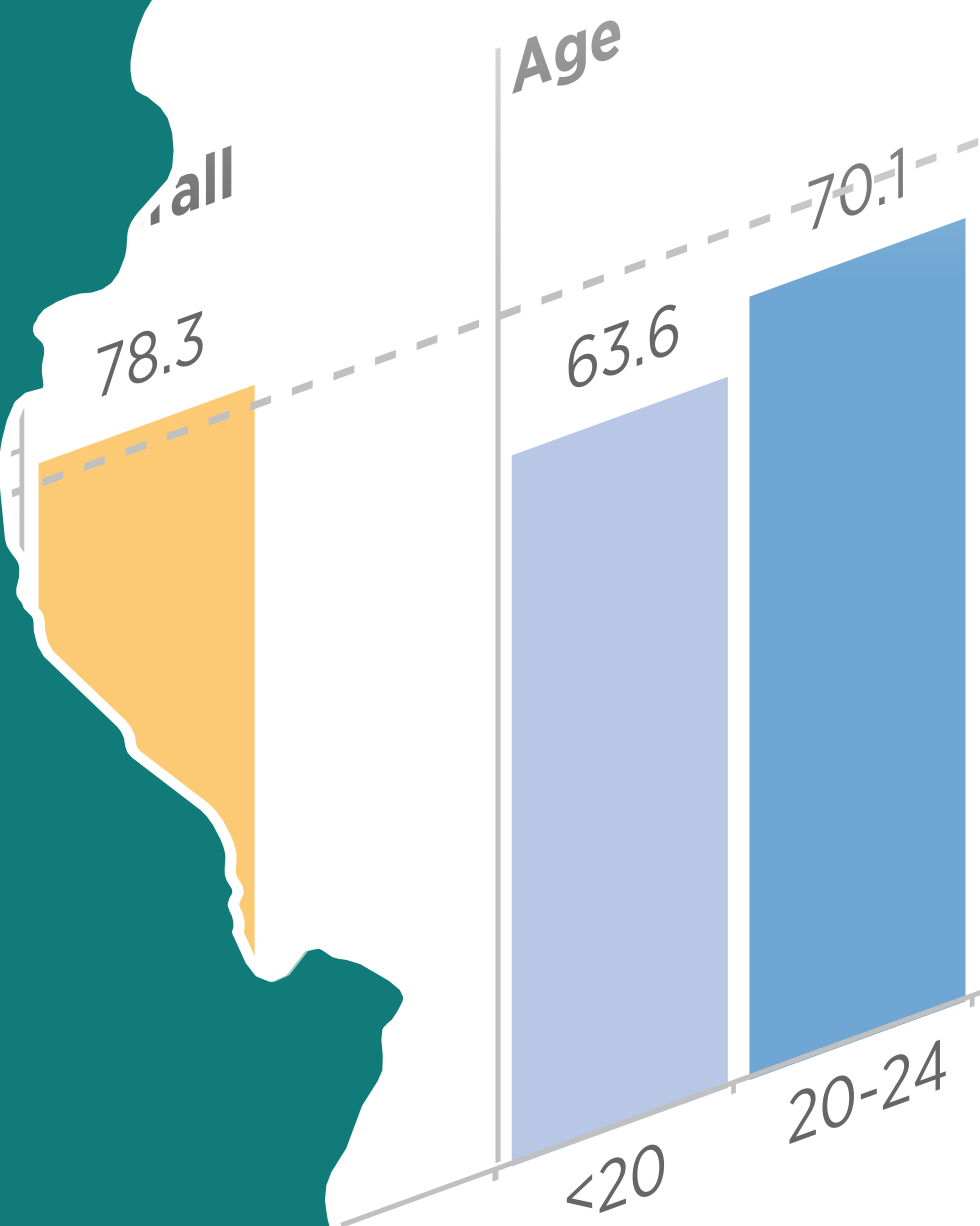




Healthy
ILLINOIS
2021



HEALTH DATA: CORE INDICATORS

increase the proportion of women who breastfeed at month 4 and number of obstetricians per 100,000 population



TABLE OF CONTENTS

EXECUTIVE SUMMARY	4
INTRODUCTION	6
NOTES ON INTERPRETATION	8
CROSS-INDICATOR SUMMARY	10
Disparity Ratios for 33 Core Indicators	
CROSS-CUTTING ISSUES	
Social Determinants/Context	15
Poverty	
Concentrated Disadvantage	
County Well-Being	
Gini Index of Income Inequality	
Daily Fine Particulate Matter	
Less than High School Education	
Age of Housing	
Lead Testing	
Unsafe Neighborhoods	
Homicide (age-adjusted)	
Motor Vehicle Accident Mortality (age-adjusted)	
Access to Care	22
Emergency Department Discharges: Pediatric Asthma	
Emergency Department Discharges: Type 2 Diabetes	
Emergency Department Discharges: Hypertension	
Children Not Having a Medical Home	
Primary Care Physicians	
Prenatal Care in First Trimester	
Women Not Receiving Adequate Prenatal Care	
Risk Factors	26
No Physical Activity in Past 30 Days, Adult	
Children Not Engaging in Vigorous Physical Activity	
Smoking, Adults	

Smoking During Last 3 Months of Pregnancy
Unsafe Sleep Practices
4 or More Adverse Childhood Experiences

HEALTH PRIORITY AREA: BEHAVIORAL HEALTH29

Poor Mental Health
Suicide (age-adjusted)

HEALTH PRIORITY AREA: CHRONIC DISEASE32

Ischemic Heart Disease Mortality (age-adjusted)
Cancer Mortality (age-adjusted)
Diabetes Prevalence, Adult
Obesity Prevalence, Age 10-17
Obesity Prevalence, Adult

HEALTH PRIORITY AREA: MATERNAL AND CHILD HEALTH.37

Infant Mortality, All Causes
Child Mortality, All Causes
Maternal Mortality from Causes Related to Pregnancy
Maternal Mortality, Any Cause Within 1 Year of Pregnancy
Severe Maternal Morbidity
Low Birthweight

ADDITIONAL DATA44

Hospital-Acquired Infections: MRSA
Hospital-Acquired Infections: *Clostridium difficile*
HIV Incidence
Gonorrhea Incidence
Chlamydia Incidence
MMR Immunization, 19-35 Months
Polio Immunization, 19-35 Months
DTaP Immunization, 19-35 Months
Tdap Immunization, 13-17 Years
Meningitis Immunization, 13-17 Years
HPV Immunization, 13-17 Years

APPENDIX50

Core Indicator Summary

EXECUTIVE SUMMARY

The mission of the public health system is to lead health improvement efforts and work toward health equity. As part of Healthy Illinois 2021, the Illinois Department of Public Health (IDPH) and the University of Illinois at Chicago School of Public Health (UIC-SPH) MidAmerica Center for Public Health Practice engaged in a process of producing summary data for a set of core indicators to support the State Health Assessment (SHA) and State Health Improvement Plan (SHIP). This document is the result of this joint effort.

Executive Summary continued »

Findings for each of 48 indicators are presented. Comparisons to national benchmarks are made whenever possible, and differences by gender, age, geography, and race/ethnicity are also examined. A summary of select findings follows.

Racial/ethnic disparities were seen for the vast majority of the 33 core indicators for which data on race and ethnicity were available. The disparities between non-Hispanic blacks and non-Hispanic whites were the most pronounced, but disparities between Hispanics and non-Hispanic whites were also evident.

- For 17 of the 33 indicators, the rates of adverse health effects were 2 or more times higher in non-Hispanic blacks than in non-Hispanic whites.
- For 7 of the 33 indicators, the rates of adverse health effects were 2 or more times higher in Hispanics than in non-Hispanic whites.
- The largest disparity between non-Hispanic blacks and non-Hispanic whites was in homicide rates; the disparity between Hispanics and non-Hispanic whites was also large for this indicator of community safety. Moreover, the percentages of non-Hispanic black and Hispanic parents who reported that their children were living in unsafe neighborhoods were 3.5 and 3.9 times higher than the percentages reported by non-Hispanic white parents, respectively.
- Racial/ethnic disparities were relatively small for some indicators, including physical activity in adults, poor mental health in adults, and cancer. Small disparities do not diminish the importance of indicators, but may inform the strategies chosen to address them.

Disparities were also considered in relation to national benchmarks. For 20 of the 24 core indicators with relevant benchmarks, one group in Illinois had met the benchmark while other groups had not.

- Non-Hispanic whites had met the benchmarks for 18 of these 20 indicators; in stark contrast, non-Hispanic blacks had **not** met the benchmarks for 17 of them and Hispanics had **not** met the benchmarks for 14.
- For homicide, the age-adjusted rate among non-Hispanic blacks was an alarming 5 times higher than the national benchmark.
- For age-adjusted cancer and suicide rates, the patterns of disparity were different. Hispanics had met the benchmark for cancer while both non-Hispanic whites and non-Hispanic blacks had not. For suicide, non-Hispanic whites had the highest rates and were the only group that had not met the benchmark.
- For childhood obesity, adult smoking, and smoking among pregnant women, racial/ethnic disparities were present, and the benchmarks had not been met by non-Hispanic blacks, Hispanics, or non-Hispanic whites.

The findings presented here provide a basis for continued monitoring of a wide spectrum of health indicators. They capture a picture of the general state of health in Illinois and can be used as a starting point for program planning and development, quality improvement efforts, and the identification of potential policy initiatives.

Finally, the process of summarizing Illinois data has pointed to ways in which the data infrastructure in Illinois can be improved to facilitate a statewide process. Building capacity will require articulating a comprehensive vision for data utilization together with a commitment to allocate the resources necessary to support analytic work that can inform program and policy.

INTRODUCTION

The mission of the public health system is to lead health improvement efforts and tackle health equity. As part of Healthy Illinois 2021, the Illinois Department of Public Health (IDPH) and the University of Illinois at Chicago School of Public Health (UIC-SPH) MidAmerica Center for Public Health Practice engaged in a process of producing summary data for a set of core indicators to support the State Health Assessment (SHA) and State Health Improvement Plan (SHIP). This document is the result of this joint effort.

Introduction continued »

Health data are used by a variety of both governmental and non-governmental organizations for multiple purposes, and each organization typically draws the data it wants from multiple, different sources. This ad hoc use of health data generates some useful information, but is limited in terms of being able to systematically consider a set of indicators to inform a statewide planning process. Even within state agencies, data are often analyzed to meet the reporting needs of specific programs but cross-program and cross-agency reporting rarely occurs. As a result, reports may include data for different years and may use different methods of analysis and presentation, making it difficult to make useful summary comparisons.

One goal of this assessment, therefore, was to select indicators and report data for those indicators in a way that promotes routine, ongoing assessment and monitoring. The indicator selection process began with a list of more than one hundred potential indicators culled from the Healthy People 2020 indicator set, already established indicators within IDPH, and other sources. UIC and IDPH then worked together to arrive at a set of forty-eight indicators specific to this process (Appendix).

Once the indicators were selected, a standard reporting template was developed. This meant defining consistent categories for race/ethnicity, age, geographic regions, and time period, and implementing a unified approach to presenting results. Alternative approaches were used either when it made sense for a given indicator from a conceptual standpoint or when data constraints dictated flexibility. Different age groupings, for example, were sometimes called for depending on the age patterns observed for a particular indicator, and although 2014 is considered the “current” year, some data were only available through 2012 or 2013. In addition, some indicators did not have available

trend data. For this first year, no multivariable analysis was planned; the intent was to provide simple descriptive statistics for each indicator. It became clear, however, that age-adjustment was necessary for several of the mortality indicators, since this approach to controlling for confounding is used by convention, including for the way in which some Healthy People 2020 benchmarks are set.

Formalizing a process for accessing and presenting health indicator data, including confronting both conceptual and technical issues such as those described above, is part of improving the ability to truly use data for decision making and accountability. In the future, refinements, modifications, and additions can be made using the basic framework that has been developed thus far.

The findings presented here provide a basis for continued monitoring of a wide spectrum of health indicators. They capture a picture of the general state of health in Illinois and can be used as a starting point for program planning, for quality improvement efforts, and for identifying potential policy initiatives. Moreover, these initial findings can be viewed as prompts for asking questions that can yield a deeper understanding of particular issues. To address those questions, a more detailed examination of each indicator or sets of related indicators will be required, taking into account the complex intersection of many factors.

Finally, the process of summarizing Illinois data has pointed to ways in which the data infrastructure in Illinois can be improved to facilitate a statewide process. Building capacity will require articulating a comprehensive vision for data utilization together with a commitment to allocate the resources necessary to support analytic work that can inform program and policy.

NOTES ON INTERPRETATION

The rates and percentages shown in this document are estimates, either from registries such as vital records, from administrative data systems such as Hospital Discharge data, or from sample surveys such as the Behavioral Risk Factor Surveillance System (BRFSS) and the Pregnancy Risk Assessment Monitoring System (PRAMS). For the sample survey data, the rates and percentages have been calculated using special statistical procedures that account for the sampling design.

The reliability of the estimates varies, and therefore 95% confidence intervals are provided in all tables and in bar charts with data from the sample surveys (BRFSS, PRAMS, NSCH). For trend data, confidence intervals are not displayed for each data point since assessing a trend, whether for one group or to compare trends across groups, requires jointly assessing the entire series of data points—an assessment of the trend lines themselves. The formal statistical procedure to do this simultaneous assessment of trend data is not included here.

In general, with or without confidence intervals, observed differences should always be interpreted with caution, whether the differences are between groups such as age groups or racial/ethnic groups, or whether there are differences across time.

Also note that while consistency across indicators was a goal, categories for race/ethnicity and age are not identical for every indicator. Sometimes categories differ because of sample size considerations, conceptual considerations, or other data limitations. For race/ethnicity, the preferred categories were non-Hispanic black, non-Hispanic white, Hispanic, Asian, and non-Hispanic other. The “Asian” category is provided when possible, but for most indicators this category is combined into “non-Hispanic other.” In addition, “Hispanic” is presented only as a single, composite category since many of the data sources used do not include separate groupings such as “Mexican,” “Puerto Rican,” or “Cuban.”

For age groups, depending on the data source and indicator, “children” may be defined as under 18 or under 20, and a category for “85 and older” is sometimes reported separately and sometimes combined with “65 and older.” In addition, sometimes more or fewer age categories are presented based on convention or data availability.

The geographic categories used in this document reflect regions of the state. County data are presented in only a few instances, and data for other smaller areas, including data for the city of Chicago, are not presented here.

Multiple dimensions to think about when comparing across indicators include the following:

- How common or rare the indicator is—how many people does it affect?
- Magnitude of the indicator—where does Illinois stand in relation to a benchmark, and are there disparities between groups, by age, race/ethnicity, or geography?
- The direction of each indicator—depending on the indicator definition, is it better to be above a benchmark or below a benchmark?
- The severity of the indicator—what are the health consequences?
- Are the resources needed to address an indicator available?
- Are there known and feasible prevention or intervention strategies to address the indicator?
- Are the indicators appropriate for making cross-indicator comparisons—are there other indicators that might be more informative?

CROSS-INDICATOR SUMMARY

As mentioned above, a total of 48 indicators were assessed (Appendix). The following table shows disparity ratios for the 33 of those indicators that had race/ethnicity information, comparing non-Hispanic blacks to non-Hispanic whites, and also comparing Hispanics to non-Hispanic whites. The disparities are defined as the ratio of rates or percentages for each of two groups. The footnote in the table shows how the disparity ratios are calculated. For example, a disparity ratio of 3 means that one group has a rate 3 times higher than the other group; a disparity ratio of 1.5 means that one group has a rate 1.5 times higher than the other group. The table is sorted according to the size of the non-Hispanic black/non-Hispanic white disparity.

For purposes of this table, all of the indicators are presented as the extent of an adverse health effect. This is typical for most health indicators, but a few indicators have been reconfigured to conform to this approach. For example, the percentage of pregnant women entering prenatal care early is presented as the percentage of women who do not enter care early. This makes it easier to directly compare disparities across indicators.

