic. [22] According to 2010-2015 data, there was a 30-year life expectancy gap between Near North Side, specifically where Lurie Children's main hospital is located, and Englewood, which is just nine miles south. [24] This was not only the widest gap in Chicago, but the widest gap in the country. [23]

Figure 10. Change in life expectancy by Chicago community area, 2019 to 2020. (IDPH Vital Records as analyzed by CDPH Office of Epidemiology)



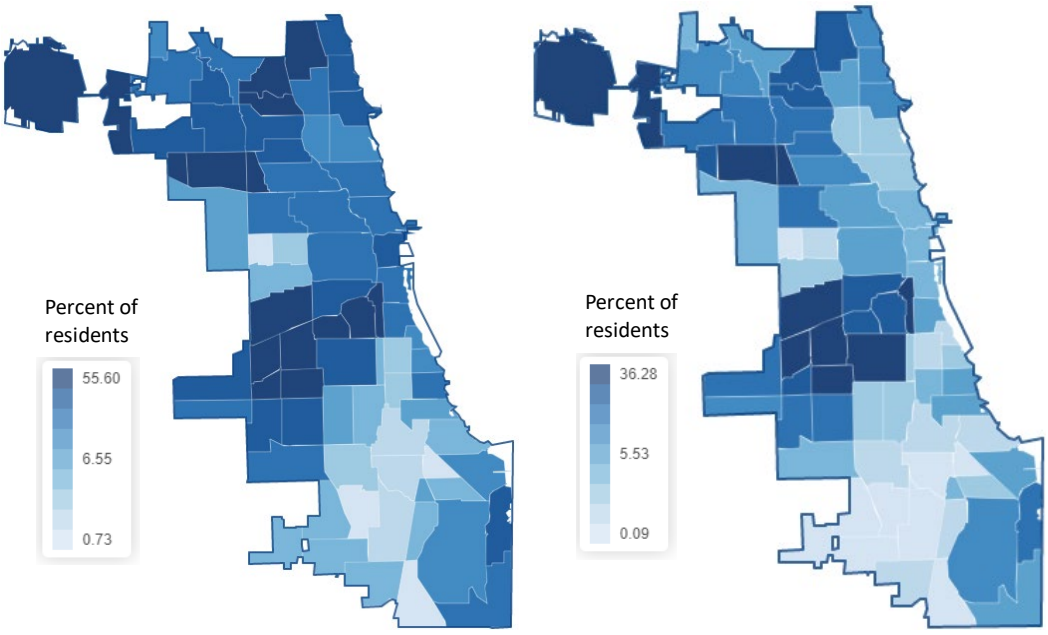
Top 10 Decreases by Community Area

Community Area	*2019*	*2020*	*Change, in years*
Gage Park	79.5	74.2	-5.2
West Elsdon	83.1	78.8	-4.3
South Lawndale	78.9	74.9	-4.0
South Deering	74.0	70.1	-3.9
Calumet Heights	74.8	70.9	-3.9
Belmont Cragin	79.2	75.4	-3.8
Hermosa	79.5	75.8	-3.7
Ashburn	76.1	72.6	-3.5
Logan Square	81.3	78.1	-3.2
Grand Boulevard	73.9	70.8	-3.1
Avalon Park	74.6	71.5	-3.1

Immigration and Refugees

More than 20 percent of Chicagoans were born outside the U.S. (Figure 11), which is over one and a half times higher than the state and national averages. In some Chicago community areas, as many as half the residents are foreign-born with 8 percent of Chicago households have limited English proficiency, meaning no household member 14 years old or older speaks English "very well." Chicago community areas with high proportions of immigrants are often the same communities with higher proportions of limited English proficiency. Such communities include Belmont Cragin, Hermosa, South Lawndale (Little Village) and Lower West Side (Pilsen), where Spanish is the primary language spoken, and Armour Square, Bridgeport and McKinley Park, where Asian languages (e.g., Chinese, Japanese, Tagalog) are primarily spoken.

Figure 11. Percent of Chicago residents who were born outside the U.S. (left) and percent of households with limited English proficiency (right). (American Community Survey, 5-year estimates, 2016-2020)



There are over 400,000 immigrants without documentation in Illinois, 4 percent under the age of 16 years and 13 percent ages 16-24. [25] The most recent estimates approximate that nearly 170,000 residents, 30 percent of the city's immigrant population, do not have immigration documentation. [26] The City of Chicago welcomes immigrants as a "Sanctuary City" codified in the Welcoming City Ordinance, which ensures that residents will not be denied services based on their immigration status, nor will the City assist U.S. Immigration and Customs Enforcement in the deportation of people without immigration documentation.

The Deferred Action for Childhood Arrivals (DACA) program was enacted 10 years ago in 2012 and protects those who came to the U.S. as children from deportation and provides a work permit. This protected status must be renewed every two years. At the end of 2021, nearly 32,000 DACA recipients lived in Illinois [27], with an estimated 48,000 residents eligible. [28] In 2021, a federal court in Texas ruled the DACA program unlawful but allowed the program to continue renewing recipients. New applicants can submit their applications, while this case is appealed, but the U.S. Citizenship and Immigration Services will not process these new applications – essentially putting a hold on new applications. [29] DACA has been successful in improving the mental health [30] and economic wellbeing [31] of DACA-eligible immigrants, but the future is uncertain with the ongoing court challenges and legislative inaction.

In early 2022, over 100 million people worldwide were forced from their homes due to global conflicts, violence and human rights abuses – the highest on record. [32] UNICEF estimates that 36.5 million children have been displaced with the number of child refugees increasing 132 percent between 2010 and 2021. [33] Refugees have protected status under special humanitarian concerns and are unable to return to their home countries because they fear persecution for reasons of race, religion, nationality, membership in a

particular social group or political opinion. In 2016, refugees comprised an estimated 4.5 percent of Chicago's foreign-born population. [26] Since 2002, over 30,000 refugees have settled in Chicago and the surrounding suburbs. [34] Most recently, Chicago has welcomed between 1,800 to 3,000 refugees from Afghanistan since 2021. [35]

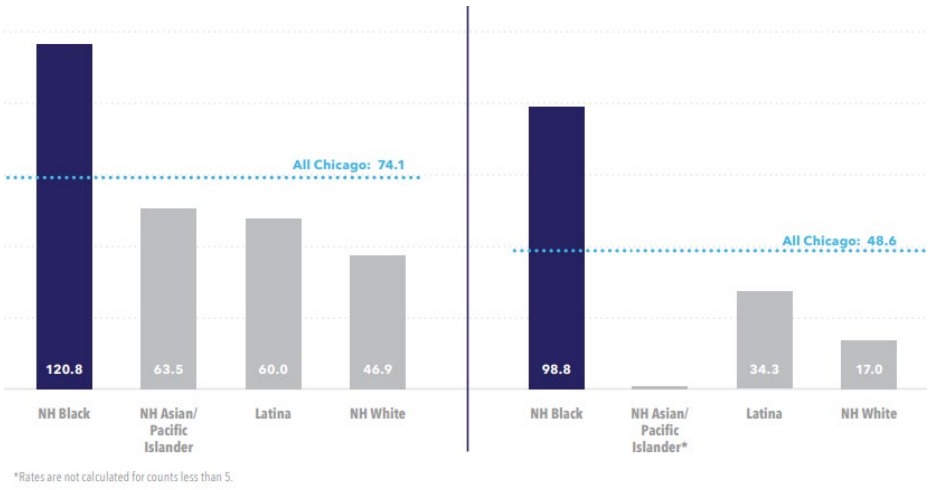
Maternal Health and Infant Mortality

Maternal health encompasses the health of birthing persons during pregnancy, childbirth and the post-partum period and is inextricably linked to newborn and infant health. Most maternal deaths are preventable, as the healthcare solutions to prevent or manage complications are well known. All birthing persons need access to high-quality care in pregnancy, and during and after childbirth. [36] Despite spending two and a half times more per person on healthcare compared to the Organization for Economic Co-operation and Development (OECD) average, the maternal mortality rate in the U.S. is 24 deaths per 100,000 live births, more than double that of other high-income countries. [37] In fact, the U.S. is one of only 13 countries in the world where the maternal mortality rate is worse now than it was 25 years ago, and it is the only industrialized country with a rising maternal mortality rate. [38]

There are several key differences between the U.S. and other high-income countries in preventing maternal mortality. The U.S. has an overall shortage of maternity care providers relative to the number of births. In addition, access to home visits after delivery vary in the U.S. but are guaranteed in other countries. The U.S. is also the only high-income country that does not guarantee paid leave after childbirth. And, with the U.S. Supreme Court's recent overturning of Roe v. Wade and the constitutional right to abortion care, reproductive health equity and maternal health experts predict an increase in pregnancy-related deaths. [38] [39] [40] [41]

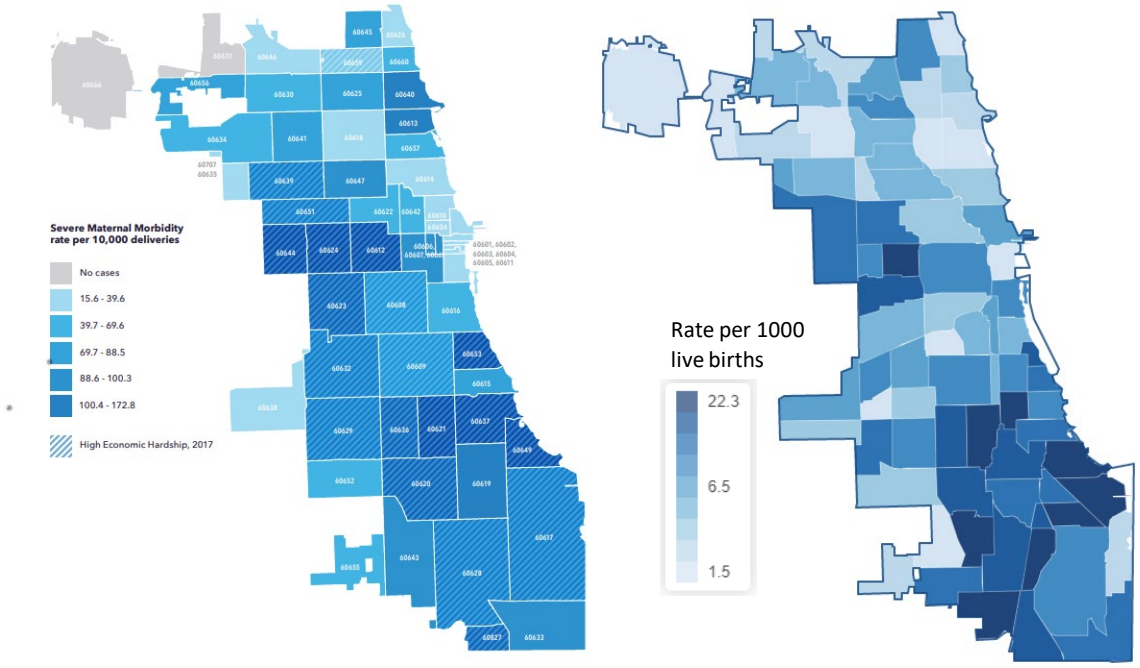
Between 2016-2017, the most recent data available, the Chicago rate of severe maternal morbidity was 74 per 10,000 deliveries (Figure 12). Severe maternal morbidity includes a collection of diagnoses and procedures occurring at the time of delivery likely to cause adverse health consequences for the birthing person. Figure X illustrates pregnancy-related mortality in Chicago with the average of 49 deaths per 100,000 births. This includes deaths during pregnancy or within the first year after pregnancy. Black Chicagoans carry a disproportionate burden of severe morbidity and mortality with morbidity rates more than 2.5 times higher than white Chicagoans and nearly six times higher mortality. [42]

Figure 12. Severe maternal morbidity rate per 10,000 deliveries in Chicago, 2016-2017 (right) and pregnancy-associated mortality ratio per 100,000 births, 2011-2016 (left). (Chicago Department of Public Health) [42]



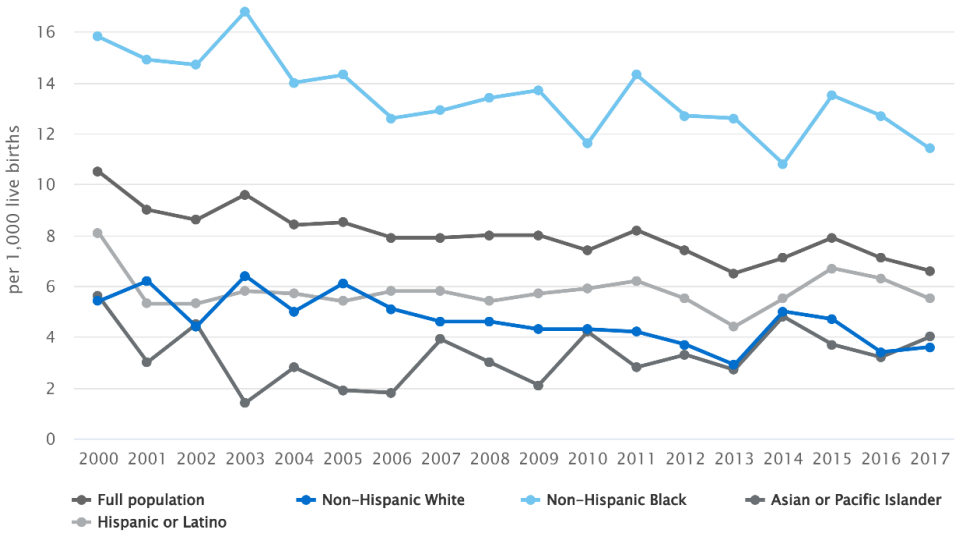
Birthing people from communities with the highest economic hardships experience the highest rates of maternal morbidity (91.5 per 10,000 deliveries). [42] These communities are predominately on the South and West Sides of the city (Figure 13). Infant mortality is also higher in communities with higher economic hardship (Figure 13).

Figure 13. Severe maternal morbidity by ZIP code and high economic hardship, 2016-2017 (left) and infant mortality rates per 1,000 live births by Chicago community area, 2013-2017 (right). (Chicago Department of Public Health) [165]



Like maternal morbidity and mortality, racial disparities are also evident in infant mortality. Overall infant mortality in Chicago has been trending slightly down since 2000; however, infant mortality for Black infants has remained significantly higher (Figure 14). According to 2017 data, the most recent available, Black infants died at three times higher rate than white infants.

Figure 14. Infant mortality rate in Chicago by race and ethnicity. (Chicago Department of Public Health, 2000-2017) [165]



Our Methods

The data presented in this CHNA report is drawn from primary and secondary sources. Data collected and aggregated from the Collaborative CHNA, conducted in partnership with the Alliance for Health Equity, is integrated throughout this report. The Alliance for Health Equity strives to strengthen work for health and racial equity and was responsible for much of the community input throughout the 2022 CHNA process. Community engagement was particularly crucial as the most up-to-date data and information about health and social well-being shifted rapidly during the COVID-19 pandemic. Methods of the collaborative CHNA are described further in **Appendix E** and **Appendix F**.

Concurrently, Lurie Children's conducted a Community Health Needs Assessment focused on our pediatric service area and priority populations. This assessment was conducted between April 2021 and July 2022 and led by staff at Lurie Children's Patrick M. Magoon Institute for Healthy Communities, in consultation with Lurie Children's Department of Data Analytics and Reporting and Smith Child Health Outcomes, Research and Evaluation Center within the Lurie Children's Stanley Manne Children's Research Institute. Two advisory groups provided oversight and guidance on the CHNA: Magoon Institute for Healthy Communities Advisory Council and Healthy Communities Internal Advisory Committee (**Appendix A and B**). Preliminary CHNA findings were presented to four established Community Health Action Team workgroups for internal feedback and discussion (**Appendix C**). A summary of key meeting dates and activities related to the Collaborative CHNA and Lurie Children's CHNA are detailed in **Appendix D.**

Primary Data Collection

Primary data related to Lurie Children's CHNA was collected between September 2021-April 2022 via a community input survey (**Appendix F**), interviews and focus groups. The Alliance for Health Equity collected more than 4,300 community input survey responses from individuals ages 10 or older living in Chicago. The survey was designed to complement existing surveys such as the Healthy Chicago Survey and CDC PLACES. It included 24 questions about the health status of participant communities, community strengths, opportunities for improvement, priority health needs and the impacts of the COVID-19 pandemic. Hospitals, community-based organizations and health departments distributed the surveys in paper and digital formats with a priority of obtaining insights from populations that have been historically excluded in assessment processes. To ensure youth voice was centered in community input, Lurie Children's promoted the survey with youth-serving community partners, recruited youth survey ambassadors to encourage peer participation and conducted two youth focus groups.

Sub-analyses were conducted focused on Lurie Children's service area and are reported here. Lurie Children's conducted additional primary data collection to gather parent and patient feedback on specific health-related topics and community priorities related to overall health assets and needs. Lurie Children's Voices of Child Health in Chicago in partnership with the Chicago Department of Public Health on the Healthy Chicago Survey Jr. and with NORC at the University of Chicago on a longitudinal parent panel survey, was the primary mechanism used to assess parent views on specific health topics including safe infant sleep, bullying, childhood nutrition, mental health and access to healthcare resources.

Additionally, Alliance for Health Equity partnered with West Side United and Rush University Medical Center to conduct 43 focus groups with community members throughout Chicago and Cook County. The focus groups were asked about health-related assets, resources, needs and priorities. Lurie Children's conducted 10 additional focus groups gathering insights from 78 patients, parents and caregivers, employees, community-based providers and youth in Lurie Children's priority areas, including Austin and Belmont Cragin. Participants were 14 years old or older and represented a diverse range of ethnic, racial, religious, socioeconomic backgrounds and medical care needs.

Secondary Data Collection and Analysis

Secondary data were collected from publicly available datasets, private datasets and proprietary sources. Publicly available datasets were accessed and reported principally from Metopio, a licensed data sharing portal which aggregates and visualizes data from publicly available data sources including the U.S. Census Bureau's American Community Survey, Youth Risk Behavior Factor Survey, USALEEP Life Expectancy and Feeding America Survey, among others. Many of the graphics and maps displayed throughout this report were rendered using the licensed Metopio data portal. In addition, the City of Chicago Health Atlas was accessed for Chicago specific data on adolescent, maternal and child health including the Illinois Youth Survey. Other secondary data included reported statistics from National Vital Statistics, Robert Wood Johnson Foundation State of Childhood Obesity, Diversity Data Kids, and COMPData, an administrative dataset managed by the Illinois Hospital Association. For Lurie Children's specific data, data were queried and reported from emergency medical record clinical data warehouses. Furthermore, the Alliance for Health Equity and Lurie Children's completed a thorough literature review and assessment of secondary sources which are referenced and cited throughout this report. **Appendix E** includes detailed list of secondary sources and methodology for specific analyses conducted by Lurie Children's.

Community Voice

Community Input Survey

Lurie Children's and the Alliance for Health Equity partners aimed to focus on voices of community members most impacted by inequities, including communities of color, youth and young adults, low-income households and households with children, youth, young adults and individuals with disabilities.

Given the challenges posed by the COVID-19 pandemic – in particular, not being able to broadly distribute paper surveys – the overall demographics of survey respondents skewed white, higher income, older and from North/Central regions (see By the Numbers). Therefore, a more in-depth equity-focused analysis of the responses by the various subpopulations was conducted, including race and ethnicity; youth and young adults; people who identify as LGBTQ+; households that included a person with a disability, youth, or young adults; low-income households under $20,000/year and surveys completed in Spanish.

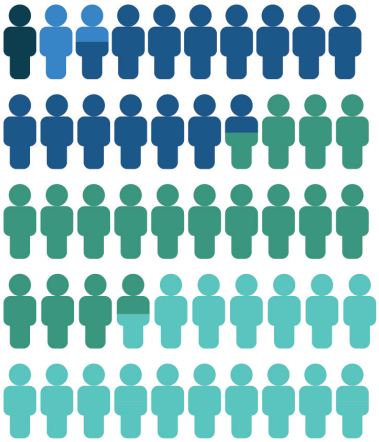
Community Input Survey: By the Numbers

By race and ethnicity (N=4,031)

- White only (59%)
- Black only (15%)
- Hispanic/Latinx only (13%)
- More than one race (6.2%)
- Asian only (5.6%)

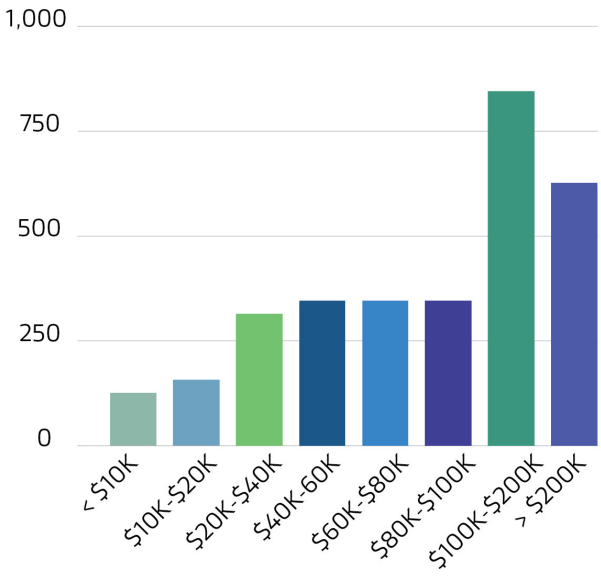
Other races and ethnicities captured:
Middle Eastern, Arab American, or Persian only (0.5%);
Other Only (0.4%);
Pacific Islander or Hawaiian Native only (0.3%);
American Indian or Alaska Native only (0.2%)

By age (N=4,223)

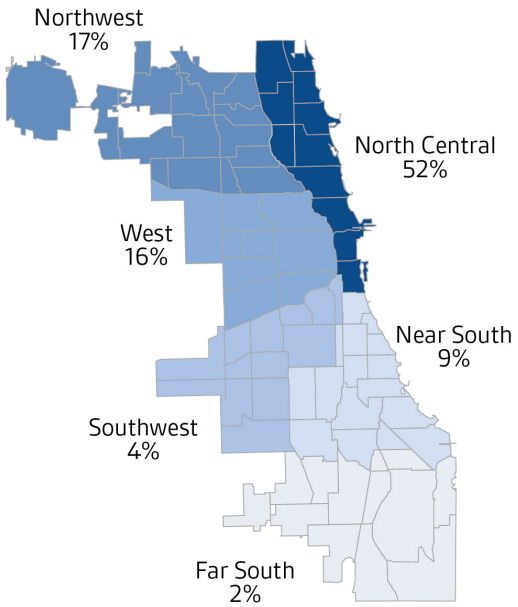


- <18 (2%)
- 18-24 (3%)
- 25-44 (28%)
- 45-64 (33%)
- >65 (34%)

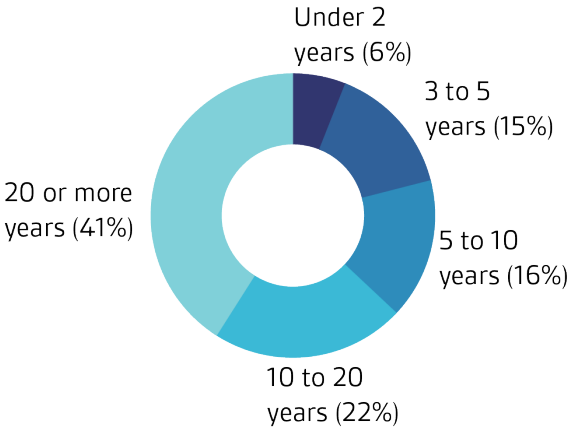
By annual household income (N=3,254)



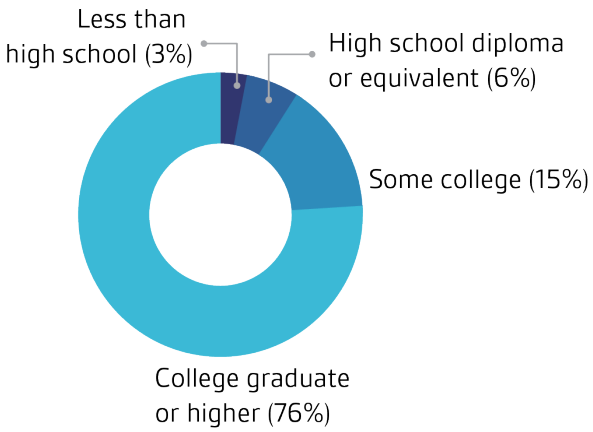
By Chicago region (N=4,318)



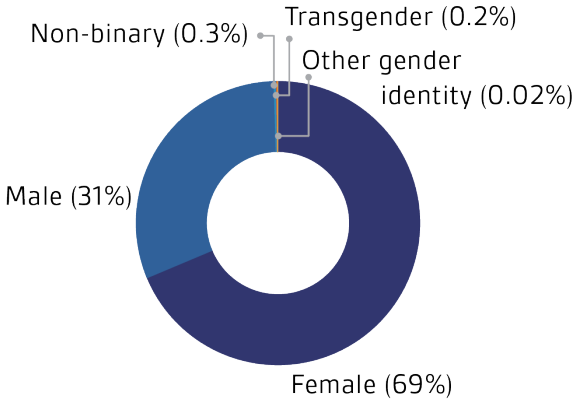
By years lived in the community (N=4,062)



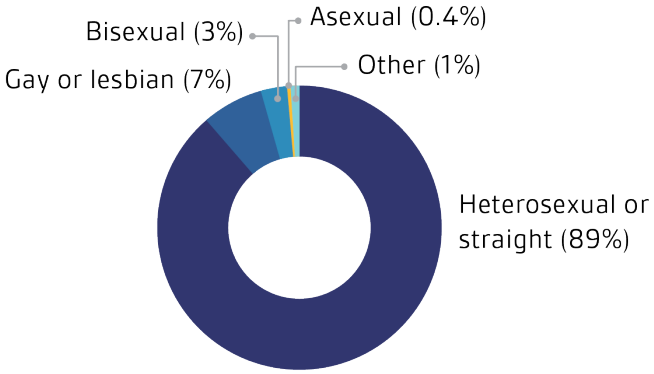
By levels of education (N=4,209)



By gender identity (N=4,200)



By sexual orientation (N=3,914)



By households including youth <18 (N=4,318)

- Households include youth (23%)
- Households without youth (77%)

By households including someone with a disability (N=4,075)

- Households include disabled person (17%)
- Household without disabled person (83%)

Priority Community Health Needs

When asked to choose the most important health needs in their community from a list of 22 options, Chicago respondents overall prioritized mental health, age-related illnesses, COVID-19, homelessness and violence as their top five (Figure 15). The top five were the same for most subpopulations, although the order of the rankings varied with a few notable differences. Youth under age 18 years were the only group to select child abuse as a top five priority. Hispanic/Latinx and Middle Eastern, Arab American, or Persian respondents selected diabetes instead of violence in their top 5. For respondents who completed the survey in Spanish, cancers, dental problems and diabetes were ranked as the top issues instead of COVID-19, homelessness or violence.

Figure 15. Top five priority health needs by group.

Overall	Youth <18	Young adults (18-24)	Households with youth
1 Mental health	1 COVID-19	1 COVID-19	1 Mental health
2 Age-related illness	2 Age-related illness	2 Mental health	2 COVID-19
3 COVID-19	3 Mental health	3 Homelessness and housing instability	3 Homelessness and housing instability
4 Homelessness and housing instability	4 Violence	4 Violence	4 Violence
5 Violence	5 Child abuse	5 Age-related illness	5 Age-related illness

Note: Mental health included depression, anxiety, PTSD, suicide, etc. Age-related illnesses included arthritis, hearing/vision loss, Alzheimer's/dementia, etc.

Mental health was in the top two rankings for nearly all subpopulations with over 1700 respondents (43 percent) identifying this as the most important health need in their communities. Only Middle Eastern, Arab American, or Persian and low-income households ranked mental health outside of the top two. Households with youth, young adults, or individuals with disabilities all ranked mental health as their top priority. Youth and young adults ranked mental health number two with COVID-19 as their top priority (for youth, age-related illnesses tied for number two).

Given the previously mentioned significant health disparities across different racial and ethnic groups, we anticipated that community members would consider racism a top health priority; however, no group selected racism among their top five health priorities. Most groups ranked racism within their top 10 health priorities; of note, youth under the age of 18 years and low-income households did not. Potential reasons for this include that racism may not be widely recognized as a public health concern, or the links selected because it was too abstract in comparison to the other options that represented distinct concerns.

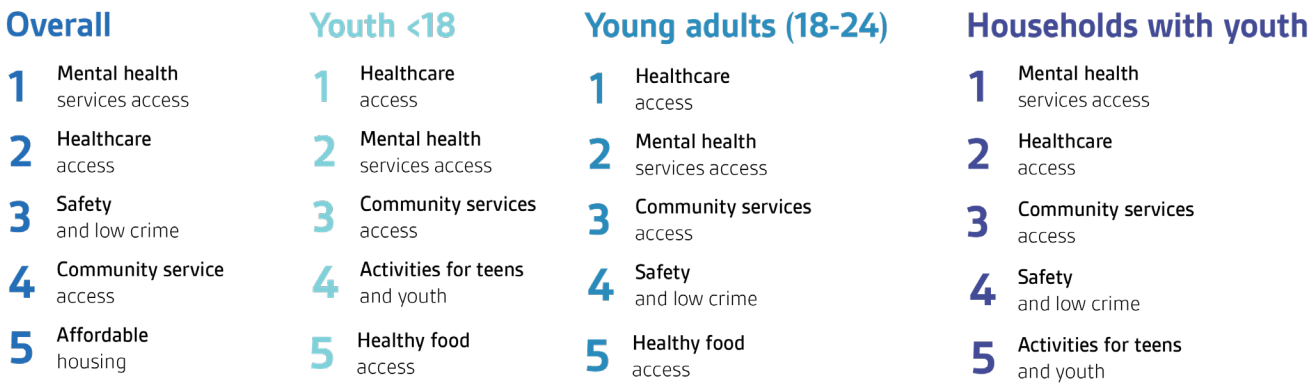
Supports Needed to Improve Health

When asked to select what types of services and resources would be most helpful in addressing their priority health needs from a list of 19 options, Chicago respondents overall ranked mental health services, healthcare, safety and low crime, community service and affordable housing as their top five supports needed (Figure 16). Access to mental health services was the top ranking across most subpopulations, including for Asian, Black, Hispanic/Latinx, and white Chicagoans, households with youth and young adults, households with a person with a disability, and low-income households. Over 1700 respondents (44 percent) identified access to mental health services as the priority need to support improvements in community health.

The top five supports needed were the same across most subpopulations, although the ranking varied. Youth and young adults selected the same top three and included healthcare access as their number one most needed support followed by access to mental health services and access to community services. Youth also selected activities for teens and youth and healthy food access in their top five instead of affordable housing and safety and low crime, while young adults selected healthy food in their top five instead of safety and low crime.

Households with youth and young adults included activities for teens and youth in their top five instead of affordable housing, which was ranked sixth for households with youth and seventh, after healthy food access, for households with young adults. Respondents from households with low income (under $20,000 annual income) included activities for teens and youth and healthy food access in their top five, instead of safety and low crime and affordable housing.

Figure 16. Top five supports needed to improve in health by group.



Social Connections and Supports

When asked about existing social supports, 84 percent of respondents answered that there are people in their community who they would feel comfortable asking for help. Although they represent a smaller number of respondents (n=20), 40 percent of Middle Eastern, Arab American, or Persian Chicagoans said they did not have people in their community they would feel comfortable asking for help – the highest rate of "No" responses among the subpopulations analyzed.

One out of four low-income households (n=297, 24 percent) also responded "No" and roughly one out of five of the following subpopulations did not have people in their community that they felt comfortable asking for help: Pacific Islander or Hawaiian Native Only (n=9, 22 percent), African American/Black Only (n=589, 21 percent), Latino(a)/Hispanic Only (n=530, 21 percent), 18-24 Years (n=113, 20 percent), and respondents that completed the survey in Spanish (n=137, 20 percent).

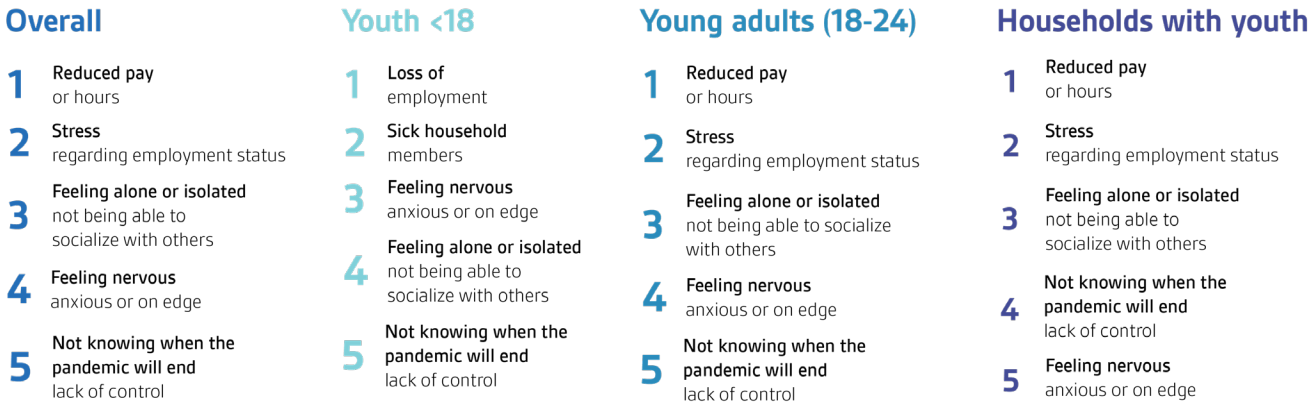
Impacts of the COVID-19 Pandemic

The COVID-19 pandemic was and continues to be challenging in many ways. When asked about how COVID-19 impacted them, the top five challenges respondents reported included (1) not knowing when the pandemic will end, lack of control, (2) feeling nervous, anxious or on edge, (3) feeling alone or isolated, not being able to socialize with other people, (4) stress regarding employment status and (5) reduced pay/hours (Figure 17). Over half of all Chicago respondents who answered this question selected the top three responses. The top five were the same, although the ranking varied, across most subpopulations.

Youth selected sick household member and loss of employment in their top rankings, instead of stress regarding employment status and reduce pay/hours. Low-income households selected loss of employment as their top priority over reduced pay/hours. In households with an individual with a disability feeling alone or isolated was their top priority. For respondents who completed the survey in Spanish, employment related issues were selected as the top three: reduced pay/hours, stress regarding employment status, and loss of employment.

Overall, 20 percent of respondents selected death of family members or friends (ranked #7 overall), with Black and American Indian or Alaskan Native respondents selecting death of loved one as one of their top five impacts.

Figure 17. Top five COVID-19 pandemic challenges.



Community Input Focus Groups

Focus group participants were asked about the top health issues facing their communities and how they envision hospitals, like Lurie Children's, addressing those issues. In the Lurie Children's focus groups, participants were also asked to identify the single most urgent health or social issue youth face that they would like to see addressed in their communities. Across focus groups, the most cited concern was mental health and trauma. Participants also identified safety, racism, poverty, maternal and child health, COVID-19 and healthcare access and more resources, including technology resources, as other priority issues to be addressed.

Focus group participants identified five major areas that were impacting community health the most: mental and behavioral health, gaps in community supports, access to healthcare, social and structural influencers of health and chronic health conditions.

Mental & Behavioral Health

- The need for holistic, integrated care with a focus on physical, mental and spiritual health

- The need for substance use prevention and treatment for addictions, including addiction to gambling

- Mental health crises and the pervasive stigma surrounding them

- The impact of the COVID-19 pandemic on mental and behavioral health

- The relationship between mental health and social influencers of health

We are seeing a lot of depression and anxiety. We should keep [youths'] minds busy because I think that would help them with anxiety and depression. We need programs to help their mental health. And we also have working parents, so children are left alone, and sometimes sad things happen that we wish did not happen.

