Healthy Chicago 2025 Strategic Plan

Chicago Department of Public Health
Dr. Olusimbo Ige, Commissioner

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Executive Summary

The **Chicago Department of Public Health** (CDPH) prioritizes health equity, collaboration, and data-driven approaches to serve the health needs of all Chicagoans. Through the **Healthy Chicago survey**, CDPH's **community health assessment**, the department has intently evaluated disparities in morbidity and mortality that have contributed to the widening racial life expectancy gap. Chicago life expectancy overall is similar to the national average, around 77 years. Within the city, however, there is an 11.4-year life expectancy gap between Black and non-Black Chicagoans. This gap is driven by the unequitable experience of key health conditions, referred to as 'drivers'. The 2025 Strategic Plan systematically addresses each of these drivers by tailoring CDPH programming to meet the unique needs of five priority communities that have experienced the lowest life expectancies or the most significant declines in life expectancy in recent years. These priority communities are East Garfield Park, West Garfield Park, North Lawndale, Englewood, and West Englewood.

In 2025, CDPH will pilot a cumulative impact model to tackle complex public health dilemmas by layering cross-cutting programs and collaborations in each community area. Therefore, the CDPH departmental Strategic Plan is comprised of seven individual actions plans designed to address each of the key drivers of the life expectancy gap. These areas of focus include chronic disease, homicide, substance use, infectious disease, infant and maternal mortality, mental health, and partnership. Continuous monitoring and evaluation will be carried out through ongoing assessments of programmatic outputs and yearly reviews of community morbidity and mortality. This process will support CDPH's efforts to remain responsive to evolving community health needs and ensure consistent progress toward the goal of eliminating the racial life expectancy gap.

Note: *Unless noted otherwise, all data presented throughout the report are owned and managed by the City of Chicago. Birth and death certificate data which are used for life expectancy analyses are owned by Illinois Department of Public Health and shared with Chicago Department of Public Health for both internal and public use. Publicly available data may be accessed through the* **Chicago Health Atlas** *or by request through* **https://bit.ly/4fS4LpL**

Mission, Vision, and Values

The Chicago Department of Public Health (CDPH) endeavors to work with communities and partners to create an equitable, safe, resilient and healthy Chicago. We envision a city where everyone thrives and achieves their optimal health and wellbeing. In pursuit of this vision, CDPH upholds four core values to be omnipresent in our work: anti-racism, informed decision making, teamwork, and excellence.

CDPH is committed to dismantling systemic racism to foster an organizational culture that actively supports anti-racist efforts by recognizing, addressing, and eradicating all forms of racism within the department and in the community. Further, the collection, sharing, and application of data to inform public health decisions and actions are essential to achieving our mission. CDPH leverages appropriate data infrastructure and technology to drive decisions and assess performance. The department cultivates a culture of belonging and respect among colleagues and community partners. We act responsibly, communicate effectively, and work cooperatively to promote growth and achieve our shared goals. Lastly, CDPH values creativity, innovation, and exploration. Through integrity, honesty, compassion, and transparency, the department continuously seek opportunities to improve processes and systems to better serve the public health needs of all Chicagoans.

The Healthy Chicago 2025 Strategic Plan embodies CDPH's mission, vision, and values in working toward the goal of creating a healthier Chicago for all.

Introduction

Overview of Healthy Chicago

All Departments of Health are required by the State and Public Health Accreditation Board to conduct Community Health Assessments (CHA) and develop a Community Health Improvement Plan (CHIP) responsive to the needs identified.

Healthy Chicago, CDPH's CHA/CHIP, goes beyond these requirements to create a movement guided by a broad coalition of partners working to address health disparities and improve community health for all Chicagoans. Since 2010, CDHP's focus has been on promoting health equity and reducing the racial life expectancy gap, with a particular emphasis on those most impacted by health inequities. Community partners play a vital role in recognizing the strengths and challenges of Chicago's neighborhoods, actively shaping and implementing the city's health improvement plan. CDPH, in collaboration with community partners, continuously tracks and evaluates progress in advancing health equity. The annual **Healthy Chicago Survey** populates a public dashboard that focuses on health equity to raise community awareness and guide internal planning efforts.

The original Healthy Chicago public health agenda was released in 2011 outlining and identifying specific strategies the health department would pursue to improve health outcomes in 12 priority

areas. **Healthy Chicago 2.0**, released in 2016, was the department's first citywide community health improvement plan. CDPH partnered with over 130 local organizations and strengthened its commitment to cultivating relationships across sectors to improve health equity in Chicago. **Healthy Chicago 2.0** identified approaches to close gaps in health disparities by addressing the root causes of health, centering its work on housing, education, public safety, and economic development in our communities.