Disparity Ratios* for 33 Core Indicators

Sorted According to the Size of the Black-White Disparity Ratio

INDICATOR	BLACK-WHITE DISPARITY RATIO	HISPANIC-WHITE DISPARITY RATIO
1. Homicide (age-adjusted)	18.1	2.6
2. Gonorrhea	17.0	1.5
3. HIV	8.1	2.8
4. Chlamydia, reported cases	7.8	2.0
5. Emergency department pediatric asthma discharges	5.7	1.5
6. Children living in unsafe neighborhoods	3.5	3.9
7. Infant mortality	3.0	1.2
8. Poverty**	2.8	1.9
9. Emergency department discharges for type 2 diabetes	2.7	1.3
10. Pregnant women not receiving adequate prenatal care	2.5	1.8
11. Emergency department discharges for hypertension	2.5	0.8
12. Unsafe sleep practices	2.3	1.8
13. Pregnant women not entering prenatal care in first trimester	2.2	1.6
14. Severe maternal morbidity	2.2	1.3
15. Child mortality	2.2	0.8
16. Children not having a medical home	2.0	2.7
17. Low birthweight	2.0	1.1
18. Less than high school education**	1.6	2.4
19. Children age 6-17 having no vigorous physical activity	1.5	2.6
20. Maternal mortality from causes clinically related to pregnancy	1.8	1.4
21. Children age 10-17 who are obese	1.7	1.3
22. Adults with 4 or more adverse childhood experiences (ACEs)	1.5	1.6
23. Adult diabetes	1.5	1.4
24. Adult obesity	1.5	1.3
25. Adult current smoker	1.5	0.8
26. Maternal mortality: Any cause within one year of pregnancy	1.4	1.3
27. Adults with no exercise in past 30 days	1.3	1.3
28. Adult with more than 7 poor mental health days per month	1.2	1.1
29. Cancer mortality (all cancers, age-adjusted)	1.2	0.6
30. Ischemic heart disease mortality (age-adjusted)	1.2	0.6
31. Motor vehicle accident mortality (age-adjusted)	1.0	0.6
32. Smoking during pregnancy [†]	0.8	0.2
33. Suicide [†] (age-adjusted)	0.4	0.4

* Black-white disparity ratio = rate or percent in non-Hispanic blacks divided by rate or percent in non-Hispanic whites; Hispanic-white disparity ratio = rate or percent in Hispanics divided by rate or percent in non-Hispanic whites.

** For poverty and education, race and Hispanic ethnicity are not mutually exclusive: "black" includes black Hispanics and "white" includes white Hispanics.

[†] For these indicators, there are important disparities, but the direction of those disparities is **reversed** from that on the other indicators; the ratio is less than 1, meaning that non-Hispanic whites had higher rates than both non-Hispanic blacks and Hispanics.

Racial/ethnic disparities were seen for the vast majority of the 33 core indicators for which data on race and ethnicity were available. The disparities between non-Hispanic blacks and non-Hispanic whites were the most pronounced, but disparities between Hispanics and non-Hispanic whites were also evident.

- For 7 of the 33 indicators, the rates of adverse health effects were 3 or more times higher among non-Hispanic blacks compared to non-Hispanic whites; for another 10 indicators, rates of adverse health effects were between 2 and 3 times higher among non-Hispanic blacks compared to non-Hispanic whites.
- For 1 of the 33 indicators, the rate of adverse health effects was more than 3 times higher among Hispanics compared to non-Hispanic whites; for another 6 indicators, rates of adverse health effects were 2 or more times higher among Hispanics compared to non-Hispanic whites.
- The largest disparity between non-Hispanic blacks and non-Hispanic whites was for homicide rates; the disparity between Hispanics and non-Hispanic whites is also large for this indicator of community safety. Moreover, the percentages of non-Hispanic black and Hispanic parents who reported that their children were living in unsafe neighborhoods were 3.5 and 3.9 times higher than the percentages reported by non-Hispanic white parents, respectively.
- Racial/ethnic disparities were relatively small for some indicators, including physical activity in adults, poor mental health in adults, and cancer. Small disparities do not diminish the importance of indicators, but may inform the strategies chosen to address them.

Reducing disparities between racial/ethnic groups is a critical component for improving health status. The disparities are important by themselves, but can be even more informative when the indicator values are considered in relation to an agreed-upon benchmark.

For example, one indicator may have large disparities, with all groups far from reaching a benchmark, while another indicator may also have large disparities, but one or more groups have already reached a benchmark while others have not. Conversely, one indicator may have no disparities between groups, but all groups are far from a benchmark, while another indicator may also have no disparities, but all groups have reached a benchmark.

Following is a summary of the relationship between core indicators and relevant benchmarks.

24 of the 48 core indicators have a relevant benchmark:

- For motor vehicle accident mortality, all racial/ethnic groups in Illinois met the benchmark.
- For childhood obesity, adult smoking, and smoking among pregnant women, racial/ethnic disparities were present, and the benchmarks had not been met by non-Hispanic blacks, Hispanics, or non-Hispanic whites.
- For the remaining 20 of the 24 core indicators with relevant benchmarks, one group in Illinois had met the benchmark while other groups had not.

Cross-Indicator Summary, continued

- » Non-Hispanic whites had met the benchmarks for 18 of these 20 indicators; in stark contrast, non-Hispanic blacks had **not** met the benchmarks for 18 of them and Hispanics had **not** met the benchmarks for 14.
- » For homicide, the age-adjusted rate among non-Hispanic blacks was an alarming 5 times higher than the national benchmark.
- » For cancer and suicide, the patterns of disparity were different. Hispanics had met the benchmark for cancer while both non-Hispanic whites and non-Hispanic blacks had not. For suicide, non-Hispanic whites had the highest rates and were the only group that had not met the benchmark.

3 of the 48 core indicators have benchmarks, but no direct assessments with regard to racial/ethnic disparities were possible:

- For gonorrhea, benchmarks are gender-specific and neither men nor women in Illinois were meeting them. Given the large disparity between non-Hispanic blacks and non-Hispanic whites, it is likely that non-Hispanic blacks, both men and women, were not meeting the gender-specific benchmark.
- For child mortality, benchmarks are age-specific and Illinois children fare better than the benchmark at each age. Non-Hispanic black children in Illinois, however, were at more than twice the risk of dying compared to non-Hispanic white children in Illinois, and were likely to have mortality rates worse than the benchmark in at least some of the age groups.
- For emergency department (ED) discharges for pediatric asthma, there is a Healthy People 2020 benchmark for children under 5 years of age; Illinois children in this age group had not met the benchmark. Given the large disparity between non-Hispanic blacks and non-Hispanic whites, it is likely that non-Hispanic black children were not meeting the benchmark. There is no benchmark for ED discharges for either type 2 diabetes or hypertension.

9 of the 48 core indicators had relevant benchmarks, but racial/ethnic disparity information was not available:

- For methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile* (C. diff), there are no benchmarks per se, but Illinois overall has lower observed numbers of infections compared to equivalent national data.
- For vaccination coverage, Illinois overall is meeting the benchmarks for MMR, polio, and DTaP in children 19-35 months, and for Tdap in adolescents 13-17 years, but is not meeting the benchmarks for HPV or meningitis vaccination in adolescents 13-17 years.

CROSS-CUTTING ISSUES

Affecting Behavioral Health, Chronic Disease, and
Maternal and Child Health

SOCIAL DETERMINANTS/CONTEXT

ACCESS TO CARE

RISK FACTORS

SOCIAL DETERMINANTS/CONTEXT

In 2014, Illinois was home to nearly 13 million people; it is the fifth most populous state. Between 2000 and 2010, the total population of Illinois increased by 3.3%.

Two-thirds of Illinois residents lived in the northeastern region of the state. Chicago is the third largest city in the nation, with approximately 2.7 million residents.

Illinois has a diverse population. While 63% of the population is white, close to 15% is non-Hispanic black and close to 17% is Hispanic.

In 2014, almost a quarter of Illinois residents were children under 18 years old, while approximately 1 in 7 of the state's residents was 65 and older.

Close to two million people living in Illinois in 2014 were living in poverty.

Select Sociodemographic Characteristics, Illinois, 2014

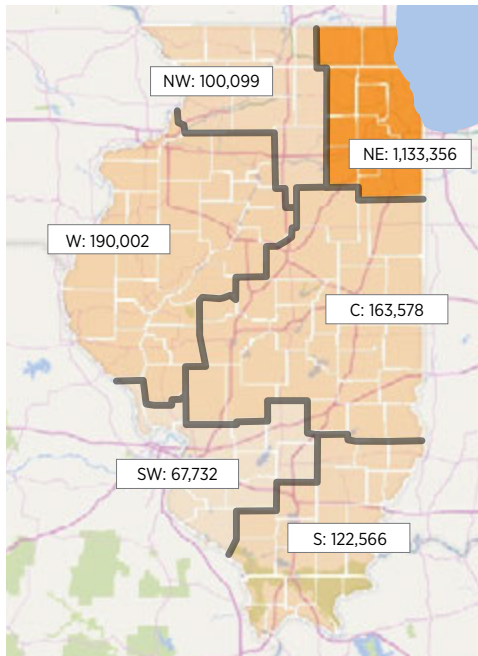
Source: IDPH, Center for Health Statistics*

	NUMBER	PERCENT
Illinois Overall	12,880,580	100.0
Race/Ethnicity		
Non-Hispanic Black	1,885,164	14.6
Non-Hispanic White	8,115,541	63.0
Hispanic	2,152,974	16.7
Asian/Pacific Islander	701,675	5.4
American Indian/Alaskan Native	25,226	0.2
Foreign-Born	1,786,926	13.9
Age		
< 18	2,988,474	23.2
18-44	4,712,911	36.6
45-64	3,390,662	26.3
65-84	1,532,481	11.9
85+	256,062	2.0
Geographic Region		
Central Illinois	426,349	3.3
Northeastern Illinois	8,687,508	67.5
Northwestern Illinois	1,251,758	9.7
Southern Illinois	972,440	7.6
Southwestern Illinois	756,311	5.9
Western Illinois	786,214	6.1
At Least High School Education, Among Ages 25 and Over	7,427,358	87.3
Below the Federal Poverty Line	1,772,333	14.1

*U.S. Census Bureau Population Estimates

Number in Poverty by Region, 2009-2013

Illinois Overall, 2009-2013: 1,772,333



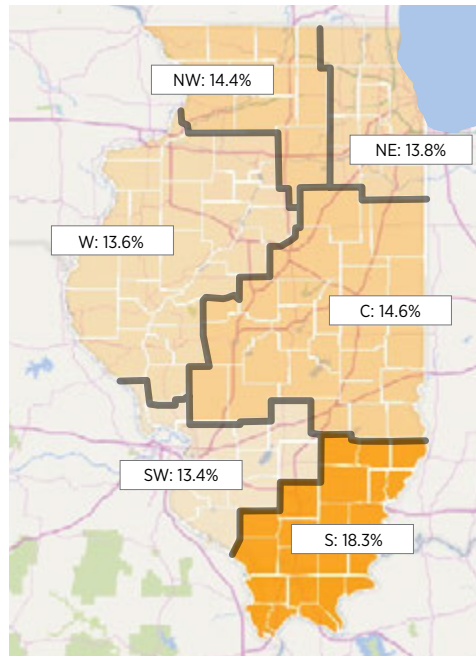
Less Poverty More Poverty

Source: U.S. Census Bureau, 2009-2013 5-Year American Community Survey

Poverty Rate by Region, 2009-2013

U.S. Overall, 2014: 14.8%

Illinois Overall, 2009-2013: 14.1%



Less Poverty More Poverty

Source: U.S. Census Bureau, Vintage Population Estimates, 2014

U.S. Census Bureau, 2009-2013 5-Year American Community Survey

Using data for 2009-2013 combined, the highest rate of poverty was in southern Illinois, but mirroring the overall distribution of population density, most of the people in poverty lived in the northeast region.

Poverty Rate*

Illinois Overall and by Race/Ethnicity, 2014

Source: U.S. Census Bureau, American Community Survey 1-Year Estimate. IDPH, Center for Health Statistics

Benchmark**	14.8
Illinois Overall	14.4
Black (including Hispanic)	30.6
White (including Hispanic)	10.8
Hispanic	19.9
All other	16.8

*Below 100% of federal poverty level.

**U.S. Overall, <http://www.census.gov/hhes/www/poverty/data/incpovhlth/2014/highlights.html>

The poverty rate in Illinois is similar to that of the nation as a whole. But while approximately 1 in 10 white Illinoisans were living in poverty in 2014, almost 1 in 5 Hispanics and closer to 1 in 3 blacks were below the federal poverty threshold.

(The race/ethnicity categories used here are not mutually exclusive; the poverty rates for non-Hispanic blacks and non-Hispanic whites might be slightly different than the rates shown in the table.)

Social Determinants/Context, continued

There are many approaches that go beyond a simple assessment of poverty in order to capture the complex circumstances in which people live. Two of these approaches are presented here, each deriving a summary indicator using several component measures:

Concentrated Disadvantage	County Well-Being
<ul style="list-style-type: none"> • Percent of individuals living in poverty • Unemployment rate • Percent of households receiving public assistance • Percent of households that are female-headed • Percent of individuals that are under 18 years old 	<ul style="list-style-type: none"> • Percent of Individuals living in poverty • Unemployment rate • Percent of Teen births • High school graduation rate
<p>Source: IDPH, Office of Women's Health and Family Services. Association of Maternal and Child Health Programs (AMCHP): http://www.amchp.org/programsandtopics/data-assessment/LifeCourseIndicatorDocuments/LC-06_ConcentratedDisad_Final-4-24-2014.pdf</p>	<p>Source: Terpstra, A., Clary, J., & Rynell, A. (2015, January). Poor by comparison: Report on Illinois poverty. Chicago: Social IMPACT Research Center at Heartland Alliance. https://www.heartlandalliance.org/research/annual-poverty-report/</p>

The two maps at right show Illinois counties according to these two approaches that jointly consider several social determinants of health. Both maps show that there were pockets of high disadvantage or lack of county well-being, but these pockets existed in every corner of the state.

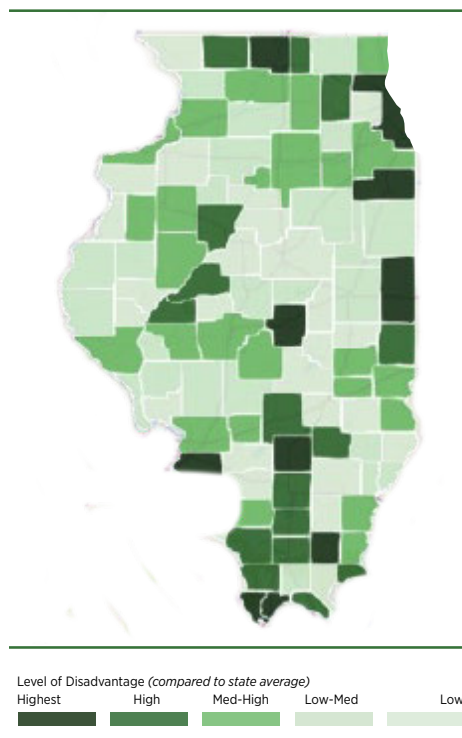
Using the Concentrated Disadvantage approach, the 10 most disadvantaged counties in Illinois (darkest green) are:

- Winnebago
- Cook
- Kankakee
- Vermilion
- Macon
- Marion
- St. Clair
- Saline
- Alexander
- Pulaski

Using the County Well Being index, 42 Illinois counties are on the well-being "watch list" (darker green) and 4 Illinois counties are on the well-being "warning list" (darkest green):

- Montgomery
- Morgan
- Union
- Wayne

Concentrated Disadvantage

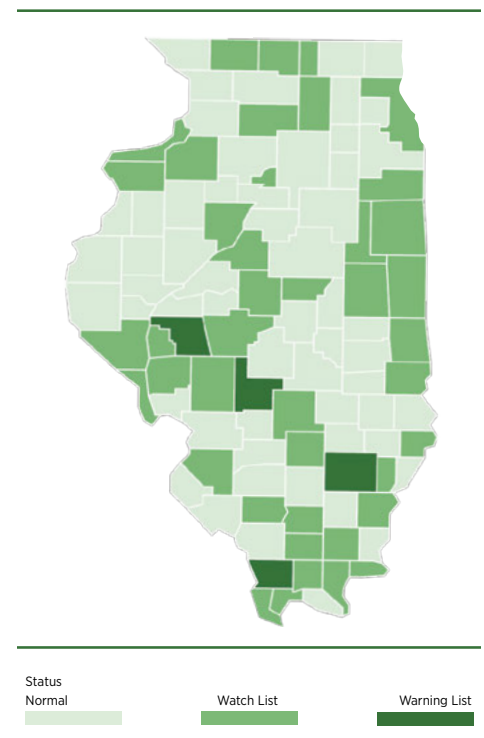


Source: IDPH, Office of Women's Health and Family Services

Concentrated Disadvantage is a summary index created from five variables in the 2008-2012 American Community Survey and 2010 Census files, as recommended by the Association of Maternal and Child Health Programs (AMCHP) Life Course Indicator Set: http://www.amchp.org/programsandtopics/data-assessment/LifeCourseIndicatorDocuments/LC-06_ConcentratedDisad_Final-4-24-2014.pdf

The 10 most disadvantaged counties (darkest green) are: Winnebago, Cook, Kankakee, Vermilion, Macon, Marion, St. Clair, Saline, Alexander, and Pulaski.