- BELMONT CRAGIN FOCUS GROUP PARTICIPANT

Gaps in Community Supports

The need for community programs and services, including:

- Positive youth programs focused on topics like life skills, career development and recreational activities

- Parent and caregiver supports such as early childhood education and affordable childcare

- Quality and equitable education

- Services to assist youth transitioning from pediatric to adult care

- Emotional support for the long term-impact of losing loved ones

> **For young Black people, we don't often get those spaces (to have someone to talk to). So definitely for me, mental health is something I'm pushing for as I had my own battles as a young person and a lot of trauma. That is the reason I am doing what I am doing today; because I wanted to be for those young people what I felt I needed when I was a teenager. I want to see us well as I know what it is not to be well.**
>
> - LURIE CHILDREN'S EMPLOYEE AUSTIN RESIDENT FOCUS GROUP PARTICIPANT

Access to Healthcare

- Barriers related to availability and affordability, such as lack of transportation to appointments or ease of clinic access, lack of insurance or enrollment in public benefits and bureaucracy

- Discrimination, racism and lack of empathy among healthcare professionals and concerns about immigration status and the lack of culturally appropriate services (e.g., language spoken)

- Needs for additional types of care including behavioral health services, affordable specialty care, telehealth coverage, expanded use of Community Health Workers and in-home health promoters/health services

- Emphasis on building trust within communities, including better communication about resources and public health

> **Most people are undocumented, and they are afraid to go in to get help. Most people don't have healthcare insurance, they get turned away because of a piece of paper, they must travel far for help, their problems are not treated as [if they are] a whole human.**
>
> - HEALTHY HOOD CHICAGO FOCUS GROUP PARTICIPANT

Social & Structural Influencers of Health

- Racism and discrimination

- The need for economic opportunity and community investment

- Limited availability of:

  - Affordable, stable, safe and quality housing
  - Healthy foods and fresh produce, farmers markets, community gardens and grocery stores
  - Quality and equitable education
  - Affordable childcare
  - Infrastructure improvements like sidewalks and vacant lots
  - Clean, lead-free water, green space and parks
  - Internet access, technology and other resources

> **The community is changing. Low-income individuals are being pushed out. Persons of color are being pushed out. The changes going on are not for us, they are for the new people coming into the neighborhood. They have to keep a certain amount of people with low income to get funding for the area. 10 years from today you won't see a person of color in this community.**
>
> - OAKLEY SQUARE APARTMENTS FOCUS GROUP PARTICIPANT

Chronic Health Conditions

- Concerns about obesity, diabetes, asthma and medically complex chronic conditions

- Concerns about not being able to prevent chronic disease due to unhealthy behaviors and social influencers of health, such as:

  - Inactivity in youth and young adults
  - Inadequate access to healthy foods
  - The cost of medical care
  - The prevalence of smoking

- The impacts of COVID-19 infection and long COVID

> **I think that we do not have an active lifestyle, starting with our young people. And lack of self-esteem which leads to all these health problems such as diabetes, high cholesterol and others that are attacking our youth.**
>
> - BELMONT CRAGIN FOCUS GROUP PARTICIPANT

Cross-cutting Factors Impacting Health

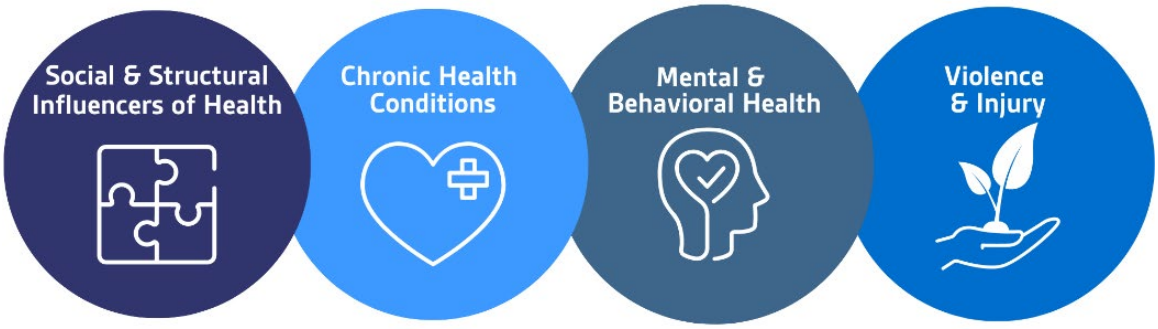
Racism and discrimination, community cohesion and communications, community safety and COVID-19 were identified as critical issues that affect all areas of health and wellbeing. These major topics were discussed across several different contexts among focus group participants and are summarized below.

Priority Health Issues

Working in partnership with our communities and based on the needs identified by community members through the Community Input Survey and focus groups, Lurie Children's focused the needs assessment on the following four key priority health issues/areas:

- Priority Area A: Social and structural influencers of health, including access to care and community resources
- Priority Area B: Chronic health conditions
- Priority Area C: Mental and behavioral health
- Priority Area D: Violence and Injury

The following CHNA findings are organized by these priority health areas.



Social and Structural Influencers of Health

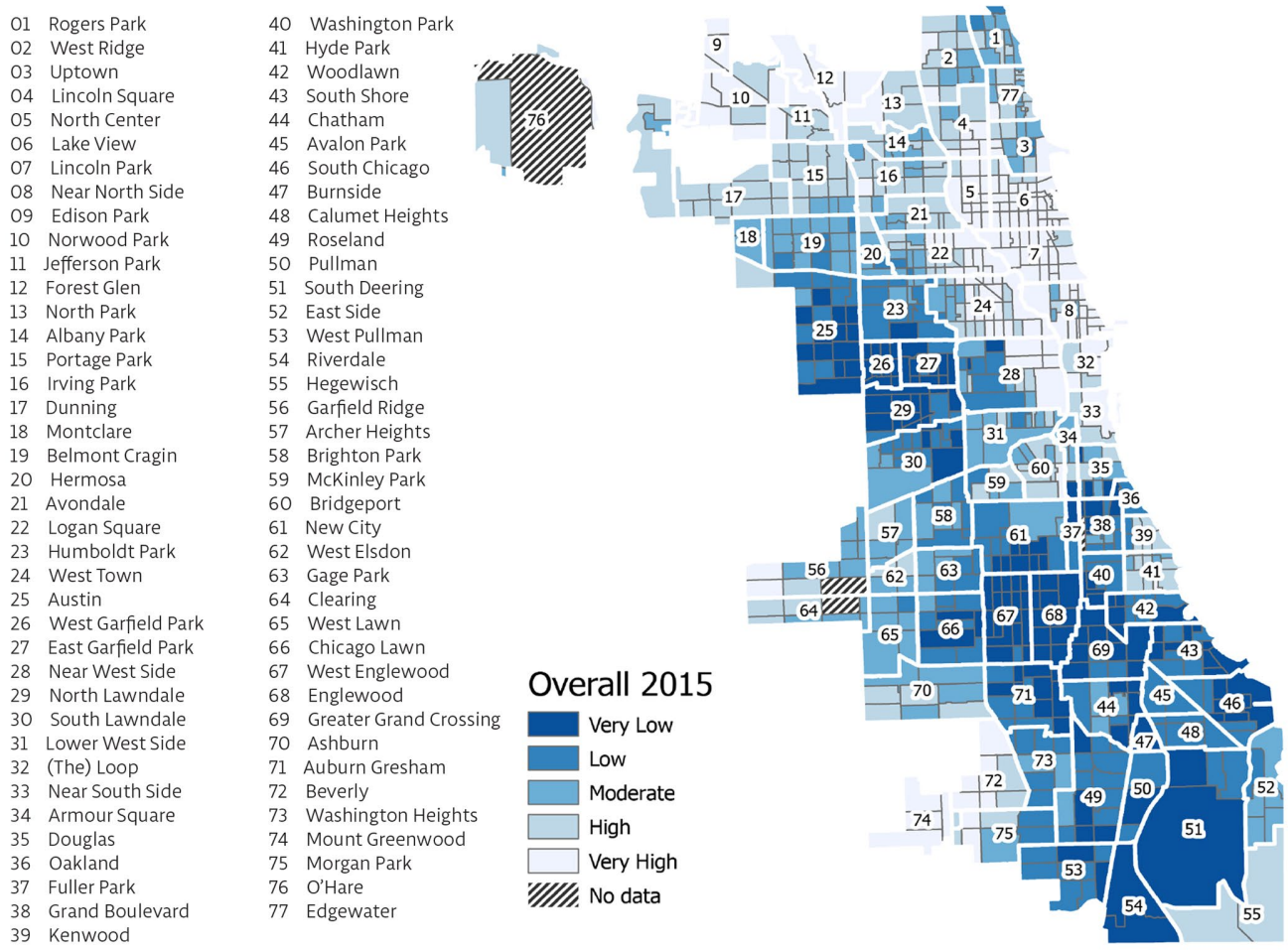
Social and structural influencers of health (SIoH) are the conditions in which we are born, live, learn, work, play and age that affect a wide range of physical and behavioral health, functioning and quality-of-life outcomes. [43] At Lurie Children's, we consciously choose to use the term "influencers" rather than the more commonly used "determinants" of health in recognition of the fact that these conditions and their outcomes are not unchangeable nor predetermined, but instead can and ought to be improved. Examples of key SIoH include, but are not limited to:

- **Education access and quality**, such as public schools that foster learning, social and emotional development.
- **Economic stability,** such as opportunities for steady employment and the ability to save money.
- **Neighborhoods and the built environment**, such as access to stable, safe and affordable housing and neighborhoods.
- **Access to quality, affordable physical, mental and behavioral healthcare**, such as qualified and culturally responsive medical providers.

The relationship between SIoH and health outcomes is well-documented. For example, individuals who do not graduate high school are more likely to experience chronic health conditions like asthma, diabetes, heart disease and high blood pressure. [44] The COVID-19 pandemic has further emphasized the links between individual health and community wellbeing, as communities with high rates of poverty, housing instability, food insecurity and limited access to healthcare were disproportionately impacted. [45]

To focus our efforts on areas that need the most support, Lurie Children's utilizes the Child Opportunity Index (COI), a composite score of the accessibility of community resources and conditions that help infants, children and adolescents develop in a healthy way. [46] We use the COI as a proxy for youth SIoH because it considers the educational, health, environmental and socioeconomic aspects and resources available in the community. [46] Figure 18 displays the most recent COI by census track overlaid with the Chicago community area boundaries; the darker the blue, the lower the COI score.

Figure 18. Chicago's community areas and their corresponding Child Opportunity Index scores. (Chicago Department of Public Health)



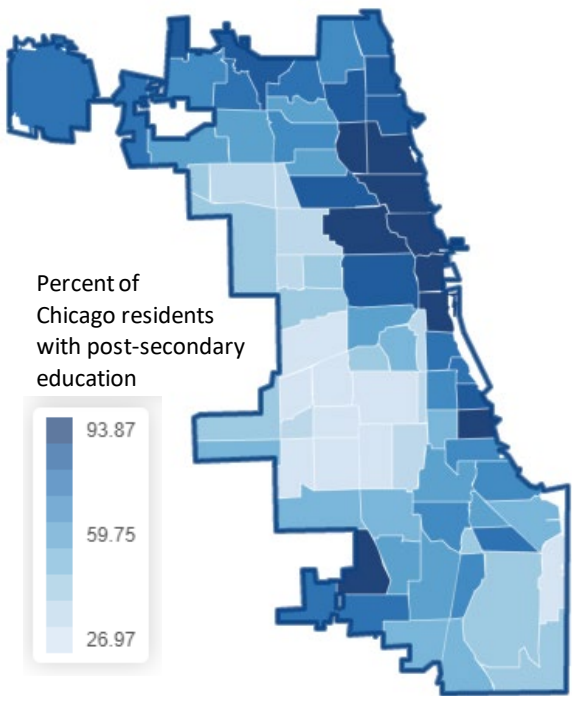
Education Access and Quality

Segregation

Like its neighborhoods, Chicago's schools are heavily segregated, with Black and Brown youth having less access to quality education. The issues around equity in schools are complex and multifaceted. For example, in 2013, CPS and then Mayor Rahm Emanuel closed fifty schools displacing 11,000 students. This was a controversial decision for many reasons, including the disproportionate impact on Black students. Of the total schools closed, 42 had a population that was 75 percent Black, and 80 percent of students affected by school closures were Black. Neighborhoods such as Englewood, Austin and Garfield Park faced the most instability. [47] In the following years, CPS has witnessed an ongoing decline in enrollment which has led to decreased funding for schools in these neighborhoods, resulting in fewer options for families.

CPS data from the 2020-2021 school year shows stark differences in access to quality schools and programs between Black and white students. For example, there were zero seats per hundred students for fine and performing arts in the Bronzeville/South Lakefront region, whereas in Greater Lincoln Park, North Lakefront, and Central Area regions, there were 50-70 seats per hundred students. [47] As indicated in Figure 19, rates of higher education are distinctly higher in Chicago's North Side than they are in the South and Southwest Sides.

Figure 19. Percentage of Chicago residents 25 years or older with any post-secondary education, including less than one year. (American Community Survey, five-year estimates, 2016-2020)



Early Education and School Attendance

What – and how – children learn in the first few years of their life can have long-lasting effects on their long-term success and health. [48] The socioeconomic status of parents is the biggest driver of school-readiness, access to quality childcare and access to early childhood education resources. [49] According to Chapin Hall, a quarter of infants and children under 6 years of age (approximately 49,000) in Chicago live at or below the federal poverty level, which is $27,750 for a family of four. [50] [51] As a result of these socioeconomic inequities, Black and Hispanic/Latinx children often lag behind their white and Asian peers when starting kindergarten and these delays can impact school success throughout the lifespan. [49]

Quality early childhood education is essential for a child's social, emotional, physical and cognitive development. The City of Chicago's Early Learning (CEL) programs offer various early learning and childcare options to pregnant people and families with children under 5 years old. The DFSS Children Services Division (CSD) manages a comprehensive, city-wide system of community-based Chicago CEL programs for children, including Early Head Start and universal pre-kindergarten, with low-income families, students with disabilities, students in temporary living situations and foster children prioritized for placement. To date, publicly funded preschool programming is now available in 64 of the 77 Chicago communities with a goal of reaching every neighborhood by 2023.

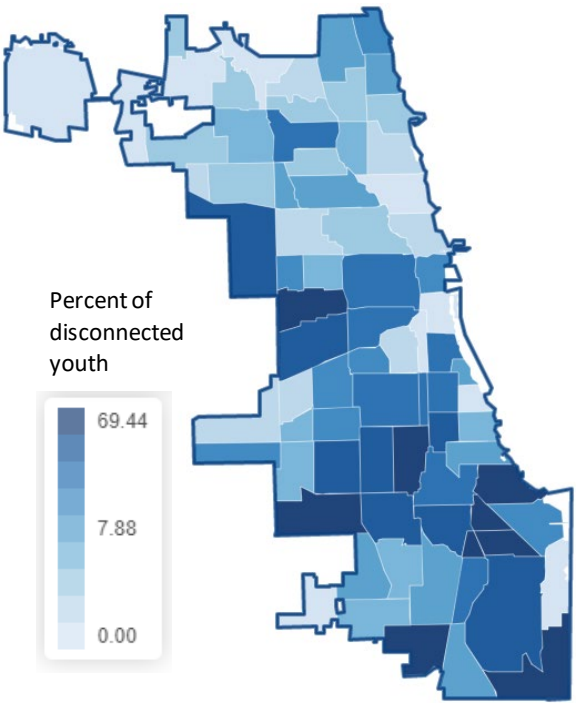
Educational attainment begins with school attendance. Across the country, school attendance rates for students of all ages were disrupted by closures due to the COVID-19 pandemic. By the end of March 2020, COVID-19 cases in Illinois had surged to such an extent that an executive order was issued requiring all individuals to stay at home and all businesses to shut down, except for essential businesses, public safety institutions and government functions. Childcare centers were included as one of the essential businesses allowed to remain open if they received an emergency license specifically enacted for

daycare programs for children of essential workers. [52] However, the Federal Office of Head Start ordered the closing of all Head Start in-person operations, including CEL community-based learning centers receiving Head Start federal funding. Only 10 CEL agencies were permitted to continue daily operations, affecting nearly 6,000 Chicago families. [52]

According to a national survey conducted by the American Institutes for Research (AIR), public school student attendance rates also decreased from Fall 2019 to Fall 2020 due to the COVID-19 pandemic. [53] Specifically, the AIR report notes lower attendance rates in districts that did not provide primarily in-person instruction, as well as in high poverty districts and districts that serve mostly students of color. [53] In the 2020-2021 school year, among high school students and high school seniors in particular, the attendance rate dropped by 7 percent, dipping to below 80 percent. [54] Now more than two years into the pandemic, attendance rates continue to fluctuate. Although high schools that serve predominantly Black students on the South and West Sides have continued to struggle with attendance, they are also among the schools with the most marked attendance gains. [54]

Even prior to the pandemic, CPS enrollment rates were steadily dropping due to factors including transfers to outside the school district and lower birth rates in Chicago. Nearly 47,000 students left CPS between Fall 2019 and Fall 2020; that number jumped to 54,000 in Fall 2021. Hispanic/Latinx students represent the largest population of CPS students at nearly 47 percent, but that racial group also saw the biggest decline in students, year-over-year, with more than 5,000 students lost. Black students now make up a slightly larger portion of the district (36 percent), while white students account for nearly 11 percent of enrollment.

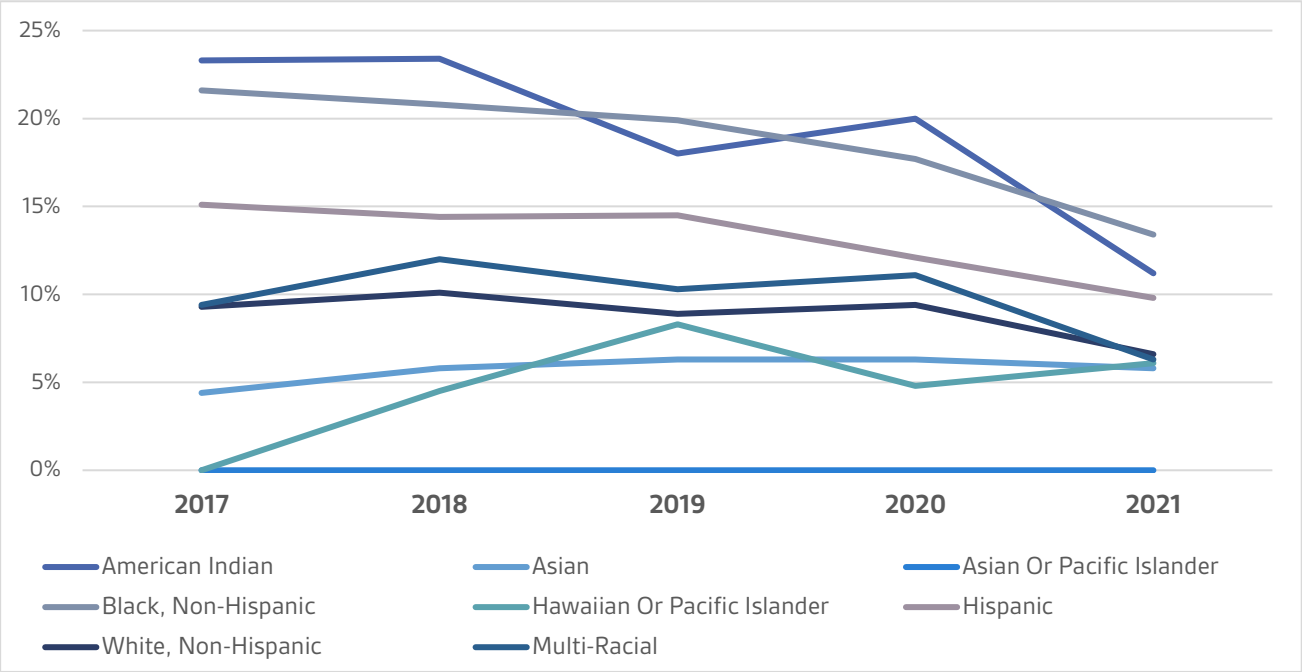
Figure 20. Percentage of residents aged 16-19 year who are neither working nor enrolled in school. (American Community Survey, five-year estimates, 2015-2019)



> I just noticed that students stopped caring about their grades, and they weren't actually learning at all and it's pretty sad because I used to love school, but now I feel like I'm not processing information correctly and can't really learn.
>
> – LURIE CHILDREN'S KIDS ADVISORY BOARD

Five-year estimates indicate that school disengagement, including dropping out, is more common in certain communities. Figure 20 above displays the disparity in rates of disconnected youth within Chicago, with demonstrably higher rates on the city's predominantly Hispanic/Latinx South and West Sides. Figure 21 also shows that, while dropout rates have decreased over time, they are highest among Black, Hispanic Latinx

Figure 21. City-wide Chicago Public Schools 5-year cohort dropout rates, by race and ethnicity. (Chicago Public Schools District Data, Cohort Dropout and Graduation Rates, 2020)

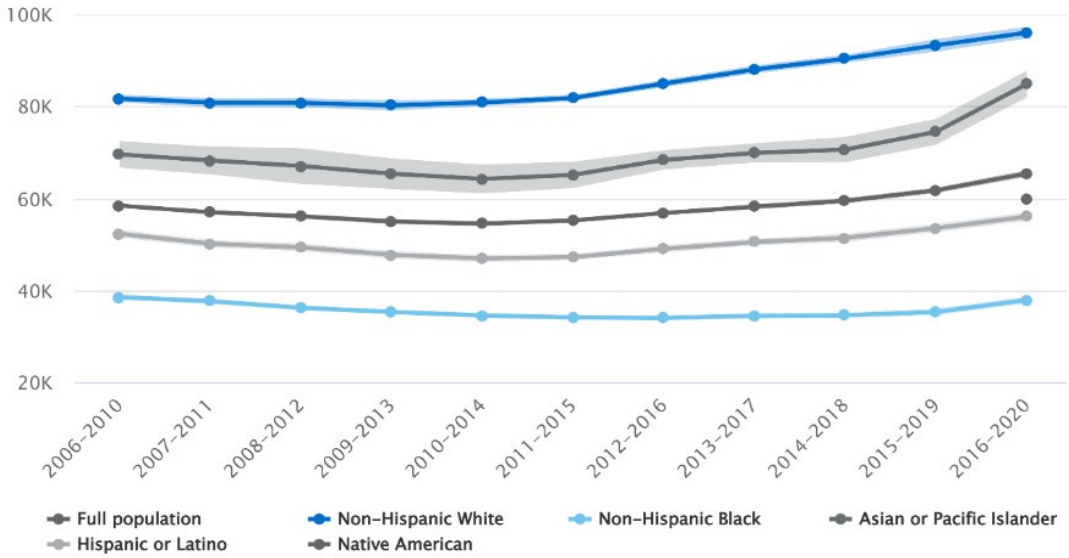


Economic Stability

As is the case in many US metropolitan areas, Chicago's Black and Hispanic/Latinx communities face disproportionate barriers to economic growth. For example, redlining policies in the early to mid-20th century effectively barred Black home buyers for qualifying for mortgages and investing in higher-opportunity neighborhoods. Although outlawed nationally with the 1968 Fair Housing Act, these discriminatory practices created wealth gaps that compounded over time and continue to hurt Black Chicagoans today. [55] Figure 22, a graph of Chicago's median household income by race/ethnicity, provides a clear example of the impacts of these barriers. Although the overall median household income has increased in the last two decades, significant wealth gaps exist and continue to widen. For example, in 2020, the median income for non-Hispanic Black households was under $40,000; white households earned over twice as much at close to $100,000.

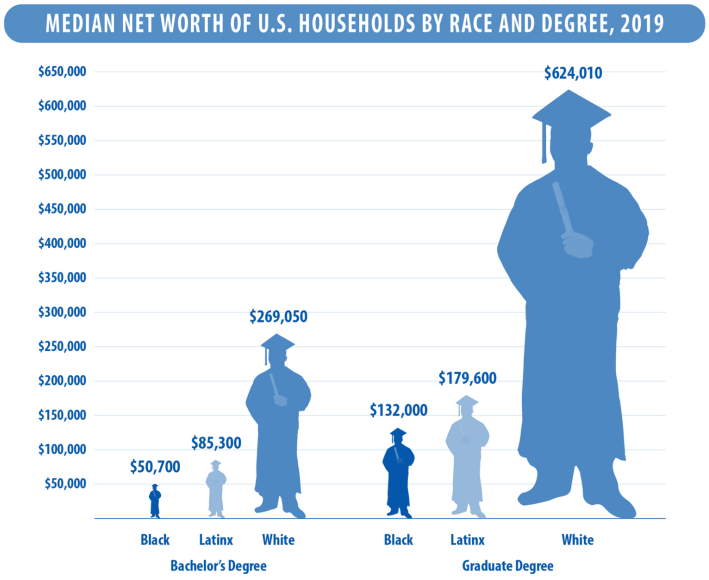
According to a study of Chicago's racial wealth gap conducted by the University of Illinois' Institute for Public Research and Policy, college graduates earn close to $1 million more dollars over the course of their lifetime than do those with a high school degree. [56] The study shares that, in the last 20 years, college enrollment levels have increased, especially among Black and Hispanic/Latinx populations. During

Figure 22. Median household income by race and ethnicity in Chicago. (American Community Survey, 5-year estimates, 2006-2020)



that same period, however, Illinois' financial support for higher education has dropped by 50 percent, translating into a steadily increasing tuition burden on families. [56] Sharp increases in tuition rates during this period have exacerbated this burden; between 1980 and 2014, while overall consumer prices went up 120 percent, college tuition nationally increased at an average of 260 percent. [56] By any measure, the increases in college tuition rates are high, but are staggeringly so when compared to the smaller increases in wages over the same period. Figure 23 demonstrates significant discrepancies in the net worth of US households with similar education levels.

Figure 23. Median net worth of U.S. households by race, ethnicity and degree in Chicago. (Chicago's Racial Wealth Gap, 2019) [171]



The economic segregation of Chicago is unjust and can stifle opportunities for growth and devastate entire communities. Residents of low-income neighborhoods are at increased risk for adverse health outcomes, mental illness, chronic disease, higher mortality and lower life expectancy, as well as higher rates of community violence. [57] Desegregation can generate more equitable, long-term economic growth. For example, if Chicago reduced the levels of economic and Black-white segregation to the national median, incomes for Black Chicagoans would rise an average of $2,982 per person per year. Overall, the entire region would earn an additional $4.4 billion in income. [3]

> **A nice (quality) grocery store would be nice. A real one, not a corner store or a liquor store; a fresh market to able to eat healthy.**
>
> - GOOD NEIGHBOR CENTER FOCUS GROUP PARTICIPANT

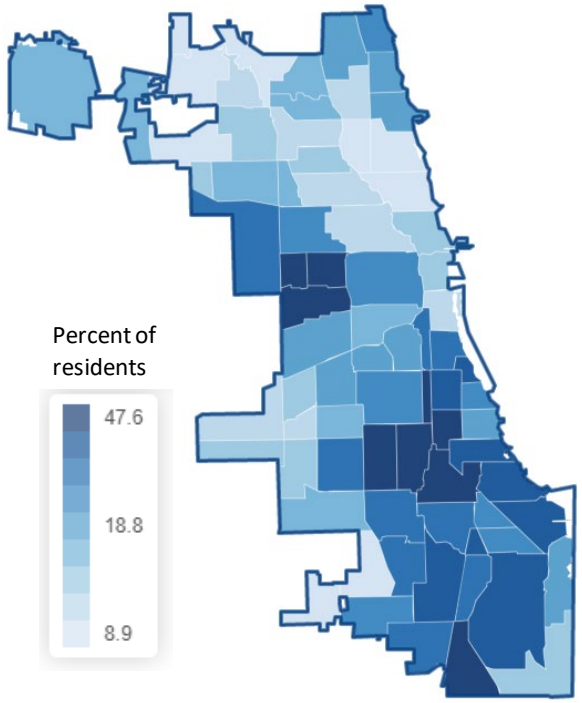
Neighborhoods and the Built Environment

Food Access and Insecurity

For children and adolescents, food insecurity can be particularly devastating and can have serious implications on their physical and mental health, academic achievement and future economic prosperity. Research shows an association between food insecurity and delayed development in young children; risk of chronic illnesses such as asthma and anemia; and behavioral problems, including hyperactivity, anxiety and aggression in school-age children and adolescents. [58] In Chicago, the highest rates of food insecurity cluster on the South and West Sides (Figure 24).

Lack of access to healthy, nutritious foods or safe spaces to exercise and play can also contribute to childhood obesity. Youth who have obesity are more likely to be obese as adults and are at higher risk for type 2 diabetes, breathing problems such as asthma and sleep apnea, joint problems and heart disease. [59]

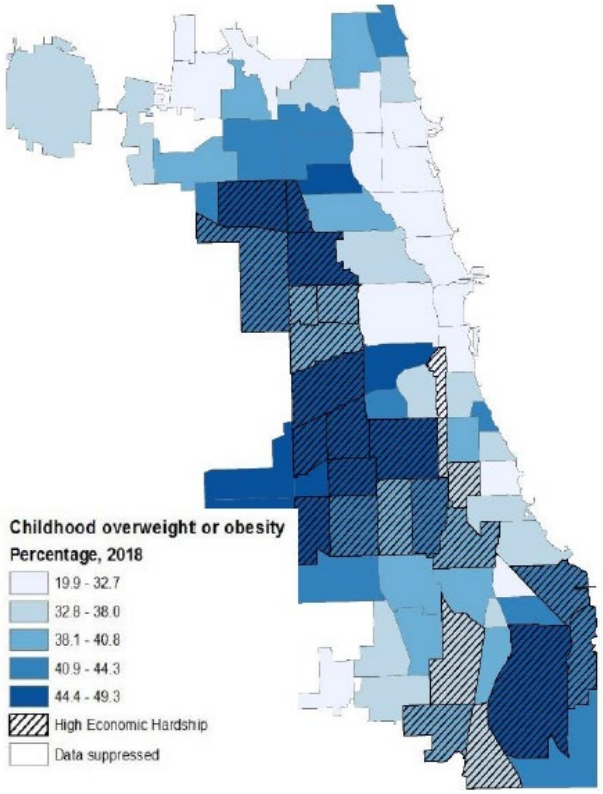
Figure 24. Percentage of Chicago's population experiencing food insecurity at some point in 2020. (Feeding America)



Approximately one in three of Chicago's children and teenagers are overweight or have obesity. On average, overweight or obesity rates have declined in CPS students in the last decade. Kindergarteners had greater improvement compared to sixth and ninth graders. Non-Hispanic white children had greater improvement than children of color. [60]

In a survey of students in Chicago Public Schools from 2010-2018, students who lived in community areas with high COI scores had the lowest rates of overweight or obesity (28 percent), compared to 43 percent of students in areas of very low opportunity. Communities with high economic hardship often correlate with communities experiencing higher rates of overweight and obesity (Figure 25). [61] Research indicates that communities with better access to healthy foods and limited access to convenience stores have healthier diets and lower rates of obesity.

Figure 25. Percentages of Chicago youth who were overweight or had obesity and Chicago community areas with high economic hardship. (Chicago Department of Public Health, 2018) [61]



> **Chronic health issues communities are facing come from diet and access to healthy and affordable foods.**
>
> - RUSH COMMUNITY HEALTH WORKER FOCUS GROUP PARTICIPANT

Low-income communities of color are less likely to have access to supermarkets and healthy foods and tend to have a higher density of fast-food restaurants and other sources of unhealthy food, such as convenience stores where it is difficult to buy good-quality, nutritious food. [62]

Access to affordable healthy foods was a frequently mentioned need among focus group participants. Those experiencing homelessness and housing instability, low-income families, older adults, and people with disabilities were described as experiencing additional barriers to accessing adequate healthy food.

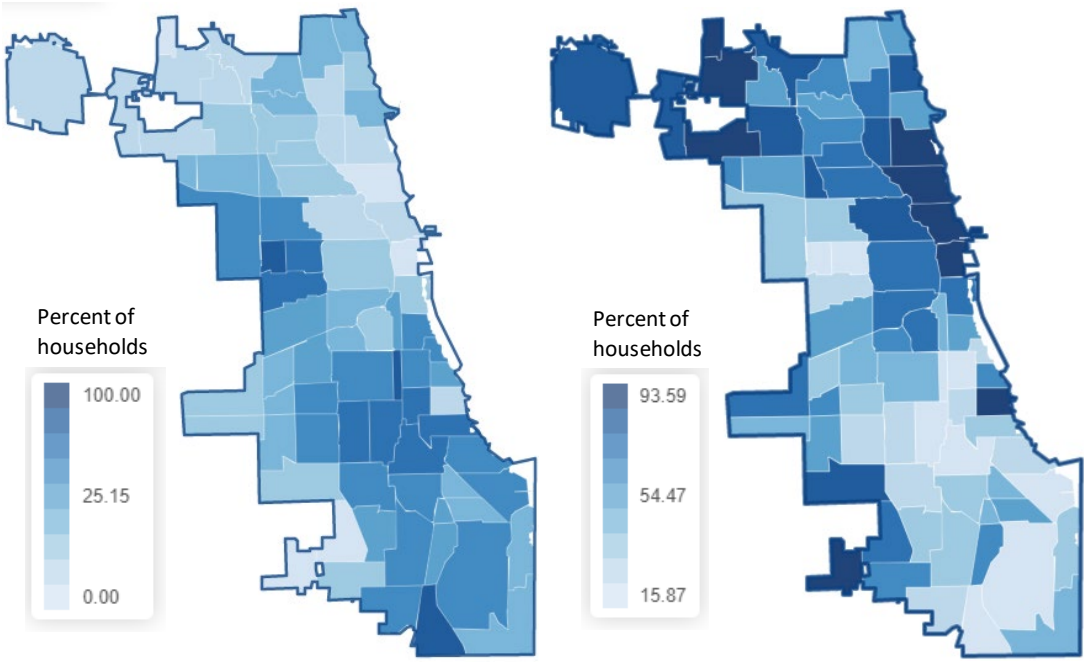
Nutrition programs and food pantries

Programs such as the Supplemental Nutrition Assistance Program (SNAP), local food pantries, summer meal programs, after school programs, shelters and food banks provide important

assistance to low-income individuals and families that struggle to access adequate nutrition. Another important nutrition program that addresses food and nutrition insecurity is Women, Infants, and Children (WIC). WIC is available to low-income pregnant people, postpartum (including chest-feeding) people, infants, and children up to age 5 years. Unlike SNAP, WIC requires recipients to participate in nutrition education; it also provides them with screening and referrals to other social services. Figure XX, a map of the geographic distribution of SNAP recipients across Chicago, shows that SNAP recipients are concentrated in lower income areas on the South and West Sides.