The third iteration, **Healthy Chicago 2025**, was launched in 2020 and also engaged hundreds of community members and organizations to develop approaches aimed at addressing health disparities across Chicago. This community health improvement plan specifically focuses on increasing life expectancy among Black Chicagoans by centering health equity and directing efforts where they are needed most.

The CHA and CHIP occur in five-year cycles, with data collected on a yearly basis for ongoing analysis. In the aftermath of the COVID-19 pandemic, CDPH recognized the need for a mid-cycle assessment to reexamine Chicagoans' health and life expectancy. The findings revealed a growing disparity in life expectancy between Black and non-Black Chicagoans, prompting CDPH to reevaluate program impacts and adjust approaches to strengthen public health in Chicago. The strategic plan outlined in this report details how CDPH aims to respond to the findings of the 2022 life-expectancy assessment to prioritize equity in health outcomes.

Life Expectancy Trends

Note: *The data presented throughout the report is accurate to the best of CDPH's knowledge. Life expectancy analysis relies on death certificate data. Race and ethnicity reporting on death certificates is known to be more accurate for the Black and White populations than for other groups. The racial and ethnic groups discussed in this Action Plan aim to be mutually exclusive, however, as 3-5% of people with Latinx ethnicity may be misclassified on death certificates, these categories are not guaranteed to be mutually exclusive.*

Data Explained

Life expectancy is a measure of the average number of years a person born today might live if all conditions in society stayed the same throughout their lifetime. Life expectancy is a summary statistic of the risk of death that a specific group of people are facing right now rather than the unique life expectancy of any given individual. Because it is calculated in a standard way, life expectancy can be compared between different times, places, and people. This allows public health professionals to identify inequities and track trends over time to learn whether programs and initiatives are actually improving the health of Chicagoans. For a more in-depth explanation of the methodology and source of data used to calculate life expectancy, refer to the 'Data Methodology' section found in the appendix.

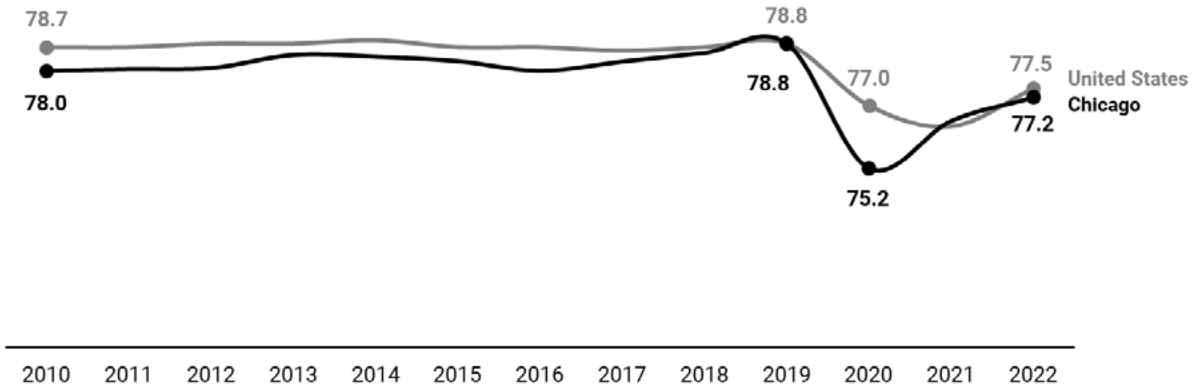
As part of Healthy Chicago 2025, CDPH has committed to monitor not only the life expectancy of all Chicagoans, but also disparities in life expectancy between racial and ethnic groups, referred to as a 'racial life expectancy gap'. When a gap in life expectancy is identified, additional analysis is performed using information about the cause of death to understand how certain health conditions, such as heart disease or opioid overdose, contribute to premature mortality. Throughout this report several causes of death and their contribution to the life expectancy gap between Black and non-Black Chicagoans will be presented. The contribution of each cause of death represents the extent to which the life expectancy could shrink if the risk of death from that cause were the same for both

groups. For instance, heart disease was found to contribute 1.9 years to the gap in life expectancy between Black and non-Black Chicagoans. This means that if the disparities in the risk of death from heart disease were eliminated the life expectancy gap would improve by 1.9 years. Identification of the causes of death that contribute the most to the difference in life expectancy allows CDPH to prioritize actions to improve health outcomes that will have the greatest impact on eliminating the life expectancy gap.