County Well-Being

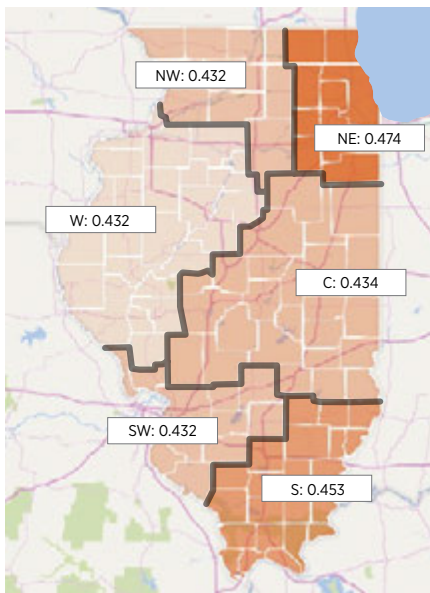


Source: Terpstra, A., Clary, J., & Rynell, A. (2015, January). Poor by comparison: Report on Illinois poverty. Chicago: Social IMPACT Research Center at Heartland Alliance. <https://www.heartlandalliance.org/research/annual-poverty-report/>

42 Illinois counties are on the well-being "watch list" (darker green), and 4 are on the well-being "warning list" (darkest green): Montgomery, Morgan, Union, and Wayne.

**Income Inequality by Region
Gini Index, 2013**

U.S. Overall: 0.474
 Illinois Overall: 0.482
 Cook County: 0.510



Less Inequality More Inequality

<http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t,Gini ID B10983>

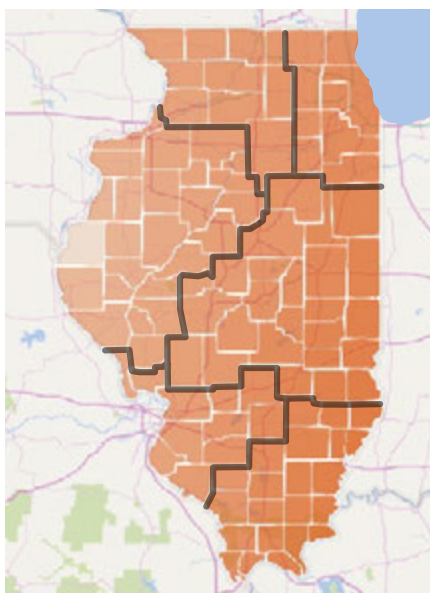
Another approach to examining income data is to assess the extent of income inequality. The Gini index is a common measure of household income inequality used by economists, with 0.0 representing total income **equality** and 1.0 equivalent to total income **inequality**.

This measure only tells a piece of the story, though, since income equality may simply mean that a geographic area is either wealthy overall or low-income overall.

In Illinois, the northeastern region, which includes Chicago and its suburbs, and the southern region had the largest income inequality in the state, according to the Gini index.

**Daily Fine Particulate Matter,
Avg Daily Measure, by County,**

Micrograms per cubic meter, 2011
 U.S. EPA PM 2.5 Standard: 12.0
 Illinois Overall: 12.6



Less Particulate More Particulate

Source: U.S. Environmental Protection Agency

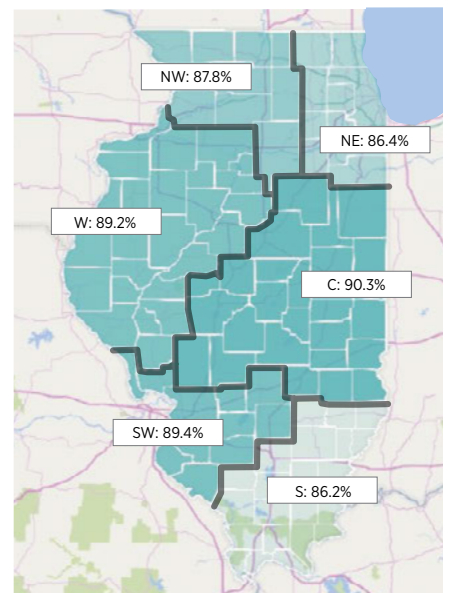
Two more views of the context in which Illinoisans live can be seen in these two maps.

The map of daily fine particulate matter (left) shows that the eastern part of the state, from north to south, had the highest levels of this measure of air pollution.

The map of high school graduation rates (right) shows a small amount of variation across the state, ranging from a low of 86.2% to a high of 90.3%, with the lowest rates in the northeastern and southern regions.

**High School Graduate or Above,
2009-2013**

U.S. Overall: 86.0%
 Illinois Overall: 87.3%



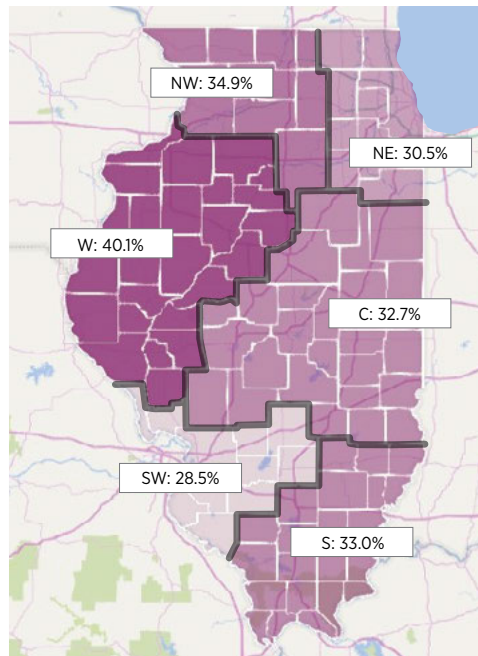
Less Education More Education

Source: S1501, 2010-2013 American Community Survey 1-year & 5-year estimates

The housing available to people living in Illinois is another indicator of the context in which people live. The maps on this page show the age of housing across the state and an estimate of the extent of elevated lead levels among children who have been tested.

Compared to other areas of Illinois, the western region had a higher percentage of older housing and a higher percentage of high lead levels among children who were tested in 2014. In addition, the percentage in the western region exceeds the Healthy People 2020 objective of 5.2% for children ages 1-5 with blood lead levels of 5 µg/dl or more.

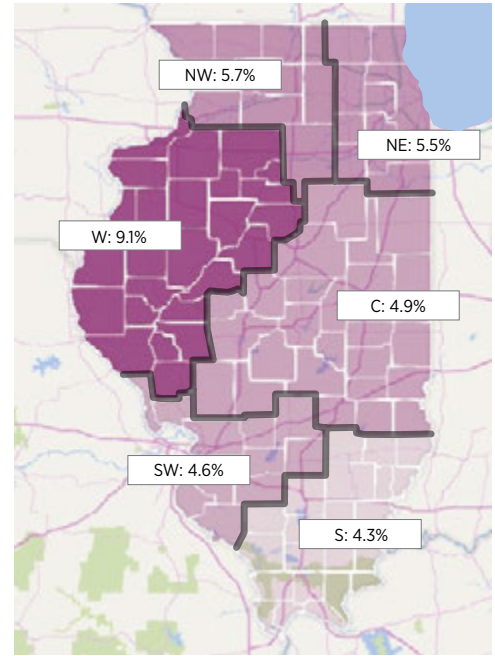
Percent of Illinois Housing Built Before 1950, by Region



Lower Higher

Source: IDPH, Center for Health Statistics and Division of Vital Records
<http://www.cdc.gov/nceh/lead/data/state/ildata.htm>

Percent Blood Lead ≥5 µg/dl of Illinois Children Tested, 72 Months and Younger, by Region, 2014



Lower Higher

Source: IDPH, Center for Health Statistics and Division of Vital Records
<http://www.cdc.gov/nceh/lead/data/state/ildata.htm>

Percent of Children Less than 18 Reported as Never or Only Sometimes Safe in Their Community/Neighborhood*

Illinois Overall and by Race/Ethnicity, 2011

Source: Child and Adolescent Health Measurement Initiative, Data Resource Center National Survey of Children's Health (NSCH)

Benchmark**	13.4	(12.9-14.0)†
Illinois Overall	14.9	(12.5-17.3)
Non-Hispanic Black	24.5	(17.3-31.6)
Non-Hispanic White	7.0	(4.8-9.3)
Hispanic	27.1	(20.3-33.8)
Non-Hispanic Other	9.6	(4.2-14.9)

**How often do you feel [child name] is safe in your community or neighborhood?" NSCH, 2011/12
 ** U.S. Overall from NSCH, 2011/12
 † (95% confidence intervals)

Lack of community safety is another social determinant of health. Like many other social determinants, it has been shown to be associated with both physical and mental health outcomes throughout the course of an individual's life.

In Illinois overall, close to 1 in 6 children were reported by a parent or guardian as living in an unsafe community. For both non-Hispanic black and Hispanic children, approximately 1 in 4 were reported as living in an unsafe community.

Homicide and mortality due to motor vehicle accidents reflect a combination of factors. In 2014, 768 Illinoisans were victims of homicide and 984 Illinoisans died in motor vehicle accidents. Even after adjusting for age, non-Hispanic blacks were far more often the victims of homicide compared to other racial/ethnic groups. Their age-adjusted rate was 18 times higher than the rate for non-Hispanic whites and more than five times higher than the Healthy People 2020 benchmark. In contrast, there was very little racial/ethnic disparity in the rate of death due to motor vehicle accidents, and in fact the age-adjusted rates in Illinois were all better than the Healthy People 2020 benchmark.

Age-Adjusted Homicide Rate

per 100,000 Population

Illinois Overall and by Race/Ethnicity, 2014*

Source: IDPH, Center for Health Statistics and Division of Vital Records

Benchmark**	5.5
Illinois Overall	6.0 (5.6-6.5)[†]
Non-Hispanic Black	27.1 (24.7-29.5)
Non-Hispanic White	1.5 (1.2-1.8)
Hispanic	3.9 (3.1-4.9)

*2014 data are provisional.
 **Healthy People 2020 IVP-29, Reduce homicides; based on age-adjusted rates.
 † (95% confidence intervals)

Age-Adjusted Motor Vehicle Accident Mortality Rate

per 100,000 Population

Illinois Overall and by Race/Ethnicity, 2014*

Source: IDPH, Center for Health Statistics and Division of Vital Records

Benchmark**	12.4
Illinois Overall	7.4 (7.0-7.9)[†]
Non-Hispanic Black	8.4 (7.1-9.7)
Non-Hispanic White	8.2 (7.6-8.9)
Hispanic	5.1 (4.2-6.0)

*2014 data are provisional.
 **Healthy People 2020 IVP-131, Reduce motor vehicle crash-related deaths; based on age-adjusted rates.
 † (95% confidence intervals)

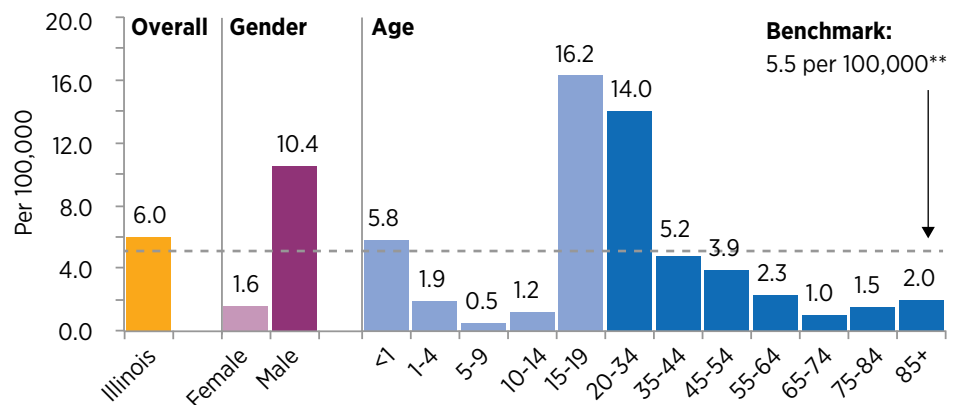
Homicide rates were also highest among men and among young adults. The motor vehicle death rate was similarly higher among men, but the age pattern was different, with a high rate among young adults and the highest rate among the elderly.

Homicide Rate

per 100,000 Population

Illinois Overall and by Gender (Age Adjusted) and by Age, 2014*

Source: IDPH, Center for Health Statistics and Division of Vital Records



*2014 data are provisional.

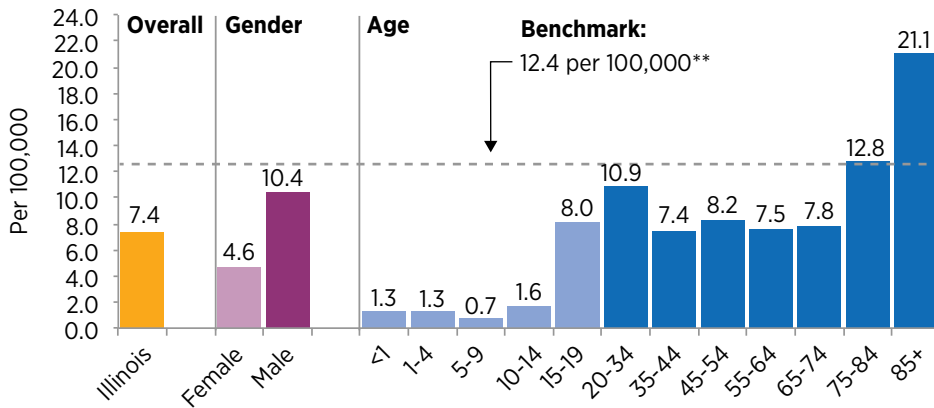
**Healthy People 2020 IVP-29, Reduce homicides; based on age-adjusted rates.

Motor Vehicle Accident Mortality Rate

per 100,000 Population

Illinois Overall and by Gender (Age-Adjusted) and Age, 2014*

Source: IDPH, Center for Health Statistics and Division of Vital Records



*2014 data are provisional.

**Healthy People 2020 IVP-13.1, Reduce motor vehicle crash-related deaths; based on age-adjusted rates.

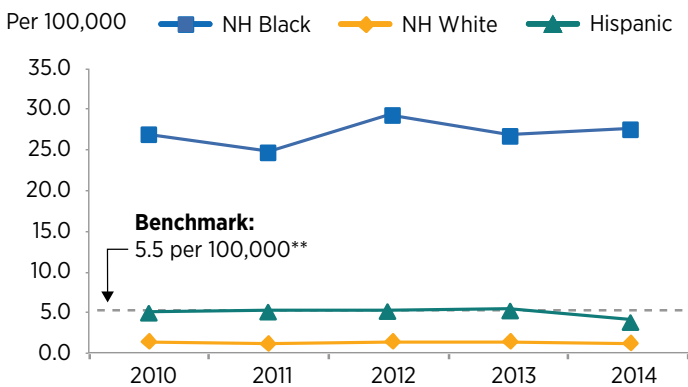
The trend data for homicide shows the persistence of the disparity between non-Hispanic blacks and other racial/ethnic groups. The trends in motor vehicle deaths were more variable, but all groups were below the benchmark throughout 2010-2014.

Age-Adjusted Homicide Rate

per 100,000 Population

by Year and Race/Ethnicity, 2010-2014*

Source: IDPH, Center for Health Statistics and Division of Vital Records



*2014 data are provisional.

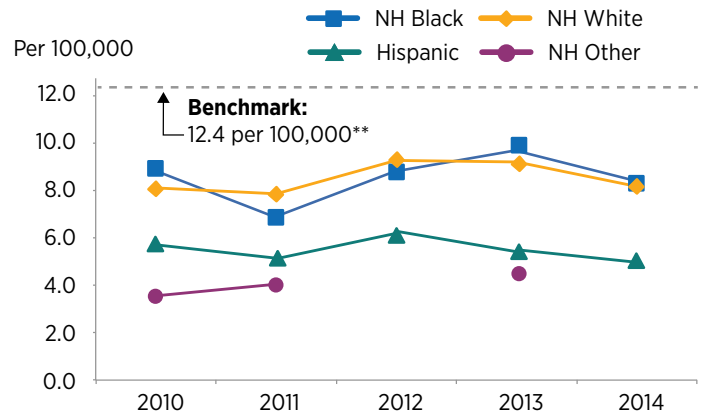
**Healthy People 2020 IVP-29, Reduce homicides; based on age-adjusted rates.

Age-Adjusted Motor Vehicle Mortality Rate

per 100,000 Population

by Year and Race/Ethnicity, 2010-2014*

Source: IDPH, Center for Health Statistics and Division of Vital Records



*2014 data are provisional.

**Healthy People 2020 IVP-13.1, Reduce motor vehicle crash-related deaths; based on age-adjusted rates.

ACCESS TO CARE

Childhood asthma, type 2 diabetes, and hypertension are often referred to as “ambulatory care sensitive conditions” since in a health care system with adequate and equal access to care, these conditions should be managed in a primary care setting. Visits to an emergency department should be rare.