Despite their availability, public benefits like SNAP and WIC are often underutilized due to reasons such as language barriers, lack of internet access, confusion about eligibility and stigma surrounding public aid programs (Figure 26). [63] The City of Chicago estimates around $60.5 million dollars may have been left unused in the WIC program in 2019, and an estimated monthly average of $29.5 million dollars in SNAP left unused between July 2019 and June 2020. [64] Concerns about ex-president Trump's public charge rule deterred immigrant families from accessing their public benefits because of fear that it would make them ineligible to become permanent residents; as of March 2021, the rule is no longer in effect after it was vacated by a Federal District Court. [65]

Figure 26. Percentage of households receiving Supplemental Nutrition Assistance Program (SNAP) benefits, (left) and with income below the poverty level who did not receive SNAP benefits (right), in the past 12 months, by Chicago community area. (American Community Survey, five-year estimates, 2016-2020)



> **I would like to say that, in our community, we do not have a lot of options as parents to buy good quality food that is priced within our means. We are surrounded by McDonalds and Burger King and we don't have a lot of options. As a working parent, it's just easier to buy junk food. Our schools do not have a lot of healthy options. Parents are spending more to buy healthy options for their kids when the school could just provide that.**
>
> - BELMONT CRAGIN FOCUS GROUP PARTICIPANT

Summer meal programs also play an important role in food access for low-income families when schools are closed and there is limited access to free or reduced-price meal programs. In Cook County, summer meal sites are most concentrated in Chicago within communities that have high rates of child poverty.

Pandemic Impacts on Food Access

In Chicago, food insecurity remains significantly above pre-pandemic levels in the Chicago metro region at 19 percent overall, with rates among Hispanic/Latinx communities at 29 percent and Black communities at 37 percent. [64]

Food insecurity has been fueled by record unemployment, school closures, and other circumstances that have led to higher rates of poverty, particularly among Black and Hispanic/Latinx neighborhoods. Due to the pandemic and unrest in the summer of 2020, over thirty grocery stores in Chicago were temporarily closed. [64]

Community members and community-driven solutions are at the forefront of the emergency food response to the COVID-19 pandemic. Approximately 40 Chicago-based mutual aid organizations worked to address food insecurity through collaboration and sharing of food, storage and transportation resources to meet the food needs of communities. [66] They engaged community members and collaborated to feed families when the traditional and emergency food systems could not. These efforts have demonstrably reduced food insecurity in Chicago, having distributed thousands of pounds of food to tens of thousands of families. [66]

Housing and Community Environment

There is a demonstrated link between health and housing, with factors generally falling into four categories: Stability, Quality and Safety, Affordability, and Neighborhood (Figure 27). [67]

Housing Stability

Observational studies have shown that a chronic lack of stable housing can lead to negative physical and mental health outcomes. [68] Even people who are not chronically homeless but face housing instability (in the form of moving frequently, falling behind on rent, or couch surfing) are also more likely to experience poor health. [68]

Residential instability is associated with health problems among youth, including increased risks of teen pregnancy, early drug use, and depression. Even children who experienced homelessness only while in utero are more likely to be hospitalized or suffer worse health, compared to their peers. [68]

Housing Quality

Many environmental factors inside homes are correlated with poor health. For example, in-home exposure to lead irreversibly damages the brain and nervous system of children. Substandard housing conditions such as water leaks, poor ventilation, dirty carpets and pest infestation have been associated with poor health outcomes, most notably those related to asthma. [68] Across Chicago's community areas, there are around 60 building violations per 1,000 units; in the West and South Sides of the city, such as in West Garfield Park and Greater Grand Crossing, rates are three times as high. Substandard housing is often concentrated in areas with older housing, particularly low-income communities of color (see Figure 28). Conditions are worsening, especially for low-income renters who also face an affordable housing crisis.

Figure 27. Four pathways connecting housing and health. (Adapted from Taylor, Housing Affairs)

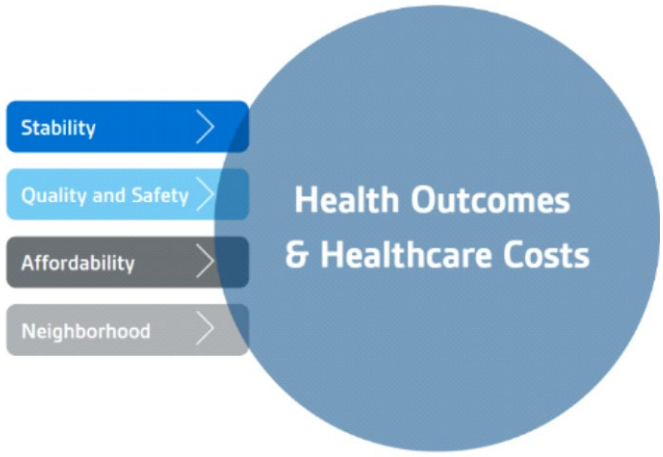
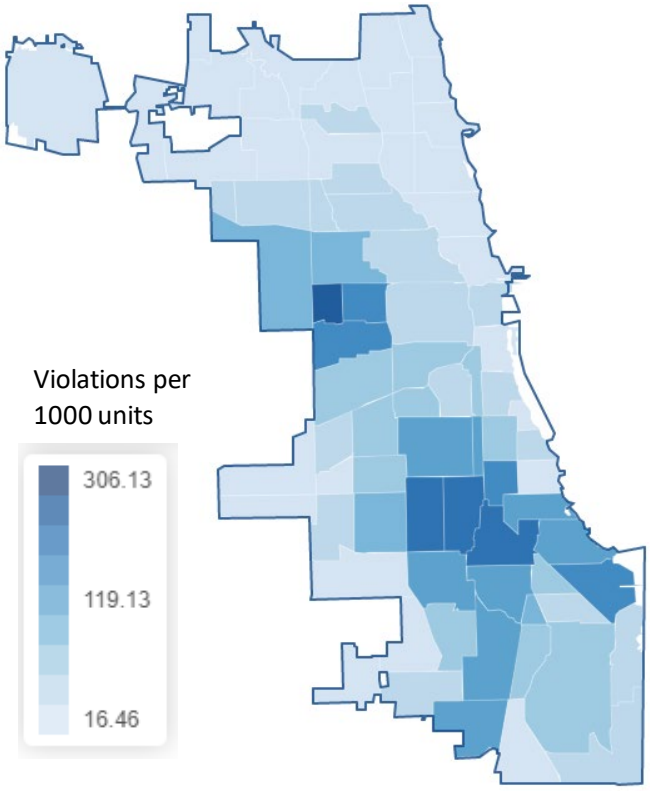


Figure 28. Building violations per 1,000 housing units in Chicago. (Chicago Dept of Buildings via Chicago Data Portal, 2017-2021)



Overcrowded housing is also a concern, and has been found to negatively impact a child's school achievement, behavior and physical health. [69] Children may also be particularly vulnerable to crowded housing because they use the space in the home to do homework, interact with family members, develop an identity, practice skills and sleep. [69] Overall, nearly 4 percent of Chicago households are overcrowded, meaning that they have more than one occupant per room. [14] The five community areas with the highest levels of overcrowded households are Archer Heights (11 percent), Brighton Park (9 percent), South Lawndale (9 percent), West Ridge (8 percent) and Gage Park (8 percent) – again, all on the city's West and South sides. [14] The COVID-19 pandemic magnified the negative health impacts of crowded housing and the need to utilize communal bathrooms, which interfere with practicing good personal hygiene and effective physical distancing and increases the risk of spreading infectious diseases. [70]

> **People applied to resources but never heard back after months, even while facing eviction.**
>
> - BEYOND HUNGER FOCUS GROUP PARTICIPANT

Housing Affordability

The United States is facing an unprecedented housing crisis. In Chicago, the average rent for a two-bedroom apartment is the 15th highest in the nation among medium-to-large cities. [71] The COVID-19 pandemic and its economic fallout exacerbated the crisis even further. [72]

Households are defined as cost-burdened if they spend more than 30 percent of their monthly gross income on housing; severely cost-burdened households have 50 percent or more of their monthly gross income devoted to housing. In Chicago, more than one in three households are cost-burdened; of note, community areas that are the least cost burdened, such as Lakeview or West Town, are among the most expensive areas to live in in the city. [14] More than one in four community input survey respondents ranked homelessness and housing instability among their top five community health concerns and one in five identified affordable housing as a necessity to improve their community's health. During focus group discussions, the lack of affordable housing in communities with lower crime rates was frequently mentioned as a key concern.

Neighborhood Environment

The physical, social and environmental characteristics of our neighborhoods can bear an enormous impact on our health. During focus groups discussions, a shared sense of connection between community members was often reported as a great strength and an essential component of a healthy community. Researchers have found that the availability of resources such as public transportation [73] and safe spaces to exercise [74] are all correlated with improved health outcomes. In one study of neighborhood blight remediation, even walking past a vacant lot that had been "greened" decreased heart rate significantly, in comparison to walking past a non-greened vacant lot. [75] Figure 29 is a map of the geographic distribution of vacant housing units and lots in Chicago, indicating that the city's South and Southwest Sides are disproportionately affected.

Research also shows that living close to high-volume roads and congested motorways can be dangerous and may result in increased rates of respiratory diseases like asthma. [76] In Chicago, the Microsoft Research Eclipse Project, in collaboration with city and community groups, installed 115 air quality sensors throughout the city in 2021, most on Chicago Transit Authority bus shelters. According to the readings, which are collected every five minutes, areas with the worst air pollution levels were along industrial corridors and included Little Village, Austin, Irving Park, Avondale, Englewood and Auburn Gresham (Figure 30). Areas on the Southeast Side and Far South Side have limited sensor data but are known to have poor air quality. Residents who live in these areas are exposed to high levels of fine particulate matter that is the single largest contributor to death and is linked several health problems, including heart and lung disease and asthma. [77]

Figure 29. The geographic distribution of the percentage of vacant housing units in Chicago. (U.S. Census Bureau, American Community Survey, five-year estimates, 2016-2020)

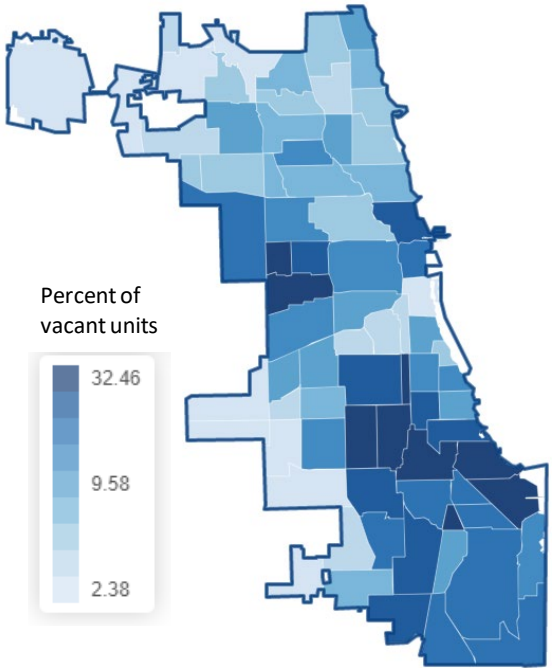
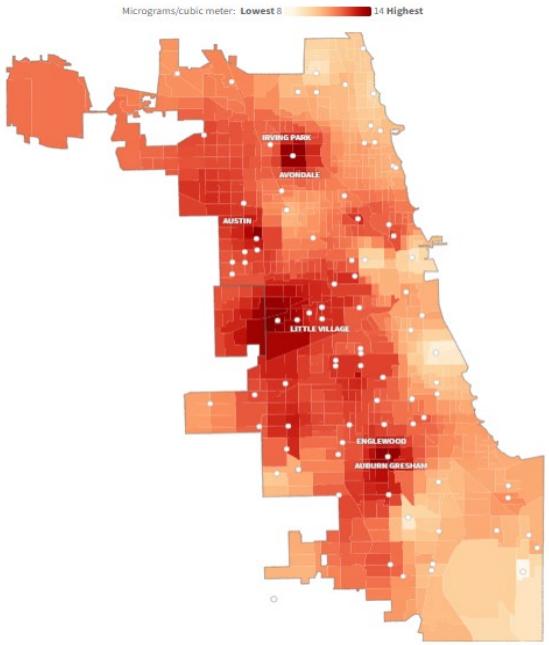
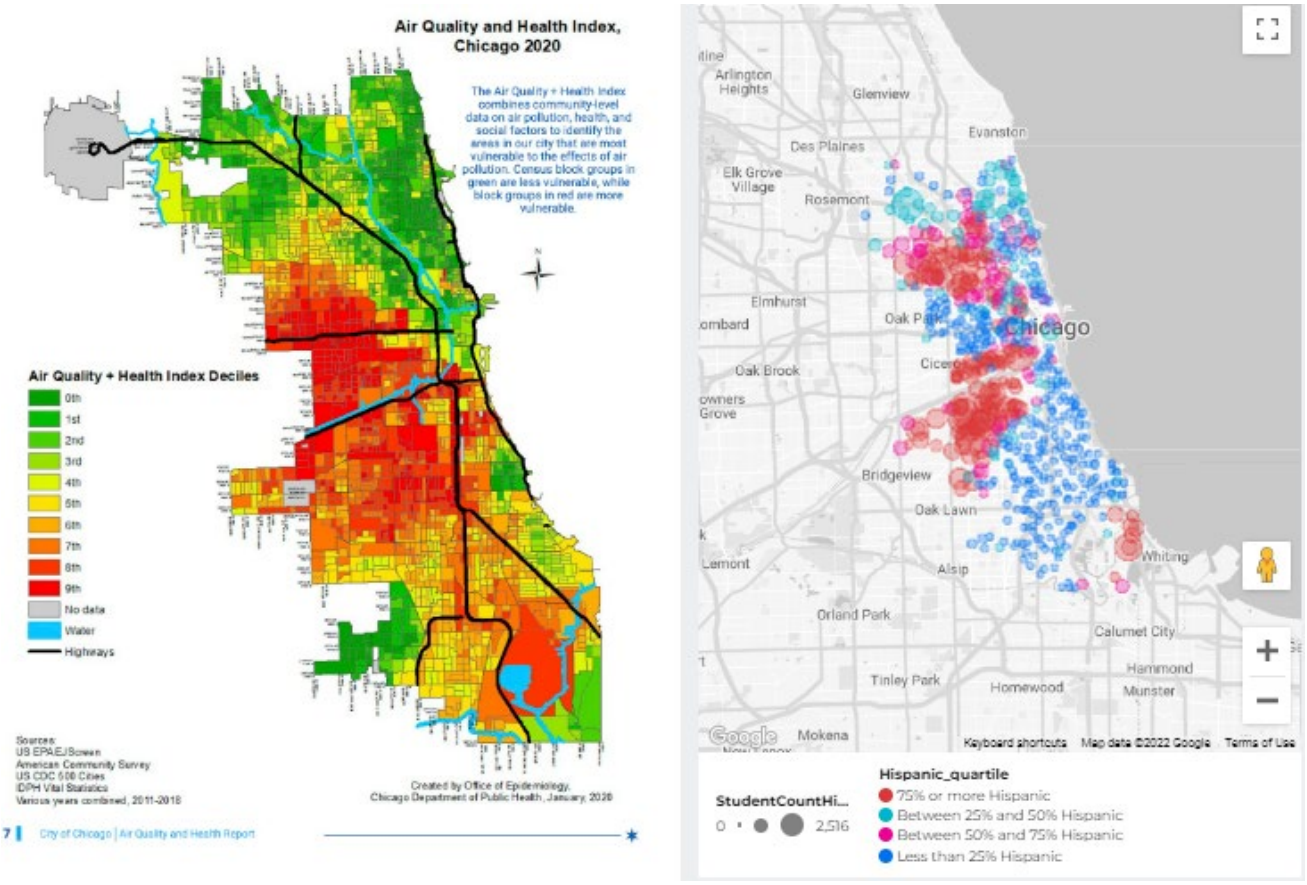


Figure 30. Air pollution hotspots in Little Village, Austin, Irving Park, Avondale, Englewood and Auburn Gresham. (Gupta et al, 2022) [77]



The UIC School of Public Health Emergency Management and Resiliency Planning program is conducting a three-part study on the environmental hazards in Chicago and found that they are more likely to be concentrated in neighborhoods with CPS schools containing higher Latinx enrollment. The study, which adopted a community-based participatory design, resulted in the creation of an interactive electronic story map that shows the distribution of certain hazard sources, including toxic release inventory facilities, rail hubs, asphalt plants and brownfields. The map in Figure 31 shows many of these industrial sites clustered near schools in Back of the Yards and Little Village (La Villita) and reveals that Hispanic/Latinx students are most likely to be affected. [78] [79] [80]

Figure 31. 2020 Air Quality and Health Index by Chicago census track (left) and Latinx/Hispanic student population at Chicago Public Schools (right). (Levine, 2022; Chicago Department of Public Health, 2020; Moser, 2022) [78] [79] [80]



Access to Care

Employer-based health insurance is the primary way that individuals access the healthcare system in the United States. Data collected prior to the COVID-19 pandemic indicates that, in Chicago, more that 21 percent of adults were uninsured; 53 percent received health insurance through their employer and 36 percent relied on public health insurance, such as Medicaid or Medicare. [14] Less than 4 percent of Chicago infants, children and teenagers under the age of 18 are uninsured. [14]

It is important to note that the pandemic changed the health insurance landscape with over 3 million workers estimated to have lost employer-based coverage in the U.S. in 2020 alone. [81] Twenty percent of Community Input Survey respondents reported a loss of employment and 16 percent were temporarily furloughed because of the pandemic. Overall, households with children or complex healthcare needs, as well as those with low-income, were more likely to report loss of employment. For example:

- 45 percent of respondents from low-income households lost employment vs. 19 percent of those who were not from low-income households
- 34 percent of respondents with less than a high school education lost income or employment vs. 17 percent of those with a college degree
- 29 percent of households including a disabled person lost employment vs. 18 percent of those that did not include a disabled person
- 26 percent of households with children lost employment vs. 18 percent of those without children

Many of the working poor do not qualify for Medicaid and are often employed in professions that do not offer employer benefits. In addition, even with healthcare marketplace and other subsidies, co-pays and deductibles remain cost-prohibitive for low-income families. Other factors, such as having undocumented status, further impact an individual's ability to obtain healthcare coverage. Delays in seeking needed healthcare frequently lead to worsening health problems and an increased need for expensive emergency care which can further increase poverty rates. Just under 9 percent of Community Input Survey respondents reported a lack of access to basic medical care during the pandemic. Similar to loss of employment, lack of access to medical care affected certain groups more than others:

> **"Immigrants are taking expired medication they brought from home (overseas) because they cannot access medical care."**
>
> - AHS FAMILY HEALTH CENTER FOCUS GROUP PARTICIPANT

- 21 percent of respondents with less than a high school diploma lacked access to basic medical care vs. 7 percent of those with a college degree
- 19 percent of low-income households lacked access to basic medical care vs. 8 percent of households that are not low income
- 15 percent of households including a disabled person lacked access to basic medical care, vs. 7 percent of those households that do not include a disabled person
- 12 percent of households with children lacked access to basic medical care vs. 7 percent of households with no children

Quality

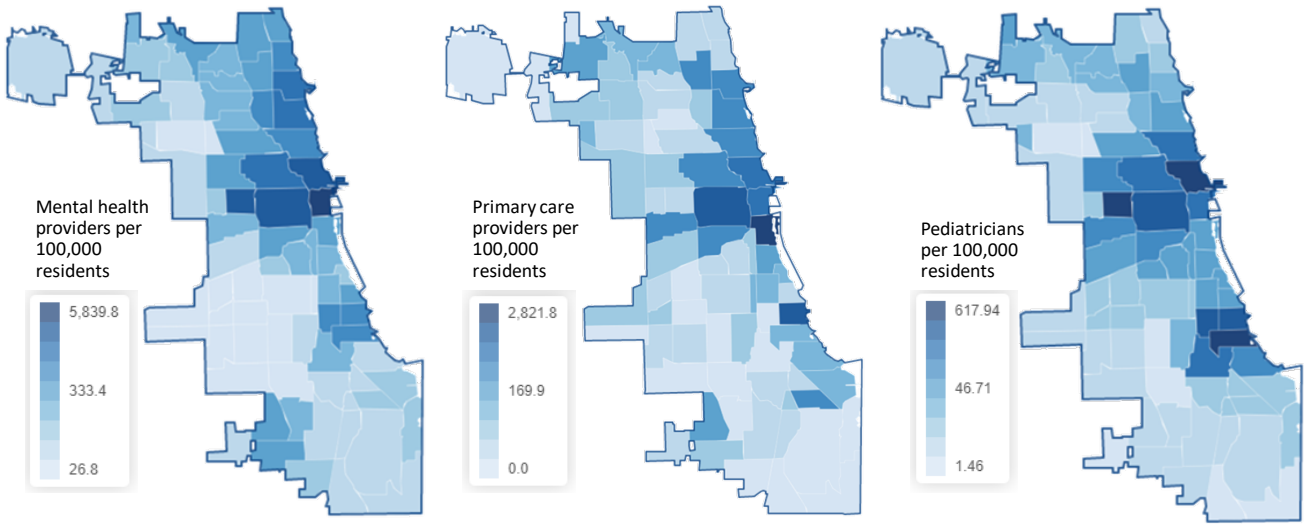
Community perception of the quality of healthcare depends on many factors, including the education and training of the healthcare staff, cleanliness and sanitation, or ease of scheduling appointments and wait times. Culturally-responsive care has been highlighted by Chicagoans as a specific need, as perceptions of discrimination on the basis of preferred language, race, ethnicity and gender identity are associated with worse health outcomes. For example, language barriers, poor provider communication or discriminatory or negative remarks from medical providers can make patients reluctant to seek necessary care, utilize preventive services or trust different providers in the future. [82]

> Not too many hospitals near the west side of Chicago that most people can go to in case they are hurt or shot at, most are far. Don't have access neither in the Southside. Also, they may not have insurance or qualify for assistance.
>
> - RUSH COMMUNITY HEALTH WORKERS FOCUS GROUP PARTICIPANT

Proximity to Healthcare Services

Despite being home to major academic medical centers specializing in world-class healthcare, Chicago has suffered from the loss of general hospitals and pediatric inpatient beds, predominantly on its South and West Sides. The city's healthcare workforce, including primary care providers and specialists alike, are concentrated in the wealthier North Side (Figure 32), whereas the South and West Sides of the city are more likely to have trauma deserts (areas without a nearby level I or II trauma hospital), pharmacy deserts (a community in which residents live more than a half a mile from a pharmacy and lack access to affordable transportation) and hospitals facing capital limitations. The impacts of the ongoing COVID-19 pandemic, along with consolidations and closures among healthcare institutions, have and continue to exacerbate these inequities. For example, during 2019-2020, multiple obstetric units and hospitals on Chicago's South Side temporarily or permanently closed. This left only three birthing hospitals on the South Side, while six remained in the North and West Sides of the city.

Figure 32. Concentrations of healthcare workforce: Mental health providers, 2021 (left); primary care providers, 2011 (middle); pediatricians, 2021 (right); by Chicago community area.



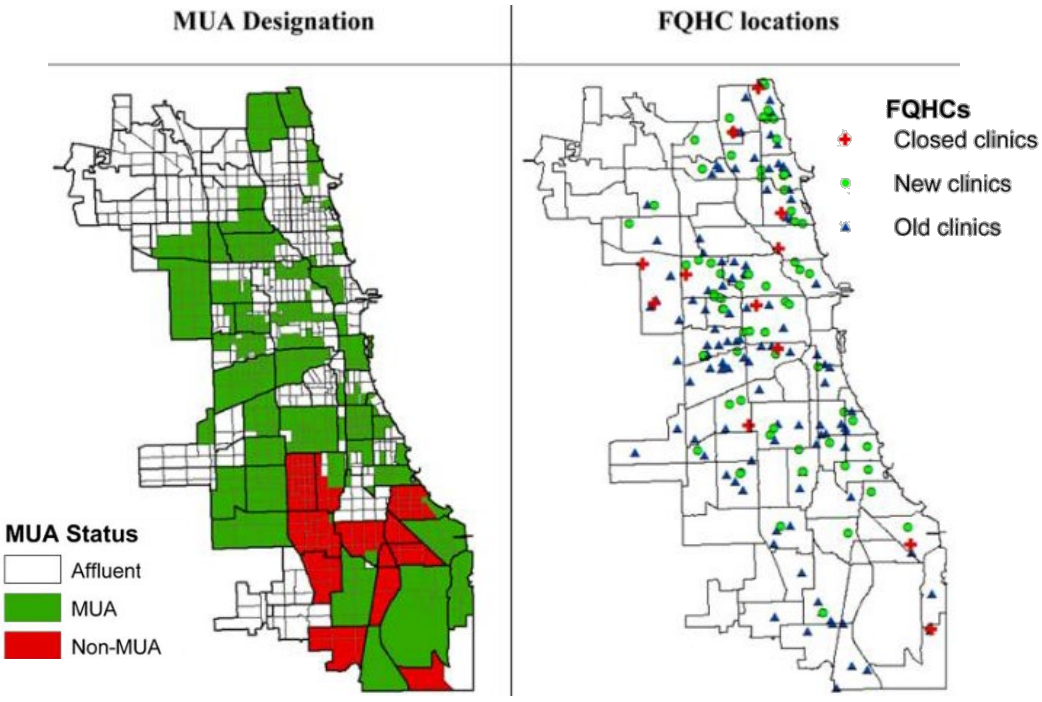
Sources: Mental Health Data Source: CMS National Provider Identifier (NPI); Primary Care Data Source: Health Resources & Services Administration American Medical Association Primary Care Physician Data; Pediatrics Data Source: CMS National Provider Identifier (NPI).

Medically Underserved Areas (MUAs) are geographic areas federally designated as lacking access to primary care services, which are eligible for enhanced reimbursement from Medicare and Medicaid for primary care services through Federally Qualified Health Centers (FQHCs). FQHCs are Lurie Children's most significant partners in providing healthcare to youth living in MUAs and provide comprehensive primary care and preventive care, including health, oral health, mental health and substance use services to persons of all ages, regardless of their ability to pay or health insurance status.

Recent studies have shown that not all neighborhoods that are MUA eligible benefit from safety net health services. In Figure 33, census tracts that were eligible and designated for MUA were clustered on the far North and West side of Chicago. The 87 census tracts that were eligible for MUA but not designated as such were predominantly on the South Side, Black and low-income. [83]

> "It's easy to get to the hospital but, only certain hospitals can help you with certain things, like a trauma center."
>
> - BREAKTHROUGH URBAN MINISTRIES FOCUS GROUP PARTICIPANT

Figure 33. Distribution of Medically Underserved Areas and Federally Qualified Health Centers in Chicago. (Kim et al., 2020) [83]



Gray lines indicate census tracts and dark lines indicate Chicago community areas. Unshaded areas indicate affluent areas that are not eligible for MUA; Green areas indicate poor areas that are eligible and designated as MUA; Red areas indicate poor areas that are eligible but not designated as MUA

Chronic Health Conditions

Chronic diseases are broadly defined as physical, cognitive or emotional health conditions that last for longer than three months, require ongoing medical attention and/or limit activities of daily living. In the United States, an estimated six in 10 adults have a chronic condition and four in 10 have two or more chronic diseases, including heart disease, cancer and diabetes, which are the leading cause of disability and death. [84] The COVID-19 pandemic clearly demonstrated the importance of preventing and effectively managing chronic diseases, many of which significantly increase a person's risk of severe illness from a COVID infection. [85]

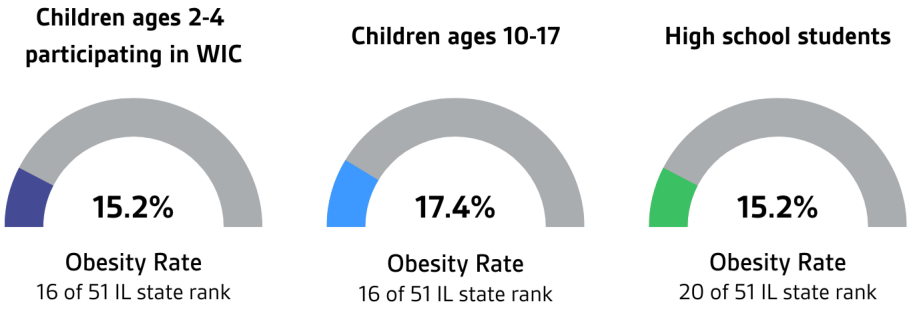
Chronic diseases are not limited to adults. In the United States, more than 40 percent of school-aged children and adolescents have at least one chronic health condition. [86] Obesity, which is considered a chronic disease, is a risk factor for many other chronic illnesses including asthma and other pulmonary conditions, type 2 diabetes and heart diseases. [87]

Overweight and Obesity

In the last decade, evidence suggests that overweight and obesity trends began to decline. This was observable in the overall declines recorded by Chicago Public School students between 2010-2018. However, nationally, the obesity rate for children and youth ages 2-19 years rose from 19.3 percent in August 2019 to 22.4 percent in August 2020. During the COVID-19 pandemic, the monthly increase of body mass index (BMI) was double pre-pandemic rates. [88] Young people who were already overweight or had obesity and children ages 6-11 years had higher rates of increases than other youth. [89]

Based on the most recent local data available, which is all pre-pandemic, Illinois had the 14th highest rate of obesity (17.4 percent) compared to the rest of the country. Below (Figure 34) are the 2018 obesity rates among children ages 2-4 years enrolled in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), as well as rates for older youth. Nationally, the obesity rate for children ages 2-4 years participating in WIC declined between 2010-2018, the most recent data available for this age group; rates among older children and adolescents aged 10-17 years and high school students held steady during the same period.

Figure 34. Obesity rates in Illinois among children ages 2-4, 2018 (left), children ages 10-17, 2019-20 (middle), high school students, 2019 (right). (stateofchildhoodobesity.org)



Even though the 2010-2018 data showed promising overweight and obesity trend declines, the rates of improvement differed by race and ethnicity. In general, white students had the most notable improvements (19 percent), more than three times greater reduction compared to all other students combined (5 percent). Overweight and obesity rates were highest in Hispanic/Latinx students (47 percent) and second highest in Black students (39 percent). The highest prevalence was seen in Hispanic/Latinx sixth grade boys at nearly 58 percent. [61] As discussed in the Social and Structural Influencers of Health section of this report, these disparities exist for many reasons, including that Chicago's Black and Hispanic/Latinx communities primarily live in low-Child Opportunity Index (COI) areas that have experienced historically disinvestment with limited access to affordable and nutritious foods, safe places to exercise and other necessities for healthy living.

Asthma

As mentioned earlier, obesity puts millions of young people at risk for chronic disease, the most common of which is asthma. Nationally, just over 8 percent of youth ages 0-17 years reported having asthma in the 2016-2018 National Health Interview Survey. [90] Children and youth with obesity are more likely to experience severe asthma, poorer disease control and overall poorer quality of life. [91] Exposure to environmental factors, such as cigarette smoke, dust, mold, or air pollution, can also induce or exacerbate asthma in children who are genetically predisposed to have the illness. Nationally, asthma rates are more prevalent among certain subpopulations:

- Boys under 18 years
- Youth ages 12-17 years
- Black, Hispanic/Latinx and multiracial individuals
- People living below the federal poverty line [90]

Chicago has been identified as an asthma epicenter, with higher prevalence in the city's West and South Sides. According to a Lurie Children's study conducted in 2020, 16 percent of Chicago families include a child diagnosed with asthma, higher than state and national levels of the disease (Figure 35). Of those families, 24 percent reported that their child visited an emergency room or urgent care center because of their asthma in the last year. While these visits can be crucial and provide life-saving treatment for children experiencing an asthma attack, they are also considered one of the most preventable emergency room visits. Parents who were in worse health themselves were also more likely to have a child with asthma. [92]

Figure 35. Effects of having a child with asthma among Chicago parents. (Voices of Child Health in Chicago, 2020) [92]

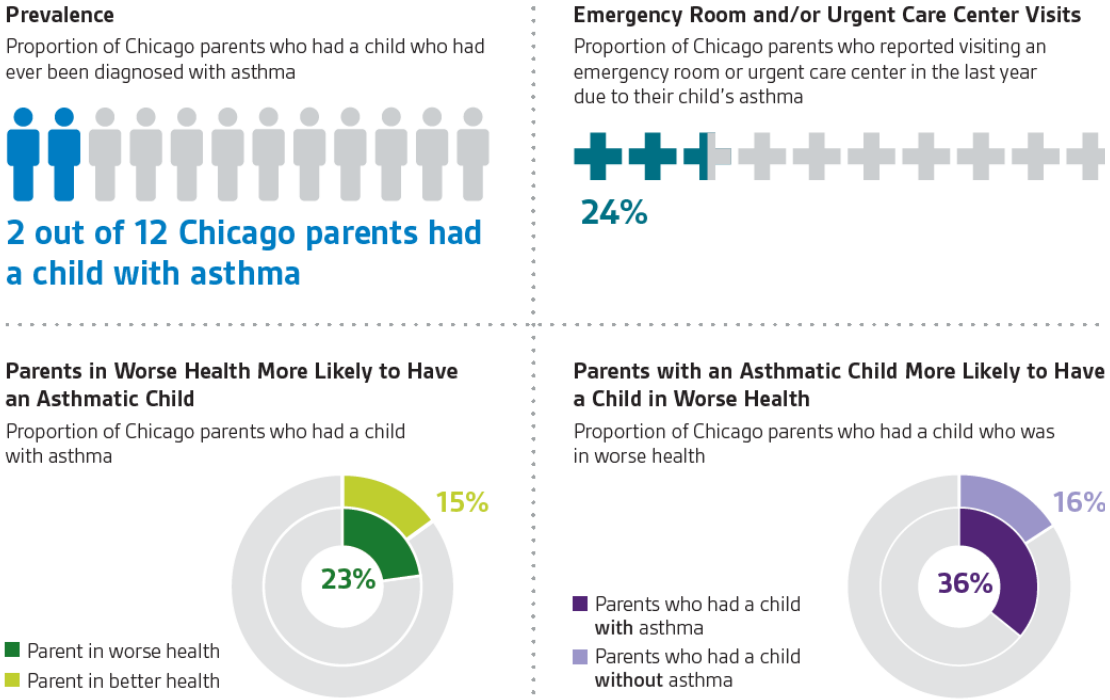
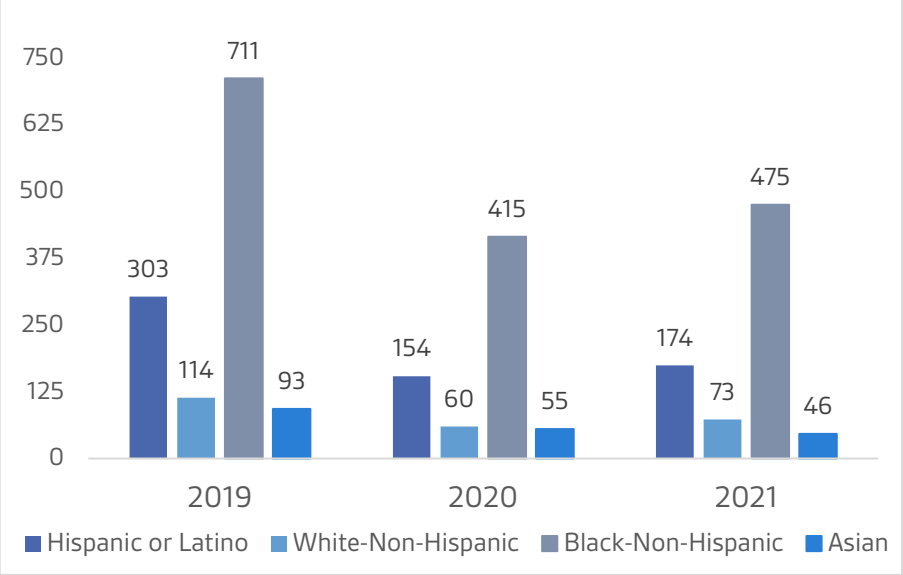


Figure 36, a graph of asthma-related hospital visits for children and youth, indicates that the overall rate of visits declined significantly during in 2020, but began to increase again in 2021. Rates were highest among Black and Hispanic/Latinx patients. This is not surprising, given that asthma can be induced and exacerbated by substandard housing (such as damp or mold) and poor air quality (such as pollution), both of which are disproportionately prevalent in the city's predominantly Black and Hispanic/Latinx South and West Sides.