In 2014, non-Hispanic blacks had much higher rates of emergency department use for pediatric asthma, type 2 diabetes, and hypertension compared to other Illinois residents.

One approach for documenting access to primary care is to measure the concept of a “medical home.” The American Academy of Pediatrics has championed development of methods for measuring this concept for children. In 2011, 2 in 5 Illinois children did **not** have a medical home; more than half of non-Hispanic black children in Illinois did **not** have a medical home.

Percent of Children Reported as Not Having a Medical Home*

Illinois Overall and by Race/Ethnicity, 2011

Source: Child and Adolescent Health Measurement Initiative, Data Resource Center National Survey of Children’s Health (NSCH)

Benchmark**	36.7	
Illinois Overall	44.1	(41.0-47.3)†
Non-Hispanic Black	54.7	(46.3-63.1)
Non-Hispanic White	27.1	(23.5-30.7)
Hispanic	72.9	(66.6-79.3)
Non-Hispanic Other	53.4	(43.0-63.7)

*Children who do not receive coordinated, ongoing, comprehensive care within a medical home
 **Healthy People 2020 MICH-30, Increase the proportion of children, including those with special health care needs, who have access to a medical home. Target: 36.7 not having a medical home.
 †(95% confidence intervals)

Ambulatory Care Sensitive Conditions

Rate of Emergency Department Discharges for Pediatric Asthma, per 10,000 Children

Illinois Overall and by Race/Ethnicity, 2014*

Source: IDPH, Division of Patient Safety and Quality

Benchmark**	-	
Illinois Overall	85.4	(84.4-86.4)†
Non-Hispanic Black	243.9	(239.7-248.2)
Non-Hispanic White	42.5	(41.5-43.5)
Hispanic	65.7	(63.9-67.6)
Non-Hispanic Other	96.3	(92.4-100.2)

*The denominator is the mean 2012-2014 data, from Claritas.

**The Healthy People 2020 Objective uses age-specific measures.

†(95% confidence intervals)

Rate of Emergency Department Discharges for Type II Diabetes, per 10,000 Adults

Illinois Overall and by Race/Ethnicity, 2014*

Source: IDPH, Division of Patient Safety and Quality

Illinois Overall	288.0	(286.9-289.0)**
Non-Hispanic Black	601.5	(597.4-605.5)
Non-Hispanic White	224.0	(222.8-225.1)
Hispanic	283.6	(280.8-286.3)
Non-Hispanic Other	296.0	(291.8-300.3)

*Denominator is the mean 2012-2014 data, from Claritas.

** (95% confidence intervals)

Rate of Emergency Department Discharges for Hypertension, per 10,000 Adults

Illinois Overall and by Race/Ethnicity, 2014*

Source: IDPH, Division of Patient Safety and Quality

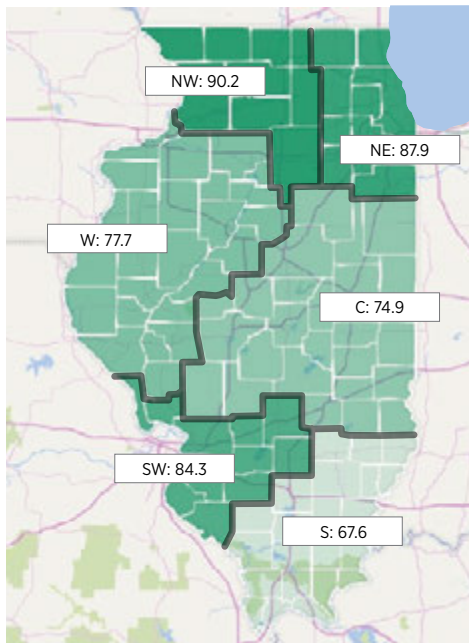
Illinois Overall	710.8	(709.2-712.4)**
Non-Hispanic Black	1510.4	(1504.3-1516.5)
Non-Hispanic White	604.7	(602.8-606.5)
Hispanic	475.5	(471.9-479.0)
Non-Hispanic Other	617.5	(611.5-623.6)

*Denominator is the mean 2012-2014 data, from Claritas.

** (95% confidence intervals)

Rate of Emergency Department Discharges, Pediatric Asthma

Per 10,000 Children, by Region, 2014
Illinois Overall: 85.4

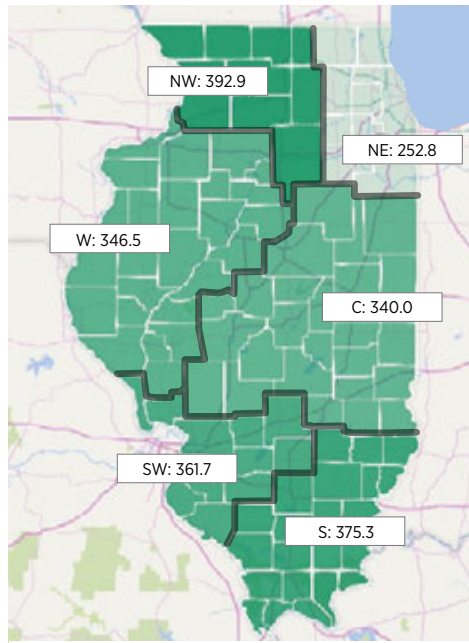


Less Asthma More Asthma

Source: IDPH, Division of Patient Safety and Quality

Rate of Emergency Department Discharges, Type 2 Diabetes

Per 10,000 Adults, by Region, 2014
Illinois Overall: 288.0

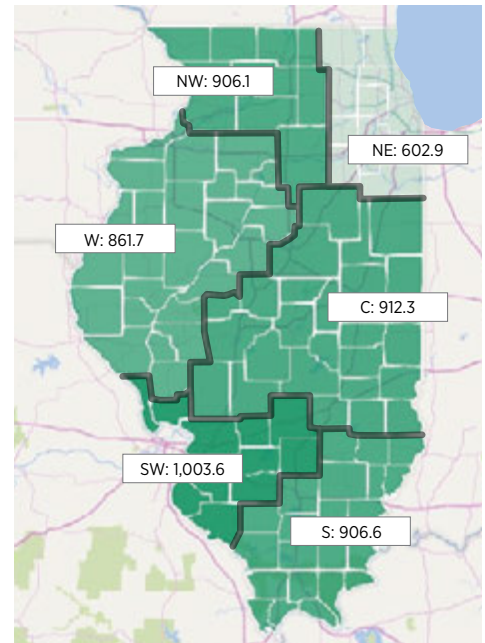


Less Diabetes More Diabetes

Source: IDPH, Division of Patient Safety and Quality

Rate of Emergency Department Discharges, Hypertension

Per 10,000 Adults, by Region, 2014
Illinois Overall: 710.8



Less Hypertension More Hypertension

Source: IDPH, Division of Patient Safety and Quality

There appears to be some geographic disparity in the use of the emergency department for pediatric asthma, Type II diabetes, and hypertension.

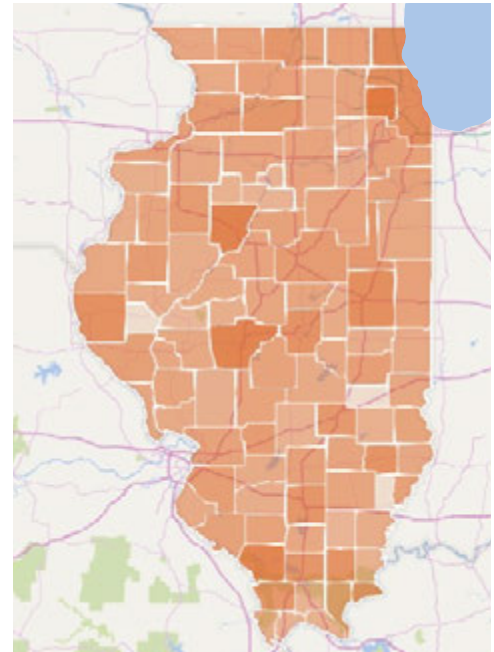
In 2014, northern Illinois and southwestern Illinois had the highest rates of emergency department use for pediatric asthma compared to other areas of the state.

In contrast, the northeastern part of the state, which includes Chicago, had lower rates of emergency department use for type 2 diabetes and hypertension, with the remainder of the state having higher rates of emergency department use for these two conditions.

Overall, in 2011 Illinois had more primary care physicians per capita than the U.S., which should translate into better access to basic health care and reduce the need for use of emergency care. The rate of primary care physicians varies by county in Illinois, but there is no clear pattern that corresponds to the geographic differences in use of the emergency department for pediatric asthma, type 2 diabetes, and hypertension.

Primary Care Physicians

per 100,000, 2011
 U.S. Overall, 2011: 78.8
 Illinois Overall: 102.9



Fewer Primary Care Physicians | More Primary Care Physicians

Source: IDPH, Division of Patient Safety and Quality
http://www.healthindicators.gov/Indicators/Primary-care-providers-per-100000_25/Profile/ClassicData

Prenatal care is another measure of whether a health care system has adequate and equal access to basic health care services. One measure of access to prenatal care is the extent to which pregnant women begin receiving care early in pregnancy. In 2014, approximately 4 in 5 pregnant women in Illinois started prenatal care in the first trimester of pregnancy, but only two-thirds of non-Hispanic black women had received early care.

A more comprehensive measure of prenatal care combines early entry with whether pregnant women receive the recommended number of visits once they are in care. The percentages of Illinois pregnant women who received adequate prenatal care overall mirror those for early entry alone. In addition, receiving prenatal care increased with age, and younger pregnant women were well below the Healthy People 2020 benchmark.

Percent of Pregnant Women Entering Prenatal Care in the First Trimester

Illinois Overall and by Race/Ethnicity, 2014*

Source: IDPH, Center for Health Statistics and Division of Vital Records

Benchmark**	77.9
Illinois Overall	80.5 (80.3-80.7)†
Non-Hispanic Black	68.7 (68.1-69.3)
Non-Hispanic White	85.8 (85.6-86.1)
Hispanic	76.9 (76.5-77.4)
Asian	80.8 (80.0-81.6)
Non-Hispanic Other	76.0 (74.1-77.8)

*2014 data are provisional.
 **Healthy People 2020 MICH-10.1, Increase the proportion of pregnant women who receive prenatal care beginning in first trimester.
 †(95% confidence intervals)

Percent of Pregnant Women with Adequate Prenatal Care

Illinois Overall and by Race/Ethnicity, 2014*

Source: IDPH, Center for Health Statistics and Division of Vital Records

Benchmark**	77.6
Illinois Overall	78.3 (78.1-78.5)†
Non-Hispanic Black	63.2 (62.6-63.8)
Non-Hispanic White	85.0 (84.7-85.2)
Hispanic	73.5 (73.0-74.0)
Asian	80.6 (79.8-81.4)
Non-Hispanic Other	74.7 (72.8-76.6)

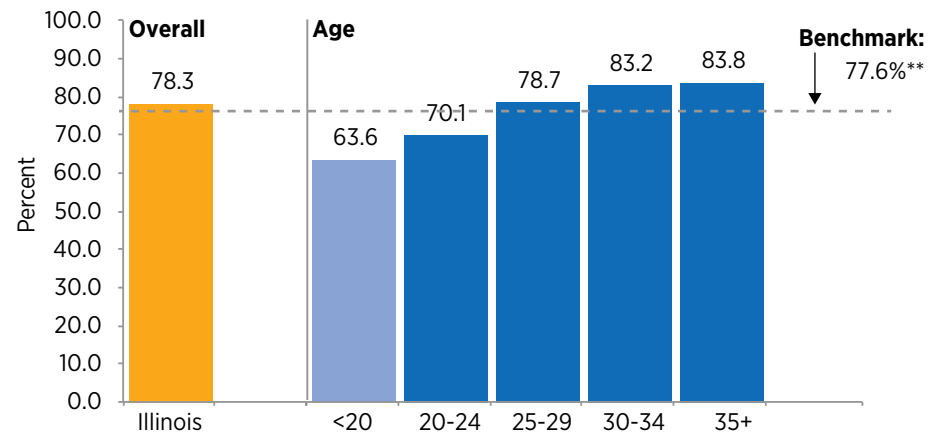
*2014 data are provisional.
 Healthy People 2020 MICH-10.2, Increase the proportion of pregnant women who receive early and adequate prenatal care—entry by month 4 **and number of visits corresponding to the recommendations of the American College of Obstetricians and Gynecologists.
 †(95% confidence intervals)

Of note, the trend data shows no improvement in adequacy of prenatal care since 2010, and the racial/ethnic disparity persists and may be increasing over this time period. The southern and southwestern regions of the state as well as the northeastern region, which includes Chicago, had lower percentages of pregnant women who had obtained adequate prenatal care.

Percent of Pregnant Women with Adequate Prenatal Care

Illinois Overall and by Age, 2014*

Source: IDPH, Center for Health Statistics and Division of Vital Records



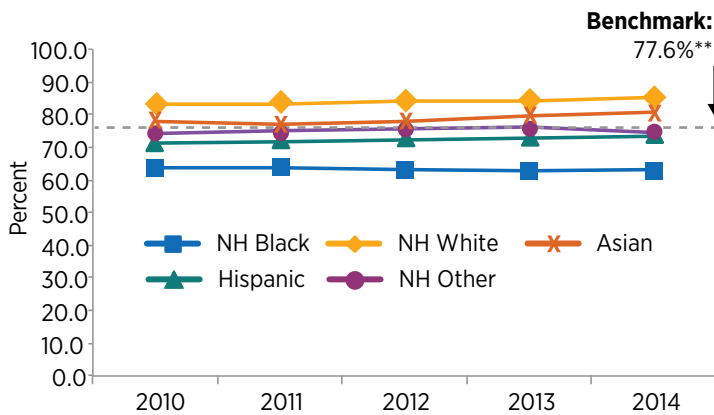
*2014 data are provisional.

**Healthy People 2020 MICH-10.2, Increase the proportion of pregnant women who receive early and adequate prenatal care—entry by month 4 and number of visits corresponding to the recommendations of the American College of Obstetricians and Gynecologists.

Percent of Pregnant Women with Adequate Prenatal Care

by Year and Race/Ethnicity, 2010-2014*

Source: IDPH, Center for Health Statistics and Division of Vital Records



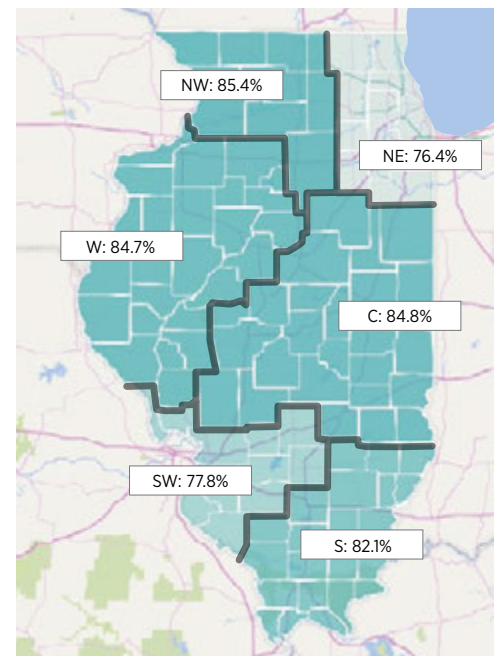
*2014 data are provisional.

**Healthy People 2020 MICH-10.2, Increase the proportion of pregnant women who receive early and adequate prenatal care—entry by month 4 and number of visits corresponding to recommendations of the American College of Obstetricians and Gynecologists.

Adequate Prenatal Care

Benchmark: 77.6%

Illinois Overall: 78.3%



Lower % Care Higher % Care

Source: IDPH, Center for Health Statistics and Division of Vital Records

RISK FACTORS

Physical activity is recognized as an approach for preventing chronic disease and disability. Around a quarter of adults in Illinois reported engaging in no physical activity in the last 30 days. Among children, the percentages are lower, but every child should be engaging in at least some vigorous physical exercise.

Percent of All Adults Reporting No Physical Activity in the Last 30 Days*

Illinois Overall and by Race/Ethnicity, 2014

Source: IDPH, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS)

Benchmark**	25.3
Illinois Overall	24.0 (22.5-25.6)†
Non-Hispanic Black	29.8 (25.1-35.0)
Non-Hispanic White	22.2 (20.5-23.9)
Hispanic	28.9 (23.8-34.5)

**During the past month, did you participate in any physical activities?
 **U.S. Overall from BRFSS, 2013
 †(95% confidence intervals)

Percent of Children 6-17 Reported as Not Engaging in Vigorous Physical Activity*

Illinois Overall and by Race/Ethnicity, 2011

Source: Child and Adolescent Health Measurement Initiative, Data Resource Center National Survey of Children's Health (NSCH)

Benchmark**	9.1
Illinois Overall	8.0 (8.6-9.7)†
Non-Hispanic Black	7.6 (2.6-12.7)
Non-Hispanic White	5.1 (3.0-7.2)
Hispanic	13.4 (7.0-19.9)
Non-Hispanic Other	11.8 (2.6-21.0)

**How many days during the past week did [child name] exercise, play a sport, or participate in physical activity for at least 20 minutes that made [him/her] sweat and breathe hard?
 **U.S. Overall from NSCH, 2011/12
 †(95% confidence intervals)

Smoking is perhaps the most well-established risk factor for a wide array of health outcomes. Overall, 1 in 6 adults in Illinois reported being current smokers in 2014, and 1 in 4 non-Hispanic black adults reported smoking. Among pregnant women, smoking rates are lower as might be expected, but approximately 10% of pregnant women still reported smoking.