Figure 36. Asthma-related emergency department visits and hospitalization rates among patients 0 to 19 years residing in Chicago per 10,000 by race and ethnicity. (COMPData Database, Illinois Hospital Association, 2019-2021)



Diabetes

Children with obesity are also four times as likely to develop type 2 diabetes. [93] Diabetes is the eighth leading cause of death in Illinois, with 11 percent of adults diagnosed with the disease (the same as the national average). [94] In 2019, the percentage of Chicago adults diagnosed with diabetes (11 percent) is similar to the state, but the rates in the city's wealthier North Side are generally below 5 percent, whereas those on the South and West Sides are closer to 20 percent (Figure 37). [95] It is important to note, as discussed in the Social Influencers of Health section, the areas with the highest prevalence of diabetes are also those with limited access to grocery stores with affordable, nutritious foods.

Figure 38 below demonstrates that, while there are fewer type 2-diabetes related hospital visits for children and youth than for asthma, racial and ethnic disparities persist in this group, as well.

Figure 37. Percentage of Chicago adults diagnosed with diabetes. (Diabetes Health Atlas, CDC)

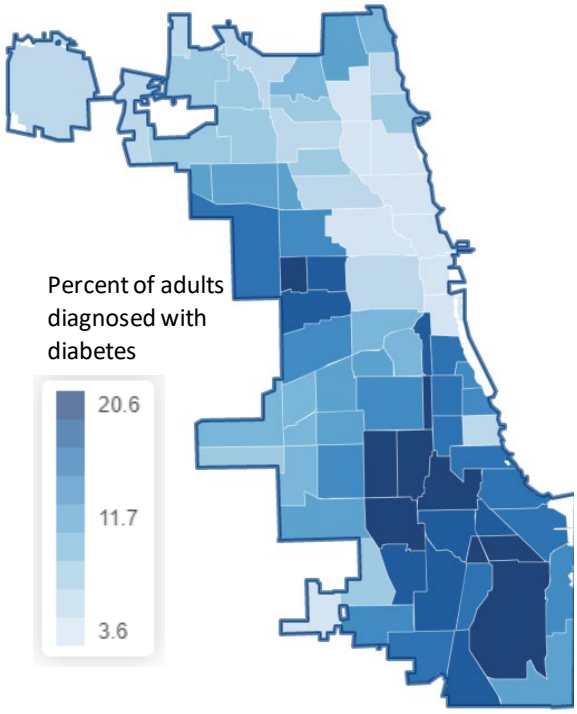
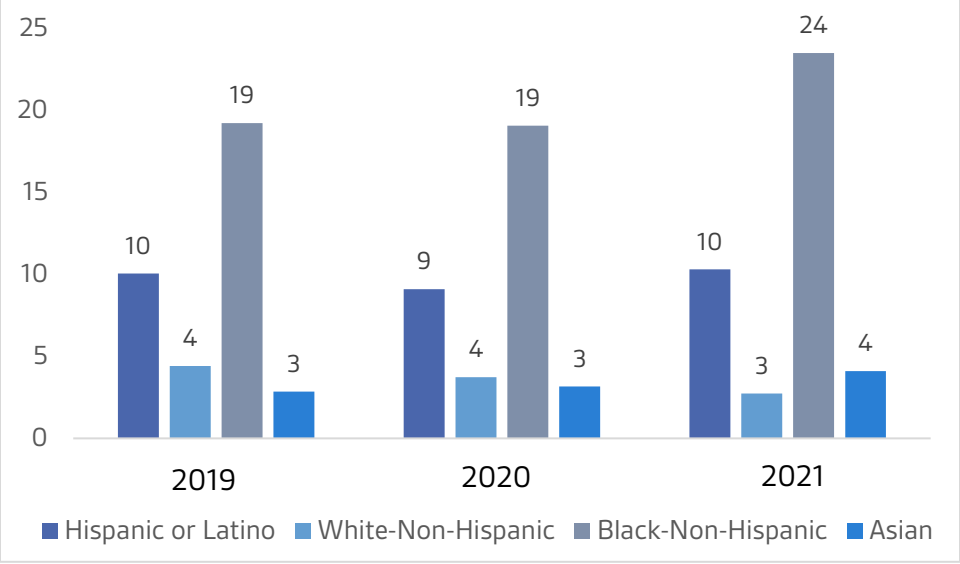


Figure 38. Type 2 diabetes related emergency department visits and hospitalizations among patients 0 to 19 years residing in Chicago per 10,000 by race and ethnicity. (COMPData Database, Illinois Hospital Association, 2019-2021)



> **The cost to caregivers is just extremely stressful. Stress is toxic. People of privilege are going to be fine, but large numbers of people who don't have those advantages are going to struggle.**
>
> - FAMILY PARTNERSHIP COUNCIL FOCUS GROUP PARTICIPANT

Complex Chronic Conditions

With the medical and surgical advances of recent decades including improved treatment for acute and chronic diseases, more youth are living with medical complexities who are dependent on technology, at risk of frequent hospitalization and have an elevated need for care coordination. [96] Figure 39 indicates the most common complex chronic conditions for Chicago youth under 19 and young adults between the ages of 20-24 years, including emergency department (ED) visits and hospitalizations. Figure 40 provides a breakdown of the race and ethnicity for pediatric patients with complex medical conditions between 2019-2021.

Figure 39. Proportion of emergency department visits and hospitalizations for complex chronic conditions among patient 0 to 24 residing in Chicago, by age group and type. (COMPData Database, Illinois Hospital Association, 2019-2021)

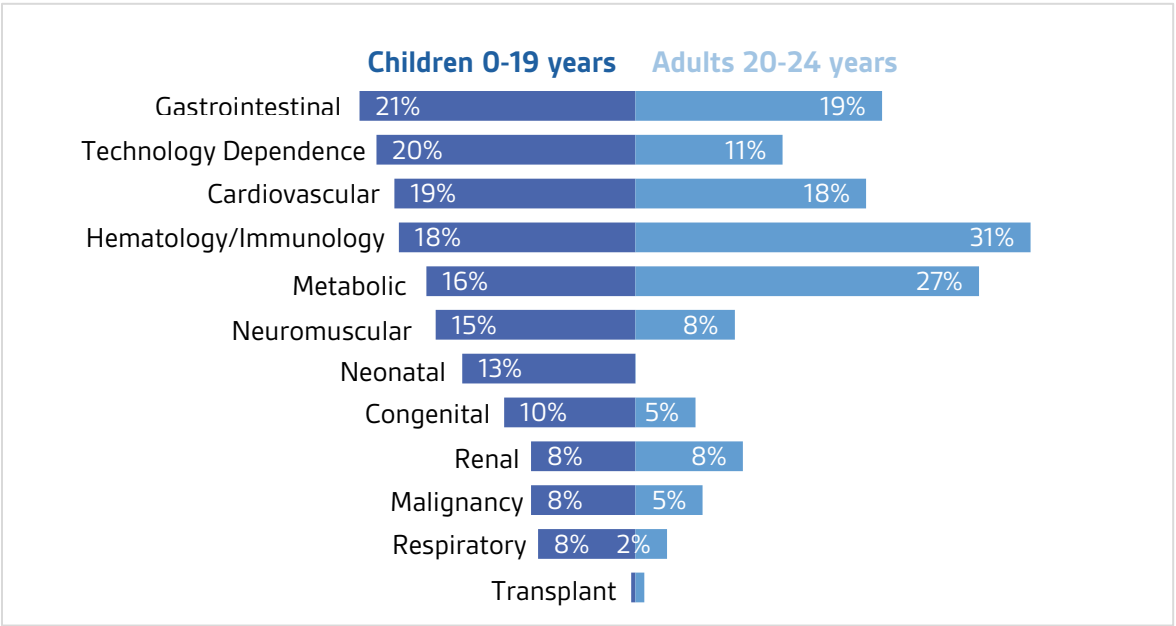
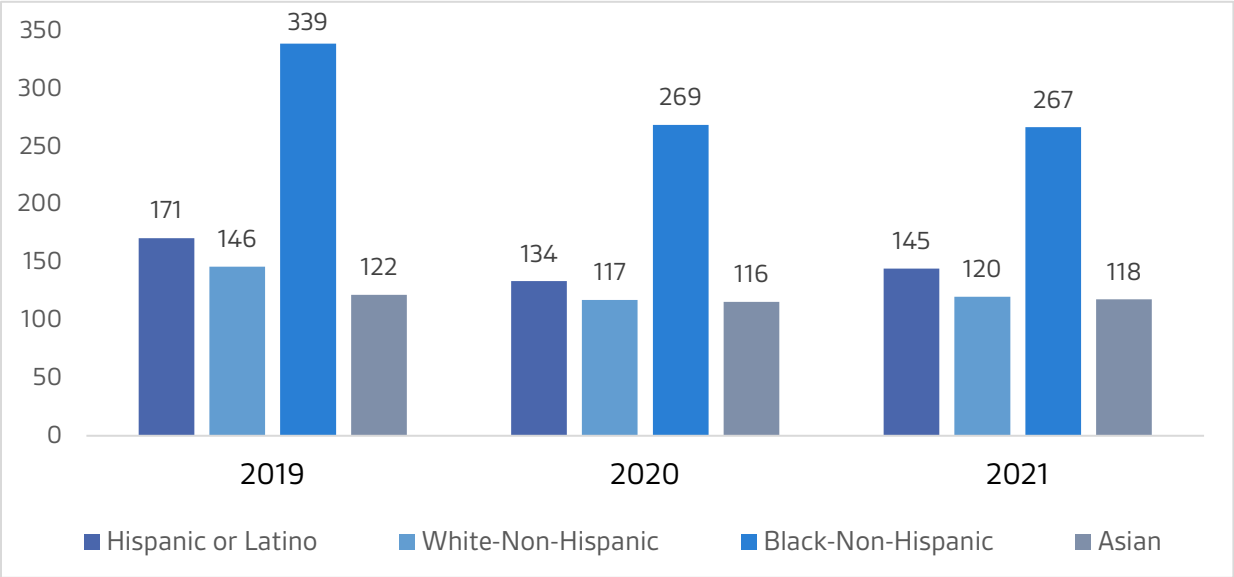


Figure 40. Complex chronic conditions emergency department visits and hospitalization rates among patients 0 to 19 years residing in Chicago per 10,000 by race and ethnicity. (COMPData Database, Illinois Hospital Association, 2019-2021)



> **For people like [my daughter] who require such physical support, there is very little upside to the COVID-19 pandemic. It took everything in the world to keep her up where she was and without that support at home, we just can't provide that help. It's no joke and the knock-on effects are going to be enormous in the next 5-10 years.**
>
> - FAMILY PARTNERSHIP COUNCIL FOCUS GROUP PARTICIPANT

Recent studies have shown that one in 20 children are discharged after hospitalization to some level of home healthcare. However, family caregivers of children with medical complexities report physical, emotional and financial challenges for providing quality care at home, particularly for children with medical technology dependence like a home ventilator. Generally, the difficulty of navigating insurance coverage, approvals for home healthcare supplies, lower insurance reimbursements and workforce challenges are significant barriers to providing quality home healthcare. Often, the lack of alternative appropriate childcare means that a caregiver, usually the mother, would take on the role of caregiver and withdraw from the workforce. [97] For many Chicago families with a child with medical complexities, the COVID-19 pandemic exacerbated these challenges.

Mental and Behavioral Health

Mental health is an integral and essential component of overall health and wellbeing. [98] Mental health includes emotional, psychological and social well-being and it affects how we think, feel and act. [99] In addition, it influences how a person handles stress, relates to others and makes healthy choices. [99]

At the end of 2021, in response to the growing youth mental health crisis, the Surgeon General of the United States released a Surgeon General's Advisory to call attention to this urgent public health issue stating that "the challenges today's generation of young people face are unprecedented and uniquely hard to navigate. And the effect these challenges have had on their mental health is devastating." [100]

Just two months prior, the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry and Children's Hospital Association released a joint declaration of a national emergency in child and adolescent mental health. [101]

Mental health continues to be a top priority for communities in Chicago. Some of the mental health needs expressed by community members in focus groups included holistic integrated care, improved education and systems for addressing mental health crises, reducing stigma around treatment, improving access to treatment and addressing the underlying social and structural influencers of mental health. As previously discussed, over 1700 or 43 percent of community input survey respondents and 48 percent of respondents in households with children identified mental health as the most important health need in their communities. Forty-four percent of community input survey respondents identified access to mental health services as being needed to support improvements in community health.

> **"Within Austin, mental health is the most urgent health issue. Education around it, comfort with talking about it, making it accessible while also making sure that these young people understand that it's okay to not be okay sometimes. They see having those type of issues as a failure, and they don't understand how mental health affects their entire lives. In Austin, we've had a spike of young people committing suicide, family losses, dropping out of school. For class of 2020, kids are feeling like that they didn't excel or accomplish anything."**
>
> - PARTICIPANT IN THE LURIE CHILDREN'S EMPLOYEE FOCUS GROUP FOR AUSTIN RESIDENTS

Mental health impacts everyone; however, children, adolescents and young adults have unique needs related to mental health. In Chicago, availability of preventative services and treatment are severely limited despite continually rising rates of youth depression, anxiety, suicide attempts and other mental health conditions. The trauma and social isolation resulting from the pandemic have worsened mental health outcomes among youth.

Additionally, the inequitable distribution of opportunity and resources in communities leads to some populations of youth and young adults experiencing a greater burden of mental health conditions. During

focus groups held throughout Chicago and through reviews of current assessments and research, several youth populations were identified as having priority needs related to mental health.

- In 2022, nearly half of youth who identify as LGBTQ+ reported seriously considering suicide in the past year and 60 percent who wanted mental health care were not able to get it. [102] Nearly three-quarters of LGBTQ+ youth have experienced discrimination for their identity, which adversely impacts mental wellbeing. [102] LGBTQ+ youth who experienced discrimination reported attempting suicide nearly three times more than LQGTB+ youth who did not experience discrimination. [102]
- Up to 75 percent of youth involved in the criminal legal system meet the criteria for a mental health or substance use disorder. [103] [104] Early identification and intervention with culturally-appropriate, community-based mental health services is the single most critical element in successfully diverting individuals from the criminal legal system. [105] Lack of these services has enormous fiscal, health and human costs, as is evident by the high number of youth with unaddressed mental health conditions involved in the legal system. [105]
- Immigrants and refugees face unique challenges related to issues such as relocation, forced migration, war and conflicts, social isolation, racism and discrimination. Refugee children and teens have high rates of traumatic experiences, especially unaccompanied youth, resulting in adverse mental health. Youth refugees face significant barriers to mental health access, including culturally and linguistically appropriate services and stigma. [106] Children of immigrants experience financial, cultural and emotional caregiving responsibilities on behalf of their parents, in addition to fear of deportation for children of undocumented immigrants, resulting in rates of depression and anxiety nearly double of their parents. [107]
- Youth in the foster care system have a disproportionate burden of mental health issues with estimates of up to 85 percent experiencing a mental health disorder. Children and adolescents in foster care often have high exposure to adverse childhood experiences. [108] [109]
- Low-income families who struggle to afford out-of-pocket expenses are vulnerable to changes in program funding and the closure of public mental health centers. [110]

When appropriate community-based treatment is not available, those experiencing serious mental health complications often seek care in emergency departments which are often ill-equipped to treat patients promptly and lack the tools to effectively connect them to long-term care. [111] In addition, focus group participants highlighted that other types of emergency services are not able to handle mental health crises and expressed reluctance to use them. In particular, police intervention was associated with negative impacts on outcomes.

Over 2.3 million youth (10 percent) age 12-17 years in the U.S. cope with severe major depression and more than 60 percent do not receive any mental health treatment. [112] One in three young adults age 18-25 years experience mental health conditions with nearly 4 million having serious thoughts of suicide. [113] Nationally, even for those who receive treatment, fewer than one in three youth receive consistent mental health care. [112] Youth substance use rates continue to be concerning as many youth and young adults use drugs or alcohol to self-medicate. Based on SAMHSA's 2020 National Survey on Drug Use and Health,

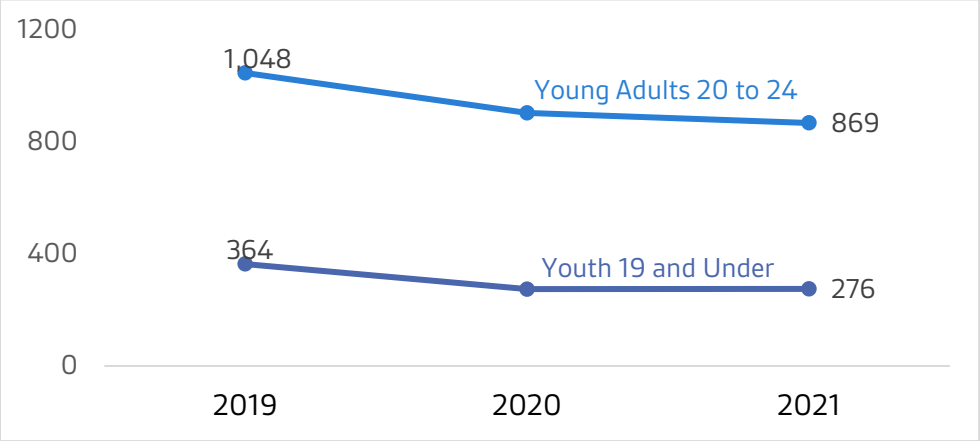
NAMI (National Alliance on Mental Illness) reports that 15-20 percent of youth and young adults who already used drugs or alcohol reported increased drug and alcohol use and Mental Health of America reports that 4 percent of youth in their 2022 national survey reported a substance use disorder in the past year. [112]

The impacts of childhood adversity, including adverse childhood experiences (ACEs), trauma and toxic stress have been well established and can lead to lifelong, physical and mental health issues. [114] More than two out of three report at least one traumatic event by the age of 16 years. Childhood adversity can manifest itself in many different forms, such as learning problems, increased use of physical and mental health services, increased involvement with the legal system and long-term health problems. Child adversity is also a risk factor for nearly all substance use and behavioral health disorders. [115]

In Illinois, 11 percent, or over 100,000 youth, experienced severe depression in 2022 and just over 4 percent, or 40,000 youth, reported a substance use disorder in line with the national average. [113] It is common for youth with depression to experience other behavioral health disorders as well, such as anxiety and disorderly behavior. Younger children also experienced mental health issues with one in six U.S. children aged 2–8 years diagnosed with a mental, behavioral or developmental disorder. [110] Consistent with other health disparities, youth in lower-income households also have higher rates of mental health disorders and less access to healthcare providers. [110]

The COVID-19 pandemic worsened the youth mental health crisis across the country. In Chicago, the Voices of Child Health in Chicago Parent Panel Survey found that 44 percent of young children experienced an increase in mental or behavioral health symptoms during the pandemic. [116] Nearly one in five youth and one in four young adults report that the pandemic had a significant negative impact on their mental health. [113] Figure 41 shows the rate of emergency department visits and hospitalizations for youth (0-19 years) and young adults (20-24 years) between 2019 and 2021.

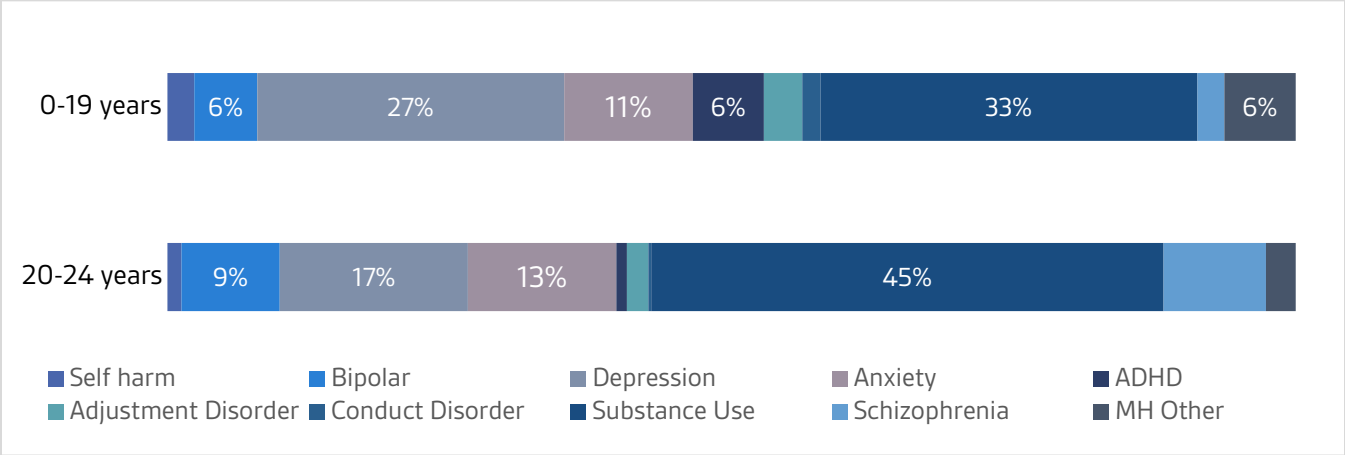
Figure 41. Rates of emergency department visits and hospitalizations for mental health conditions among patients 0 to 24 years residing in Chicago per 10,000 by age group. (COMPData Database, Illinois Hospital Association, 2019-2021)



During the pandemic, the decline in available inpatient beds due to physical distancing public health guidance and staffing shortages due to COVID-19 illness contributed to the resulting drops in ED and hospital visits in 2020 and 2021. At Lurie Children's, in fiscal years 2021 and 2022, patient intakes were limited when as many as 30 percent of psychiatry and behavioral health staff were not able to work due to COVID-19 illness. Between fiscal years 2019 and 2021, Lurie Children's saw a 200 percent uptick in psychiatric patient deflections with 97 percent of those due to a full census – meaning we could not accept these patients because all of our staffed beds were full. [117]

Figure 42 shows the proportion of mental health related ED visits and hospitalizations in Chicago for selected conditions in 2021. For patients with more than one condition, we attributed the mental health condition in the following sequence: self-harm, schizophrenia, bipolar, depression, adjustment disorder, anxiety, attention deficit hyperactivity disorder (ADHD), conduct disorder, substance use, or other. The majority of mental health visits for youth 0-19 years were substance use (33 percent), depression (27 percent) and anxiety (11 percent). For young adults, although the top three reasons were the same, nearly half (45 percent) were for substance use followed by depression (17 percent) and anxiety (13 percent).

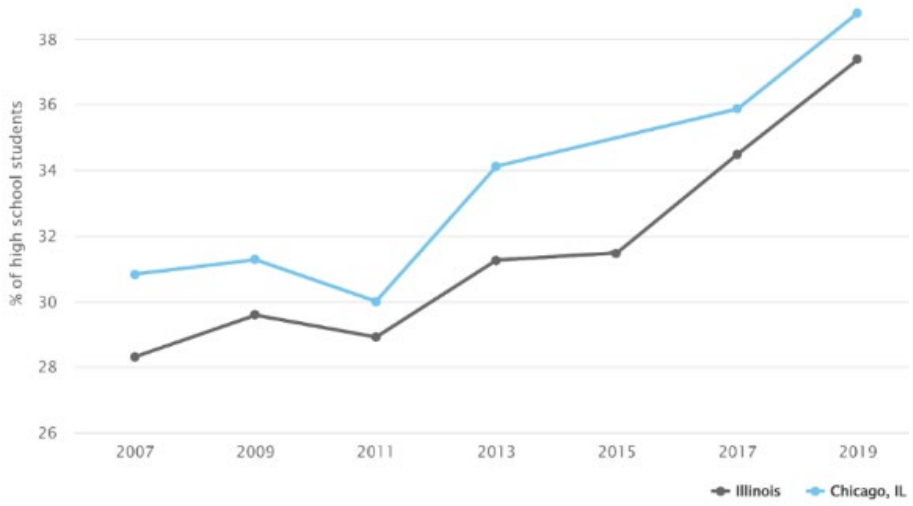
Figure 42. Proportion of mental health related emergency department visits and hospitalizations by type and age group. (COMPData Database, Illinois Hospital Association, 2021)



Depression, Anxiety, ADHD and Bipolar Disorder

Self-reported depression among youth has been increasing over time. [118] In 2019, 39 percent of Chicago high school students reported experiencing symptoms of depression, specifically that they felt sad or hopeless almost every day for two weeks or more in a row, impacting their ability to do usual activities (Figure 43). This is a 125 percent increase since 2007 and consistently higher than the Illinois average. Like many adverse health and economic outcomes, the pandemic exacerbated youth depression and anxiety with estimates suggesting a doubling effect. [119]

Figure 43. Depression among high school students. (Youth Risk Behavior Surveillance System, CDC) [118]

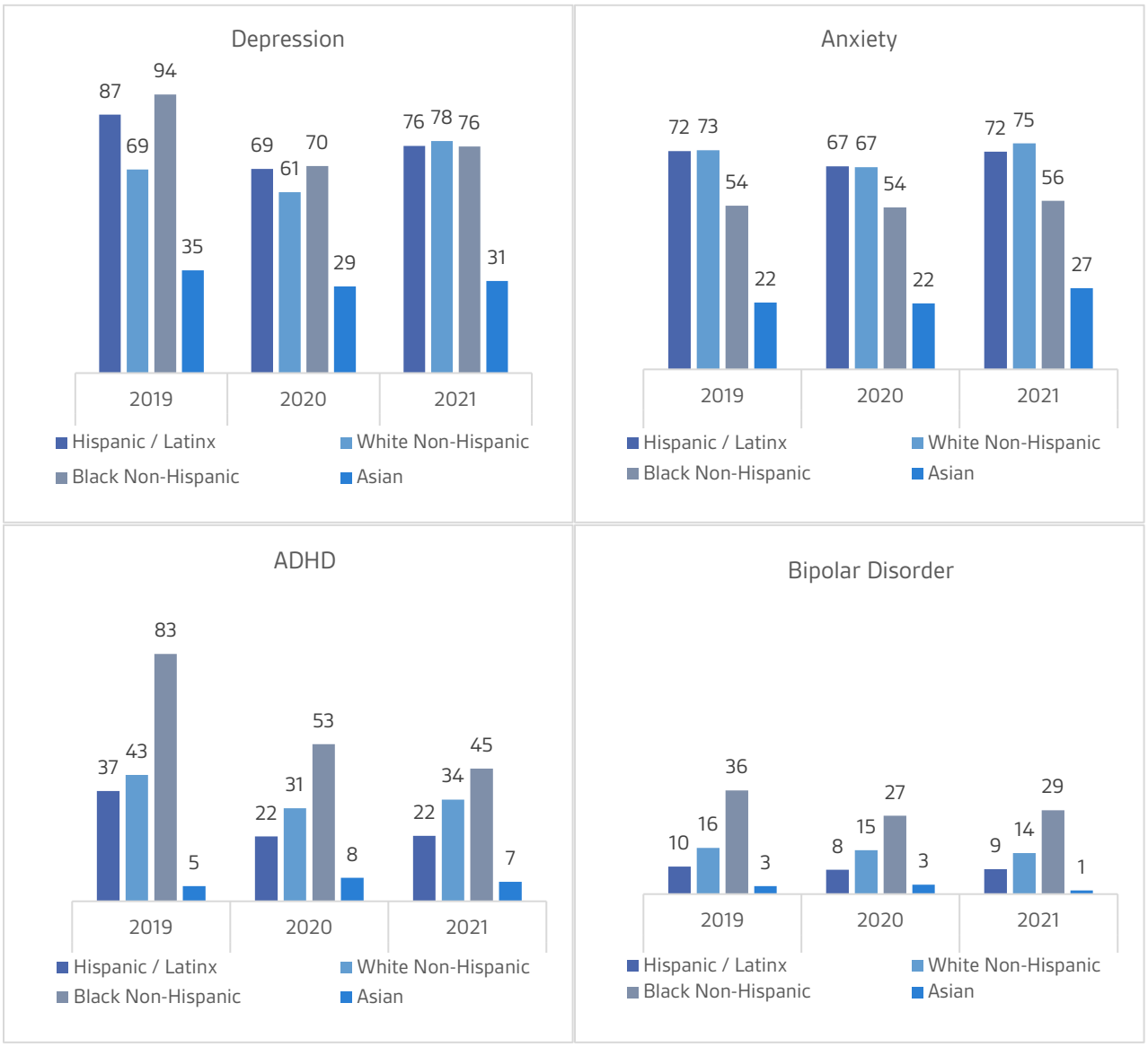


A direct link exists between social and economic inequity and mental health. [120] In addition, experiences of individual, structural, direct and/or vicarious racism, discrimination, social exclusion and trauma can have lasting impacts on mental health. [121] Racial and ethnic disparities are evident in ED visits and hospitalization rates in Chicago for youth with common mental health conditions, although the disparities are not consistent over time. It is important to note that mental health issues that rise to the need of immediate emergency care or hospitalization do not capture the less acute mental health issues that many young people experience.

Although rates for Black and Hispanic/Latinx youth presenting with depression were 26-37 percent higher in 2019, the gap closes by 2021 (Figure 44). ED visits and hospitalizations for anxiety are comparable between Hispanic/Latinx and white youth, while visits for Black youth are 20-25 percent lower than those. The most notable disparity is that of Asian youth, whose ED and hospitalization rates were as much as 68 percent lower. For attention-deficit/hyperactivity disorder (ADHD) and bipolar disorder, Black youth in Chicago had the highest rate of ED visits and hospitalization between 2019 and 2021.

> **We need more mental health supports, especially due to COVID and isolation – again, in the language individuals speak.**
>
> - PARTICIPANT IN THE LURIE CHILDREN'S EMPLOYEE FOCUS GROUP FOR AUSTIN RESIDENTS

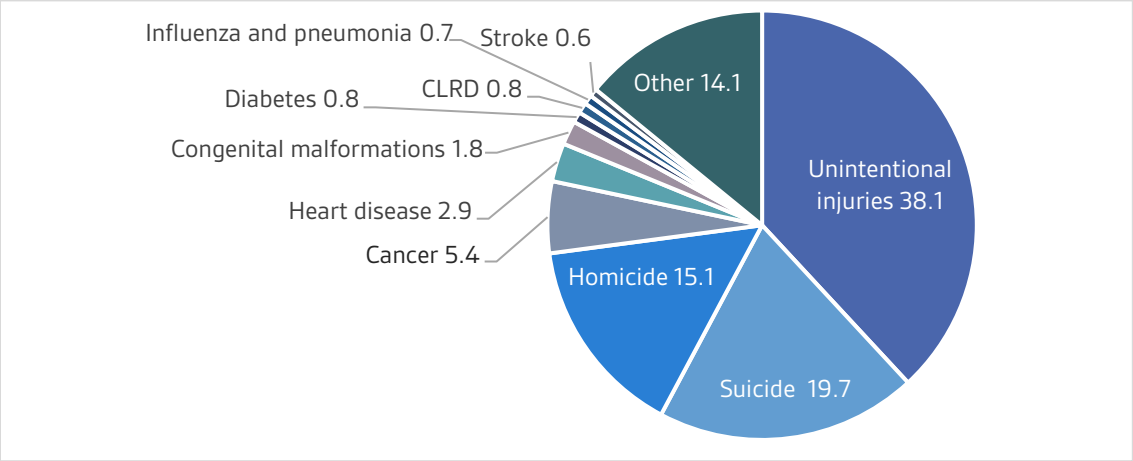
Figure 44. Rates of common mental health related emergency department visits and hospitalizations among youth 0-19 years residing in Chicago per 10,000 by race and ethnicity. (COMPData database, Illinois Hospital Association, 2019-2021)



Suicide and Self Harm

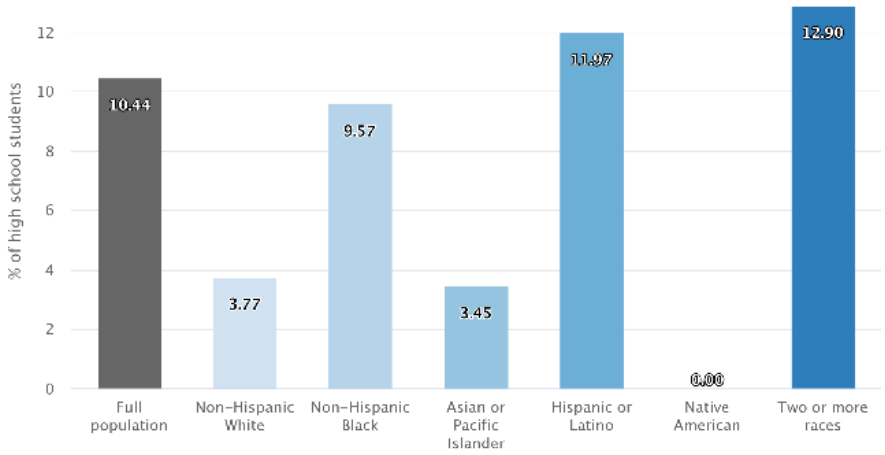
Overall, across the US, there has been a year over year rise in youth suicide since 2007. [122] Even before the pandemic, suicide rates for youth and young adults aged 10-24 years increased nearly 60 percent between 2007 and 2018. [122] In addition to increased rates of depression and anxiety, emergency department visits for youth suicide attempts among youth aged 12-17 years increased by 31 percent in 2020 compared to 2019. [123] In 2019, suicide was the second leading cause of death for youth and young adults (Figure 45). [124]

Figure 45. Percentage distribution of the ten leading causes of death nationally for young people age 10-24 years in 2019. (National Vital Statistics Report, Centers for Disease Control and Prevention) [124]



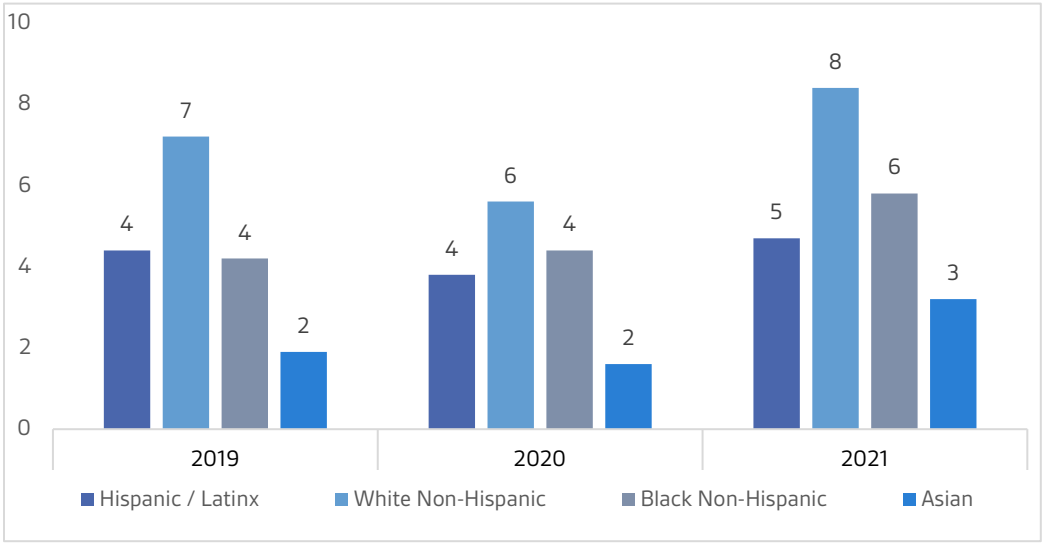
Nationally, in 2019, the suicide rate per 100,000 was highest for American Indian or Alaskan Native youth (23) and white youth (6.1) compared to Black (4.3), Asian or Pacific Islander (5.1) and Hispanic youth (4.4). [125] However, the largest percent increase was in Black and Asian or Pacific Islander youth. There are also significant disparities in suicide attempts by race and ethnicity. In Chicago, multiracial, Hispanic/Latinx and Black youth carry the highest burden (Figure 46). [123]

Figure 46. Suicide attempts among high school students in Chicago by race and ethnicity. (Youth Risk Behavior Surveillance System, CDC, 2019) [118]



Hospital discharge data for ED visits and hospitalizations related to self-harm, including attempted suicide, in Chicago align more closely with national trends. White youth had the highest rate for self-harm related visits between 2019 and 2021 with visits increasing across all race and ethnicities in 2021 (Figure 47).