Percent of All Adults Reporting Smoking*

Illinois Overall and by Race/Ethnicity, 2014

Source: IDPH, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS)

Benchmark**	12.0
Illinois Overall	16.7 (15.2-18.2)†
Non-Hispanic Black	25.2 (20.3-30.9)
Non-Hispanic White	16.5 (14.8-18.2)
Hispanic	12.9 (9.6-17.1)

*Current smoker
 **Healthy People 2020 TU-11, Reduce cigarette smoking by adults.
 †(95% confidence intervals)

Percent of Women Reporting Smoking During the Last 3 Months of Pregnancy

Illinois Overall and by Race/Ethnicity, 2012

Source: Illinois Center for Health Statistics, Pregnancy Risk Assessment Monitoring System (PRAMS)

Benchmark*	1.4
Illinois Overall	8.8 (7.1-11.0)**
Non-Hispanic Black	10.1 (5.2-18.7)
Non-Hispanic White	12.0 (9.5-15.2)
Hispanic	1.9 (0.9-4.3)

*Healthy People 2020 MICH-11.3, Increase abstinence from cigarette smoking among pregnant women. Target: 98.6 percent for abstinence; 1.4 percent for smoking.
 ** (95% confidence intervals)

Percent of Women Who Report Always Placing Their Infants on Their Backs to Sleep

Illinois Overall and by Race/Ethnicity, 2012

Source: IDPH, Center for Health Statistics
Pregnancy Risk Assessment Monitoring System (PRAMS)

Benchmark*	75.9
Illinois Overall	77.5 (74.4-80.2)**
Non-Hispanic Black	56.0 (45.2-66.3)
Non-Hispanic White	85.0 (81.6-87.9)
Hispanic	73.7 (67.6-79.0)
Non-Hispanic Other	78.8 (68.1-86.6)
*Healthy People 2020 MICH-20, Increase the proportion of infants who are put to sleep on their backs. **(95% confidence intervals)	

Safe sleep practices are one component of preventing infant mortality. An important safe sleep practice is to ensure that infants sleep on their backs and not on their stomachs or sides. In 2012, close to a quarter of Illinois women who recently gave birth reported **not** always placing their infants on their back to sleep.

Percent of Adults Reporting Adverse Childhood Experiences (ACEs)*

Illinois Overall and by Race/Ethnicity, 2013

Source: IDPH, Center for Health Statistics,
Behavioral Risk Factor Surveillance System (BRFSS)

Benchmark	-
Illinois Overall	14.1 (12.5-15.8)**
Non-Hispanic Black	19.0 (13.5-24.4)
Non-Hispanic White	12.5 (11.1-14.0)
Hispanic	20.4 (13.7-27.1)
Non-Hispanic Other	3.7 (1.0-6.4)
*4 or more ACEs reported. ACEs include physical, sexual or verbal abuse, or living in a household with an alcohol or drug user, with someone with mental illness/depression, with someone ever incarcerated, with physical abuse among adults, or with divorced parents. **(95% confidence intervals)	

Adverse childhood experiences (ACEs) have been shown to have an impact on both physical and mental health outcomes.

Overall, approximately 1 in 7 Illinois adults reported 4 or more adverse childhood experiences. Among non-Hispanic white adults, 1 in 8 reported 4 or more ACEs, while among both non-Hispanic black and Hispanic adults, approximately 1 in 5 reported 4 or more ACEs.

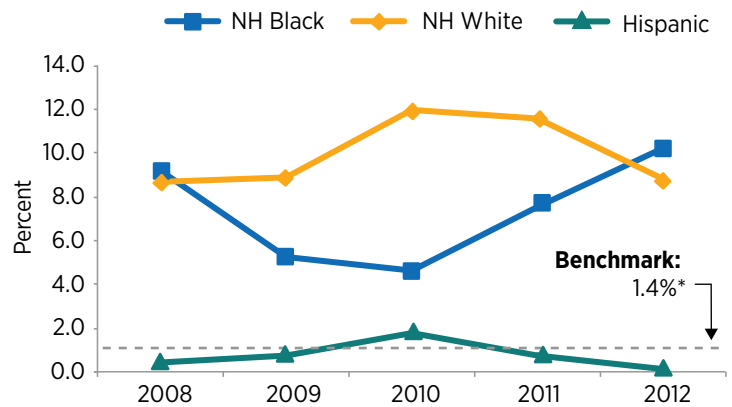
The percentage of Illinois women who reported that they smoked during pregnancy fluctuated from 2008 to 2012. While non-Hispanic black and non-Hispanic white women had similar rates in 2012, it appears that smoking during pregnancy is on the rise among non-Hispanic black women, while it may be decreasing among non-Hispanic white women.

Continued monitoring with additional years of data is needed to determine whether the direction in the trends is real or due to small sample size.

Percent of Women Who Smoke During Last Three Months of Pregnancy, 2008-2012

by Race and Ethnicity

Source: IDPH Center for Health Statistics, Pregnancy Risk Assessment Monitoring System (PRAMS)



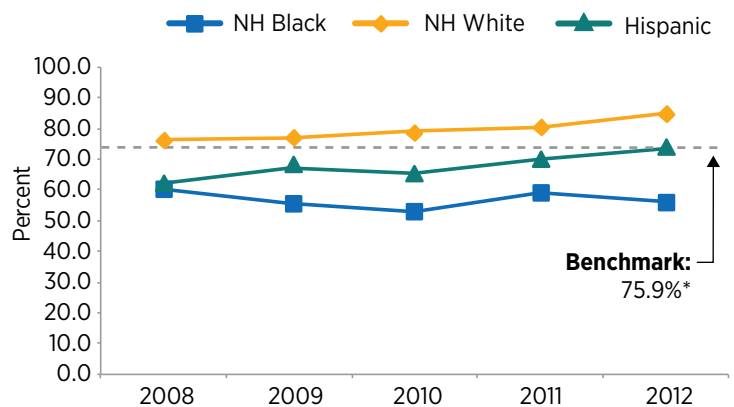
*Healthy People 2020 MICH-11.3, Increase abstinence from cigarette smoking among pregnant women. Target: 98.6 percent for abstinence; 1.4 percent for smoking.

While quite small, the trend in the percentage of women reporting safe sleep practices does appear to be moving in the right direction. This is particularly evident for non-Hispanic white women and for Hispanic women. The trend for non-Hispanic black women, on the other hand, is essentially flat, and this group remains well below the Healthy People 2020 objective.

Percent of Women Who Report Always Placing Their Infants on Their Backs to Sleep, 2008-2012

by Year and Race/Ethnicity

Source: IDPH Center for Health Statistics, Pregnancy Risk Assessment Monitoring System (PRAMS)



*Healthy People 2020 MICH-20, Increase the proportion of infants who are put to sleep on their backs.

**HEALTH PRIORITY AREA:
BEHAVIORAL HEALTH**

Unlike many other indicators, the racial and ethnic disparities in how Illinois adults reported experiencing poor mental health for more than one week in a month were relatively small.

Approximately 15-17% of all Illinois adults reported experiencing poor mental health for more than one week in a month.

Also, unlike many other indicators, reports of poor mental health for more than one week in a month occurred more frequently in women than in men, and more frequently in young adults, with decreasing frequency in older age groups.

In 2014, 1 of 5 young adults in Illinois—ages 18-24—reported experiencing poor mental health for more than one week in a month. In contrast, according to this measure, 1 in 10 adults 65 and older reported poor mental health.

Percent of Adults Reporting Poor Mental Health More than 7 Days in a Month*

Illinois Overall and by Race/Ethnicity, 2014

Source: IDPH, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS)

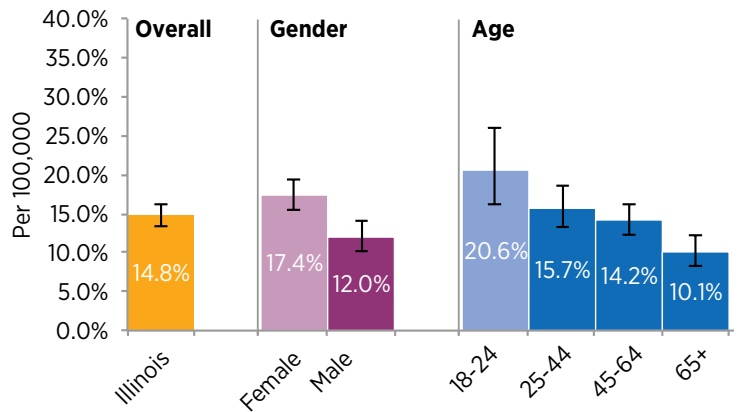
Benchmark	-
Illinois Overall	14.8 (15.2-18.2)**
Non-Hispanic Black	17.3 (13.6-21.8)
Non-Hispanic White	14.7 (13.2-16.4)
Hispanic	15.5 (11.8-20.1)

* "... how many days during the past 30 days was your mental health not good?"
 **(95% confidence intervals)

Percent of Adults Reporting Poor Mental Health More than 7 Days in a Month*

Illinois Overall and by Gender and Age, 2014

Source: IDPH, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS)



*"... how many days during the past 30 days was your mental health not good?"
 Note: Error bars represent 95% confidence intervals

In 2014, 1,365 people living in Illinois committed suicide. Suicide in Illinois showed a different pattern across racial/ethnic groups and was also different than for other indicators, with the rate for non-Hispanic whites being worse than the Healthy People 2020 objective and more than twice as high as the rates in other groups whose rates were already below the national objective.

In addition, in 2014, men had a suicide rate 4 times that of women in Illinois. The suicide rates among adults were similar across age groups, although those ages 45-64 had the highest rate.

Age-Adjusted Suicide Rate per 100,000 Population

Illinois Overall and by Race/Ethnicity, 2014*

Source: IDPH, Center for Health Statistics and Division of Vital Records

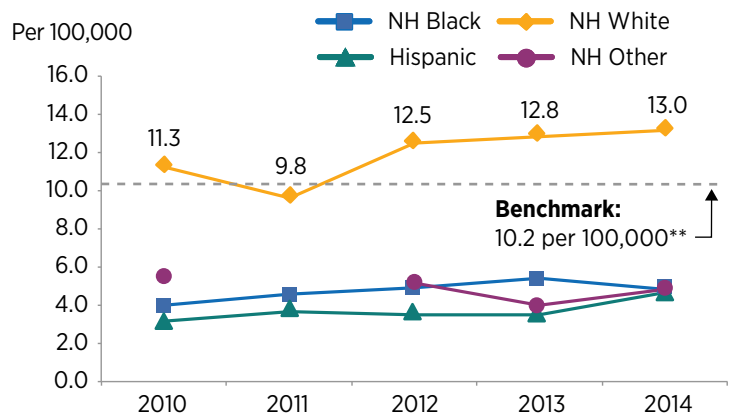
Benchmark**	10.2
Illinois Overall	10.2 (9.6-10.8)[†]
Non-Hispanic Black	4.9 (3.9-6.0)
Non-Hispanic White	13.0 (12.2-13.8)
Hispanic	5.2 (4.2-6.1)
Non-Hispanic Other	4.8 (3.4-6.7)

*2014 data are provisional.
 **Healthy People 2020 MHMD-1, Reduce the suicide rate; based on age-adjusted rates.
 †(95% confidence intervals)

Age-Adjusted Suicide Rate per 100,000 Population

by Year and Race/Ethnicity, 2010-2014*

Source: IDPH, Center for Health Statistics and Division of Vital Records

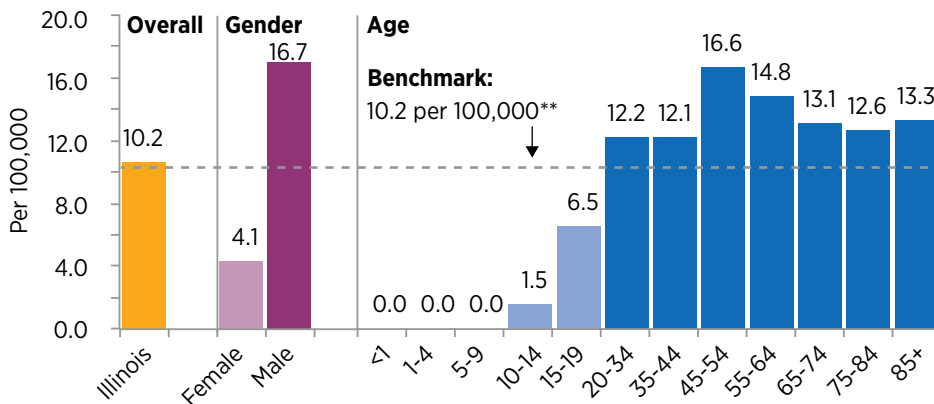


*2014 data are provisional.
 **Healthy People 2020 MHMD-1, Reduce the suicide rate; based on age-adjusted rates.

Suicide Rate per 100,000 Population

Illinois Overall and by Gender (Age Adjusted) and Age, 2014*

Source: IDPH, Center for Health Statistics and Division of Vital Records



*2014 data are provisional.
 **Healthy People 2020 MHMD-1, Reduce the suicide rate; based on age-adjusted rates.

**HEALTH PRIORITY AREA:
CHRONIC DISEASE**

Similar to national data, the two leading causes of death in Illinois are heart disease and cancer. Heart disease and cancer each account for approximately 24,000 deaths in Illinois each year. The subset of deaths due to ischemic heart disease accounts for approximately 13,000 deaths in Illinois annually.

Age-Adjusted Ischemic Heart Disease* Mortality Rate per 100,000 Population

Illinois Overall and by Race/Ethnicity, 2014**

Source: IDPH, Center for Health Statistics and Division of Vital Records

Benchmark†	103.4
Illinois Overall	91.5 (89.7-93.2)††
Non-Hispanic Black	112.0 (107.5-116.5)
Non-Hispanic White	93.3 (90.7-95.8)
Hispanic	52.0 (50.0-54.0)
Non-Hispanic Other	50.3 (50.0-54.0)

*Death due to ischemic heart diseases (acute myocardial infarction, other acute ischemic heart diseases, and other forms of chronic ischemic heart disease).

**2014 data are provisional.

†Healthy People 2020 HDS-2, Reduce coronary heart disease deaths; based on age-adjusted rates.

††(95% confidence intervals)

After adjusting for age, the mortality rates for ischemic heart disease and for cancer were each close to the corresponding Healthy People 2020 objectives. Non-Hispanic blacks in Illinois, however, had rates that are worse than the benchmark for both causes of death. Hispanics had lower mortality rates for both heart disease and cancer compared to either non-Hispanic blacks or non-Hispanic whites.

Age-Adjusted Cancer* Mortality Rate per 100,000 Population

Illinois Overall and by Race/Ethnicity, 2014**

Source: IDPH, Center for Health Statistics and Division of Vital Records

Benchmark†	161.4
Illinois Overall	165.7 (163.4-168.1)††
Non-Hispanic Black	210.2 (203.8-216.5)
Non-Hispanic White	169.7 (166.3-173.0)
Hispanic	99.2 (96.3-102.1)
Non-Hispanic Other	87.5 (81.5-93.5)

*Death due to all cancers.

**2014 data are provisional.

†Healthy People 2020 C-1, Reduce the overall cancer death rate; based on age-adjusted rates.

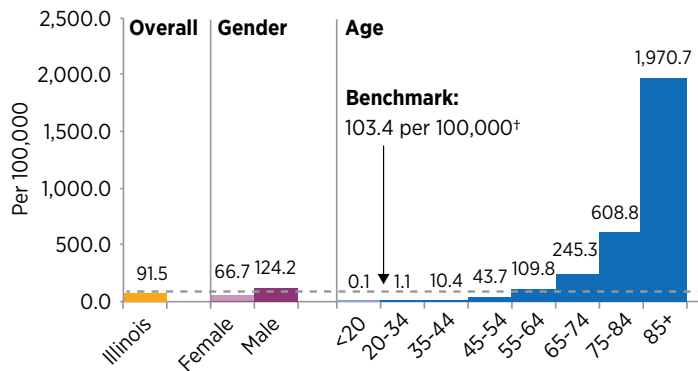
††(95% confidence intervals)

As would be expected, there is a strong age gradient with both heart disease and cancer. In addition, men have higher age-adjusted rates than do women for both causes of death. From a prevention perspective, monitoring the mortality rates for these causes among those in early and middle adulthood may be important. In 2014, 2,755 Illinois residents or approximately 20% of those dying from ischemic heart disease were ages 20-64, while close to 7,000 Illinois residents or almost 30% of those dying from cancer were in this age group.

Heart Disease Mortality Rate per 100,000 Population

Illinois Overall and by Gender (Age-Adjusted) and Age, 2014*

Source: IDPH, Center for Health Statistics and Division of Vital Records

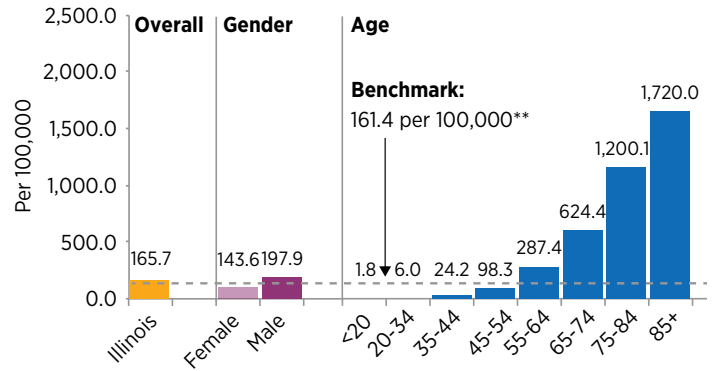


*2014 data are provisional.
 **Healthy People 2020 HDS-2, Reduce coronary heart disease deaths; based on age-adjusted rates.

All Cancer Mortality Rate per 100,000 Population

Illinois Overall and by Gender (Age-Adjusted) and Age, 2014*

Source: IDPH, Center for Health Statistics and Division of Vital Records



*2014 data are provisional.
 **Healthy People 2020 C-1, Reduce the overall cancer death rate; based on age-adjusted rates.

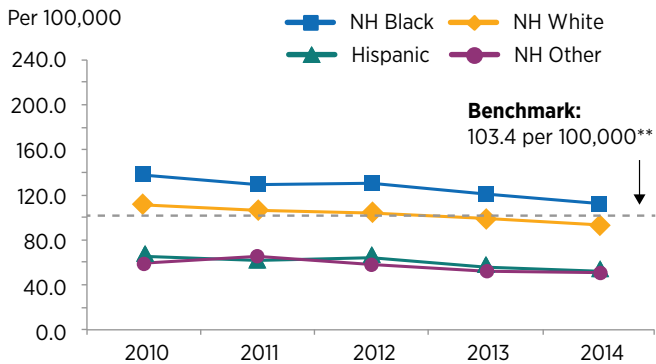
Chronic Disease, continued

The age-adjusted trend data for both heart disease and cancer mortality show a persistent racial/ethnic disparity over time. For heart disease mortality, rates appear to be improving over time, with non-Hispanic whites reaching the benchmark by 2014 and non-Hispanic blacks getting close. For cancer mortality, while rates also appear to be slightly improving over time, both non-Hispanic blacks and non-Hispanic whites have rates higher than the benchmark.

Age-Adjusted Heart Disease Mortality Rate per 100,000 Population

by Year and Race/Ethnicity, 2010-2014*

Source: IDPH, Center for Health Statistics and Division of Vital Records



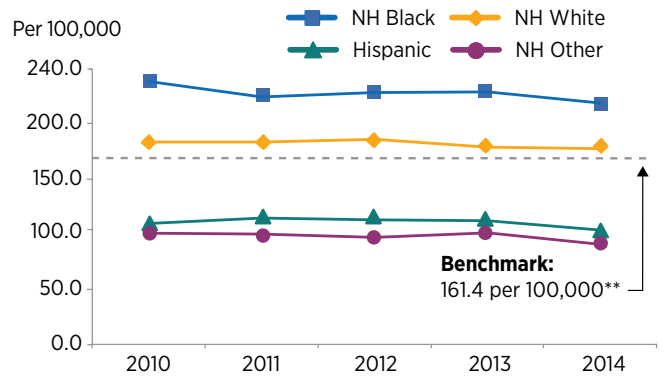
*2014 data are provisional.

**Healthy People 2020 HDS-2, Reduce coronary heart disease deaths; based on age-adjusted rates.

Age-Adjusted Cancer Rate per 100,000 Population

by Year and Race/Ethnicity, 2010-2014*

Source: IDPH, Center for Health Statistics and Division of Vital Records



*2014 data are provisional.

**Healthy People 2020 C-1, Reduce the overall cancer death rate; based on age-adjusted rates.

The percentage of Illinois adults who reported having diabetes was similar to the percentage of adults who reported diabetes nationally. A higher percentage of both non-Hispanic blacks and Hispanics reported having diabetes compared to non-Hispanic whites.

Percent of Adults Reporting Diabetes*

Illinois Overall and by Race/Ethnicity, 2014

Source: IDPH, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS)

Benchmark**	9.7
Illinois Overall	10.2 (9.2-11.2) [†]
Non-Hispanic Black	14.0 (10.9-17.6)
Non-Hispanic White	9.1 (8.1-10.1)
Hispanic	12.7 (9.4-17.1)

***Have you ever been told by a doctor that you have diabetes?*

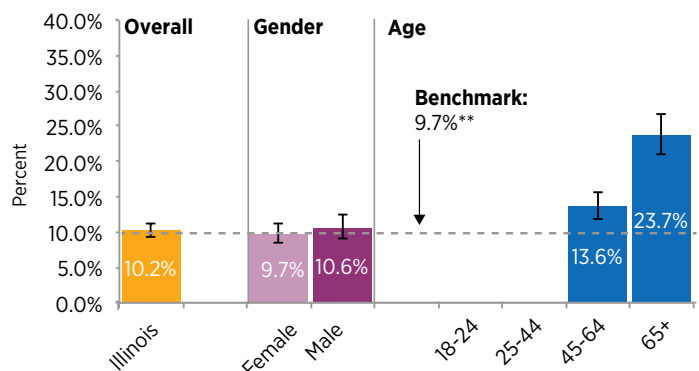
**U.S. Overall from BRFSS 2013.

[†](95% confidence intervals)

Percent of Adults Reporting Diabetes*

Illinois Overall and by Gender and Age, 2014

Source: IDPH, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS)



***Have you ever been told by a doctor that you have diabetes?*

**U.S. Overall from BRFSS 2013.

Note: Error bars represent 95% confidence intervals

Chronic Disease, continued

Obesity is both a risk factor for chronic disease and an outcome itself, and it occurs across the lifespan.

Approximately 1 in 5 children in Illinois were obese; closer to 1 in 3 non-Hispanic black children were obese.

Almost 1 in 3 Illinois adults were obese, with obesity defined according to the consensus cut-point on the Body Mass Index (BMI). Approximately 2 in 5 non-Hispanic black adults were in this category. There were only slight differences in obesity by gender and age.

Percent of Obesity Among Children Ages 10-17*

Illinois Overall and by Race/Ethnicity, 2011

Source: Child and Adolescent Health Measurement Initiative, Data Resource Center National Survey of Children's Health (NSCH)

Benchmark**	14.5
Illinois Overall	19.3 (15.4-23.1)[†]
Non-Hispanic Black	28.5 (18.1-39.0)
Non-Hispanic White	16.3 (11.5-21.1)
Hispanic	21.4 (11.5-31.3)
Non-Hispanic Other	8.8 (2.1-15.5)

*Based on 95th percentile of Body Mass Index (BMI) for age.
 **Healthy People 2020 NWS-10.4, Reduce the proportion of children and adolescents aged 2 to 19 years who are considered obese. Target: 14.5, based on BMI 95th percentile.
 †(95% confidence intervals)

Percent of Obesity Among Adults*

Illinois Overall and by Race/Ethnicity, 2014

Source: IDPH, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS)

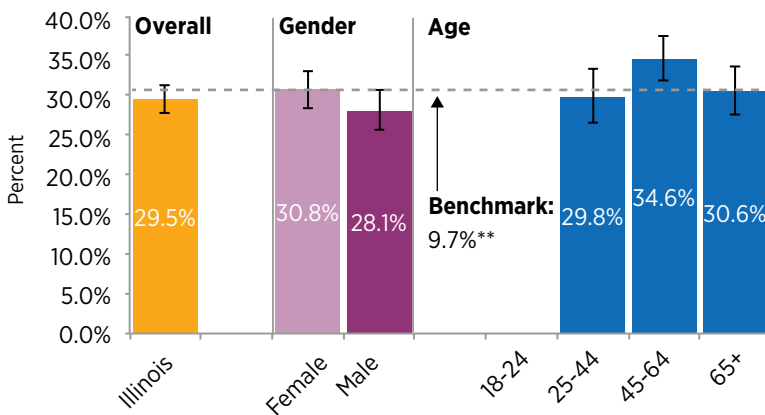
Benchmark**	30.5
Illinois Overall	29.5 (27.8-31.2)[†]
Non-Hispanic Black	42.5 (37.1-48.1)
Non-Hispanic White	27.6 (25.7-29.5)
Hispanic	34.7 (25.7-29.5)

*Body Mass Index (BMI) of 30 or more.
 **Healthy People 2020 NWS-9, Reduce the proportion of adults who are obese. The benchmark is based on age-adjusted rates so is not directly comparable to the data as shown.
 †(95% confidence intervals)

Percent of Obesity Among Adults*

Illinois Overall and by Gender and Age, 2014

Source: IDPH, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS)



*Body Mass Index (BMI) of 30 or more.

**Healthy People 2020 NWS-9, Reduce the proportion of adults who are obese. The benchmark is based on age-adjusted rates so is not directly comparable to the data as shown.

**HEALTH PRIORITY AREA:
MATERNAL AND CHILD HEALTH**

Maternal and Child Health, continued

Infant mortality (infant death) is used all over the world as a marker for the health of a society overall. Child mortality is also a worldwide measure of health.

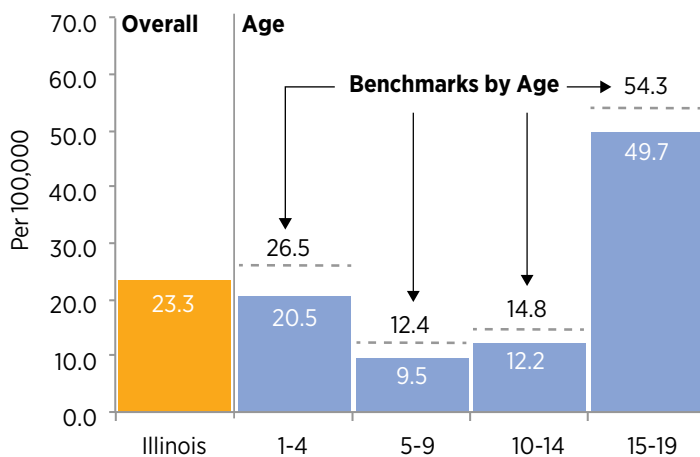
In 2014, the infant mortality rates for non-Hispanic white, Hispanic, and non-Hispanic other Illinois infants were better than the national objective, but the rate for non-Hispanic black infants was approximately 3 times higher, far worse than the national objective.

In 2014, the child mortality rates for Illinois children ages 1-4, 5-9, 10-14, and 15-19 were all better than the national age-specific objectives. Looking at race/ethnicity, however, the rate for non-Hispanic black children was more than twice as high as that for all other children.

Child Mortality Rate from All Causes per 100,000 Children Ages 1-19

Illinois Overall and by Age, 2014*

Source: IDPH, Center for Health Statistics and Division of Vital Records



*2014 data are provisional.

**Healthy People 2020 MCH-3.1, 3.2, Reduce the rate of deaths among children aged 1-4 years, 5-9 years. MICH-4.1, 4.2, Reduce the rate of adolescent and young adult deaths, 10-14, 15-19.

Infant Mortality* Rate per 1,000 Live Births

Illinois Overall and by Race/Ethnicity, 2013

Source: IDPH, Center for Health Statistics and Division of Vital Records

Benchmark**	6.0
Illinois Overall	6.0 (5.6-6.4)†
Non-Hispanic Black	13.0 (11.6-14.3)
Non-Hispanic White	4.3 (3.9-4.7)
Hispanic	5.3 (4.5-6.1)
Non-Hispanic Other	4.4 (3.1-5.7)

*Death in the first year of life.
 **Healthy People 2020 MICH-1.3, Reduce the rate of all infant deaths (within 1 year).
 †(95% confidence intervals)

Child Mortality* Rate from All Causes per 100,000 Children Ages 1-19

Illinois Overall and by Race/Ethnicity, 2014*

Source: IDPH, Center for Health Statistics and Division of Vital Records

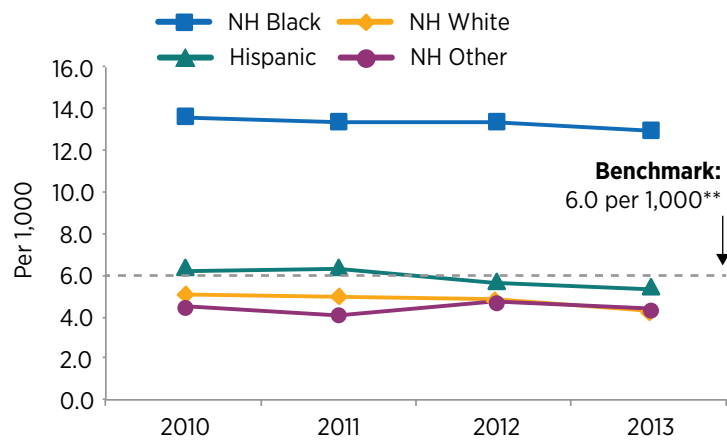
Benchmark**	-
Illinois Overall	23.3 (21.6-25.0)†
Non-Hispanic Black	47.5 (41.6-53.3)
Non-Hispanic White	19.6 (17.5-21.7)
Hispanic	16.8 (13.9-19.7)
Non-Hispanic Other	13.9 (8.4-19.5)

*2014 data are provisional.
 **Healthy People 2020 MCH-3.1, 3.2, Reduce the rate of deaths among children aged 1-4 years, 5-9 years. MICH-4.1, 4.2, Reduce the rate of adolescent and young adult deaths, 10-14, 15-19.
 †(95% confidence intervals)

Infant Mortality* Rate per 1,000 Live Births, 2010-2013

by Year and Race and Ethnicity

Source: IDPH, Center for Health Statistics and Division of Vital Records



*Death in the first year of life.

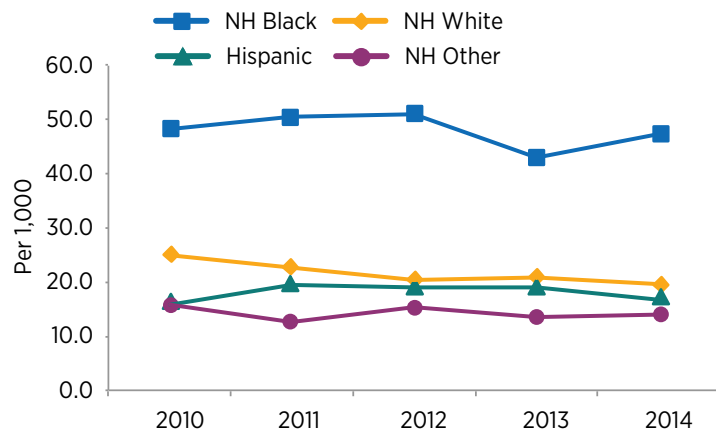
**Healthy People 2020 MICH-1.3, Reduce the rate of all infant deaths (within 1 year).

The three-fold disparity in infant death between non-Hispanic blacks and all other racial/ethnic groups is persistent over time. In addition, the trend data for all groups shows very little change from 2010 to 2013.

Child Mortality* Rate per 1,000 Live Births, 2010-2013

by Year and Race and Ethnicity

Source: IDPH, Center for Health Statistics and Division of Vital Records



*2014 data are provisional.

**Healthy People 2020 MCH-3.1, 3.2, Reduce the rate of deaths among children aged 1-4 years, 5-9 years. MICH-4.1, 4.2, Reduce the rate of adolescent and young adult deaths, 10-14, 15-19.

Although the child mortality rates in Illinois were better than the Healthy People 2020 objective, the pattern over time looks similar to that for infant mortality, with the same, persistent disparity in rates between non-Hispanic blacks and all other racial/ethnic groups, and with little change from 2010 to 2013.