Figure 47. Rates of self-harm related emergency department visits and hospitalizations among youth 0-19 years residing in Chicago per 10,000 by race and ethnicity. (COMPData database, Illinois Hospital Association, 2019-2021)



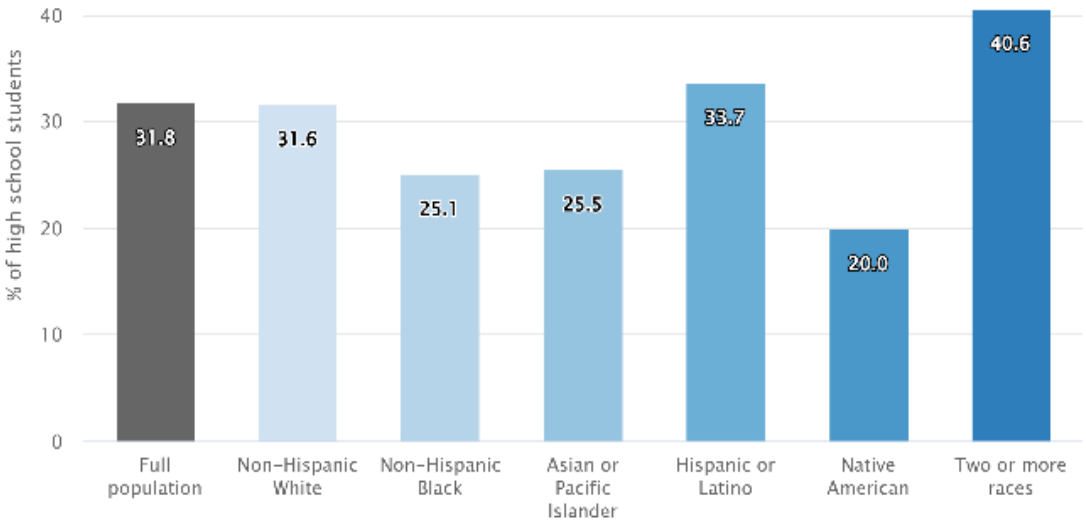
Substance Use and Behavioral Addictions

As previously discussed, SAMHSA's National Survey on Drug Use and Health found youth drug and alcohol use increased in 2020 for those who already used; however, researchers at the University of Michigan and the National Institute on Drug Abuse found a decrease in youth drug use in 2021 through an annual survey of eighth, 10th and 12th grade students. The 2021 survey reported the largest one-year decrease in overall illicit drug use across all grades since the survey began in 1975. [126] However, substance use among these age groups remains a concern and future surveys as youth progress through the COVID-19 pandemic will show if the overall reported downward trend persists.

A 2021 study of data collected from 2015-2018 estimates the lifetime prevalence of substance use among adolescents at 27 percent. [127] In this same study, prevalence of substance use disorders varied by substance and age group. [127]

In Chicago in 2019, more than 30 percent of high school students reported being offered, sold or given an illegal drug on school property which is higher than the national and state averages. [118] Figure 48 shows the percent of these youth by race and ethnicity. Although the rates were relatively consistent, multiracial youth reported the highest rates and Native American youth the lowest.

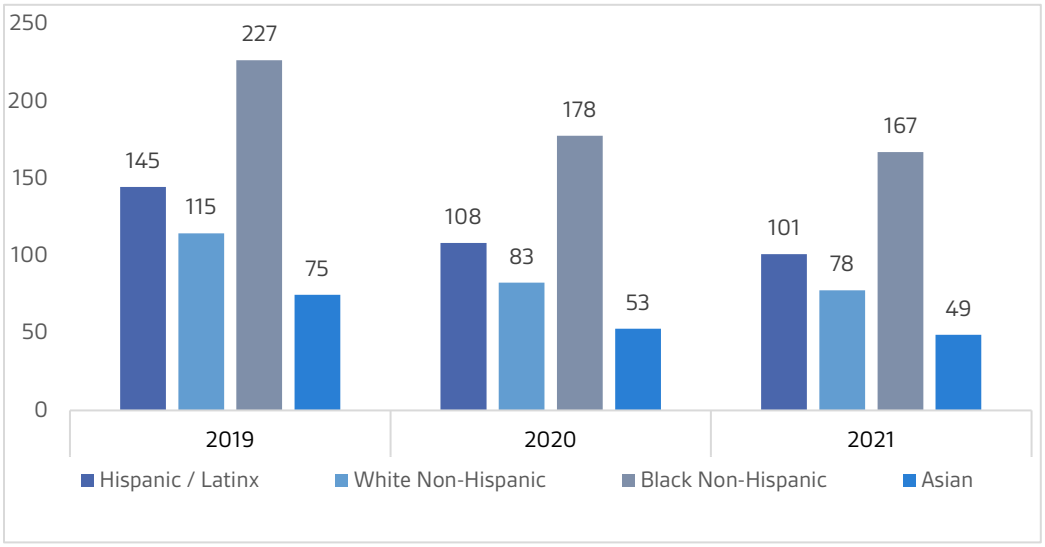
Figure 48. Students reporting being offered, sold or given an illegal drug on school property in Chicago by race and ethnicity. (Youth Risk Behavior Surveillance System, CDC, 2019) [118]



Substance use related ED visits and hospitalizations for youth in Chicago illustrate a larger disparity with the rates for Black youth between one and half to three times higher than Hispanic/Latinx, white or Asian youth between 2019-2021 (Figure 49).

The disparate monitoring systems provide an incomplete picture and better systems are needed to fully understand the burden of substance use disorders among children and adolescents particularly in light of pandemic impacts.

Figure 49. Substance use related emergency department visits and hospitalization rates among patients 0 to 19 years residing in Chicago per 10,000 by race and ethnicity (COMPData Database, Illinois Hospital Association, 2019-2021)



Behavioral addictions, specifically gambling, were discussed in multiple youth focus groups highlighting a potentially growing youth mental health issue. However, data is limited for youth gambling. It is estimated that about 1 percent of U.S. adults meet the criteria for severe gambling problems with as many as 6 million more with mild or moderate gambling problems. [128] The International Centre for Youth Gambling Programs and High-Risk Behavior estimates that 4-6 percent of youth in the U.S., Canada, New Zealand, Europe and Australia have a serious gambling problem with another 10-14 percent at-risk for developing a serious problem. [129] Other behavior addictions, such as gaming disorders, Internet use disorders and excessive smartphone use, can contribute to negative mental health outcomes such as increased depression, anxiety and stress; although youth prevalence data are limited and more research is needed. [130]

Treatment Access, Quality and Responsiveness

As previously mentioned, community input respondents identified access to mental health services as the improvement most needed to support community health. In a 2022 participatory action research report created by young men of color in Chicago, youth researchers found that, in addition to limited access, youth of color also face issues related to inequities in the quality of services available and lack of care that is responsive to the unique needs of youth. [131] In this report, *Changing the Beat of Mental Health: Amplifying our Voice*, youth researchers found that "systems are not built to truly support their mental health and wellness, and that young people cannot share their full experiences and emotions without negative repercussions. For example, young people fear involvement with the child protective system and also fear being institutionalized by the mental health system." [131]

The consequences of untreated mental illness are staggering for both individuals and society and extend beyond health outcomes. [113] Untreated mental health conditions can result in unnecessary disability, unemployment, homelessness, substance abuse, inappropriate incarceration, suicide, poor health outcomes and poor quality of life. [113] Estimates value the economic cost of mental health disorders to be $193.2 billion annually in the U.S. [113]

Several issues impacting access to treatment were discussed among focus group participants.

- Lack of access to quality insurance coverage for regular mental health services is a barrier and mental health centers that serve uninsured or underinsured are particularly needed.
- Many mental health services are fully booked with long wait times for treatment, which is particularly problematic for those experiencing a crisis.
- Lack of mental health providers that reflect the demographics of patients seeking care.
- Need for more awareness about how to identify someone experiencing a mental health crisis or suicidal ideation and how to connect them with appropriate services within communities.
- Need for tools for parents so they know how to promote the mental health and well-being of their children.
- There are gaps in knowledge about existing resources with multiple groups mentioning the need for better communication about programs and services.

- Better support is needed for caregivers including better systems for discharge planning and care coordination.
- Individual, community, provider and institutional stigma surrounding mental illness prevents many people from seeking help.

As mentioned throughout this chapter, COVID-19 has had a profound impact on mental health and substance use disorders within communities. Healthcare systems across the nation are experiencing dramatic increases in the need for mental health care and substance use disorders treatment. Chicago communities highlighted several impacts that COVID-19 has had on behavioral health.

- COVID-19 has caused long-term mental health issues due to death, lost-income and other inequities within communities exacerbated by the pandemic.
- Depression, anxiety, stress, fear of getting sick/getting others sick, inactivity and insomnia are some of the common struggles communities are facing. In addition, the pandemic has caused isolation as well as division and fear within communities.
- Many mental health services were limited or discontinued during the pandemic.
- Essential workers are experiencing heightened levels of stress during the pandemic and require additional support.

> **Violence needs to be addressed, especially for young men. Groups like Ceasefire need to be back in the community. Incentives are needed for anti-violence program participation for young black men, even if incentives are small -- like $5.**
>
> – NORTH LAWNDALE EMPLOYMENT NETWORK FOCUS GROUP PARTICIPANT

Violence and Injury

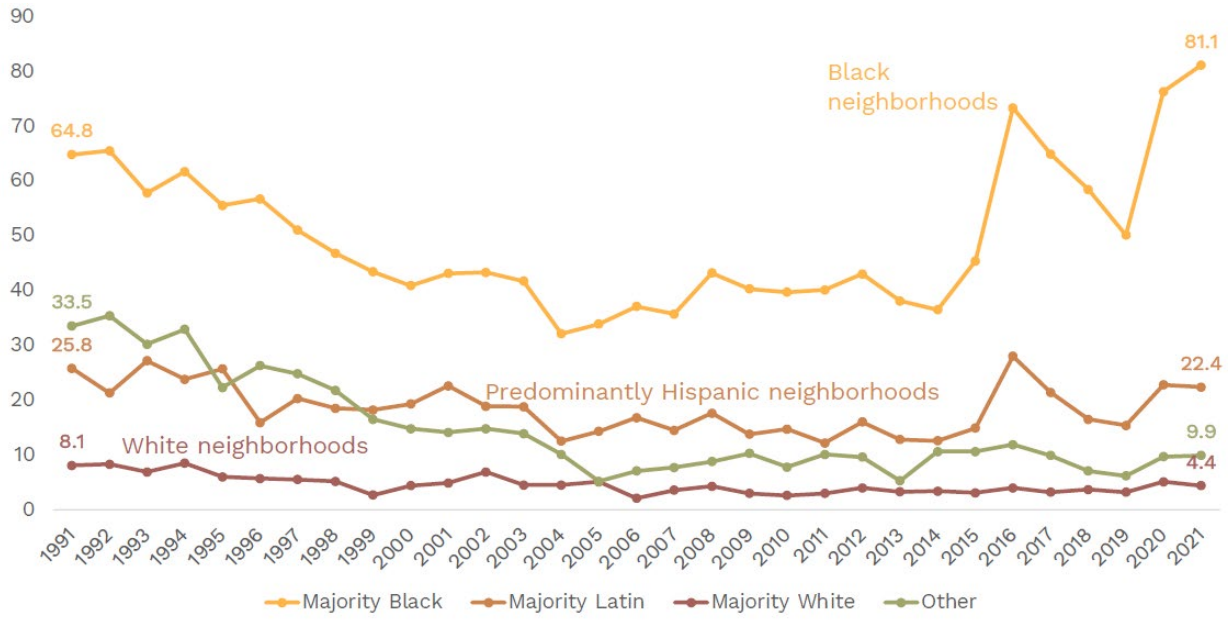
Gun Violence

According to the most recent data from the Centers for Disease Control and Prevention published in 2022, firearm injuries are the *single* leading cause of death for children and adolescents 0-19 years of age, with a staggering 83 percent increase in youth firearm fatalities over the past decade. [132] Nearly two-thirds of youth firearm deaths were from homicides. Strikingly, Black youth had an unprecedented 40 percent increase in firearm fatalities between 2019 to 2020. [132] In 2020, Black, non-Hispanic adolescent boys (aged 15–19 years) died by firearm homicide at a rate that was 21 times higher than that for white, non-Hispanic adolescent boys. [132]

These considerable racial disparities are rooted in poverty and structural and cultural racism and result in a victim-blaming and biased perception of firearm-related violence. In fact, firearm risk behaviors differ from these trends, as white, rural and higher-income adolescents were most likely to carry a fire-arm in 2015-2019. [132] Although firearm fatality rates started to rise in 2014, the COVID-19 pandemic likely accelerated this increase with the escalation of mental health stressors experienced by youth. The seismic shift caused by the pandemic occurred in the context of a decades' long void of research funding and prevention efforts to decrease firearm injuries and deaths. [133]

In Chicago's predominantly Black neighborhoods, rates of firearm-related homicides are even higher today (81 per 100,000 residents) than they were during the crack cocaine epidemic of the early 1990s (65 per 100,000 residents). For comparison, the current rate in predominantly white, affluent neighborhoods is four per 100,000 residents, dropping by nearly 50 percent since 1991. [134] Predominantly Hispanic/Latinx and Black neighborhoods on the city's South and West Sides have experienced similar or significantly higher rates (see Figure 50). [134]

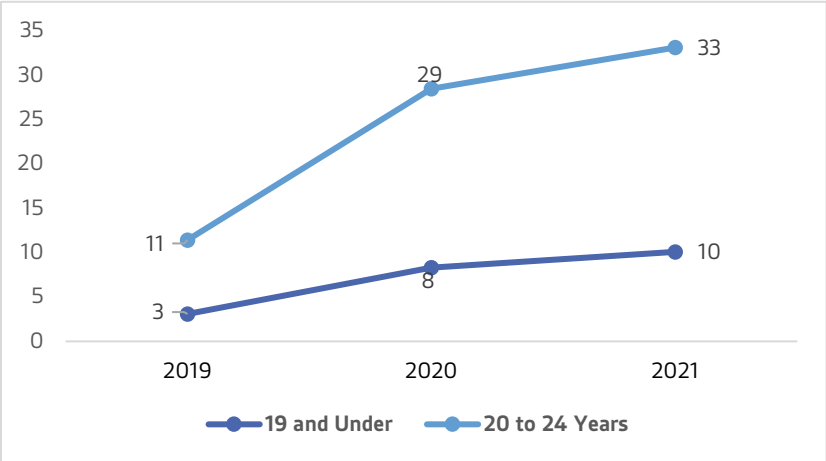
Figure 50. Chicago homicides per 100,000 residents by racial demographics of community area, 1991-2021. (University of Chicago Urban Labs Crime Lab, 2022) [172]



For Community Input Survey respondents residing in Chicago, violence was consistently reported as one of their top five community health concerns. During focus group discussions, participants described a chronic lack in educational and recreational opportunities which contributes to higher rates of violence. Participants also described pervasive concerns about safety that prevented them from spending time outdoors or in public spaces. In 2019, 13 percent of Chicago's high school students self-reported that they carried a gun at least one day in the previous year, and 10 percent did not go to school in the last 30 days because they felt it was unsafe to do so. [118] The city's ED admission and hospitalization rates for gun-related injury have tripled since 2019, with rates for 20-24-year-olds over three times as high as youth ages 19 years and younger (Figure 51).

> **When police get a call of shooting around here, they hear that street 'stuff like that always happens there' so they take their time. Then the person dies waiting.**
>
> – MAAFA REDEMPTION PROJECT FOCUS GROUP PARTICIPANT

Figure 51. Unintentional firearm injury emergency department visits and hospitalization rates among patients 0 to 24 years residing in Chicagp per 10,000 by age. (COMPData database, Illinois Hospital Association, 2019-2021)



Interpersonal Violence

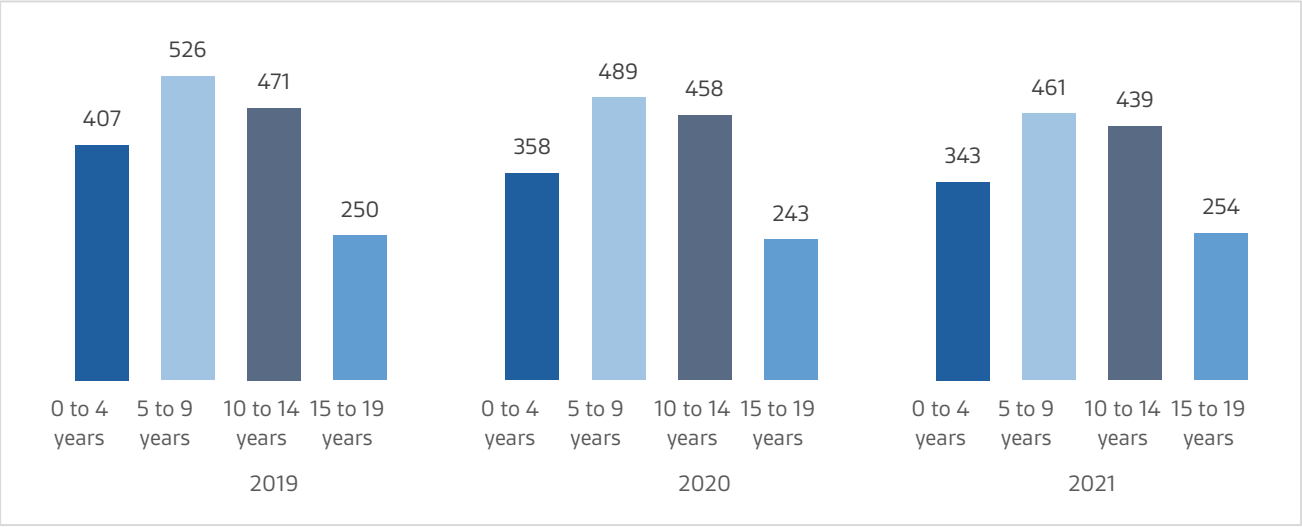
Bullying

In 2017-2019, Chicago's rates of in-school and electronic bullying declined slightly from 15 percent to 12 percent; the CDPH Healthy Chicago initiative aims to further reduce bullying to 9 percent by 2025. In a survey conducted by Voices of Chicago Health in Chicago, nearly half of Chicago parent respondents reported feeling concerned that their child is a victim of bullying and over one in 10 were concerned that their child is a perpetrator. [135] Parents were most likely to first seek help from teachers to address bullying and just under half of parents said that their child's school engaged in social skills building activities to help prevent bullying. To prevent cyberbullying, nearly three out of four parent respondents agreed that parents should monitor their child's use of social media platforms frequently. There were significant socioeconomic differences in how parents felt about bullying in schools; Black parents (78 percent), parents with less than a high school degree (80 percent), and parents under the poverty line (89 percent) were most concerned. [135]

Child Abuse

Nationally, there are approximately 115,000 victims of child physical abuse each year and 6,000 in Illinois. In 2019, physical abuse caused at least 700 child deaths in the U.S. and more than 100 in Illinois. [136] Chicago averages nearly six substantiated cases of abuse per 1,000 children ages 0-5 years, a number that is likely underreported for many reasons, including the lack of healthcare providers reporting their findings and COVID-related closures that has diminished mandated reporters' access to children. [137] According to a multicenter study led by Lurie Children's, pediatric emergency department encounters related to physical abuse decreased by 19 percent during the COVID-19 pandemic. (Figure 52).

Figure 52. Count of emergency department visits and hospitalizations for child maltreatment-related injuries by age and year. (COMPData database, Illinois Hospital Association, 2019-2021)

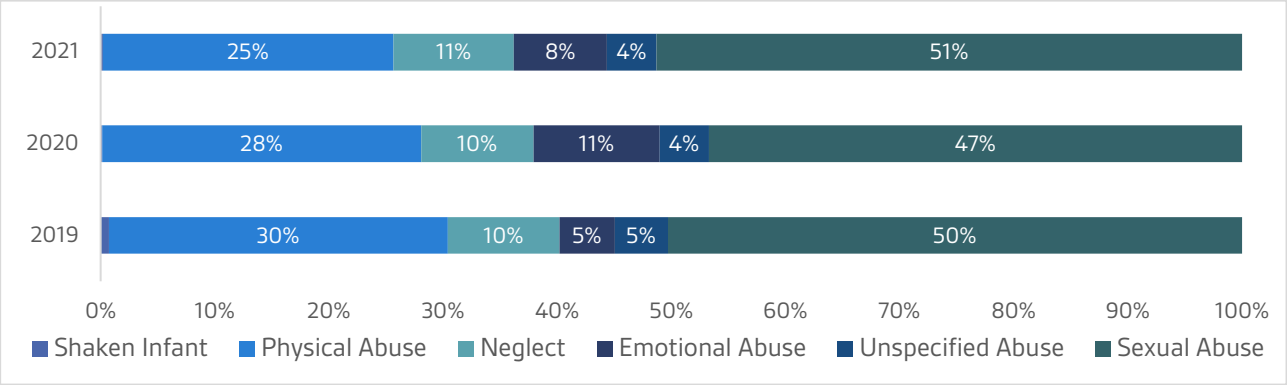


However, while encounter rates with lower clinical severity dropped during the pandemic, encounter rates with higher clinical severity remained unchanged. This pattern raises concern for unrecognized harm, as opposed to true reductions in child abuse. The study found that the greatest reduction in ED encounters for physical abuse concerns were among preschool children, followed by school-aged children. [138]

Between 2019-2021 in Chicago, among abuse-related ED admissions and hospitalizations for patients under 19 years old, the most common types of abuse were (Figure 53):

- Sexual abuse
- Physical abuse
- Neglect
- Unspecified abuse
- Emotional abuse

Figure 53. Proportion of child maltreatment emergency department visits and hospitalizations by maltreatment type and year. (COMPData database, Illinois Hospital Association, 2019-2021)



Of those visits and hospitalizations, Black patients had the highest visit rate (54 per 10,000), followed by Hispanic/Latinx patients (17 per 10,000). The rates of Black patients decreased slightly between 2019-2021, whereas rates among Hispanic/Latinx and white patients remained stable. It is important to note that poverty-related child neglect (like lack of supervision, food, clothing or shelter) jeopardizes the safety of children but could be considered as a separate category from child abuse or child endangerment.

Unintentional Injury

As previously discussed, firearms are the *single* leading cause of death for children and adolescents 0-19 years of age; however, when combined, unintentional injuries remain the leading cause of death and disability for children and youth 0-24 years in the United States. [139] In 2019, more than 7,000 children and teenagers died from unintentional injuries, averaging 20 deaths each day. Nationally, the leading causes of child unintentional injury (Table 1) include motor vehicle crashes, drowning, suffocation, poisoning and fires. [139]

Table 1. Leading causes of unintentional injury-related deaths by age group in the U.S. (National Center for Health Statistics (NCHS), National Vital Statistics System, 2018)

RANK	AGES <1	AGES 1-4	AGES 5-9	AGES 10-14	AGES 15-24
1	Suffocation [977]	Drowning [443]	Motor Vehicle Crash [341]	Motor Vehicle Crash [360]	Motor Vehicle Crash [6,308]
2	Motor Vehicle Crash [80]	Motor Vehicle Crash [292]	Drowning [130]	Drowning [86]	Poisoning [4,245]
3	Drowning [39]	Fire/Burn [123]	Fire/Burn [99]	Fire/Burn [52]	Drowning [431]
4	Natural / Environment* [22]	Suffocation [112]	Suffocation [30]	Suffocation [43]	N/A
5	N/A	Pedestrian [15]	Transportation vehicle (non-motor) [20]	Transportation vehicle (non-motor) [37]	N/A

*(e.g., extreme heat or cold)

Although overall unintentional injury death rates decreased by 11 percent from 2010-2019 [140], rates increased within certain groups:

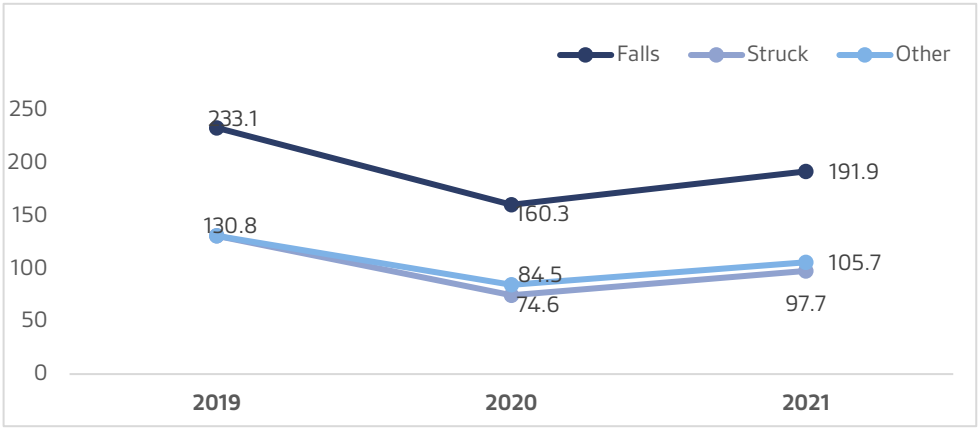
- Suffocation death rates increased 20 percent among infants overall and 21 percent among Black children. [140]
- Motor vehicle death rates among Black children increased 9 percent while rates among white children decreased 24 percent. [140]
- Poisoning death rates increased 50 percent among Hispanic children and 37 percent among Black children, while rates among white children decreased by 24 percent. [140]

As the disparities above indicate, certain groups are at increased risk for unintentional as well as intentional injury. According to a report by the Child Safety Network, the following groups are at a disproportionately higher risk:

- **Males** have higher rates of injury-related hospitalization and death than females, except hospitalization related to suicide attempts (i.e., self-inflicted injuries). [141]
- **American Indian/Alaska Native infants from birth to 12 months** have a significantly higher risk of fatal motor vehicle traffic (MVT) injuries when compared with other racial groups. [141]
- **Black and Hispanic/Latinx youth ages 15 to 19 years** are at increased risk of homicide and assault compared to white and Asian/Pacific Islander youth. [141]
- **Youth with disabilities** face a heightened risk of violence and unintentional injury compared with youth without disabilities, and they face different types and levels of risks depending on their type of disability. [141]
- **Youth with attention deficit/hyperactivity disorder (ADHD)** are at higher risk of sustaining head injuries, unintentional poisonings, and pedestrian injuries compared with youth without ADHD.
- **LBGTQ+ youth** have an increased risk for suicidal and non-suicidal self-injury compared with their non-LGBTQ counterparts. [141]
- **LGBTQ+ youth** have elevated risks of bullying and assault, particularly while at school, compared with non-LGBTQ youth. [141]
- **LGBTQ+ youth** are more likely to experience physical dating violence than their non-minority peers. [141]

In Illinois, falls, traumatic brain injury (TBI) and poisoning are the top three leading causes of injury-related hospitalizations for youth less than 14 years old between 2019 and 2021. [142] For older youth between 15-24 years, poisoning, suicide and assault are the top three leading causes of injury-related hospitalizations. [142] Among youth residing in Chicago, the leading causes of injury-related ED visits and hospitalizations were for falls and being struck by or against an object. The cases in that period were highest among Black patients, followed by Hispanic Latinx, white and Asian patients (Figure 54).

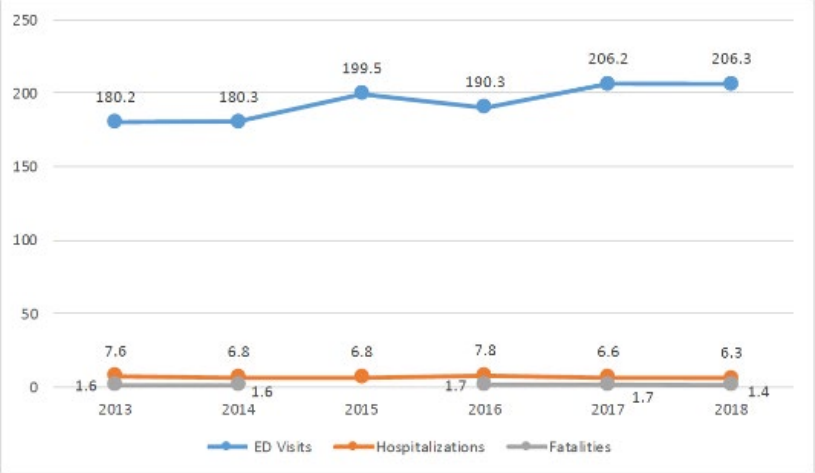
Figure 54. Top three causes of unintentional injury-related ED visits and hospitalizations among patients 0-19 per 10,000 in Chicago. (COMPData Database, Illinois Hospital Association, 2019-2021)



Motor Vehicle Crashes

The US motor vehicle crash rate is twice the average of other high-income countries, according to the most recent data. Risky behaviors, such as not wearing front-seat belts or using car seats or booster seats are also more common in the US. [143] In Illinois, 5 percent of car crash fatalities due to traumatic brain injuries were sustained by young adults ages 15-24 years. [142] Overall, the rate of motor vehicle crash fatalities, hospitalizations and ED visits among this age group have generally been trending upwards in recent years (Figure 55).

Figure 55. Rate of motor vehicle crash emergency department visits, hospitalizations and fatalities among youth 15-24 years old in Illinois, 2013-2018. (Making Illinois Safer: Injury, Violence, and Suicide Prevention Data Book, Illinois Department of Public Health, August 2021)



Compared to the rest of the country, Chicago and Illinois high schoolers are more likely to have ridden in a car with a driver who had been drinking alcohol. Risky behaviors, such as drinking or using their phones while driving, are comparable to national rates and have increased between 2017 and 2019 (Table 2). [118]

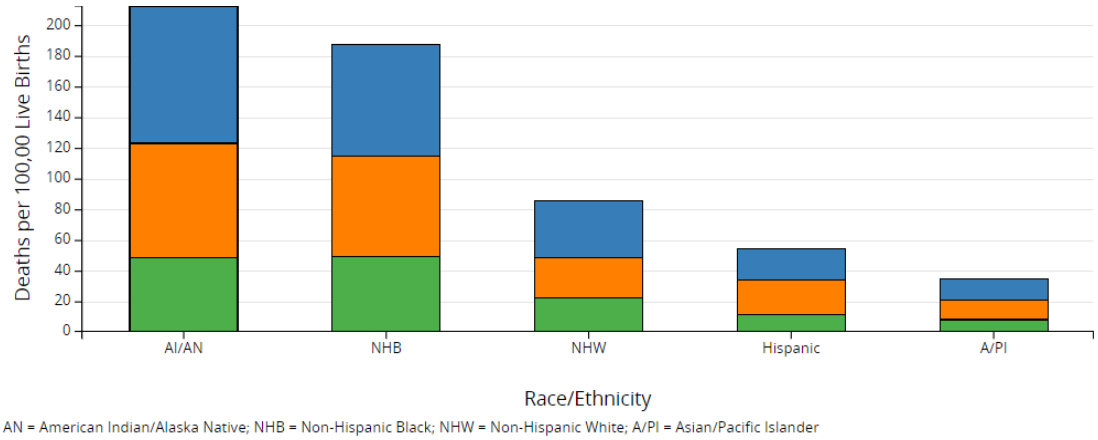
Table 2. Percentage of youth engaging in risky behaviors that could cause motor vehicle accidents. Youth Risk Behavior Surveillance System, CDC, 1991-2019) [118]

Risky Behavior	Chicago 2017	Chicago 2019	Illinois 2017	Illinois 2019	U.S. 2017	U.S. 2019
Rode with a driver who had been drinking alcohol.	23.5%	21.4%	19.2%	17.9%	16.5%	16.7%
Drove when they had been drinking alcohol.	5.4%	4.9%	5.2%	5%	5.5%	5.4%
Texted or e-mailed while driving a car or other vehicle.	27.4%	28.4%	37.1%	43.3%	39.2%	39%

Suffocation and Sudden Unexpected Infant Death

Sudden unexpected infant death (SUID) is the term used to describe the death of an infant who is less than 1 year old in which the cause of death was not obvious before investigation. SUID often occurs in the baby's sleep area and includes sudden infant death syndrome (SIDS). Nationally, 37 percent of infant deaths are now attributed to SUID; almost 3,500 infants die from SUID in the United States each year, an average of nine babies every day. [142] Nationally, rates of SUID demonstrate significant racial and ethnic disparities with American Indian/Alaska Native and non-Hispanic Black infants experiencing more than twice the rate of SUID compared to non-Hispanic white infants. [142] SUID rates per 100,000 live births were lowest among Hispanic and Asian/Pacific Islander infants (Figure 56). [144]

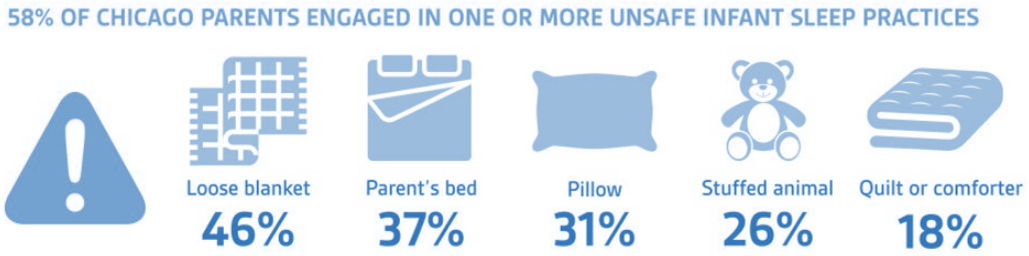
Figure 56. Sudden unexpected infant death by race and ethnicity, 2014-2018. (Centers for Disease Control)



AN = American Indian/Alaska Native; NHB = Non-Hispanic Black; NHW = Non-Hispanic White; A/PI = Asian/Pacific Islander

In a 2021 Voices of Child Health in Chicago study, more than half of Chicago parents reported engaging in one or more unsafe sleep practices with their infants. These included putting the baby to sleep in unsafe locations, such as in the parent's own bed or the bed of another person or in a car seat or bouncy seat (see Figure 57). Latinx parents were the most likely to engage in at least one unsafe infant sleep practice, followed by Black parents, Asian/Other-race parents and white parents. The same study found that parents with a high school education or below were most likely to engage in one or more unsafe infant sleep practices. Infant sleep practices also differed by household income — parents with low household income were most likely to engage in unsafe infant sleep practices. [145]

Figure 57. Most frequent unsafe infant sleep practices reported by Chicago parents and the proportion of parents who reported in engaging in each. (Voices of Child Health in Chicago Report, 2022) [145]



Falls

Among children under the age of 14 years, falls are the leading cause of ED visits, accounting for 2.4 million visits annually. For children under 4 years, falls are the primary cause of traumatic brain injuries. Overall, child actions (e.g., running) accounted for the greatest proportion of injuries and actions by others (e.g., carrying) was highest for children younger than 1 year. Most falls occur in the home, and involve surfaces, fixtures, furniture, and baby products. [146] In Chicago, window falls tend to take place from the second story of buildings, typically during the summer. Between 2002 and 2016, the rate of window falls among children younger than 5 years of age decreased by 50 percent following the launch of *Stop the Falls*, a multi-stakeholder window falls prevention campaign led by Lurie Children's experts. [147]

Drowning

In the United States, drowning is the leading cause of injury death for children age 1-4 years. [139] Children in this age group are at higher risk of drowning in a swimming pool, whereas older children and youth (ages 5-19 years) have a higher risk of drowning in natural water. [141] Drowning death rates were 2.6 times higher among Black children age 5–9 years and 3.6 times higher among Black children age 10–14 years when compared with white children of the same age. [139] Many factors contribute to the increased risk of drowning, including lack of basic water skills, underlying medical conditions, environment and behavior. [148]

Fires and Burns

Nationally, children under 16 years represent approximately 26 percent of all admissions to burn center hospitals. [149] Children are at particularly high risk for burn injuries due to their thinner dermal layers, leading to deeper burn injuries at lower temperatures or shorter exposure times. The most common types of burns for this age group are scald burn injuries associated with cooking, drinking, and serving hot liquids and dangerously high tap-water temperatures. Urban areas, particularly rental units, are at high risk for unsafe water temperatures that can vary from heater thermostat settings. [149]

Poisoning

Children under 6 years comprise a disproportionate percentage of all poisoning cases. Poisoning most commonly takes place in children ages 1-2 years but poisoning in teenagers can be more serious. [150] For youth, the top poisonous substances are:

- Cosmetic and personal care products
- Household cleaning substances
- Pain medications
- Dietary supplements and homeopathic remedies
- Vitamins [150]

Fumes, gases, or vapors (including carbon monoxide), followed closely by pain medications, were the most frequent causes of pediatric fatalities reported to Poison Control between 2016 and 2020. [150]






COMMUNITY HEALTH IMPLEMENTATION STRATEGY

Lurie Children's 2023-2025 Plan

Improving the health and well-being of infants, children and adolescents where they live, learn and grow is a critical part of our mission at Lurie Children's. Working closely with community-based organizations and leaders, we connect clinical care, research, advocacy, education and community expertise to inform community health initiatives and program development. Through the Patrick M. Magoon Institute for Healthy Communities, Lurie Children's continues to develop and foster community partnerships and initiatives to reach youth and families across Chicago. A list of our current and potential community partners can be found in **Appendix G**. Additionally, a summary of existing community resources for each of our priority areas is available in **Appendix H**.