Maternal Mortality Rate A Deaths to Women Directly Related to Pregnancy per 100,000 Live Births

Illinois Overall and by Race/Ethnicity, 2013*

Source: IDPH, Center for Health Statistics
and Division of Vital Records

Benchmark**	11.4
Illinois Overall	12.1 (6.7-17.5)[†]
Non-Hispanic Black	18.6 (2.3-34.8)
Non-Hispanic White	10.4 (3.6-17.2)
Hispanic	15.0 (1.8-28.1)

*2014 data are provisional.

**Healthy People 2020 MICH-5, Reduce the rate of maternal mortality—number of female deaths due to obstetric causes within 42 days of pregnancy.

[†](95% confidence intervals)

Maternal Mortality Rate B Deaths to Women within One Year of Pregnancy per 100,000 Live Births

Illinois Overall and by Race/Ethnicity, 2013*

Source: IDPH, Center for Health Statistics
and Division of Vital Records

Benchmark**	-
Illinois Overall	34.4 (25.2-43.6)[†]
Non-Hispanic Black	44.5 (19.3-69.7)
Non-Hispanic White	32.4 (20.4-44.3)
Hispanic	41.9 (19.9-63.8)

*2014 data are provisional.

**There is no benchmark; these deaths include deaths directly related to pregnancy both before and after 42 days, and other deaths indirectly related to pregnancy.

[†](95% confidence intervals)

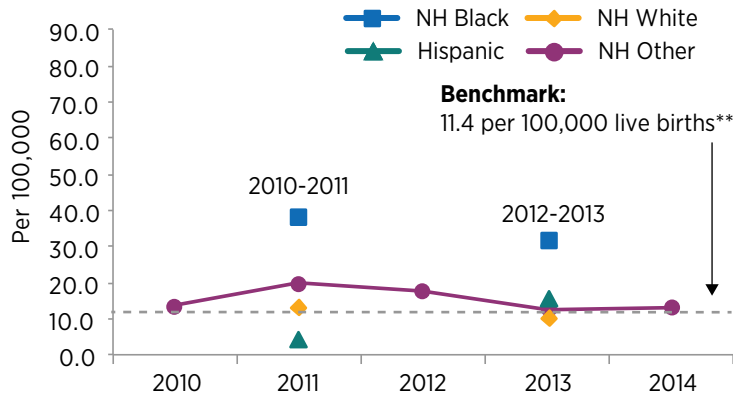
Maternal mortality is very rare, but like infant mortality, it is monitored worldwide as an indicator that reflects broadly on the health of a society. Historically, maternal deaths resulting directly from medical complications of pregnancy have been monitored, but it is becoming more typical to also document all deaths to women occurring within one year following pregnancy. In 2013, 19 Illinois women died from causes related to pregnancy itself, and a total of 54 Illinois women died within one year of being pregnant from all causes combined.

There was a large disparity between non-Hispanic blacks and non-Hispanic whites, and also between Hispanics and non-Hispanic whites with respect to maternal death due to medical causes related to pregnancy itself, and only the rate for non-Hispanic whites met the Healthy People 2020 benchmark. The disparities also exist, though to a lesser extent, when considering any cause of death within one year of pregnancy.

Maternal Mortality Rate A Deaths to Women Directly Related to Pregnancy per 100,000 Live Births, 2010-2014*

Overall by Year and 2-Year Combined for Race/Ethnicity

Source: IDPH, Center for Health Statistics and Division of Vital Records



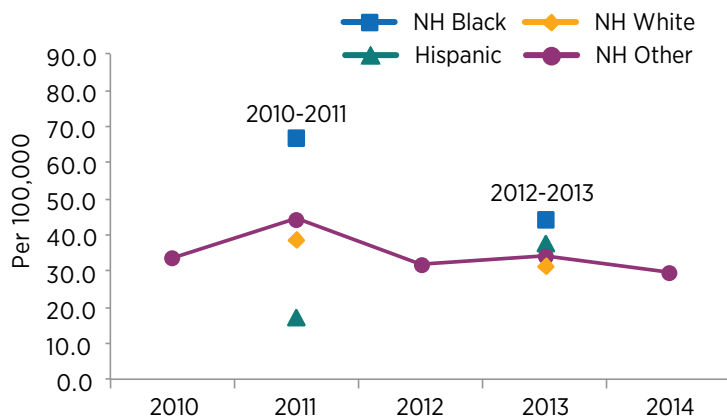
* 2014 data are provisional.

Healthy People 2020 MICH-5, Reduce the rate of maternal mortality—number of female deaths due to **obstetric causes within 42 days of pregnancy.

Maternal Mortality Rate B Deaths to Women within One Year of Pregnancy per 100,000 Live Births, 2010-2014*

Overall by Year and 2-Year Combined for Race/Ethnicity

Source: IDPH, Center for Health Statistics and Division of Vital Records



* 2014 data are provisional.

There is no benchmark; these deaths include deaths directly related to pregnancy both before and after 42 days, and other deaths indirectly related to pregnancy.

Because maternal mortality is so rare, annual data are displayed only for Illinois overall. In order to gain more reliability in the estimates by race/ethnicity, data have been combined for two 2-year periods—2010-2011 and 2012-2013.

The trend for Illinois overall for maternal deaths from medical causes related to pregnancy shows that the Healthy People 2020 benchmark was not met during this time period. After combining two years of data, the persistent disparity between non-Hispanic blacks and non-Hispanic whites was evident.

Considering deaths from all causes to women within one year of pregnancy, the racial/ethnic disparities were also present.

Note that for the broader definition of maternal mortality, causes include issues such as homicide, suicide, and motor vehicle accidents. It is important to understand whether women are more or less vulnerable to experiencing these non-clinical causes in the year following pregnancy than they would be otherwise.

While there appears to have been an increase in maternal deaths (on both measures) in 2011, with rates decreasing since then, this may be random fluctuation due to very small numbers.

Pregnant women with severe maternal morbidity are women who have potentially life-threatening conditions related to their pregnancy.

Non-Hispanic black women had an elevated rate of severe maternal morbidity compared to other racial/ethnic groups, but only non-Hispanic white women in Illinois were meeting the benchmark. There was no

Rate of Severe Maternal Morbidity* per 10,000 Delivery Hospitalizations

Illinois Overall and by Race/Ethnicity, 2014

Source: IDPH, Division of Patient Safety and Quality

Benchmark**	129.0
Illinois Overall	167.8 (161.3-174.3)†
Non-Hispanic Black	287.7 (266.7-308.8)
Non-Hispanic White	128.8 (120.7-136.9)
Hispanic	165.3 (150.7-179.9)
Asian	162.7 (133.5-192.0)
Non-Hispanic Other	176.8 (153.9-199.7)

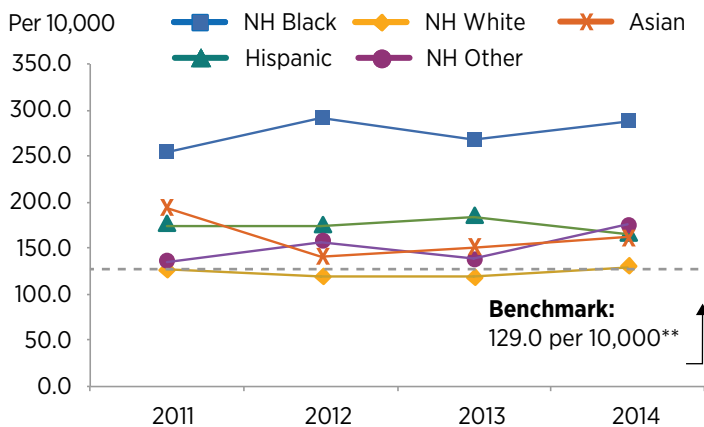
*Severe maternal morbidity is defined using an algorithm identifying pregnant women with any of 25 markers of potentially life-threatening obstetric diagnoses and procedures. Callaghan WM, et al. Identification of severe maternal morbidity during delivery hospitalizations, United States, 1991-2003. Am J Obstet Gynecol 2008; 199:133. e1-8.

**National estimate from analysis of the 2008-2009 Nationwide Inpatient Sample. Callaghan WM, et al. Severe maternal morbidity among delivery and postpartum hospitalizations in the United States. Am J Obstet Gynecol 2012;120:1029-36. †(95% confidence intervals)

Rate of Severe Maternal Morbidity* per 10,000 Delivery Hospitalizations

by Year and Race/Ethnicity, 2011-2014

Source: IDPH, Division of Patient Safety and Quality



*Severe maternal morbidity is defined using an algorithm identifying pregnant women with any of 25 markers of potentially life-threatening obstetric diagnoses and procedures. See Callaghan WM, et al. Identification of severe maternal morbidity during delivery hospitalizations, United States, 1991-2003. Am J Obstet Gynecol 2008;199:133. e1-8.

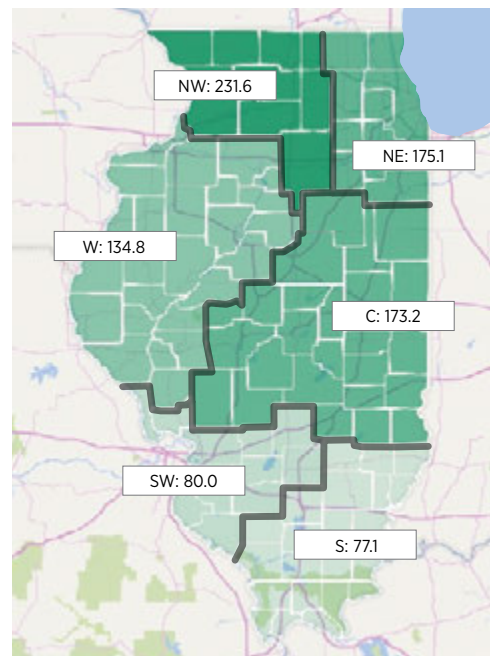
**National estimate from analysis of the 2008-2009 Nationwide Inpatient Sample. Callaghan WM, et al. Severe Maternal Morbidity Among Delivery and Postpartum Hospitalizations in the United States. Am J Obstet Gynecol 2012;120:1029-36.

improvement in the rate of severe maternal mortality from 2010 to 2014, either in the rates themselves or in the racial/ethnic disparities.

There was variation in rates of severe maternal morbidity across Illinois. This variation may be related to access to care, quality of care, and/or social determinants of health.

Rate of Severe Maternal Morbidity* per 10,000 Delivery Hospitalizations, by Region, 2014

Benchmark: 129.0**
Illinois Overall: 167.8



Less Morbidity (light green) to More Morbidity (dark green)

Source: IDPH, Division of Patient Safety and Quality

*Severe maternal morbidity is defined using an algorithm identifying pregnant women with any of 25 markers of potentially life-threatening obstetric diagnoses and procedures. Callaghan WM, et al. Identification of severe maternal morbidity during delivery hospitalizations, United States, 1991-2003. Am J Obstet Gynecol 2008; 199:133. e1-8.

**National estimate from analysis of the 2008-2009 Nationwide Inpatient Sample. Callaghan WM, et al. Severe maternal morbidity among delivery and postpartum hospitalizations in the United States, Am J Obstet Gynecol 2012;120:1029-36.

Percent of Live Births Born at Low Birthweight*

Illinois Overall and by Race/Ethnicity, 2013

Source: IDPH, Center for Health Statistics and Division of Vital Records

Benchmark**	7.8
Illinois Overall	8.3 (8.1-8.4)[†]
Non-Hispanic Black	13.9 (13.5-14.3)
Non-Hispanic White	6.8 (6.6-7.0)
Hispanic	7.2 (6.9-7.4)
Non-Hispanic Other	9.2 (8.6-9.8)

*Low birthweight is weight less than 2500 grams.
 **Healthy People 2020 MICH-8.1, Reduce low birthweight.
 †(95% confidence intervals)

In Illinois in 2013, approximately 1 in 12 infants was born at low birthweight, which puts these infants at risk of death as well as other health problems if they survive.

As with many maternal and child health indicators, both younger and older women were at highest risk of delivering a low birthweight infant.

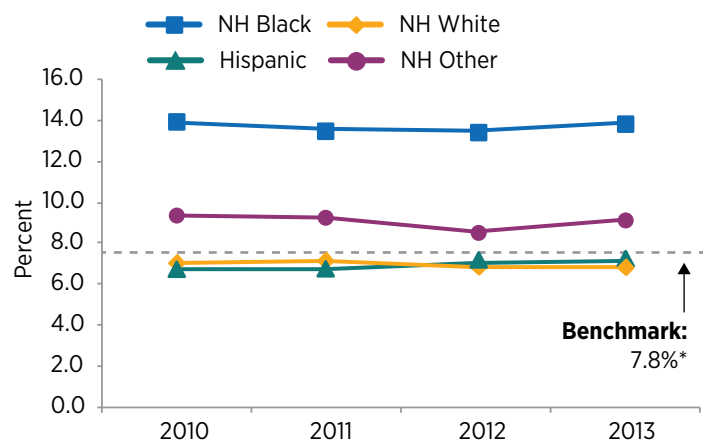
While non-Hispanic white and Hispanic women had met the Healthy People 2020 objective in 2013, non-Hispanic black and non-Hispanic other women had not. Almost 1 in 7 non-Hispanic black pregnant women delivered a low birthweight infant in 2013.

From 2010 to 2013, there was little change in the rates of low birthweight, and the racial/ethnic disparity also remained the same.

Percent of Live Births Born at Low Birthweight*

by Year and Race/Ethnicity, 2010-2013

Source: IDPH, Center for Health Statistics and Division of Vital Records

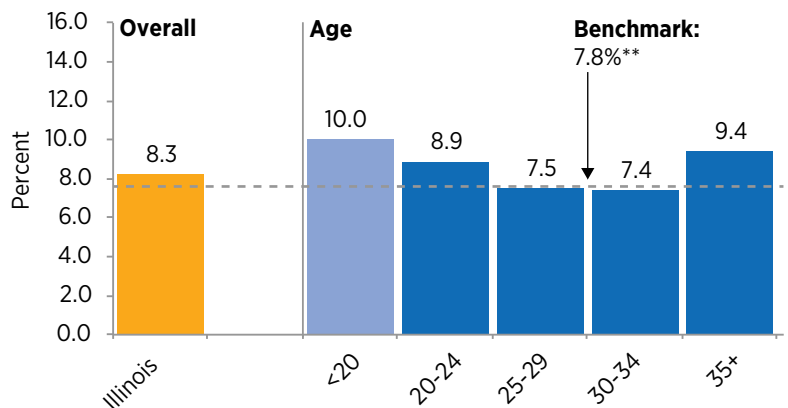


*Low birthweight is weight less than 2500 grams.
 **Healthy People 2020 MICH-8.1, Reduce low birthweight.

Percent of Live Births Born at Low Birthweight

Illinois Overall and by Age, 2013*

Source: IDPH, Center for Health Statistics and Division of Vital Records



*Low birthweight is weight less than 2500 grams.
 **Healthy People 2020 MICH-8.1, Reduce low birthweight.

ADDITIONAL DATA

Additional Data, continued

The rates of methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile* (C. diff) infections were lower than the national baseline; the standardized infection ratios (SIRs) were less than 1.

The SIR compares the number of infections in a facility or state to the number of infections that were “predicted” or would be expected based on previous years of reported data (national baseline 2010-2011). The national and state SIRs are summary statistics calculated by the Centers for Disease Control and Prevention (CDC) as the total number of observed infections, divided by the total number of predicted infections.

Illinois MRSA Trend Data*, 2012-2014

Source: CDC's National Healthcare Safety Network (NHSN)

Year Reported	MRSA Infections (Observed)	MRSA Infections (Predicted)	Patient Days	Standardized Infection Ratio (SIR)* (95% Conf. Interval)
2012	358	420	7012696	0.853 (0.816-0.889)
2013	292	409	6754633	0.715 (0.663-0.766)
2014	296	419	6885640	0.706 (0.655-0.758)

*Surveillance is “hospital-specific” surveillance data and therefore, the statewide standardized infection ratio (SIR) is the more meaningful measure vs. rate.

Illinois C. Diff Trend Data*, 2012-2013

Source: CDC's National Healthcare Safety Network (NHSN)

Reporting Year	C. Diff Infections (Observed)	C. Diff Infections (Predicted)	SIR (95% Conf. Interval)
2012	4620	4994.79	0.925 (0.899-0.952)
2013	4466	4939.25	0.904 (0.878-0.931)

*Surveillance is “hospital-specific” surveillance data and therefore, the statewide standardized infection ratio (SIR) is the more meaningful measure vs. rate.

In 2014, 1,691 Illinoisans were diagnosed with HIV, and almost half of these—814 cases—were non-Hispanic blacks. Non-Hispanic whites and non-Hispanic others were well below the Healthy People 2020 benchmark, and Hispanics were close to it, but the rate for non-Hispanic blacks was far higher than the benchmark.