Chicago's communities have demonstrated tremendous resilience in recent years, particularly in the face of concurrent and interrelated pandemics of COVID-19, the youth mental health crisis and racism that is deeply entrenched in our city's systems and policies. By developing evidence-based and community-informed initiatives, we are better able to identify health inequities and take concrete steps to address.

Based on the findings previously reported in the CHNA section, we have developed the following 2023-2025 plan to address the priority health needs identified through community input and clinical and public health data. This plan expands and builds upon our 2020-2022 Community Health Implementation Strategy; the progress report of that strategy is available in **Appendix I**.

Aim and Priority Health Issues

Lurie Children's aims to ***advance health equity for youth and families so our communities can thrive***. In our CHNA process, we examined and reflected on the community health needs that emerged as priorities and how we, as a children's hospital and anchor institution, can leverage our expertise and resources to help address them. We identified myriad health inequities that disproportionately impact communities who have been historically and routinely disinvested and marginalized. Each of these inequities can be traced back to the following drivers of health:

- Priority Area A: Social and structural influencers of health, including access to care and community resources

We also identified other priority areas related to specific health issues:

- Priority Area B: Chronic health conditions
- Priority Area C: Mental and behavioral health
- Priority Area D: Injury and violence

Lurie Children's 2023-2025 Community Health Implementation Strategy focuses efforts on Chicago youth aged 0-24 years and their families, particularly those who have been historically marginalized. The intended impact of many of these strategies is not limited to city boundaries and may expand to county, state and federal levels.

Advisory and Community Health Action Teams

Three groups of experts collaborated to identify key infant, child and adolescent health issues, prioritize community health strategies and develop evaluation plans to track our progress and impact and include:

- **Magoon Institute Advisory Council** – An advisory council to Lurie Children's Medical Center Board comprised of external community leaders and experts who provide advice and recommendations from the community health perspective.
- **Healthy Communities Internal Advisory Committee** – An internal multidisciplinary committee comprised of clinical, public health and administrative leaders from across Lurie Children's who provide guidance and expertise.
- **Community Health Action Teams** – Four work groups comprised of over 100 leaders, physicians, researchers, nurses, social workers and other community health specialists with expertise in (1) social and structural influencers of health and access to care, (2) chronic health conditions, (3) mental and behavioral health and/or (4) injury and violence.

Over nine sessions in the Spring of 2022, the Community Health Action Teams convened to discuss, develop and design the 2023-2025 Community Health Implementation Strategy. Feedback was garnered from our advisory groups and integrated throughout this process.

See **Appendix A-C** for list of members and **Appendix D** for timeline and key dates.

Guiding Principles

We defined the following six guiding principles to connect and ground our efforts to improve community health. These principles serve as the foundation for all our community health strategies.

YOUTH & COMMUNITY VOICE | Elevate and center youth and community voices to inform our community health strategies and initiatives, research, education and advocacy.

EQUITY LENS | Integrate an equity lens into hospital policies and practices, with a focus on racial justice to explicitly address health inequities and advance antidiscrimination and antiracism.

PARTNERSHIPS & COLLABORATION | Strengthen our partnerships and continue engagement in collaborative initiatives and citywide planning to ensure inclusion of pediatric and adolescent perspectives.

COMMUNITY HEALTH TRAINING & ENGAGEMENT | Integrate community health training, education and engagement opportunities across the Lurie Children's workforce and trainees.

EVALUATION & SUSTAINABILITY | Prioritize sustainability, evaluation and data sharing across systems to measure our impact.

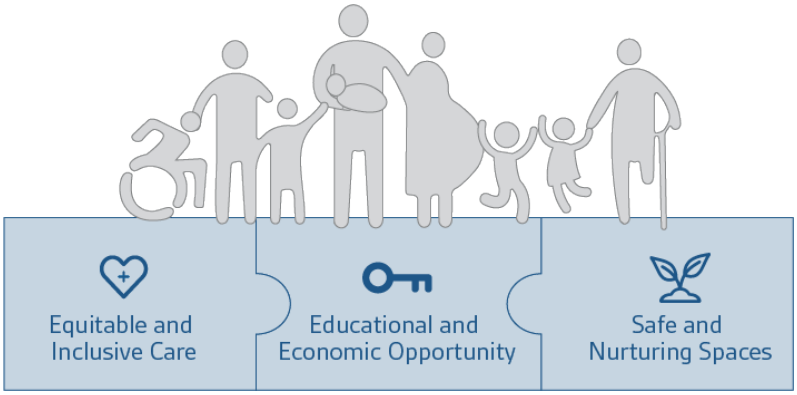
POLICY & ADVOCACY | Advocate for policies and systems that bring lasting change to community health, particularly for those who have been historically marginalized or disenfranchised.

Impact Framework

As we developed our community health strategies, we categorized them into the following domains that reflect our long-term goals:

- **EQUITABLE and INCLUSIVE CARE |** Goal: Expand the availability and accessibility of physical, mental and behavioral health and social services closer to home for youth living in disinvested communities.
- **EDUCATIONAL and ECONOMIC OPPORTUNITY |** Goal: Foster educational and economic opportunities to help infants, children, youth, and their families and communities thrive.
- **SAFE and NURTURING SPACES |** Goal: Cultivate safe, supportive, nurturing and accessible physical and social environments for youth where they live, learn and play.

This Impact Framework demonstrates the interconnectedness of these domains and goals. We felt that it was essential to emphasize that these domains can be mutually dependent; for example, safe learning environments and after-school activities foster academic success. With this framework, we are moving toward an impact-focused, asset-based and inclusive approach to address the priority health issues of the populations we serve more holistically and comprehensively.



Community Health Strategies

While we address individual health conditions through Lurie Children's clinical care and research efforts, our approach to community health is intentionally holistic. We focus our efforts on upstream prevention and early intervention at the community level. The following strategies address the identified health priority areas through that interconnected and holistic lens, rather than solely addressing each priority health area with a singular strategy. For this reason, there are no health priorities identified that we are not addressing. All strategies are resourced through a combination of hospital operations, grants and philanthropy.

Each domain below includes strategies for which specific evaluation plans have been or are in the process of being designed. In addition, we are designing a comprehensive evaluation focused on the broader impact these strategies will have collectively and over time. Specific methodologies are currently in development; however, for the purpose of this report, key metrics are summarized below.

Equitable and Inclusive Care

We plan to improve access to healthcare and behavioral health services in underserved areas, enhance social needs and safety screenings and support providers and families in navigating and coordinating care.

Strategies	Key Metrics
BUILD COMMUNITY-CLINIC HUB on WEST SIDE Plan, construct and open a new clinic-community physical location on Chicago's West Side	• Patient visits, demographics, service types • ED visits from surrounding communities • Economic and workforce impacts
BRING CARE TO AREAS with GREATEST DISPARITIES Increase community access to specialty care through the expansion of mobile health, telehealth and partnerships with FQHCs and community providers	• Mobile health and telehealth volumes • FQHC and community provider linkages and communications
INCREASE SOCIAL NEEDS SCREENING and CARE COORDINATION Expand social needs and safety screenings, care coordination and referrals to community-based services for patients	• Patients screened and social/safety needs identified • Referrals and linkages to services and resources • Care coordination patient volumes and outcomes
SUPPORT PRIMARY CARE PEDIATRICIANS Educate and equip primary care pediatricians with preventive strategies and resources to better address patients' chronic physical and behavioral health conditions	• Engagement, education and communication with community-based providers • Community provider referrals and consultations with specialists • Patients evaluated and care plans developed
SCREEN FOR BEHAVIORAL HEALTH and SUICIDE Expand screening, early intervention, therapeutic treatments and referrals to intensive interventions for various mental health and substance use disorders	• Patients screened and behavioral health needs identified • Referrals and linkages to therapeutic treatments and intensive interventions

Educational and Economic Opportunities

We plan to create economic, educational and workforce development opportunities for our communities, provide health education to youth and their families and support schools to help students develop the skills they need to succeed.

Strategies	Key Metrics
ADVANCE ANCHOR MISSION ACTIVITIES Continue and expand activities focused on economic and workforce development; and build capacity for community and mental health workforce	• Employees/physicians hired and promoted from historically marginalized/underrepresented groups • Internship and mentorship outcomes • Procurement and investments in disinvested communities • Community and mental health workforce changes
EXPAND HEALTH PROMOTION and EDUCATION Increase and broaden health education for youth, families and community partners via digital platforms, virtual and in-person clinical and community spaces	• Health education delivered and trainings conducted, changes in knowledge, skills and attitudes • Communication reach and impact
SUPPORT YOUTH in SCHOOLS Grow school-based initiatives and partnerships that address student health and safety needs	• Schools, teachers and students reached • Individual changes in knowledge, skills and attitudes • School-level changes in health benchmarks achieved, culture and school environment

Safe and Nurturing Spaces

We plan to take a multifaceted, collaborative approach to creating emotionally and physically safe spaces for youth in schools, in their neighborhoods and at home.

Strategies	Key Metrics
GROW HEALING CENTERED ENVIRONMENTS Expand training and supports for healing centered / trauma-responsive practices in schools, youth serving organizations, and within families and our hospital	• Schools, youth-serving organizations and families engaged, changes in knowledge, practice and environment • Hospital policy and practice improvements and patient impact
EXPAND INJURY and VIOLENCE PREVENTION Continue and expand evidence-informed injury and violence prevention to address leading causes of youth death and disability with the greatest racial disparities	• Youth, families and community partners engaged, changes in knowledge, skills, attitudes and practices • Safety products distributed and education provided • Advocacy successes, policy changes made, resulting health impacts
SUPPORT YOUTH PROGRAMMING and ACTIVITIES Increase support of and access to city, community and youth-serving organizations to provide and expand youth programming and out-of-school activities	• Youth and families reached • Youth programming provided, programming referrals made and gaps identified • Community partners engaged; types and results of support provided
MAGNIFY CAREGIVER and FAMILY WRAPAROUND SUPPORTS Expand parent, caregiver and family wraparound services to support relational health, starting at birth and continuing through infancy, early childhood and beyond	• Parent/caregivers connected to resources and services, including evidence-based programs that promote positive parenting • Types of resources needed, provided and gaps identified for improvements
CHAMPION BUILT ENVIRONMENT IMPROVEMENTS Support neighborhood improvements and community development for safety, food access, physical activity, inclusive accessibility and social connectedness	• Walkability assessments completed, action plans developed, and improvements made • Community partners engaged; needs identified

CONCLUSION

Lurie Children's 2022 Community Health Needs Assessment combines youth and community voice, public health and clinical data, existing research and other relevant assessments to better understand the current health needs of infants, children and youth. Working in partnership with our communities, Lurie Children's is taking concrete steps to address the following key priority health issues/areas:

- Priority Area A: Social and structural influencers of health, including access to care and community resources
- Priority Area B: Chronic health conditions
- Priority Area C: Mental and behavioral health
- Priority Area D: Violence and injury

Our 2023-2025 Community Health Implementation Strategy prioritizes 13 key strategies to address needs within the priority health areas through collaboration, innovation and long-term commitment. These efforts are focused on advancing health equity for Chicago's youth by providing equitable and inclusive care, fostering educational and economic opportunities and cultivating safe and nurturing spaces.

These efforts were and will continue to be facilitated, monitored and supported by the Patrick M. Magoon Institute for Healthy Communities, the hub for all community health initiatives within Lurie Children's, in collaboration with clinical divisions across Lurie Children's and community partners across Chicago. By implementing strategies and supporting existing work within the priority areas, Lurie Children's aims to promote health equity, reduce health disparities and improve the overall health and well-being of infants, children, adolescents, young adults and their families in Chicago.

Adoption of CHNA and Implementation Strategy by Governing Body

Lurie Children's 2022 Community Health Needs Assessment (CHNA) was presented on April 19, 2022 and the 2023-2025 Community Health Implementation Strategy was presented on June 24, 2022 to the Patrick M. Magoon Institute for Healthy Communities Advisory Council of the Medical Center Board. The CHNA and Implementation Strategy were unanimously approved to recommend to the Medical Center Board for approval and adoption. The CHNA and Implementation Strategy were presented to the full Medical Center Board on August 18, 2022 and were approved and unanimously adopted.

Public Availability and Contact

Lurie Children's 2022 Community Health Needs Assessment and 2023-2025 Community Health Implementation Strategy are publicly available online at luriechildrens.org/chna and hard copies are also available. For additional questions or to request a hard copy, please contact the Patrick M. Magoon Institute for Healthy Communities at healthycommunities@luriechildrens.org.

REFERENCES

1. Centers for Disease Control and Prevention. Health Equity. 2022. Available at: https://www.cdc.gov/chronicdisease/healthequity/index.htm.

2. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States. *Communities in Action: Pathways to Health Equity*. Washington, DC: National Academies Press (US); 2017.

3. Metropolitan Planning Council, Urban Institute. The Cost of Segregation. 2017. Available at: https://www.metroplanning.org/work/project/33/subpage/15?utm_source=%2fequityupdates&utm_medium=web&utm_campaign=redirect&RedirectReferrer=https%3a%2f%2fwww.google.com%2f#:~:text=We%20partnered%20with%20the%20Urban,and%2083%2C000%20less%20bachelors%20degr.

4. Braveman PA, Arkin E, Proctor D, Kauh T, Holm N. Systemic And Structural Racism: Definitions, Examples, Health Damages, And Approaches To Dismantling. *Health Affairs*. February 2022;41(2):171-178.

5. Braveman P. What Are Health Disparities and Health Equity? We Need to Be Clear. *Public Health Reports*. 2014;129(Suppl 2):5-8.

6. Centers for Disease Control and Prevention. Health Disparities Amoung LGBTQ Youth. 2019. Available at: https://www.cdc.gov/healthyyouth/disparities/health-disparities-among-lgbtq-youth.htm.

7. Chang CD. Social Determinants of Health and Health Disparities Among Immigrants and their Children. *Current Problems in Pediatric adn Adolescent Health Care*. 2019;49(1):23-30.

8. Kaiser Family Foundation. Health Coverage of Immigrants. April 6, 2022. Available at: https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/.

9. Truhe N. Achieving Health Equity for Youth in Child Welfare and Juvenile Justice. *United Healthcare*. February 28, 2022. Available at: https://www.uhccommunityandstate.com/content/blog-post/nicole-truhe-posts/achieving-health-equity-for-youth-in-child-welfare-and-juvenile-.

10. UNICEF. Children with disabilities overview. February 2022. Available at: https://data.unicef.org/topic/child-disability/overview/.

11. Heard-Garris N, Boyd R, Kan K, Perez-Cardona L, Heard NJ, Johnson TJ. Structuring Poverty: How Racism Shapes Child Poverty and Child and Adolescent Health. *Academic Pediatrics*. 2021;21(8S):S108-S116.

12. youth.gov. Disparities and Resiliency in Adolescent Health. n.d.. Available at: https://youth.gov/youth-topics/adolescent-health/disparities-resiliency?

13. U.S. Census Bureau. City of Chicago, Illinois. July 1, 2021. Available at: https://www.census.gov/quickfacts/chicagocityillinois.

14. U.S. Census Bureau. *2016-2020 American Community Survey 5-Year Estimates* 2020.

15. American Public Health Association. Racism and Health. 2019. Available at: https://www.apha.org/topics-and-issues/health-equity/racism-and-health.

16. Menendian S, Gambhir S, Gailes A. The Roots of Structural Racism Project: Twenty-First Century Racial Residential Segregation in the United States. *Othering & Belonging Institute*. June 30, 2021. Available at: https://belonging.berkeley.edu/roots-structural-racism.

17. Theodos B, Hangen E, Meixell B, Rajasekaran P. Neighborhood Disparities in Investment Flows in Chicago. 2019. Available at: https://www.urban.org/sites/default/files/publication/100261/neighborhood_disparities_in_investment_flows_in_chicago_1.pdf.

18. Chicago Coalition for the Homeless. Estimate of Homeless People in Chicago. 2021. Available at: https://s6624.pcdn.co/wp-content/uploads/2021/08/Homeless-Estimate-2021_FINAL.pdf.

19. Sharkey P, Marsteller A. The University of Chicago Law Review. *Neighborhood Inequality and Violence in Chicago, 1965-2020*. Available at: https://www.bing.com/ck/a?&&p=6502dfdd1d3b5e04434b7ffc494927154cc41cb3f1c4d88e81b7791d4bbb120dJmltdHM9MTY1ODE2MzkxMyZpZ3VpZD04ZjQ3YmI1NC1mZTY5LTRjY2YtYjUzZC1iNDAzZjdhNzdjNjMmaW5zaWQ9NTE2Mg&ptn=3&fclid=c9bbf801-06bb-11ed-bf35-298add18226d&u=a1aHR0cHM6Ly9s.

20. Fredrick E. Death, Violence, Health, and Poverty. *Harvard Public Health Review*. 2018. Available at: https://hphr.org/19-article-fredrick/.

21. Chicago Public Schools. District Data: 2021-2022. Available at: https://www.cps.edu/about/district-data/demographics/.

22. Chicago Department of Public Health. The Impact of the COVID-19 Pandemic on Life and Death in Chicago, 2020. 2022. Available at: https://www.chicago.gov/content/dam/city/sites/covid/documents/le-roundtable/COVID-19_Impact_on_2020_Life_Expectancy_Roundtable_Data_Summary_Slideset_April_25_2022.pdf .

23. City Health Dashboard. Chicago, IL: Life Expectancy in 2015. Available at: https://www.cityhealthdashboard.com/.

24. Metric Detail for Life Expectancy in 2015. *City Health Dashboard*. 2015. Available at: https://www.cityhealthdashboard.com/il/chicago/metric-detail?metric=837&metricYearRange=2010-2015%2C+6+Year+Modeled+Estimate&dataRange=city.

25. Migration Policy Institute. Profile of the Unauthorized Population: Illinois. 2020. Available at: https://www.migrationpolicy.org/data/unauthorized-immigrant-population/state/IL#.

26. Gateways for Growth. New Americans in Chicago: A Snapshot of the Demographic and Economic Contributions of Immigrants in the City. 2018. Available at: http://www.newamericaneconomy.org/wp-content/uploads/2018/11/G4G_Chicago.pdf.

27. U.S. Citizenship and Immigration Services. Active DACA Recipients – December 2021. *Immigration and Citizenship Data*. March 09, 2022. https://www.uscis.gov/tools/reports-and-studies/immigration-and-citizenship-data.

28. Migration Policy Institute. Estimates of DACA-eligible Population at U.S. and State Levels. *Migration Policy Institute*. 2021. Available at: https://www.migrationpolicy.org/programs/data-hub/deferred-action-childhood-arrivals-daca-profiles.

29. U.S. Department of Homeland Security. Deferred Action for Childhood Arrivals (DACA). 2021. Available at: https://www.dhs.gov/deferred-action-childhood-arrivals-daca.

30. Venkataramani AS, Shah SJ, O'Brien R, Kawachi I, Tsai AC. Health Consequences of the US Deferred Action for Childhood Arrivals (DACA) Immigration Programme: A Quasi-Experimental Study. April 2017;2(4):e175-e181.

31. Amuedo-Dorantes C, Antman F. Can Authorization Reduce Poverty Among Undocumented Immigrants? Evidence from the Deferred Action for Childhood Arrivals Program. *IZA Discussion Papers, Institute of Labor Economics*. August 2016.

32. United Nations High Commissioner for Refugees. Refugee Statistics. 2022. Available at: https://www.unrefugees.org/refugee-facts/statistics/.

33. UNICEF. Child Displacement. June 2022. Available at: https://data.unicef.org/topic/child-migration-and-displacement/displacement/.

34. Husain N, Marx R. Refugees in Illinois: More than 40% from Banned Countries. *Chicago Tribune*. January 2017.

35. Malagon E. As Another Wave of Afghans Arrives in Chicago, Volunteers Say More Help is Needed. *Chicago Sun Times*. February 2022.

36. SDG Target 3.1: Reduce the Global Maternal Mortality Ratio to Less than 70 per 100,000 Live Births. *World Health Organization*. Available at:

https://www.who.int/data/gho/data/themes/topics/topic-details/GHO/sdgtarget3-1-reduce-maternal-mortality.

37. Hoyert DL. Maternal Mortality Rates in the United States, 2020. *Centers for Disease Control and Prevention*. February 23, 2020. Available at: https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/maternal-mortality-rates-2020.htm#Table.

38. The Commonwealth Fund. Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries. 2020. Available at: https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries.

39. Schreiber M. 'A Matter of Life and Death': Maternal Mortality Rate will Rise Without Roe, Experts Warn. *The Guardian*. June 2022.

40. Rice A. Roe v. Wade: The Mental and Physical Health Effects of Anti-Abortion Laws. *Healthline*. June 2022.

41. Associated Press. WHO Chief: U.S. Abortion Ruling 'A Setback,' will Cost Lives. *The Washington Post*. June 2022.

42. Chicago Department of Public Health. Maternal Morbidity & Mortality in Chicago. 2019. Available at: https://www.healthychicagobabies.org/wp-content/uploads/2019/11/CDPH-002_MaternalMortality_Databook_r4c_DIGITAL.pdf.

43. About Social Determinants of Health (SDOH). *Social Determinants of Health: Know What Affects Health*. March 10, 2021. Available at: https://www.cdc.gov/socialdeterminants/about.html.

44. High School Graduation. *Healthy People 2030*. Available at: https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/high-school-graduation.

45. Quality of Housing. *Healthy People 2030*. Available at: https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/quality-housing.

46. Child Opportunity Index (COI). *Diversity Data Kids*. 2020. Available at: https://www.diversitydatakids.org/child-opportunity-index.

47. Parrish M, Ikoro C. Chicago Public Schools and Segregatiion. *South Side Weekly*. Feburary 2022.

48. Eunice Kennedy Shriver National Institute of Child Helath and Human Development. Why is early learning important? *National Institutes of Health*. July 8, 2021. Available at: https://www.nichd.nih.gov/health/topics/early-

learning/conditioninfo/matter#:~:text=Early%20learning%20paves%20the%20way,children%2C%20teens%2C%20and%20adults.

49. Garcia E, Elaine W. *Early Education Gaps by Social Class and Race Start U.S. Children Out on Unequal Footing: A Summary of the Major Findings in Inequalities at the Starting Gate*: Economic Policy Institute; 2015.

50. *Chicago Children Services Community Assessment 2021*. Chicago: Chicago Department of Family and Support Services; 2021.

51. U.S. Department of Health and Human Services. HHS Poverty Guidelines for 2022. *Office of the Assistant Secretary for Planning and Evaluation*. January 12, 2022. Available at: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines.

52. Chicago Department of Family and Support Services. *Chicago Children Services Community Assessment 2020*: Chicago Department of Family and Support Services; 2020.

53. Carminucci J, Hodgman S, Rickles J, Garet M. *Student Attendance and Enrollment Loss 2020-2021*: American Institutes for Research; 2021.

54. Koumpilova M. COVID Surges, 'Re-Entry Anxiety' Hamper Chicago's Efforts to Boost Attendance. *Chalkbeat Chicago*. January 2022.

55. Zhong M, Williams AR. In Chicago, Neighborhoods Have Stark Differences in Economic Opportunity. February 1, 2022. Available at: https://www.urban.org/urban-wire/chicago-neighborhoods-have-stark-differences-economic-opportunity.

56. Fructoso BJM, Cuddy , Lewis AE, Arenas I. *Chicago's Racial Wealth Gap: Legacies of the Past, Challenges in the Present, Uncertain Futures*. Chicago: Institute for Research on Race and Public Policy; 2021.

57. Healthy People 2020. *Poverty*. 2020. Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/poverty#:~:text=Residents%20of%20impoverished%20neighborhoods%20or,mortality%2C%20and%20lower%20life%20expectancy.&text=Some%20population%20group.

58. Feeding America. Hunger and Child Development. *Feeding America*. Available at: https://www.feedingamerica.org/hunger-in-america/impact-of-hunger#:~:text=Research%20shows%20an%20association%20between,aggression%20in%20school%2Dage%20children.

59. Centers for Disease Control and Prevention. Consequences of Obesity. May 23, 2022. Available at: https://www.cdc.gov/obesity/basics/consequences.html.

60. Chicago Department of Public Health. Healthy Chicago Data Brief: Overweight or Obesity in Chicago Public Schools, 2010-2018. 2018. Available at: https://www.chicago.gov/content/dam/city/depts/cdph/CDPH/Childhood%20Overweight%20Data%20Brief%2012.2020.pdf.

61. Chicago Department of Public Health. Healthy Chicago Data Brief: Overweight or Obesity in Chicago Public Schools, 2010-2018. 2018. Available at: https://www.chicago.gov/content/dam/city/depts/cdph/CDPH/Childhood%20Overweight%20Data%20Brief%2012.2020.pdf.

62. Larson NI, Story MT, Nelson MC. Neighborhood Environments: Disparities in Access to Healthy Foods in the U.S. *American Journal of Preventive Medicine*. January 2009;36(1).

63. Sabino P. At Least 8,000 Chicago Families Living In Poverty Aren't Getting Food Assistance, Depository Says. New Program Aims To Find Out Why. *Block Club Chicago*. June 2021.

64. City of Chicago, Healthy Chicago 2025, Greater Chicago Food Depository. *Chicago Food Equity Agenda: Building a More Equitable Food System, Together*. 2021. Available at: https://www.chicago.gov/content/dam/city/sites/food-equity/pdfs/City_Food_Equity_Agenda.pdf.

65. 2022 Commissioners Letter - SNAP Policy on Public Charge. *USA Food and Nutrition Service, U.S. Department of Agriculture*. January 12, 2022. https://www.fns.usda.gov/snap/2022-commissioners-letter-snap-policy-public-charge.

66. Lofton S, Kersten M, Simonovich SD, Martin A. Mutual Aid Organisations and their Role in Reducing Food Insecurity in Chicago's Urban Communities during COVID-19. *Public Health Nutrition*. August 2021;1(25):110-122.

67. Swope CB, Hernandez D. Housing as a Determinant of Health Equity: A Conceptual Model. *Social Science and Medicine*. September 2019;243(112571).

68. Taylor L. Housing And Health: An Overview Of The Literature. *Health Affairs*. June 2018.

69. Solan CD, Mare RD. Housing Crowding Effects on Children's Wellbeing. *Social Science Research*. March 2012;41(2):464-476.

70. Ahmad K, Erqou S, Shah N, et al. Association of poor housing conditions with COVID-19 incidence and mortality across US counties. *PLOS One*. November 2020;15(11).

71. Eng M. National and Local Rents Keep Rising. *Axios Chicago*. December 2021. Available at: https://www.axios.com/local/chicago/2022/02/10/national-and-local-rents-keep-rising.

72. Swope CB, Hernandez D. Housing as a Determinant of Health Equity: A Conceptual Model. *Soc Sci Med*. 2019;243(112571).

73. Djurhuus S, Hansen HS, Aadahl M, Glumer C. The Association between Access to Public Transportation and Self-Reported Active Commuting. *Int J Environ Res Public Health*. December 2014;11(12):12632-12651.

74. Ou JY, Levy I, Peters JL, et al. A Walk in the Park: The Influence of Urban Parks and Community Violence on Physical Activity in Chelsea, MA. *Int J Environ Res Public Health.* January 2016;13(1).

75. South EC, Kondo MC, Cheney RA, Branas CC. Neighborhood Blight, Stress, and Health: A Walking Trial of Urban Greening and Ambulatory Heart Rate. *American Journal of Public Health*. May 2015;105(5).

76. American Lung Association. Living Near Highways and Air Pollution. Available at: https://www.lung.org/clean-air/outdoors/who-is-at-risk/highways.

77. Gupta S, Bergin D, Zamudio MI, Chase B, Runes C. Chicagoans Who Live Near Heavy-Traffic Corridors are Breathing the Most Polluted Air. May 16, 2022. Available at: https://www.wbez.org/stories/a-new-sensor-network-reveals-chicagos-air-quality-disparities/22398e94-982c-4dcc-8c13-ff0113ff95b6.

78. Levine L. Making the Invisible Visible. *South Side Weekly*. May 20, 2022. Available at: https://southsideweekly.com/making-the-invisible-visible/.

79. Chicago Department of Public Health. Air Quality and Health Report. 2020. Available at: https://www.chicago.gov/city/en/depts/cdph/provdrs/healthy_communities/svcs/air-quality-and-health.html.

80. Moser A. CPS Hispanic Schools. 2022. Available at: https://datastudio.google.com/reporting/b873b71a-a57a-4e02-b450-14523d2db4cf/page/vNumC.

81. Frostin P, Woodbury SA. The Commonwealth Fund. *Update: How Many Americans Have Lost Jobs with Employer Health Coverage During the Pandmeic*. January 11, 2021. Available at: https://www.commonwealthfund.org/blog/2021/update-how-many-americans-have-lost-jobs-employer-health-coverage-during-pandemic.

82. Chicago Department of Public Health. Healthy Chicago 2025: Closing Our Life Expectancy Gap. 2020. Available at: https://www.chicago.gov/content/dam/city/depts/cdph/statistics_and_reports/HC2025_917_FINAL.pdf.

83. Kim SJ, Peterson CE, Warnecke R, Barrett R, Glassgow AE. The Uneven Distribution of Medically Underserved Areas in Chicago. *Health Equity*. December 2020;4(1):556-554.

84. Centers for Disease Control and Prevention. About Chronic Diseases. May 2022. Available at: https://www.cdc.gov/chronicdisease/about/index.htm.

85. Centers for Disease Control and Prevention. People with Certain Medical Conditions. May 2, 2022. Available at: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html.

86. Centers for Disease Control and Prevention. CDC Healthy Schools: Managing Health Conditions. 2021. Available at: https://www.cdc.gov/healthyschools/chronicconditions.htm#:~:text=In%20the%20United%20States%2C%20more,%2C%20and%20behavior%2Flearning%20problems.

87. Obesity Basics. *Centers for Disease Control and Prevention*. June 3, 2022. Available at: https://www.cdc.gov/obesity/basics/index.html.

88. Lange SJ, Kompaniyets , Freedman DS, et al. Longitudinal Trends in Body Mass Index Before and During the COVID-19 Pandemic Among Persons Aged 2–19 Years — United States, 2018–2020. *Morbidity and Mortality Weekly Report (MMWR), Centers for Disease Control and Preventioin*. September 2021;70(37):1278-1283.

89. *From Crisis to Opportunity: Reforming Our Nation's Policies to Help All Children Grow Up Healthy*: Robert Wood Johnson Foundation; 2021.

90. Pate CA, Zahran HS, Qin X, Johnson C, Hummelman E, Malilay J. Asthma Surveillance - United States, 2006-2018. *MMWR Surveill Summ*. September 2021.

91. Peters Ubong, Dixon AE, Forno E. Obesity and Asthma. *J Allergy Clin Immunol*. April 2018;141(4).

92. Chicago Department of Public Health, Stanley Manne Children's Research Institute. Childhood Asthma in Chicago. *Voices of Child Health in Chicago Report*. July 2020;2(6).

93. Endocrine Society. Childhood Obesity Quadruples Risk of Developing Type 2 Diabetes. 2017. Available at: https://endocrinenews.endocrine.org/childhood-obesity-quadruples-risk-developing-type-2-diabetes/.

94. United Health Foundation. America's Health Rankings. 2021. Available at: https://www.americashealthrankings.org/.

95. Centers for Disease Control and Prevention. United States Diabetes Surveillance System. 2019. Available at: https://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html.

96. Cohen E, Kuo DZ, Agrawal R, et al. Children with Medical Complexity: An Emerging Population for Clinical and Research Initiatives. *Pediatrics*. March 2011;127(3):529-538.

97. Foster C, Fuentes M, Wadlington L, et al. Caregiver and Provider Experiences of Home Healthcare Quality for Children with Medical Complexity. *Home Healthc Now*. May 2021;38(3).

98. World Health Organization. Mental Health: Strenthening Our Response. June 17, 2022. Available at: https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response.

99. Centers for Disease Control and Prevention. About Mental Health. June 28, 2021. Available at: https://www.cdc.gov/mentalhealth/learn/index.htm.

100. Office of the U.S. Surgeon General. Protecting Youth Mental Health: The U.S. Surgeon General's Advisory. 2021. Available at: https://www.hhs.gov/surgeongeneral/priorities/youth-mental-health/index.html.

101. American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry and Children's Hospital Association. AAP-AACAP-CHA Declaration of a National Emergency in Child and Adolescent Mental Health

102. The Trevor Project. 2022 National Survey on LGBTQ Youth Mental Health. 2022. Available at: https://www.thetrevorproject.org/survey-2022/.

103. Underwood LA, Washington A. Mental Illness and Juvenile Offenders. *International Journal of Environmental Research and Public Health*. February 2016;13(2).

104. Office of Juvenile Justice and Delinquency Prevention. Intersection between Mental Health and the Juvenile Justice System. 2017. Available at: https://ojjdp.ojp.gov/model-programs-guide/literature-reviews/intsection_between_mental_health_and_the_juvenile_justice_system.pdf.

105. Mental Health America. Mental Health and Criminal Justice Issues. Available at: https://www.mhanational.org/issues/mental-health-and-criminal-justice-issues.

106. Wasik H. *Youth Mental Health in the Unaccompanied Refugee Minors Program: Findings from a Descriptive Study*. Washington, DC: U.S. Department of Health and Human Services; 2021. OPRE Report #2021-36.

107. Todd H, Martin E. *Children of Immigrants and their Mental Health Needs*: Think Global Health; 2020.

108. Austin L. Mental Health Needs of Youth in Foster Care: Challenges and Strategies. *The Connection*. 2004;20(4):6-13.

109. Steenbakkers A, Van Der Steen S, Grietens H. The Needs of Foster Children and How to Satisfy Them: A Systematic Review of the Literature. *Clinical Child and Family Psychology Review*. 2018;21:1-12.