A similar pattern of racial/ethnic disparities is seen for gonorrhea incidence in Illinois. There were 14,121 gonorrhea cases reported in Illinois in 2014; more than half of these—8,089 cases—were reported for non-Hispanic blacks. There are separate Healthy People 2020 benchmarks for men and women ages 15-44: the benchmarks are 194.8 per 100,000 for men and 251.9 per 100,000 for women. Neither men nor women ages 15-44 in Illinois were meeting these benchmarks.

There were 58,969 cases of chlamydia reported for Illinoisans ages 15-44 in 2014. Racial/ethnic disparity was again present, with non-Hispanic blacks having the highest rate, well above the rates for other groups.

HIV Incidence per 100,000

Illinois Overall and by Race/Ethnicity, 2014

Source: IDPH, Infectious Disease Division

Benchmark*	11.4
Illinois Overall	13.1 (12.5-13.8)**
Non-Hispanic Black	43.2 (40.2-46.1)
Non-Hispanic White	5.3 (4.8-5.9)
Hispanic	15.0 (13.4-16.7)
Non-Hispanic Other	9.5 (7.3-11.7)

*Healthy People 2020: HIV-2, Reduce the number of new HIV infections among adolescents and adults. The Healthy People 2020 benchmark is the number of new cases; the rate shown here was calculated using the target number and the U.S. total population.
 **(95% confidence intervals)

Gonorrhea Incidence per 100,000 Ages 15-44

Illinois Overall and by Race/Ethnicity, 2014

Source: IDPH, Infectious Disease Division

Benchmark*	-
Illinois Overall	270.0 (265.5-274.4)**
Non-Hispanic Black	996.2 (974.6-1,017.8)
Non-Hispanic White	67.5 (64.6-70.4)
Hispanic	77.7 (72.3-83.0)
Non-Hispanic Other	73.0 (64.0-82.0)

*Healthy People 2020: STD-6.1, Reduce gonorrhea rates among females aged 15 to 44 years; STD-6.2, Reduce gonorrhea rates among males aged 15 to 44 years.
 **(95% confidence intervals)

Chlamydia Incidence per 100,000 Ages 15-44

Illinois Overall and by Race/Ethnicity, 2014

Source: IDPH, Infectious Disease Division

Benchmark*	-
Illinois Overall	1,127.4 (1,118.4-1,136.5)**
Non-Hispanic Black	2,954.4 (2,917.5-2,991.2)
Non-Hispanic White	440.1 (432.6-447.5)
Hispanic	672.2 (656.6-687.9)
Non-Hispanic Other	450.5 (428.2-472.9)

*Healthy People 2020 objectives for chlamydia are in terms of participation in particular services, e.g., family planning.
 **(95% confidence intervals)

Additional Data, continued

In 2014, Illinois children ages 19-35 months were meeting the Healthy People 2020 benchmarks for MMR, polio, and DTaP vaccination. Of note, however, the rates of vaccine coverage, particularly for polio and DTaP, have been dropping in the last five years.

Illinois adolescents had met the benchmarks for Tdap and MenACWY vaccination, but were below the benchmark for HPV vaccination.

Estimated Vaccination Coverage Among Children (19-35 Months)

Illinois Overall, 2010-2014

Source: National Immunization Survey

Year		1+ MMR [*]	3+ Polio ^{**}	3+ DTaP [†]
	Benchmark ^{††}	90.0	90.0	90.0
2014	IL - Chicago	90.5 ±4.7	90.4 ±5.0	90.8 ±5.0
	IL - Rest of State	94.1 ±3.5	94.5 ±3.8	94.6 ±3.8
2013	IL - Chicago	90.0 ±5.2	91.0 ±5.3	92.1 ±5.0
	IL - Rest of State	91.9 ±3.8	91.3 ±4.3	93.4 ±3.9
2012	IL - Chicago	86.8 ±6.1	89.3 ±5.4	90.5 ±5.3
	IL - Rest of State	93.2 ±2.9	94.5 ±2.7	96.0 ±2.3
2011	IL - Chicago	90.6 ±4.5	94.1 ±3.3	96.7 ±2.6
	IL - Rest of State	90.8 ±4.2	94.1 ±3.5	94.9 ±3.4
2010	IL - Chicago	88.8 ±3.8	94.4 ±2.8	95.1 ±2.7
	IL - Rest of State	91.1 ±4.2	96.4 ±2.3	97.8 ±1.7

^{*} ≥1 dose of measles, mumps, and rubella (MMR) vaccine

^{**} ≥3 doses of any poliovirus (polio) vaccine

[†] ≥3 doses of diphtheria, tetanus toxoids, and acellular pertussis vaccine (includes children who might have been vaccinated with diphtheria and tetanus toxoids vaccine, or diphtheria, tetanus toxoids, and pertussis vaccine)

^{††} Benchmarks:

HP2020 Objective IID-7.4; target 90.0%. Maintain an effective coverage level of 1 dose of measles-mumps-rubella (MMR) vaccine among children by age 19 to 35 months

HP2020 Objective IID-7.5; target 90.0%. Maintain an effective coverage level of 3 doses of polio vaccine among children by age 19 to 35 months

HP2020 Objective IID-7.1; target 90%. Maintain an effective vaccination coverage level of 4 doses of the diphtheria-tetanus-acellular pertussis (DTaP) vaccine among children by age 19 to 35 months. *The data above for DTaP are for 3+ doses, not 4+ doses as in the benchmark.*

Estimated Vaccination Coverage with Selected Vaccines and Doses among Female and Male Adolescents Aged 13- 17 Years, 2011-2014

Source: National Immunization Survey

Year	Location	≥1 Tdap1 % (95% CI)	≥1 MenACWY2% (95% CI)
	Benchmark ³	80.0	80.0
2014	IL - Chicago	84.6 (±5.8)	83.4 (±5.9)
	IL - Rest of State	93.6 (±2.6)	75.6 (±5.0)
2013	IL - Chicago	89.7 (±5.2)	83.3 (±6.3)
	IL - Rest of State	85.4 (±5.0)	78.0 (±5.4)
2012	IL - Chicago	78.5 (±6.1)	77.0 (±6.2)
	IL - Rest of State	77.0 (±6.5)	65.4 (±7.2)
2011	IL - Chicago	69.8 (±5.6)	72.2 (±5.7)
	IL - Rest of State	72.3 (±5.6)	65.2 (±6.1)
2010	IL - Chicago	76.6 (±5.1)	63.8 (±6.0)
	IL - Rest of State	78.9 (±5.3)	54.7 (±3.8)

¹ ≥ 1 dose of tetanus-diphtheria-acellular pertussis (Tdap) vaccine since age 10 years.

² 1 dose of meningococcal conjugate (MenACWY) vaccine or meningococcal-unknown type vaccine

Benchmarks:

HP2020 Objective IID-11.1; target 80.0%. Increase the vaccination coverage level of 1 dose of (Tdap) booster vaccine for adolescents by age 13 to 15

HP2020 Objective IID-11.3.; target 80.0%. Increase the vaccination coverage level of 1 dose of MenACWY for adolescents by age 13 to 15

Estimated Vaccination Coverage with Selected Vaccines and Doses among Female and Male Adolescents Aged 13-17 Years, 2011-2014

Source: National Immunization Survey

Year	Location	Females			Males		
		>1 HPV % (95% CI)	>2 HPV % (95% CI)	>3 HPV % (95% CI)	>1 HPV % (95% CI)	>2 HPV % (95% CI)	>3 HPV % (95% CI)
	Benchmark ¹	80.0			80.0		
2014	IL - Chicago	78.1 (± 8.1)	68.8 (± 9.5)	52.6 (±10.7)	64.9 (±10.0)	44.3 (±10.8)	26.1 (±9.3)
	IL - Rest of State	61.2 (± 7.7)	55.5 (± 8.0)	46.5 (± 8.2)	40.0 (± 7.6)	31.9 (± 7.3)	21.8 (±6.6)
2013	IL - Chicago	61.8 (±12.7)	49.2 (±12.8)	38.6 (±12.1)	45.3 (±20.2)	29.1 (±10.4)	19.8 (±8.5)
	IL - Rest of State	51.2 (± 9.0)	41.1 (± 8.9)	32.6 (± 8.5)	NA	19.4 (± 7.8)	15.8 (± 7.6)
2012	IL - Chicago	61.4 (±10.4)	44.5 (±11.0)	37.8 (±10.8)	40.2 (±10.5)	27.8 (±10.1)	17.0 (± 9.3)
	IL - Rest of State	36.2 (±10.1)	24.5 (± 9.1)	16.9 (± 7.3)	20.5 (± 9.4)	NA	NA
2011	IL - Chicago	47.0 (± 9.5)	NA	24.7 (±8.2)	NA	NA	NA
	IL - Rest of State	52.7 (± 9.0)	NA	36.2 (±9.5)	NA	NA	NA

¹ Benchmarks:

HP2020 Objective IID-11.4; target 80.0%. Increase the vaccination coverage level of 3 doses of human papillomavirus (HPV) vaccine for females by age 13 to 15 years

HP2020 Objective IID-11.5; target 80.0%. Increase the vaccination coverage level of 3 doses of human papillomavirus (HPV) vaccine for males by age 13 to 15 years

Benchmarks NOTE: The data above are for children aged 13-17 years, not 13-15 as in the included benchmark.

APPENDIX: CORE INDICATOR SUMMARY

Appendix: Core Indicator Summary, continued

Forty-eight indicators were identified for the State Health Assessment and State Health Improvement Plan. The indicator set is not necessarily the “best” possible set nor is it comprehensive; it is not static and should be reconsidered annually.

Whenever possible and as appropriate, each indicator was examined by gender, race/ethnicity, age, geographic region, and over time. When race/ethnicity data were available, comparisons between non-Hispanic blacks and non-Hispanic whites, and between Hispanics and non-Hispanic whites, were made by computing disparity ratios.

SET OF 48 CORE INDICATORS USED IN THE 2015 STATE HEALTH ASSESSMENT AND STATE HEALTH IMPROVEMENT PLAN

1. Poverty	24. 4 or more adverse childhood experiences
2. Concentrated disadvantage	25. Poor mental health
3. County well-being	26. Suicide (age-adjusted)
4. Gini index of income inequality	27. Ischemic heart disease mortality (age-adjusted)
5. Daily fine particulate matter	28. Cancer mortality (age-adjusted)
6. Less than high school education	29. Diabetes prevalence, adult
7. Age of Housing	30. Obesity ages 10-17
8. Lead testing	31. Obesity prevalence, adult
9. Unsafe neighborhoods	32. Infant mortality, all causes
10. Homicide (age-adjusted)	33. Child mortality, all causes
11. Motor vehicle accident mortality (age-adjusted)	34. Maternal mortality from causes related to pregnancy
12. Emergency department discharges for pediatric asthma	35. Maternal mortality, any cause within 1 year of pregnancy
13. Emergency department discharges for type 2 diabetes, adults	36. Severe maternal morbidity
14. Emergency department discharges for hypertension, adults	37. Low birthweight
15. Children not having a medical home	38. Hospital-acquired infections: MRSA
16. Primary care physicians	39. Hospital-acquired infections: <i>Clostridium difficile</i>
17. Prenatal care in first trimester	40. HIV incidence
18. Women not receiving adequate prenatal care	41. Gonorrhea incidence
19. No physical activity in past 30 days, adult	42. Chlamydia incidence
20. Children not engaging in vigorous physical activity	43. MMR immunization, 19-35 months
21. Smoking, adults	44. Polio immunization, 19-35 months
22. Smoking during last 3 months of pregnancy	45. DTaP immunization, 19-35 months
23. Unsafe sleep practices	46. Tdap immunization, 13-17 years
	47. Meningitis immunization, 13-17 years
	48. HPV immunization, 13-17 years

The following table shows that of the 48 core indicators, 24 had both race/ethnicity information and relevant benchmarks, while the remaining 24 did not. For the 24 with both pieces of information, the table lists indicators according to whether the benchmark had been met by all, some, or none of the three major race/ethnic groups.

**48 CORE INDICATORS IN RELATION TO BENCHMARKS
(FOR NON-HISPANIC BLACKS, NON-HISPANIC WHITES, AND HISPANICS)**

All Racial/Ethnic Groups Meet the Benchmark	Some Racial/Ethnic Groups Meet a Benchmark While Others Do Not	No Racial/Ethnic Group Meets the Benchmark	No Overall Benchmark, No Race/Ethnicity Information, or No Benchmark At All
24 Indicators* with both Race/Ethnicity Information and a Benchmark Ordered according to the Magnitude of the Disparity Ratios			24 Indicators
<ol style="list-style-type: none"> 1. Motor vehicle accident mortality (age-adjusted) 	<ol style="list-style-type: none"> 1. Homicide (age-adjusted) 2. HIV 3. Children living in unsafe neighborhoods 4. Infant mortality 5. Poverty 6. Pregnant women not receiving adequate prenatal care 7. Unsafe sleep practices 8. Pregnant women not entering prenatal care in 1st trimester 9. Severe maternal morbidity 10. Children not having a medical home 11. Low birthweight 12. Less than high school education 13. Children 6-17 having no vigorous physical activity 14. Maternal mortality from causes clinically related to pregnancy 15. Adult diabetes 16. Adult obesity 17. Adults with no exercise in past 30 days 18. Cancer mortality (age-adjusted) 19. Ischemic heart disease mortality (age-adjusted) 20. Suicide (age-adjusted) 	<ol style="list-style-type: none"> 1. Children 10-17 who are obese 2. Current smoker 3. Smoking during pregnancy 	<p>Benchmarks, but only age or gender-specific</p> <ol style="list-style-type: none"> 1. Gonorrhea* 2. Child mortality* 3. Emergency department pediatric asthma discharges* <p>Overall benchmarks, but no race/ethnicity data</p> <ol style="list-style-type: none"> 1. MRSA 2. Cdiff 3. MMR 19-35 months 4. Polio 19-35 months 5. DTaP 19-35 months 6. Tdap 13-17 years 7. HPV 13-17 years 8. Meningitis 13-17 years 9. Lead testing 10. Primary Care Physicians <p>No benchmarks</p> <ol style="list-style-type: none"> 1. Chlamydia* 2. Emergency department discharges for type 2 diabetes* 3. Emergency department discharges for hypertension* 4. Adults with 4 or more adverse childhood experiences (ACEs)* 5. Maternal mortality: any cause within one year of pregnancy* 6. Adults with more than 7 poor mental health days in a month* 7. Fine particulate matter 8. Age of housing 9. Gini index of income inequality 10. Concentrated disadvantage 11. County well-being

* A total of 33 of the 48 core indicators had race/ethnicity information; 24 also had relevant benchmarks, 9 did not.

Appendix: Core Indicator Summary, continued

This next table lists 21 indicators for which non-Hispanic blacks had not met a benchmark, 17 for which Hispanics had not met a benchmark, and 5 for which non-Hispanic whites had not met a benchmark.

INDICATORS FOR WHICH A BENCHMARK IS **NOT** BEING MET BY RACE/ETHNICITY FOR THE 24 INDICATORS WITH BOTH RACE/ETHNICITY INFORMATION AND A RELEVANT BENCHMARK

Non-Hispanic Blacks (21 Indicators)	Hispanics (17 Indicators)	Non-Hispanic Whites (5 Indicators)
<ul style="list-style-type: none"> • Homicide • Ischemic heart disease mortality • Infant mortality • Low birthweight 		
	<ul style="list-style-type: none"> • Children 6-17 having no vigorous physical activity 	
		<ul style="list-style-type: none"> • Suicide
<ul style="list-style-type: none"> • Children 10-17 who are obese • Current smoker • Smoking during pregnancy 	<ul style="list-style-type: none"> • Children 10-17 who are obese • Current smoker • Smoking during pregnancy 	<ul style="list-style-type: none"> • Children 10-17 who are obese • Current smoker • Smoking during pregnancy
<ul style="list-style-type: none"> • HIV • Children living in unsafe neighborhoods • Poverty • Pregnant women not receiving adequate prenatal care • Unsafe sleep practices • Pregnant women not entering prenatal care in 1st trimester • Severe maternal morbidity • Children not having a medical home • Less than high school education • Maternal mortality from causes clinically related to pregnancy • Adult diabetes • Adult obesity • Adults with no exercise in past 30 days 	<ul style="list-style-type: none"> • HIV • Children living in unsafe neighborhoods • Poverty • Pregnant women not receiving adequate prenatal care • Unsafe sleep practices • Pregnant women not entering prenatal care in 1st trimester • Severe maternal morbidity • Children not having a medical home • Less than high school education • Maternal mortality from causes clinically related to pregnancy • Adult diabetes • Adult obesity • Adults with no exercise in past 30 days 	
<ul style="list-style-type: none"> • Cancer mortality 		<ul style="list-style-type: none"> • Cancer mortality



For more information, please visit:
www.healthycommunities.illinois.gov

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