110. Cree RA, Bitsko RH, Robinson LR, et al. Health Care, Family, and Community Factors Associated with Mental, Behavioral, and Developmental Disorders and Poverty Among Children Aged 2–8 Years -- United States, 2016. *Morbidity and Mortality Weekly Report*. December 2018;50.

111. Kalter L. Association of American Medical Colleges. *Treating Mental Illness in the ED*. September 3, 2019. Available at: https://www.aamc.org/news-insights/treating-mental-illness-ed.

112. Mental Health America. The State of Mental Health in America. 2022. Available at: https://www.mhanational.org/issues/state-mental-health-america.

113. National Alliance on Mental Illness (NAMI). Mental Health by the Numbers. 2020. Available at: https://www.nami.org/mhstats.

114. Dym Bartlett J, Sacks V. Adverse childhood experiences are different than child trauma, and it's critical to understand why. *Child Trends*. 2019. Available at: https://www.childtrends.org/blog/adverse-childhood-experiences-different-than-child-trauma-critical-to-understand-why.

115. Substance Abuse and Mental Health Servcies Administration (SAMHSA). Understanding Child Trauma. 2022. Available at: https://www.samhsa.gov/child-trauma/understanding-child-trauma.

116. Voices of Child Health in Chicago. *Youth Mental Health in Chicago During the COVID-19 Pandemic*: Ann & Robert H. Lurie Children's Hospital of Chicago; 2021.

117. Pritzker Department of Psychiatry and Behavioral Health, Ann & Robert H. Lurie Children's Hospital of Chicago. Throughput and Capacity: FY22 YTD through April.

118. Centers for Disease Control and Prevention (CDC). 1991-2019 High School Youth Risk Behavior Survey Data. Available at: http://yrbs-explorer.services.cdc.gov.

119. Slomski A. Pediatric Depression and Anxiety Doubled During the Pandemic. *JAMA*. October 2021;326(13).

120. Macintyre A, Ferris D, Gonçalves B, Quinn N. What has Economics got to do with it? The Impact of Socioeconomic Factors on Mental Health and the Case for Collective Action. *Palgrave Communications*. December 2018;4(1).

121. Williams DR, Etkins OS. Racism and Mental Health. *World Psychiatry*. June 2021;20(2):194-195.

122. Curtin SC. State Suicide Rates Among Adolescents and Young Adults Aged 10–24: United States, 2000-2018. *National Vital Statistics Reports, Centers for Disease Control and Prevention*. September 2020;69(11).

123. Yard E, Radhakrishnan L, Ballesteros MF, et al. *Emergency Department Visits for Suspected Suicide Attempts Among Persons Aged 12–25 Years Before and During the COVID-19 Pandemic — United States, January 2019–May 2021*: Centers for Disease Control and Prevention; 2021.

124. Heron M. Deaths: Leading Causes for 2019. *National Vital Statistics Report, Centers for Disease Control and Prevention*. July 2021;70(9).

125. Ramchand R, Gordon JA, Pearson JL. Trends in Suicide Rates by Race and Ethnicity in the United States. *JAMA Network Open*. May 2021;4(5).

126. National Institute on Drug Abuse. Percentage of Adolescents Reporting Drug Use Decreased Significantly in 2021 as the COVID-19 Pandemic Endured. 2021. Available at: https://nida.nih.gov/news-events/news-releases/2021/12/percentage-of-adolescents-reporting-drug-use-decreased-significantly-in-2021-as-the-covid-19-pandemic-endured.

127. Volkow ND, Han B, Einstein EB, Compton WM. Prevalence of Substance Use Disorders by Time Since First Substance Use Among Young People in the US. *JAMA Pediatrics*. June 2021;175(6).

128. National Council on Program Gambling. FAQ: How Widespread is Problem Gambling in the U.S. n.d.. Available at: https://www.ncpgambling.org/help-treatment/faq/.

129. International Centre for Youth Gambling Problems and High-risk Behaviors. Information on Gambling. n.d.. Available at: http://www.youthgambling.com/.

130. Sohn SY, Rees P, Wildridge B, Kalk NJ, Carter B. Prevalence of problematic smartphone usage and associated mental health outcomes amongst children and young people: a systematic review, meta-analysis and GRADE of the evidence. *BMC Psychiatry*. 2019;356.

131. Ujima Youth Researchers, Healing through Justice. Changing the Beat of Mental Health: Amplifying Our Voice. February 2022. Available at: https://www.healingthroughjustice.org/_files/ugd/7de017_24ae0dbf2403443bbd898cb19e085a60.pdf.

132. Lee LK, Chaudhary S, Kemal S, Kiragu A, Sheehan K, Fleegler EW. Addressing the Void: Firearm Injury Prevention in the USA. *The Lancet Child & Adolescent Health*. May 2022;4642(22).

133. Ann & Robert H. Lurie Children's Hospital of Chicago. Firearms Are Leading Cause of Death Among U.S. Youth. May 26, 2022. Available at: https://www.luriechildrens.org/en/news-stories/firearms-are-leading-cause-of-death-among-u.s.-youth/.

134. Gun Violence in Chicago (and what it could have been). *UChicago UrbanLabs*. March 2022. https://urbanlabs.uchicago.edu/projects/gun-violence-in-chicago-and-what-could-have-been.

135. Voices of Child Health in Chicago. *Bullying Prevention and Social Emotional Learning in Childhood and Adolescence*: Ann & Robert H. Lurie Children's Hospital of Chicago; 2020.

136. State of Illinois Proclamation from Governor Pritzker. August 24, 2021. https://www.luriechildrens.org/globalassets/media/pages/research/tricam/ten-4/ten-4-day---governor-pritzker.pdf.

137. Chicago Department of Family & Support Services. Children of Chicago: A Community Assessment. 2019. Available at: https://www.chicago.gov/city/en/depts/fss/supp_info/CoC_CommunityAssessment2019.html.

138. Chaiyachati B, Wood J, Carter C, et al. Emergency Department Child Abuse Evaluations During COVID-19: A Multicenter Study. *Pediatrics*. July 2022.

139. Centers for Disease Control and Prevention. Injuries Among Children and Teens. *Injury Prevention & Control*. September 22, 2021. Available at: https://www.cdc.gov/injury/features/child-injury/index.html#:~:text=Child%20unintentional%20injury%20death%20rates,about%2020%20deaths%20each%20day.

140. Prevention CfDCa. Injuries Among Children and Teens. *Injury Prevention and Control*. 2021. Available at: https://www.cdc.gov/injury/features/child-injury/index.html#:~:text=Child%20unintentional%20injury%20death%20rates,of%20unintentional%20injuries%20in%202019.

141. Children's Safety Network. Understanding Disparities in Child and Adolescent Injury: A Review of the Research. 2017. Available at: https://www.childrenssafetynetwork.org/sites/childrenssafetynetwork.org/files/CSN-NCCSI%20Injury%20Disparities%20White%20Paper.pdf.

142. Illinois Department of Public Health. Making Illinois Safer: Injury, Violence and Suicide Prevention Data Book. 2021. Available at: https://dph.illinois.gov/content/dam/soi/en/web/idph/publications/idph/topics-and-services/prevention-wellness/injury-violence-prevention/ohpmivp-databooknav3docx-08302021v2-1-final.pdf.

143. Centers for Disease Control and Prevention. Motor Vehicle Crash Deaths: How is the US doing? *Vital Signs*. July 6, 2016. Available at: https://www.cdc.gov/vitalsigns/motor-vehicle-safety/.

144. Sudden Unexpected Infant Death and Sudden Infant Death Syndrome. *Centers for Disease Control and Prevention*. April 28, 2021. Available at: https://www.cdc.gov/sids/data.htm.

145. Attridge M, Heffernan ME, Smith TL, et al. Infant Sleep Practices in Chicago Families. *Voices of Child Health in Chicago Report*. January 2022;4(1).

146. Haarbauer-Krupa J, Haileyesus T, Gilchrist J, Mack KA, Law CS, Joseph A. Fall-Related Traumatic Brain Injury in Children Ages 0–4 Years. *Journal of Safety Research*. 2019;70.

147. Ann & Robert H. Lurie Children's Hospital of Chicago. Stop the Falls Data Brief. 2018. Available at: https://www.luriechildrens.org/globalassets/media/story-images/documents/stop-the-falls-data-brief.pdf.

148. Clemens T, Moreland B, Lee R. Persistent Racial/Ethnic Disparities in Fatal Unintentional Drowing Rates Among Persons *Morbidity and Mortality Weekly Report*. June 2021;70(24).

149. American Burn Association. Scald Statistics and Data Resources. 2018. Available at: https://ameriburn.org/wp-content/uploads/2018/12/nbaw2019_statsdataresources_120618-1.pdf.

150. Poison Statistics, National Data 2020. *Poison Control - National Capital Poison Center*. 2020. Available at: https://www.poison.org/poison-statistics-national.

151. Tsao F. *Illinois' Undocumented Immigrant Population: A Summary of Recent Research by Rob Paral and Associates* 2014.

152. Mahowald L, Gruberg S, Halpin J. *The State of the LGBTQ Community in 2020: A National Public Opinion Study*: Center for American Progress; 2020.

153. Coryne H. In Chicago, Urban Density May Not Be to Blame for the Spread of the Coronavirus. *ProPublica*. 30 2020.

154. Barriteau CM, Feinglass J, Kayle M, et al. Emergency Department Visits and Hospitalizations Among Pateints with Sickle Cell Disease in Illinois, 2016-2020. *Pediatric Hematology and Oncology*. May 2022.

155. Weiner D, Heaton L, Stiehl M, et al. *Chapin Hall Issue Brief: COVID-19 and Child Welfare: Using Data to Understand Trends in Maltreatment and Response*: Chapin Hall; 2020.

156. Monarrez T, Chien C. *Dividing Lines: Racially Unequal School Boundaries in US Public School Systems*: Urban Institute; 2021.

157. Kullgren JT, Mclaughlin CG, Mitra N, Armstrong K. Nonfinancial Barriers and Access to Care for U.S. Adults. *Health Services Research*. 2012:462-485.

158. American Immigration Council. Immigrants in Illinois. 2020. Available at: https://www.americanimmigrationcouncil.org/research/immigrants-in-illinois.

159. Greater Chicago Food Depository. Hunger In Our Community: A Spring 2021 Status Report. 2021. Available at: https://www.chicagosfoodbank.org/wp-content/uploads/2021/04/Food-Depository-Hunger-Report-Spring-2021.pdf.

160. U.S. Census Bureau. *2013-2017 American Community Survey 5-Year Estimates* 2017.

161. National Low Income Housing Coalition. Out of Reach: The High Cost of Housing. 2021. Available at: https://nlihc.org/sites/default/files/oor/2021/Out-of-Reach_2021.pdf.

162. U.S. Census Bureau. *2015-2019 American Community Survey 5-Year Estimates* 2019.

163. Robert Wood Johnson Foundation. From Crisis to Opportunity: Reforming Our Nation's Policies to Help All Children Grow Up Healthy (State of Childhood Obesity Annual Report). *State of Childhood Obesity Annual Report*. 2021. Available at: https://stateofchildhoodobesity.org/2021report/.

164. Chicago Department of Public Health. Healthy Chicago Data Brief: Overweight or Obesity in Chicago Public Schools, 2010-2018. 2018. Available at: https://www.chicago.gov/content/dam/city/depts/cdph/CDPH/Childhood%20Overweight%20Data%20Brief%2012.2020.pdf.

165. Chicago Department of Public Health. *Chicago Health Atlas*. Available at: https://chicagohealthatlas.org/.

166. Chicago Public Schools. *District Data Metrics*.

167. Centers for Disease Control and Prevention. Sickle Cell Disease. June 7, 2022. Available at: https://www.cdc.gov/ncbddd/sicklecell/facts.html.

168. Race Forward. Moving the Race Conversation Forward. 2014. Available at: https://www.raceforward.org/research/reports/moving-race-conversation-forward?

169. Shipow A, Singh A, Adhiambo J. Is your data inclusive? *The Busara Blog*. June 26, 2020. Available at: https://medium.com/busara-center-blog/is-your-data-inclusive-ddd59933f108.

170. Ruth T. Equity Series, for Design in Tech Report.

171. Basaldua Jr. F, Cuddy , Lewis AE, Arenas I. Chicago's Racial Wealth Gap: Legacies of the Past, Challenges in the Present, Uncertain Futures. *Institute for Research on Race and Public Policy (IRRPP), Univerity of Illinois Chicago*. February 2021. Available at: https://irrpp.uic.edu/state-of-racial-justice/reports/.

172. University of Chicago Crime Lab. Gun Violence in Chicago (and what could have been). 2022. Available at: https://urbanlabs.uchicago.edu/projects/gun-violence-in-chicago-and-what-could-have-been.

APPENDICES

APPENDIX A: MAGOON INSTITUTE EXTERNAL ADVISORY COUNCIL MEMBERS

- Chair, Esther Corpuz, Chief Executive Officer, Alivio Medical Center
- Vice Chair, Matthew M. Davis, MD, MAPP, Chief of Community Health Transformation, Chair of Pediatrics
- Jake Ament, Director, Neighborhood Network, LISC Chicago
- David Cherry, City Leader, All Stars Project of Chicago
- Pat Garcia, MD, Associate Dean for Curriculum and Professor of Obstetrics and Gynecology and Medical Education, Northwestern University Feinberg School of Medicine
- Lauren Gorter, Lurie Children's Founders' Board
- Darlene Hightower, President and CEO, Metropolitan Planning Council
- Erika Holliday, Past President, Lurie Children's Family Advisory Board
- Angela Ingram, Senior VP of Communications, iHeart Media
- Nicole Kazee, Senior Vice President of Strategy and Business Development, Erie Family Health Center
- Norman Kerr, Chief Executive Officer, Trajectory Changing Solutions (TCS)
- Michelle Martinez, Parent and former Lurie Children's Family Advisory Board
- Roxanne Nava, Executive Director, Metropolitan Family Services, North/Evanston/Skokie Valley Centers
- Leticia Reyes-Nash, Principal, Health Management Associates (HMA)
- James Rudyk, Executive Director, Northwest Center
- David A. Sanders, MSEd, President, Malcolm X College
- Smita Shah, President and CEO of SPAAN Tech, Inc, and Lurie Children's Board Member
- Darnell Shields, Executive Director, Austin Coming Together
- Cinaiya Stubbs, President and Chief Executive Officer, Children's Place Association
- Monsignor Kenneth Velo, Big Shoulders Fund, DePaul University and Lurie Children's Board

APPENDIX B: INTERNAL ADVISORY COMMITTEE MEMBERS

- Rishi Agrawal, MD Hospital-based Medicine
- Adam Becker, PhD, Consortium to Lower Obesity in Chicago Children
- Kevin Braden, Lurie Children's Foundation
- Jennifer Calligan, Marketing and Communications
- Colleen Cicchetti, PhD, Center for Childhood Resilience
- Mary Kate Daly, Patrick M. Magoon Institute for Healthy Communities
- Matthew M. Davis, MD, MAPP, Chief of Community Health Transformation, Chair of Pediatrics
- Kelli Day, Patrick M. Magoon Institute for Healthy Communities
- Jill Fraggos, Government Relations
- Mariana Glusman, MD, FAAP, Advanced General Pediatrics and Primary Care
- Chris Haen, Lurie Children's Health Partners Care Coordination
- Susan Hayes Gordon, External Affairs
- Marie Heffernan, PhD, Voices of Child Health in Chicago
- Leslie Helmcamp, Strengthening Chicago's Youth
- Amy Hill, Injury Prevention & Research Center
- Katelyn Kanwischer, ConnecTeen
- Cynthia LaBella, MD, Institute for Sports Medicine
- Jennifer Leininger, Potocsnak Family Division of Adolescent and Young Adult Medicine
- Anya Maziak, Lurie Children's Foundation
- Nell McKitrick, Center for Childhood Resilience
- Adeola Oduwole, Office of Equity, Diversity and Inclusion
- Mo Otting, Emergency Medicine
- Stephanie Pelligra, Pediatrics Administration and Operations
- Madiha Qureshi, Teamwork to Reduce Infant, Child and Adolescent Mortality
- Maria Rivera, Mentorship and Workforce Development
- Andrea Romaniuk, Population Health, Information Management
- Susan Ruohonen, Family Services
- Corinne Sadecki-Lund, Emergency Medicine
- Michelle Sagan, MD, Orthopedic Surgery & Sports Medicine
- Parag Shah, MD, Hospital-based Medicine
- Karen Sheehan, MD, MPH, Patrick M. Magoon Institute for Healthy Communities
- Sara Sitkie, Population Health, Information Management
- Tracie Smith, Data Analytics and Reporting
- Renee Walker, DrPH, MPH, Patrick M. Magoon Institute for Healthy Communities

APPENDIX C: COMMUNITY HEALTH ACTION TEAMS

Community Health Action Teams Co-Chairs

Social Influencers of Health and Access to Care

- Mariana Glusman, MD, FAAP
- Renee Walker, DrPH, MPH

Chronic Health Conditions

- Kristin Kan, MD, MPH, MSc
- Jacinta Staples, MSN, RN

Mental and Behavioral Health

- Colleen Cicchetti, PhD
- Aron Janssen, MD

Unintentional Injury and Violence

- Audrey Brewer, MD, MPH, FAAP
- Karen Sheehan, MD, MPH

Community Health Action Teams Members

Action Teams are comprised of clinical and public health experts from the following departments and programs across Lurie Children's:

- Advanced General Pediatrics
- Allergy & Immunology
- Ambulatory Patient Care Services
- Anesthesia
- Cardiology
- Child Abuse Pediatrics
- Child and Adolescent Psychiatry
- Child Life
- Clinical and Organizational Development
- Data Analytics and Reporting
- Department of Pediatrics
- Emergency Medicine
- External Affairs/Government Relations
- Family Services/Social Work
- Finance and Procurement
- Gastroenterology, Hepatology & Nutrition
- Health Information Management
- Hospital-Based Medicine
- Human Resources
- Institute for Sports Medicine
- Lurie Children's Health Partners Care Coordination
- Nursing
- Office of Equity, Diversity & Inclusion
- Orthopedic Surgery
- Patient-Family Services
- Patrick M. Magoon Institute for Healthy Communities
- Pediatric Critical Care Medicine
- Pediatric Pulmonology
- Pediatric Surgery
- Potocsnak Family Division of Adolescent and Young Adult Medicine
- Pritzker Department of Psychiatry and Behavioral Health
- Smith Child Health Outcomes, Research and Evaluation
- Telemedicine
- Urology

APPENDIX D: TIMELINE AND KEY DATES

Lurie Children's Patrick M. Magoon Institute for Healthy Communities team led the CHNA planning and implementation process with oversight and guidance from the Magoon Institute Advisory Council and Internal Advisory Committee. We also asked these committees to review and provide feedback on drafts of the Alliance for Health Equity's Collaborative CHNA and Lurie Children's CHNA and Implementation Strategy. Summary of key meeting dates and Lurie Children's participation in the Alliance for Health Equity Collaborative CHNA planning and implementation:

DATE	MEETING	BRIEF AGENDA
Apr 2021	Alliance for Health Equity (AHE) Collaborative CHNA Committee	Overview of Collaborative CHNA, timeline, process
Apr 2021	Magoon Institute Advisory Council	CHNA and CHIS goals, process and priorities review, future data collection discussion
May 2021	AHE Collaborative CHNA Committee	Collaborative CHNA goals, timeline and community input planning
Jun 2021	AHE Collaborative CHNA Committee	Community input survey and focus group development
Jul 2021	AHE Collaborative CHNA Committee	Timeline update, focus group scheduling, secondary data analysis and survey editing
Aug 2021	AHE Collaborative CHNA Committee	Community input survey fielded, secondary data analysis underway, CHNA outline overview
Oct 2021	AHE Collaborative CHNA Committee	Community input survey and focus group update
Nov 2021	Internal Advisory Committee	Collaborative CHNA overview, community input survey update, Lurie Children's CHNA/CHIS timeline
Nov 2021	AHE Collaborative CHNA Committee	General update, including survey dissemination status and targeting underrepresented groups for survey collection
Dec 2021	AHE Collaborative CHNA Committee	Community input survey fielding completed, review of demographics
Jan 2022	Internal Advisory Committee	Community input survey and focus group completion review, Lurie Children's focus group planning
Mar 2022	AHE Collaborative CHNA Committee	Community input data review, CHNA draft report review, implementation strategies alignment and priorities
Mar/Apr 2022	Community Health Action Teams	Collaborative CHNA overview and community input, Lurie Children's CHNA priority domains and CHIS 2023-2025 strategies and strategy leads brainstorm
Apr 2022	Magoon Institute Advisory Council	Collaborative CHNA, service area, community input, secondary data and priority domains
Apr 2022	Internal Advisory Committee	Collaborative CHNA, service area, community input, secondary data, priority domains and potential community health strategies

DATE	MEETING	BRIEF AGENDA
May 2022	Community Health Action Teams	Advisory Council feedback review, CHIS impact framework and strategy prioritization, and activities and outcomes brainstorm
Jun 2022	Community Health Action Teams	CHIS guiding principles, impact framework and strategies review, and key partners and metrics brainstorm
Jun 2022	Magoon Institute Advisory Council	Community Health Implementation Strategy (CHIS) impact framework, community health strategies, community partners and key metrics. The CHNA and Implementation Strategy were unanimously approved to recommend to the Medical Center Board for approval and adoption
Jul 2022	Magoon Institute Advisory Council	Review and approval of final Lurie Children's CHNA/CHIS
Aug 2022	Medical Center Board of Directors	Review, approval and formal adoption of final Lurie Children's CHNA and CHIS
Aug 2022		Publish CHNA and CHIS online

APPENDIX E: DETAILED METHODOLOGY

Collaborative CHNA Alliance for Health Equity Secondary Sources

The Alliance for Health Equity conducted a thorough literature review for the collaborative CHNA and accessed several secondary sources. A full list of secondary data sources is below:

Local data compiled by agencies, including:

- Chicago Department of Public Health
- Cook County Department of Public Health
- Chicago Metropolitan Agency for Planning
- Chicago Department of Family and Support Services
- Chicago Department for Planning and Development
- Housing Authority of Cook County
- Local police departments

Local data compiled by community-based organizations, including:

- Greater Chicago Food Depository
- Feeding America
- Voices of Child Health in Chicago
- Health Chicago Equity Zones
- Mapping COVID-19 Recovery initiative

Data compiled by state agencies, including:

- Illinois Department for Healthcare and Family Services
- Illinois Department of Human Services
- Illinois State Board of Education
- Illinois Department of Public Health

Data from federal sources, including:

- U.S. Census Bureau American Community Survey
- Centers for Disease Control and Prevention PLACES project
- Centers for Medicare and Medicaid Services
- Health Resources and Services Administration
- United States Department of Agriculture

Licensed Data Portals and Publicly Available Datasets

Data access by Lurie Children's Hospital for the CHNA were principally compiled from publicly available datasets via data sharing portals and publicly available data sharing tools. See below for a comprehensive list of the data portals accessed for the Lurie Children's 2022 CHNA. Where possible we focused our analysis on the most recently available data including 2019, 2020, and 2021, where possible.

Data Portal	Description	Website
Chicago Health Atlas	Chicago Health Atlas was created by the Chicago Department of Public Health in partnership with Population Health Analytics, Metrics and Evaluation and the University of Illinois at Chicago and Metopio. The Chicago Health Atlas was used for data reporting and visualization across the CHNA report for Chicago specific data.	https://chicagohealthatlas.org/
Metopio	Metopio is a licensed data portal that aggregates publicly available datasets as they become available across the web. Indicators are created from publicly available datasets and comparisons can be made across years and geographic areas. Metopio was used for data reporting and visualization across the CHNA report for Chicago specific data.	https://public.metop.io/about/
Diversity Data Kids, Child Opportunity Index (COI)	Developed in 2014, the Child Opportunity Index is a composite measure of neighborhood opportunity capturing 29 features relevant to health and development of children. The index is applied and merged with other population level statistics at the zip code level to identify and visualize neighborhoods assets and intervention need. The latest COI measures neighborhood conditions around 2015.	https://www.diversitydatakids.org/child-opportunity-index
U.S. Census Bureau, American Community Survey	The American Community Survey was accessed to establish population level denominators by race, ethnicity, age, and ZIP code.	https://data.census.gov/cedsci/
Youth Risk Behavior Surveillance System (YRBSS)	The YRBSS monitors the health and well-being of youth via the nation school-based youth behavior risk survey. Surveys collect self-reported data on youth behaviors related to injury and violence, substance use, diet and physical activity, and sexual risk taking behaviors. We compared YRBSS data to the nation, state, and city levels through the CHNA.	https://www.cdc.gov/healthyyouth/data/yrbs/index.htm

Lurie Children's Hospital - Electronic Health Record Data & VOCHIC

Lurie Children's utilizes electronic health record vendor EPIC for medical record data collection. Lurie specific data cited throughout the CHNA, are reported directly from the EHR clinical data warehouses or via hospital operational reports created in Power BI software and maintained by LCH Data Analytics and Reporting. All data were access and reported for years 2019 through 2021, where applicable.

Voices of Child Health (VOCHIC) is a program at Lurie Children's which surveys parents in Chicago to better understand issues impacting child health. Previously published VOCHIC reports were accessed and relevant data were incorporated through the CHNA. For more information about VOCHIC, full details and previous reports can be access here: https://www.luriechildrens.org/en/voices-of-child-health-in-chicago/

Illinois Hospital Association - COMPData Hospital Discharge Data

We utilized COMPData to estimate unadjusted rates of disease within Chicago communities for years 2019-2021 to understand the burden and distribution of disease among the LCH service area. We estimated rates for all ED and hospital admissions, computing rates by several parameters including age (children 0 to 19 years of age; young adults 20 to 24) and by race and ethnicity. All analyses were conducted at Lurie Children's Hospital using SAS Enterprise Guide.

Geographic Parameters: We limited our analysis to all Chicago ZIP codes including all 606 zip codes and codes 60706, 60827, 60707 for year 2019-2021.

Numerators: We categorized patient visits into broad health domains including common chronic conditions, mental health, injury, violence, child maltreatment, and complex chronic conditions. Specific disease or condition indicators were created within each health domain. Indicators were select based on their relevance to the pediatric population as well as subspecialist provider interest at Lurie Children's Hospital. Common chronic conditions were defined as asthma, sickle cell disease, diabetes (type I & II), and food allergy. Complex chronic conditions were defined by Fuedtner et. al's Complex Chronic Care (CCC v2) classification system. Mental Health was defined as schizophrenia, bipolar, depression, adjustment disorder, anxiety, ADHD, conduct disorder, substance use, and neurodevelopment disorders. We referenced the Center for Disease Control and Preventions external cause of injury matrix to define and create modified disease categorizations for intentional and unintentional injury. Intentional Injury included injury by firearm, sharp objects/knives, blunt object, physical force, sexual assault, and other assault. Unintentional Injury included injury by firearm, machinery, vehicle, other transportation, natural events, striking, or injury involving a pedestrian or pedalist. Child maltreatment was defined as abuse including psychological, neglect, sexual, physical, and shaken infant.

Population Denominators: Population level estimates as reported by the U.S. Census Bureau for children 0 to 19 years of and young adults 20 to 24, restricted to the city of Chicago, were used as the population denominator. Given the delay in published estimates from the 2020 decennial census and the uncertainty in the experimental population estimates from the American Community Survey 2020, we utilized the American Community Survey (2015-2020) five year population estimates.

Limitations: Illinois COMPdata is aggregated and reported at the visit level; therefore, estimated rates of disease are likely overestimated.

Common Conditions - Disease Specific Measures	
	Lurie Children's Definition based on ICD-10 Codes (If present on Any Visit Diagnosis)
Asthma	'J45'
Diabetes (Type 1 or 2)	'E10','E11'
Sickle Cell Disease	'D57'
Food Allergy (Dermatitis or Anaphylactic reaction)	'L236', 'L254', 'L272','T780'

Mental Health - Composite and Individual Measures	
	Lurie Children's Definition (If Present on Any Visit Diagnosis)
Mental Health Composite Measure	Mental health includes schizophrenia, bipolar, depression, adjustment disorder, anxiety, ADHD, conduct disorder, substance use, and other neurodevelopment disorders. All hospital providers, all payers, based on patient residence.
Self-harm	'X60','X61','X62','X63','X64','X65','X66','X67','X68','X69','X70','X71','X72','X73','X74','X75','X76','X77','X78','X79','X80','X81','X82','X83','X84') (
Schizophrenia	('F20','F25')
Bipolar	('F31')
Depression	('F32','F33')
Adjustment disorder	('F43','F94')
Anxiety	('F40','F41')
ADHD	('F90')
Conduct disorder	('F91')
Substance use	('F10','F11','F12','F13','F14','F15','F16','F17','F18','F19','T51)
Neurodevelopment	('F70','F71','F72','F73','F74','F75','F76','F77','F78','F79','F80','F81','F82','F83','F84','F85','F86','F87','F88','F89')
Other Mental Health	('F') otherwise not specified above.

Intentional Injury - Composite and Individual Measures	
	Lurie Children's Definition (Any Diagnosis)
Intentional Injury Composite	Intentional Injury includes any diagnosis on a claim including the ICD-10 codes, defined below for: firearm injury, injury by sharp objects/knives, blunt objects, injury due to physical force, sexual assault, and other assault.
Firearm	'X93','X94','X95'
Sharps	'X99'
Blunt Object	'Y00'
Force	'Y04'
Sexual Assault	'T7421XA','T7421XD','T7421XS','T7621XA','T7621XD','T7621XS','Z0441'
Other Assault	'Y08'

Unintentional Injury - Composite and Individual Measures	
	Lurie Children's Definition (If Present on Any Visit Diagnosis)
Unintentional Injury Composite	Unintentional Injury includes any diagnosis on a claim including the ICD-10 codes, defined below for: Cutting, drowning, falls, injury due to fire, unintentional injuries due to firearm, machinery, vehicle injury, pedalist injury, pedestrian, transportation, natural events, struck, other.
Cut	('W25','W26','W27','W28','W29','W45')
Drown	('W65','W66','W67','W68','W69','W70','W71','W72','W73','W74')
Fall	('W00','W01','W02','W03','W04','W05','W06','W07','W08','W09','W10','W11','W12','W13','W14','W15','W16','W17','W18','W19')
Fire	('X00','X01','X02','X03','X04','X05','X06','X07','X08','X09','X10','X11','X12','X13','X14','X15','X16','X17','X18','X19')
Firearm	'W32','W33','W34'
Machine	'W24','W30','W31'
Vehicle	'V304','V305','V306','V307','V309','V314','V315','V316','V317','V319','V324','V325','V326','V327','V329','V334', 'V335','V336','V337','V339','V344','V345','V346','V347','V349','V354','V355','V356','V357','V359','V364','V365','V366','V367','V369','V374','V375','V376','V377','V379','V384','V385','V386','V387','V389','V394','V395','V396','V398','V399','V404','V405','V406','V407','V409','V414','V415','V416','V417','V419','V424','V425','V426','V427','V429','V434','V435','V436','V437','V439','V444','V445','V446','V447','V449','V454','V455','V456','V457','V459','V464','V465','V466','V467','V469','V474','V475','V476','V477','V479','V484','V485','V486','V487','V489','V494','V495','V496','V498','V499','V504','V505','V506','V507','V509','V514','V515','V516','V517','V519','V524','V525','V526','V527','V529','V534','V535','V536','V537','V539','V544','V545','V546','V547','V549','V554','V555','V556','V557','V559','V564','V565','V566','V567','V569','V574','V575','V576','V577','V579','V584','V585','V586','V587','V589','V594','V595','V596','V598','V599','V605','V605','V606','V609','V614','V615','V616','V617','V619','V624','V625','V262','V627','V629','V634','V635','V636','V637','V639','V644','V645','V646','V647','V649','V654','V655','V656','V657','V659','V664','V665','V666','V667','V669','V674','V675','V676','V677','V679','V684','V685','V686','V687','V689','V694','V695','V696','V698','V699','V704','V705','V706','V707','V709','V714','V715','V716','V717','V719','V724','V725','V726','V727','V729','V734','V735','V736','V737','V739','V744','V745','V746','V747','V749','V754','V755','V756','V757','V759','V764','V765','V766','V767','V769','V774','V775','V776','V777','V779','V784','V785','V786','V787','V789','V794','V795','V796','V798','V799','V83','V830','V831','V832','V833','V203','V204','V205','V029','V213','V214','V215','V219','V223','V224','V225','V229','V233','V234','V235','V239','V243','V244','V245','V249','V253','V254','V255','V259','V263','V264','V265','V269','V273','V274','V275','V279','V283','V284','V285','V289','V294','V295','V296','V298','V299','V123','V124','V125','V129','V133','V134','V135','V139','V143','V144','V145','V149','V194','V195','V196','V021','V029','V031','V039','V041','V049','V092','V803','V804','V805','V811','V821', 'V84','V85','V86','V87'
Pedalist	'V10','V11','V12','V13','V14','V15','V16','V17','V18','V19'
Pedestrian	'V01','V02','V03','V04','V05','V06','V09'
Transportation	('V20','V21','V22','V23','V24','V25','V26','V27','V28','V29','V30','V31','V32','V33','V34','V35','V36','V37','V38','V39','V40','V41','V42','V43','V44','V45','V46','V47','V48','V49','V50','V51','V52','V53','V54','V55','V56','V57','V58','V59','V60','V61','V62','V63','V64','V65','V66','V67','V68','V69','V70','V71','V72','V73','V74','V75','V76','V77','V78','V79','V80','V81','V82','V88','V89','V90','V91','V92','V93','V94','V95','V96','V97','V98','V99')
Natural Events	'W42','W53','W54','W55','W56','W57','W58','W59','W60','W61','W62','W64','W92','W93','W94','W99','X30','X31','X32','X34','X35','X36','X37','X38','X39','X52'
Struck	'W20','W21','W22','W50','W51','W52'
Other	'W23','W35','W36','W37','W38','W39','W40','W49','W85','W86','W88','W89','W90','X58','Y86'

Child Maltreatment	
	Lurie Children's Definition (Any Diagnosis)
Child Maltreatment Composite	Child maltreatment is defined by the categories below including unspecified, psychological, neglect, sexual abuse, physical abuse, and shaken infant.
Unspecified	'T7492XA','T7492XD','T7492XS','T7692XA','T7692XD','T7692XS'
Psychological	'T7432XA','T7432XD','T7432XS','T7632XA','T7632XD','T7632XS'
Neglect	'T7402XA','T7402XD','T7402XS','T7602XA','T7602XD','T7602XS'
Sexual Abuse	'T7422XA','T7422XD','T7422XS','T7622XA','T7622XD','T7622XS','Z0442','Z0472','T7422','T7622','Z0442','Z047'
Physical	'T7411XA','T7411XD','T7411XS','T7412XA','T7412XD','T7412XS','T7611XA','T7611XD','T7611XS','T7612XA','T612XD','T7612XS','Z0472'
Shaken Infant	'T744XXA','T744XXD','T744XXS'

Chronic Conditions	
	Lurie Children's Definition based on ICD-10 Codes (If present on Any Visit Diagnosis)
Chronic Conditions	The Feudtner Laboratory at Children's Hospital of Philadelphia strives to improve the understanding and impact of complex chronic conditions on children and families. The Feudtner lab maintains a publicly available grouper CCC v2 classification system to identify children with complex conditions in large administrative datasets. We applied the CCC V2 to compute rates of complex chronic conditions among children in the Chicago area. The classification system grouper is available in SAS and R here: https://www.research.chop.edu/feudtner-laboratory/resources

APPENDIX F: ALLIANCE FOR HEALTH EQUITY COMMUNITY INPUT SURVEY

Between September 2021 and December 2021, Alliance for Health Equity partners collected over 4,300 community input surveys from individuals ten years or older living in Chicago. The surveys were available online in English and Spanish – both follow. In addition, surveys were collected in paper format at focus groups and select in-person events. The survey asked participants about the health status of their communities, community strengths, opportunities for improvement, priority health needs and COVID-19 impacts. Hospitals, community-based organizations and health departments distributed the surveys with the intention of gaining insight from priority populations that have been historically excluded from assessment processes.

The final survey tool included 24 questions – two multi-select questions about health priorities and needs; five open-ended questions about community strengths, resources and needs; four questions about COVID-19 impacts, recovery and vaccine access; one question about access to help; two questions related to ZIP code and community of residence; and ten demographic questions.

Community Input Survey

for Chicago and Suburban Cook County

The Alliance for Health Equity is a group of over 30 hospitals, local health departments, and community organizations in Chicago and Suburban Cook County that are working together to conduct a Community Health Needs Assessment (CHNA). Your input is very important and will help create a plan to improve community health. The survey should take about 5 minutes to complete. Your responses are anonymous, and you will not be asked your name. If you have any questions about the survey, please contact Leah.Barth@iphionline.org. More information about the CHNA process is available online at www.allhealthequity.org.

Do you live in Chicago or Suburban Cook County? ☐ Yes

NOTE: This survey is intended for residents of Chicago and Cook County of all ages. If you do not live in Chicago or Cook County, please return the survey to the survey distributor.

Tell us about your community

Community can have many different meanings. For this survey, we are interested in learning about the places where you live, work, and play. The information you share is anonymous.

1. **What is your home zip code?** *(5 digits)*

2. **How many years have you lived in your community?**

3. **What are the best things about your community?** *(List up to three)*

   1.

   2.

   3.

4. **Are there people in your community that you would feel comfortable asking for help?**

   ☐ Yes ☐ No

5. **What is one health related resource or service that is <u>working well</u> for your community?**

6. **What is one health related resource or service that is <u>missing</u> in your community?**

7. **What are the most important health needs in your community?**
(Please rank your top three choices with 1 being the most important)

	Age-related illness *(arthritis, hearing/vision loss, Alzheimer's/dementia, etc.)*		Lung disease *(asthma, COPD, etc.)*
	Cancers *(breast, prostrate, skin, colon, etc.)*		Mental health *(depression, anxiety, PTSD, suicide, etc.)*
	Child abuse		Mother and Infant health
	COVID-19		Motor vehicle crash injuries
	Dental problems		Obesity *(obese, overweight)*
	Diabetes *(high blood sugar)*		Police brutality
	Domestic Violence *(intimate partner/relationship)*		Preventable injuries *(falls, drowning, concussions)*
	Heart disease and stroke		Sexually Transmitted Infections *(STIs/STDs, HIV)*
	Homelessness and housing instability		Substance-use *(alcohol, prescription misuse, and other drugs)*
	Hunger		Violence
	Infectious diseases *(hepatitis, TB, flu, etc.)*		Vaccine preventable illnesses *(measles, chicken pox, HPV, etc.)*

8. **Are there any other priority community health needs that you would like to add?**

9. What is needed to support improvements in the health issues you chose? *(Please rank your top three choices with 1 being the most important)*

- Access to community services
- Access to health care
- Access to mental health services
- Access to healthy food
- Access to transportation *(buses, trains)*
- Activities for teens and youth
- Affordable childcare
- Affordable housing
- Arts and cultural events
- Clean environment *(safe water, clean air)*
- Diversity
- Early childhood programs
- Good schools
- Parks and recreation
- Quality job opportunities
- Religion or spirituality
- Safety and low crime
- Strong family life
- Welcoming neighbors and social groups

10. Are there any other types of support that you think would be helpful for addressing your community health needs?

Tell us how COVID-19 has impacted your life

11. If you wanted to get vaccinated, were you able to access the COVID-19 vaccine?

☐ Yes ☐ No ☐ Did not want to get vaccinated ☐ Prefer not to answer

12. If you answered <u>NO</u> to question 12, why were you unable to access the COVID-19 vaccine? *(Select all that apply)*

- ☐ Scheduling or difficulty making an appointment
- ☐ Lack of transportation
- ☐ Disability
- ☐ Another reason *(write in)*
- ☐ Prefer not to answer

13. If you are vaccinated, where did you receive your COVID-19 vaccine?

- ☐ Hospital
- ☐ Health department site
- ☐ Community clinic (heath center, urgent care, etc.)
- ☐ Mobile vaccination event
- ☐ Pharmacy (CVS, Walgreens, etc.)
- ☐ Onsite at workplace
- ☐ At home
- ☐ United Center
- ☐ Another vaccination site (*write in)*
- ☐ Prefer not to answer

14. The COVID-19 pandemic is challenging in many ways. Did anyone in your household experience any of the following due to the COVID-19 pandemic? *(Select all that apply)*

- ☐ Lack of access to basic medical care
- ☐ Shortage of food/hunger
- ☐ Shortage of infant supplies (formula, diapers, etc.)
- ☐ Temporary layoff or furlough
- ☐ Loss of employment
- ☐ Reduced pay/hours
- ☐ Stress regarding employment status
- ☐ Loss or reduction of insurance coverage
- ☐ Loss of childcare
- ☐ Sick household members
- ☐ Ongoing or long-term illness
- ☐ Death of family members or friends
- ☐ Feeling alone or isolated, not being able to socialize with other people
- ☐ Feeling nervous, anxious, or on edge
- ☐ Not knowing when the pandemic will end, lack of control
- ☐ Lack of access to technology *(internet access, WIFI, computer, tablet, etc.)*
- ☐ Lack of skills to use technology to communicate
- ☐ Unstable housing or homelessness
- ☐ Transportation difficulty
- ☐ Another impact - Write In
- ☐ Prefer not to answer

Tell us about yourself

This section will help us learn more about the diverse groups of people living in Chicago and Suburban Cook County and their specific health needs. The information you share is anonymous.

15. What is your age?

- ☐ Younger than 10
- ☐ 10-13
- ☐ 14-17
- ☐ 18-24
- ☐ 25-34
- ☐ 35-44
- ☐ 45-54
- ☐ 55-64
- ☐ 65-74
- ☐ 75-84
- ☐ 85 and older
- ☐ Prefer not to answer

16. What is your gender identity?

- ☐ Female
- ☐ Male
- ☐ Transgender female
- ☐ Transgender male
- ☐ Non-binary
- ☐ Another gender identity *(write in)*
- ☐ Prefer not to answer

17. Which racial and ethnic groups do you identify with? (*Choose all that apply)*

- ☐ African American/Black
- ☐ American Indian or Alaskan Native
- ☐ Hispanic/Latino(a)
- ☐ Middle Eastern/Arab American or Persian
- ☐ Pacific Islander or Hawaiian Native
- ☐ White
- ☐ Another race or ethnicity *(write in)*
- ☐ Prefer not to answer

18. What is the highest level of education you have completed?

- ☐ Elementary school (K-5)
- ☐ Middle school (6-8)
- ☐ Some high school
- ☐ High school graduate or GED
- ☐ Vocational or technical school
- ☐ Some college
- ☐ College graduate or higher
- ☐ Prefer not to answer

19. Including yourself, how many people regularly live in your home?

20. How many children/youth of the following ages are regularly living in your home? *(Circle one for each line)*

Children aged 0-4 in my household	**0**	**1**	**2**	**3**	**4**	**5 or more**
Children aged 5-12 in my household	**0**	**1**	**2**	**3**	**4**	**5 or more**
Adolescents aged 13-17 in my household	**0**	**1**	**2**	**3**	**4**	**5 or more**
Young adults aged 18-24 in my household	**0**	**1**	**2**	**3**	**4**	**5 or more**

21. Does anyone in your household live with a physical, mental, or intellectual disability?

☐ Yes ☐ No ☐ Prefer not to answer

22. What is your annual household income?

- ☐ Less than $10,000
- ☐ $10,000 to $19,999
- ☐ $20,000 to $39,999
- ☐ $40,000 to $59,999
- ☐ $60,000 to $79,999
- ☐ $80,000 to $99,999
- ☐ $100,000 to $199,999
- ☐ Over $200,000
- ☐ Prefer not to answer

Thank you for taking our survey! Your response is very important to us. If you have any questions about the survey, please contact Leah.Barth@iphionline.org. Survey results will be posted on allhealthequity.org by June 30, 2022.

Encuesta de opinión de la comunidad

para Chicago y los suburbios del condado de Cook

La Alianza para la Equidad en Salud es un grupo de más de 30 hospitales, departamentos de salud locales y organizaciones comunitarias en Chicago y los suburbios del condado de Cook que trabajan juntos para llevar a cabo una Evaluación de Necesidades de Salud Comunitaria (CHNA). Las opiniones de usted son muy importantes y ayudarán a crear un plan para mejorar la salud de la comunidad. Le tomará unos 5-10 minutos completar la encuesta. Sus respuestas son anónimas y no se le preguntará su nombre. Si tiene alguna pregunta sobre la encuesta, comuníquese con Leah.Barth@iphionline.org. Puede encontrar más información sobre el proceso de CHNA en línea en www.allhealthequity.org.

¿Vive en Chicago o en los suburbios del condado de Cook? ☐ Sí

NOTA: Esta encuesta es para las personas de toda edad que viven en Chicago y el condado de Cook. Si no vive en Chicago o en el condado de Cook, devuelva la encuesta al distribuidor de la encuesta.

Cuéntenos acerca de su comunidad

Para esta encuesta, nos interesa conocer los lugares donde usted vive, trabaja y juega. La información que comparta es anónima.

1. **¿Cuál es su código postal?** *(5 dígitos)*

2. **¿Cuántos años ha vivido en su comunidad?**

3. **¿Qué es lo mejor de su comunidad?** *(Díganos hasta tres cosas)*

   1.

   2.

   3.

4. **¿Hay personas en su comunidad con las que se sentiría cómodo(a) pidiendo ayuda?**

   ☐ Sí ☐ No

5. ¿Cuál recurso o servicio relacionado con la salud <u>funciona bien</u> en su comunidad?

6. ¿Cuál recurso o servicio relacionado con la salud <u>hace falta</u> en su comunidad?

7. ¿Cuáles son las 3 necesidades de salud más importantes en su comunidad?
(Escoja tres opciones más importantes. Use el "1" para la más importante.)

- Enfermedad relacionada con la edad *(artritis, pérdida de audición/visión, Alzheimer/demencia, etc.)*
- Cánceres *(mama, próstata, piel, colon, etc.)*
- Abuso de menores
- COVID-19
- Problemas dentales
- Diabetes *(nivel alto de azúcar en la sangre)*
- Violencia doméstica *(pareja/relación íntima)*
- Enfermedad cardíaca o accidente cerebrovascular
- Falta de vivienda e inestabilidad de la vivienda
- Hambre
- Enfermedades infecciosas *(hepatitis, TB, gripe, etc.)*
- Enfermedad pulmonar *(asma, EPOC, etc.)*
- Salud mental *(depresión, ansiedad, trastorno de estrés postraumático, suicidio, etc.)*
- Salud de madres y bebés
- Lesiones por accidentes automovilísticos
- Obesidad *(sobrepeso)*
- Brutalidad policial
- Lesiones prevenibles *(caídas, ahogos, conmociones cerebrales)*
- *Racismo y discriminación*
- Infecciones de transmisión sexual *(ITS/ETS, VIH)*
- Uso de sustancias *(alcohol, drogas, y uso indebido de medicamentos recetados)*
- Violencia
- Enfermedades prevenibles mediante vacunas *(sarampión, varicela, VPH, etc.)*

8. ¿Hay alguna otra necesidad de salud comunitaria que le gustaría agregar?

9. ¿Qué se necesita para apoyar y mejorar en las cuestiones de salud que usted eligió? *(Escoja tres opciones más importantes. Use el "1" para la más importante.)*

- Acceso a servicios comunitarios
- Acceso a la atención médica
- Acceso a servicios de salud mental
- Acceso a alimentos saludables
- Acceso al transporte *(autobuses, trenes)*
- Actividades para adolescentes y jóvenes
- Cuidado infantil accesible
- Vivienda accesible
- Programas de capacitación y educación de adultos
- Eventos artísticos y culturales
- Diversidad
- Medio ambiente limpio *(agua potable, aire limpio)*
- Programas para la primera infancia
- Buenas escuelas
- Parques y recreación
- Oportunidades de empleo de calidad
- Religión o espiritualidad
- Seguridad y baja criminalidad
- Una fuerte vida familiar
- Buenos vecinos y grupos sociales

10. ¿Hay otros tipos de apoyos que puedan ayudar para resolver las necesidades de salud de su comunidad?

Cuéntenos qué impacto ha tenido COVID-19 en su vida

11. Si quería vacunarse, ¿pudo acceder a la vacuna contra COVID-19?

☐ Sí ☐ No ☐ No quería vacunarme ☐ Prefiero no responder

12. Si respondió <u>NO</u> a la pregunta 11, ¿por qué no pudo acceder a la vacuna contra el COVID-19? *(Seleccione todo lo que corresponda.)*

- ☐ Dificultad para programar o hacer una cita
- ☐ Falta de transporte
- ☐ Discapacidad
- ☐ Otra razón *(escriba cuál)*
- ☐ Prefiero no responder

13. Si se vacunó, ¿dónde recibió su vacuna contra COVID-19?

- ☐ Hospital
- ☐ Sitio del departamento de salud
- ☐ Clínica comunitaria (centro de salud, atención urgente, etc.)
- ☐ Evento de vacunación móvil
- ☐ Farmacia (CVS, Walgreens, etc.)
- ☐ En el lugar de trabajo
- ☐ En casa
- ☐ United Center
- ☐ Otro sitio de vacunas *(escriba cuál)*
- ☐ Prefiero no responder

14. La pandemia de COVID-19 es un desafío en muchos sentidos. ¿Experimentó alguien en su hogar algo de lo siguiente debido a la pandemia de COVID-19? *(Seleccione todo lo que corresponda.)*

- ☐ Falta de acceso a atención médica básica
- ☐ Escasez de alimentos/hambre
- ☐ Escasez de suministros para bebés (fórmula, pañales, etc.)
- ☐ Despido o suspensión temporal
- ☐ Pérdida de empleo
- ☐ Reducción de salario/horas
- ☐ Estrés con respecto a la situación laboral
- ☐ Pérdida o reducción de la cobertura del seguro medico
- ☐ Pérdida del cuidado de los niños
- ☐ Miembros de la familia enfermos
- ☐ Enfermedad continua o de larga duración
- ☐ Muerte de familiares o amigos
- ☐ Sentirse solo(a) o aislado(a), no poder socializar con otras personas
- ☐ Sentirse nervioso(a), ansioso o inquieto
- ☐ No saber cuándo terminará la pandemia, falta de control
- ☐ Falta de acceso a la tecnología (acceso a internet, WIFI, computadora, tableta, etc.)
- ☐ Falta de habilidades para usar la tecnología para comunicarse
- ☐ Vivienda inestable o falta de vivienda
- ☐ Dificultad de transporte
- ☐ Otro impacto (escriba cuál)
- ☐ Prefiero no responder

Cuéntenos sobre usted

Esta sección nos ayudará a aprender más sobre los diversos grupos de personas que viven en Chicago y los suburbios del condado de Cook y sus necesidades de salud específicas. La información que usted comparta es anónima.

15. ¿Cuántos años tiene?

- ☐ Menos de 10 años
- ☐ 10-13
- ☐ 14-17
- ☐ 18-24
- ☐ 25-34
- ☐ 35-44
- ☐ 45-54
- ☐ 55-64
- ☐ 65-74
- ☐ 75-84
- ☐ 85 años o más
- ☐ Prefiero no responder

16. ¿Cuál es su identidad de género?

- ☐ Mujer
- ☐ Hombre
- ☐ Mujer transgénero
- ☐ Hombre transgénero
- ☐ No binario
- ☐ Otra identidad de género *(escriba cuál)*
- ☐ Prefiero no responder

17. ¿Cuál es su orientación sexual?

- ☐ Heterosexual
- ☐ Gay o lesbiana
- ☐ Bisexual
- ☐ Asexual
- ☐ Otra orientacion sexual *(escriba cuál)*
- ☐ Prefiero no responder

18. ¿Con qué grupos raciales y étnicos se identifica? *(Marque todo lo que corresponda)*

- ☐ Afro-americano / Black
- ☐ Indio americano o nativo de Alaska
- ☐ Asiático(a)
- ☐ Latino(a) / Hispano(a)
- ☐ Del Oriente Medio/ Árabe Americano o Persia
- ☐ Nativo de Hawái o de otra isla del Pacífico
- ☐ Blanco(a)
- ☐ Otra raza o etnia *(escriba cuál)*
- ☐ Prefiero no responder

19. ¿Cuál es el nivel más alto de educación que ha completado?

- ☐ Escuela primaria (K-5)
- ☐ Escuela intermedia (6-8)
- ☐ Algo de escuela secundaria
- ☐ Graduado de la escuela secundaria o GED
- ☐ Escuela vocacional o técnica
- ☐ Algo de universidad
- ☐ Graduado universitario o superior
- ☐ Prefiero no responder

20. Incluyéndose a usted, ¿cuántas personas viven en su casa?

21. ¿Cuántos niños/jóvenes de las siguientes edades viven habitualmente en su casa? *(Marque un número con un círculo en cada línea.)*

Niños de 0 a 4 años en mi casa	**0**	**1**	**2**	**3**	**4**	**5 o más**
Niños de 5 a 12 años en mi casa	**0**	**1**	**2**	**3**	**4**	**5 o más**
Adolescentes de 13 a 17 años en mi casa	**0**	**1**	**2**	**3**	**4**	**5 o más**
Adultos jóvenes de 18 a 24 años en mi casa	**0**	**1**	**2**	**3**	**4**	**5 o más**

22. ¿Vive alguien en su casa con una discapacidad física, mental o intelectual?

☐ Sí ☐ No ☐ Prefiero no responder

23. ¿Cuál es el ingreso anual del hogar?

- ☐ Menos de $10,000
- ☐ De $10,000 a $19,999
- ☐ De $20,000 a $39,999
- ☐ De $40,000 a $59,999
- ☐ De $60,000 a $79,999
- ☐ De $80,000 a $99,999
- ☐ De $100,000 a $199,999
- ☐ Más de $200,000
- ☐ Prefiero no responder

¡Gracias por participar en nuestra encuesta! Sus respuestas son muy importantes para nosotros. Si tiene alguna pregunta sobre la encuesta, por favor diríjase a Leah.Barth@iphionline.org. Se publicarán los resultados de la encuesta en allhealthequity.org antes del 30 de junio de 2022.

APPENDIX G: CURRENT AND POTENTIAL COMMUNITY PARTNERS

Lurie Children's is grateful for longstanding and new community partners who share a commitment to improving child health equity in Chicago. Below is a list of partners that will be updated regularly as we continue to work together to develop and implement evidence-based programs and initiatives.

- Access Living
- Afterschool Matters
- Afterschool and summer youth programs
- AIDS Foundation of Chicago
- Allergy Asthma Network
- Alliance for Health Equity
- ALSO
- Alternatives, Inc.
- Archdiocese of Chicago
- Austin Coming Together
- Bethel New Life
- Boys & Girls Club of Chicago
- Bright Star Church and Community Outreach
- Broadway Youth Center
- BUILD
- Cabrini Green Legal Aid
- CareAdvisors
- Catholic Charities
- Chicago Children's Advocacy Center
- Chicago Children's Theater
- Chicago HEAL Initiative
- Chicago House
- Chicago Medical-Legal Partnership for Children
- Chicago Park District
- Chicago Police Department
- Chicago Public Libraries
- Chicago Public Schools, charter, private and Catholic schools
- Chicago Recovery Alliance
- Chicago United for Equity
- Chicago Youth Programs
- Children's Home + Aid
- Children's Place Association
- ChildServ
- Circle Urban Ministries
- City of Chicago and city-level child-serving agencies
- Communities United
- Community Anti-Drug Coalitions of America
- Community Counseling Centers of Chicago (C4)
- Community development financial institutions (CDFIs), including Allies for Community Business, Chicago Community Loan Fund, IFF and LISC Chicago
- Community mental health providers
- Community Organizing and Family Issues (COFI)
- Enlace
- Equality Illinois
- Erickson Institute
- EverThrive Illinois
- Federally Qualified Health Centers, including ACCESS Community Health, Alivio Medical Center, Erie Family Health Centers, Esperanza Health Centers, Heartland Health Centers, Infant Welfare Society, Lawndale Christian Health Center, Near North Health, PrimeCare Health, PCC Community Wellness Center
- Gary Comer Youth Center
- Girl Scouts of Greater Chicago and Northwest Indiana
- Golden Apple
- Greater Chicago Food Depository
- Haymarket Center
- Health & Safety Institute
- Health and Medicine Policy Research Group
- Heartland Alliance
- Hermosa Neighborhood Association
- Home healthcare agencies
- Hospital partners
- Howard Area Community Center

- Iglesia Evangelica Emanuel Church and Food Pantry
- Illinois Chapter, American Academy of Pediatrics
- Illinois Childhood Trauma Coalition
- Illinois Children's Healthcare Foundation
- Illinois Children's Mental Health Partnership
- Illinois Collaboration on Youth (ICOY)
- Illinois Council Against Handgun Violence
- Illinois Hospital Association
- Illinois Justice Project
- Illinois Public Health Institute
- Illinois Safe Schools Alliance
- Injury Free Coalition for Kids
- Institute for Public Health and Medicine
- Kennedy Forum Illinois
- La Casa Norte
- Lawrence Hall Youth Services
- Legal Council for Health Justice
- LISC Chicago
- Lively Stone MB Church
- Lutheran Social Services of Illinois
- Malcom X City College of Chicago and other community colleges
- Metropolitan Family Services
- Midwest Asian Health Association
- Mikva Challenge
- Ministers Leaders Network
- Mothers of Children Having Allergies (MOCHA)
- NAMI (National Alliance on Mental Illness)
- New Life/Urban Life Skills
- New Moms
- Northwest Center
- Northwestern University Feinberg School of Medicine
- Nourishing Hope (formerly Lakeview Pantry)
- Onward Neighborhood House
- Ounce of Prevention
- Partnership for Resilience
- Prevention First
- Primo Center
- Project ECHO
- Respiratory Health Association
- Safe Kids Worldwide
- Salvation Army
- School-based health centers
- Sesame Street
- SGA Youth & Family Services
- Southwest Organizing Project
- State of Illinois and state-level child-serving agencies
- Stone Community Development Corporation
- Substance abuse programs/providers
- TASC
- Teamwork Englewood
- The Center on Halsted
- The Changing Children's Worlds Foundation
- Thresholds
- UCAN
- UMOJA
- Unite Us (formerly NowPow)
- United Way
- University partners
- Voices for Illinois Children
- Voices of Youth in Chicago Education (VOYCE)
- West Side United
- Westside Ministers Coalition
- YMCA of Metropolitan Chicago
- Youth Guidance
- Youth Outreach Service

APPENDIX H: SUMMARY OF RESOURCES TO ADDRESS HEALTH NEEDS

The following is a summary of the resources and assets identified through Lurie Children's CHNA and the Alliance for Health Equity's Collaborative CHNA to address community health needs and priority health issues related to social influencers of health, access to care, chronic health conditions, mental and behavioral health and injury and violence.

Social and Structural Influencers of Health

EDUCATION, ECONOMIC VITALITY AND WORKFORCE DEVELOPMENT – Key resources to address economic vitality and workforce development include: Chicagoland Healthcare Workforce Collaborative, West Side Anchor Committee / West Side United, Chicago Anchors for a Strong Economy (CASE), Chicagoland Workforce Funder Alliance, Chicago Cook Workforce Partnership, Illinois Department of Human Services (IDHS) Division of Rehabilitation Services (DRS), Illinois State Board of Education (ISBE), SAFER Foundation, CARA, community colleges in the City and suburban Cook County, Chicago Public Schools, community development finance institutions (CDFIs), chambers of commerce, Area Health Education Centers (AHECs), LISC quality of life plans, United Way neighborhood networks, and dozens of workforce development programs and community development corporations (CDCs) across the City and county, Community Assistance Programs (CAPs), Chicago House. Youth Guidance (Career Readiness and Success), Sankofa.

HOUSING, COMMUNITY DEVELOPMENT AND NEIGHBORHOOD ENVIRONMENT – Key resources to address housing, community development, and the neighborhood environment include: Safe and Healthy Homes Program(lead poisoning prevention), Youth Guidance (Becoming a Man - BAM, Working on Womanhood - WOW, STRIVE, school-based counseling), Chicago Ready to Learn: Birth to Pre-K Programs, Chicago STAR Scholarship (City College of Chicago), Habitat for Humanity Chicago, Chicago Complete Streets, Alliance for Health Equity Housing Workgroup, One Chicago, Center for Housing and Health, governmental housing and planning and transportation agencies, innovative partnership strategies such as the flexible housing pool, Chicago Coalition for the Homeless, All Chicago, Alliance to End Homelessness in Suburban Cook County, Housing Forward, Beds Plus, South Suburban PADS, Corporation for Supportive Housing, community development finance institutions (CDFIs), nonprofit affordable housing developers, legal aid organizations focused on housing including medical-legal partnerships, organizations focused on tenants' rights and housing quality such as Metropolitan Tenants Organization (MTO), Uptown People's Law Center (UPLC) Tenants' rights work, Eviction Help Illinois Offers Free Legal Help for Illinois Residents, Lawyers Committee for Better Housing and thought leaders such as Chicago United for Equity (CUE), Metropolitan Planning Council (MPC), Illinois Housing Council, Center for Neighborhood Technology (CNT), Chicagoland Rehab Network, and dozens of community development corporations (CDCs) and supportive housing and homeless services providers across the City and county, The Resurrection Project. JCFS Chicago, La Casa Norte, North Side Housing Supportive Services, Heartland Health Outreach, Access Living of Metro Chicago.

FOOD SECURITY AND FOOD ACCESS – Key resources to address food security and food access include: Greater Chicago Food Depository and its network of hundreds of pantries and soup kitchens across the City and County, Chicago Food Policy Action Council, Advocates for Urban Agriculture, Alliance for Health Equity Food Workgroup; governmental planning, human service and health agencies as well as the recently adopted good food purchasing program (GFPP) in City and County; Windy City Harvest and Veggie Rx, hundreds of community gardens/urban farms and local producers, farmers markets, WIC sites, sub-regional healthy food access initiatives such as Proviso Partners for Health and West Side United and Grow Greater Englewood, local faith-based and community-based initiatives focused on healthy food access, FQHCs working on food security initiatives, coordinated screening and referral initiatives such as West Side ConnectED, and provider organizations working on food as medicine such as ICAAP and IAFP. A just Harvest, City of Chicago – Grocery store map (online), Supplemental Nutrition Assistance Program.

MATERNAL AND CHILD HEALTH – Key resources to address maternal and child health include: Health Resources and Services Administration's (HSRA) Maternal and Child Health Bureau (MCHB) state and local initiatives, IDHS Division for Early Childhood and Division of Family & Community Services, early childhood coalitions like Ever Thrive Illinois, March of Dimes, and the Ounce of Prevention, Illinois Perinatal Quality Collaborative, prenatal and perinatal care partnerships, pilot maternal infant home visiting programs, governmental programs such as WIC and Medicaid Moms & Babies, and community-based organizations such as New Moms.

Access to Care and Community Resources

Key resources to address access to care include:

For the city of Chicago: ConnecTeen (a program at Lurie Children's), City of Chicago Services (adolescent and school health), No Wrong Door Illinois, Chicago IL Free & Income Based Clinics, City of Chicago Services (Find a Community Health Center), Health Resources and Services Administration (Find a Health Center).

For Illinois: Health Resources and Services Administration's (HSRA) Maternal and Child Health Bureau (MCHB) state and local initiatives; IDHS Division for Early Childhood and Division of Family & Community Services; early childhood coalitions like Ever Thrive Illinois, March of Dimes, and the Ounce of Prevention, Illinois Perinatal Quality Collaborative; The Salvation Army; prenatal and perinatal care partnerships; pilot maternal infant home visiting programs; governmental programs such as WIC and Medicaid Moms & Babies; community-based organizations such as New Moms; Department of Human Services (IDHS) divisions, partnerships between hundreds of community-based primary clinics including FQHCs, free clinics, community-based behavioral health providers, Heartland Alliance and Protect Our Care Illinois, Alliance for Welcoming Healthcare and related initiatives focused on serving immigrants and refugees with quality, easily accessible, culturally-relevant care; professional provider associations such as the ICAAP, IAFP, Illinois Nurses Association, and Illinois Community Health Worker (CHW) Association; Illinois

School Based Health Alliance and the School Health Access Collaborative (SHAC); enrollment for public insurance; coordinated screening and referral for social determinants.

Chronic Health Conditions

Key resources to address chronic conditions include: Lurie Children's specialty clinics, partnerships with associations such as the American Heart Association, American Cancer Society, American Diabetes Association, Academy of Nutrition and Dietetics; partnerships between primary care providers such as FQHCs, pediatricians, and family physicians and other sites of care such as hospitals; HRSA MCHB's Leadership Education in Neurodevelopmental & Related Disabilities (LEND) program, governmental agencies such as Social Security Administration, Equip for Equality, IDHS Division for Developmental Disabilities (DD) and Division of Rehabilitation Services (DRS), City of Chicago Mayor's Office for People with Disabilities, park districts, forest preserves, planning agencies, and the recently adopted good food purchasing program (GFPP); policy, systems and environmental change initiatives led by coalitions such as Consortium to Lower Obesity in Chicago Children (CLOCC), Proviso Partners for Health, health departments, Active Transportation Alliance, Center for Faith and Community Health Transformation, and ISPAN; and hundreds of culturally-tailored, community-based and school-based chronic disease prevention initiatives across the City and County.

ASTHMA – Key resources to address asthma include: Stroger Hospital Asthma Clinics, Respiratory Health Association, Chicago Asthma Consortium, Sinai Urban Asthma Institute, LaRabida Asthma Clinic, and Chicago Asthma Consortium, Asthma Resource Line 833-327-8462, Rush University, UI hospital & Health Sciences System, CFA+A (Chicago Family Asthma & Allergy).

COMPLEX CHRONIC CONDITIONS – Key resources to address complex chronic conditions include: The Arc of Illinois, University of Illinois at Chicago's (UIC) Division of Specialized Care for Children, UIC's Institute for Disability and Human Development and other area university research institutes; Chicagoland Disabled People of Color Coalition (DPOCC); statewide networks serving adults and youth with disabilities such as Immigrant & Refugee-Led Capacity Development Network of Illinois (IRLCDN) and Centers for Independent Living (CILs); IDHS Office of Welcoming Centers; Great Lakes ADA; Illinois Self-Advocacy Alliance; Illinois Council on Developmental Disabilities (ICDD); Maryville Academy, Almost Home Kids, Illinois Mentor, Near North Health Service Corporation and HabitNu.

OBESITY, DIABETES, NUTRITION AND PHYSICAL ACTIVITY – Key resources to address obesity, nutrition, and physical activity include: CLOCC (a program of Lurie Children's), Chicago Department of Public Health, and City of Chicago Services (free exercise classes), Girls on the Run, Great Lakes Adaptive Sports Association (GLASA), Dare2Tri, SRAL Tengelsen Family Foundation Sports for Kids, Special Recreation Association Network of Illinois (SRANI).

Mental and Behavioral Health

Key resources to address mental health and substance use disorders include: Lurie Children's Center for Childhood Resilience, Association of Community Mental Health Authorities of Illinois (ACHMAI), Behavioral Health Treatment Services Locator, Illinois Justice Project, Justice, Equity, and Opportunity (JEO) Initiative, Juvenile Justice Initiative, Sarah's Inn, SIU School of Medicine, Substance Abuse and Mental Health Services Administration (SAMHSA) National Helpline, Suicide Prevention Lifeline, IDHS Divisions of Mental Health and Substance Use Prevention & Recovery, Comprehensive Community-Based Youth Services (CCBYS), Statewide Unintentional Drug Overdose Reporting System, Alliance for Health Equity Mental Health Committee, Alliance for Health Equity Hospital Opioid Treatment and Response Learning Collaborative, NAMI Chicago, NAMI Metro Suburban, NAMI South Suburban, Kennedy Forum, Thresholds, Your Story Counseling, professional provider associations such as the Illinois Association for Behavioral Health, Illinois Association for Infant Mental Health, Illinois Chapter of American Academy of Pediatrics, Illinois Childhood Trauma Coalition, Illinois Collaboration on Youth, Illinois Criminal Justice Information Authority, Illinois School Psychologists Association, Illinois Alcohol and Other Drug Abuse Professional Certification Association (IAODAPCA), Illinois Alcoholism & Drug Dependence Association (IADDA), Illinois Art Therapy Association (IATA), Illinois Counseling Association (ICA), Illinois Institute for Addiction Recovery (IIAR), Illinois Mental Health Counselors Association (IMHCA), Illinois Psychological Association (IPA), Illinois Psychological Association of Graduate Students (IPAGS), Illinois Recreation Therapy Association (IRTA), Illinois School Counselor Association (ISCA), Illinois School Psychologists Association (ISPA), Coalition of Illinois Counselor Organizations (CICO), Community Behavioral Healthcare Association, Association of Community Mental Health Authorities of Illinois, Mental Health America of Illinois, Mental Health Association of Illinois (MHAI), Aurora University School of Social Work, and National Association of Social Workers, governmental human service and behavioral health agencies including Chicago Department of Public Health, Department of Children and Family Services, Illinois Department of Juvenile Justice, Illinois Department of Public Health, Illinois Office of the Attorney General, Illinois State Board of Education, peer workforce including certified recovery support specialists (CRSS), several learning collaboratives of FQHCs focused on primary care and behavioral health integration, community mental health centers, substance abuse treatment and harm reduction initiatives, and the trauma/resilience, youth development, and housing/homelessness organizations listed above.

Injury and Violence

UNINTENTIONAL INJURY – Key resources to address unintentional injury include**:** Lurie Children's Injury Prevention & Research Center, Safe Kids Chicago, Safe Kids Illinois, Safe Kids Worldwide, Injury Free Coalition for Kids, Sankofa Safe Child Initiative.

CHILD MALTREATMENT – Key resources to address child maltreatment include: Prevent Child Abuse, Chicago Children's Advocacy Center, Lurie Children's Safety and Wellness Clinic, Community Counseling Centers of Chicago, Tuesday's Child Chicago and Safe Start at Casa Central.

VIOLENCE, TRAUMA, AND COMMUNITY SAFETY — Key resources to address violence, trauma, and community safety include: Strengthening Chicago's Youth (SCY), Mayor's Commission for a Safer Chicago, City of Chicago /Office of Violence Prevention, Chicago HEAL Initiative, Alliance for Health Equity Trauma-Informed Hospitals Collaborative led by Illinois ACEs Response Collaborative and Health and Medicine Policy Research Group, Communities Partnering for Peace (CP4P), Illinois Coalition Against Domestic Violence, hundreds of youth development initiatives across the City and County including youth-led initiatives like Voices of Youth in Chicago Education (VOYCE), Mikva Challenge and My Block My Hood My City and Youth Crossroads Lurie Children's Center for Childhood Resilience, READI Chicago, Chicago's Trauma-Informed City initiative, hospital-based violence intervention programs, and local trauma-informed initiatives such as Bright Star Community Outreach, I Am Able, and the Illinois Violent Death Reporting System. The Y's Youth Safety and Violence Prevention program (YSVP), Lakeview Neighborhood, Family Bridges, Cicero Community Collaborative.

Ann & Robert H. Lurie
Children's Hospital of Chicago®