Life Expectancy by the Numbers

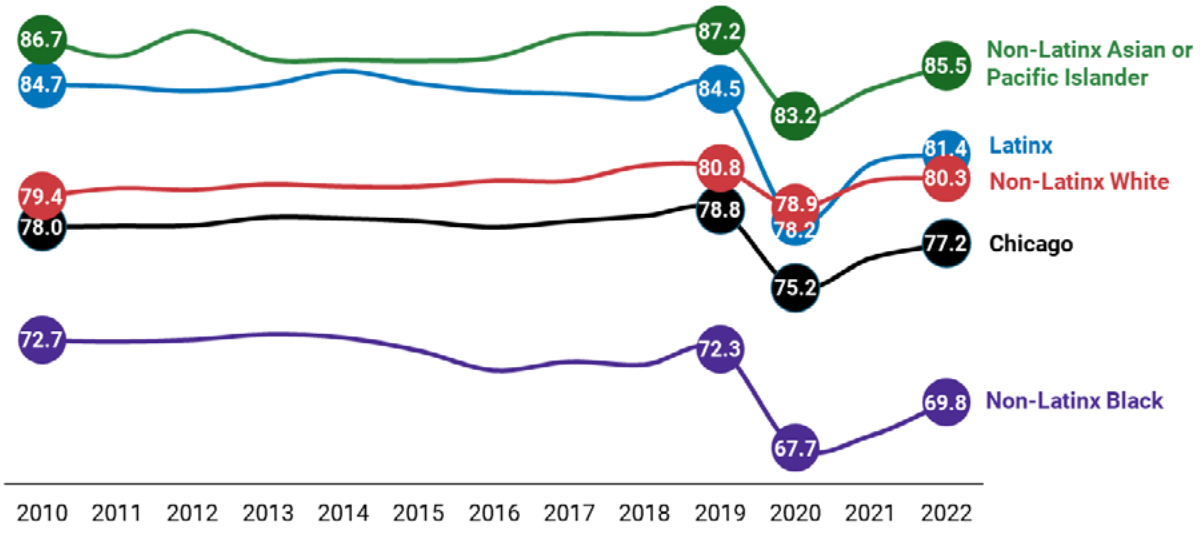
A population's wellbeing or lack thereof is considerably impacted by various social, environmental, and physical factors that may pose either risk or benefit. Nationally, Americans on average can expect to live 77.5 years; at 77.2 years, Chicagoans overall are on par with the national average (Figure 1). Although life expectancy for the average Chicagoan is similar to national trends, there are notable inequities in life expectancy when broken down by race and ethnicity. (Figure 2).

Figure 1. United States and Chicago life expectancy in years, 2010 to 2022.



Source: Illinois Department of Public Health, Division of Vital Records, Death Certificate Data Files, 2010-2022; U.S. Census Bureau, 2010 and 2020 Decennial Census; National Center for Health Statistics, National Vital Statistics Reports 2010-2022.

Figure 2. Life expectancy in years of Chicagoans at birth by race and ethnicity, Chicago, 2010-2022



Source: Illinois Department of Public Health, Division of Vital Records, Death Certificate Data Files, 2010-2022; U.S. Census Bureau, 2010 and 2020 Decennial Census

The Racial Life Expectancy Gap

In 2010, the average expected age of death for Black Chicagoans was 72.7 years compared to 81.1 years for non-Black Chicagoans, representing an 8.4-year gap between the two groups. Nine years later, that gap had increased to 10.1 years as life expectancy among non-Black Chicagoans had risen to 82.4 years while Black life expectancy had fallen slightly. With the emergence of the COVID-19 pandemic, this disparity was exacerbated, reaching an all-time high of 12.7 years in 2021. Although all racial and ethnicity groups in Chicago have begun to see improvements in life expectancy since the pandemic, as of 2022, Black Chicagoans remain the racial group with lowest life expectancy at 69.8 years, indicating an 11.4-year gap between Black Chicagoans and their non-Black counterparts (Figure 3). Many communities on the South and West Side currently fall even further below this number.

Black Chicagoans' Life Expectancy

Black life expectancy has been consistently lower than that of all other racial and ethnic groups. In 2010, the average life expectancy for Black Chicagoans was 72.7 years. In the decade that followed, Black life expectancy experienced a decline, reaching a low in 2016 before ending the decade at 72.3 years. The first year of the pandemic resulted in a loss of another 4.6 years, resulting in an average life expectancy for Black Chicagoans at 67.7 years. Since then, 2.1 years have been regained, making the most recent life expectancy estimates 69.8 years.

White Chicagoans' Life Expectancy

White Chicagoans' life expectancy is closest to the city's average, hovering a couple of years higher. In 2010, life expectancy was 79.4 and trended upwards in the decade that followed, surpassing the threshold of 80 years for the first time in 2016. During the pandemic, white Chicagoans experienced a 1.9-year decrease in life expectancy although have since nearly fully recovered. The most recent life expectancy estimate is 80.3 years, just 0.5 years lower than the pre-pandemic peak of 80.8.

Latinx Chicagoans' Life Expectancy

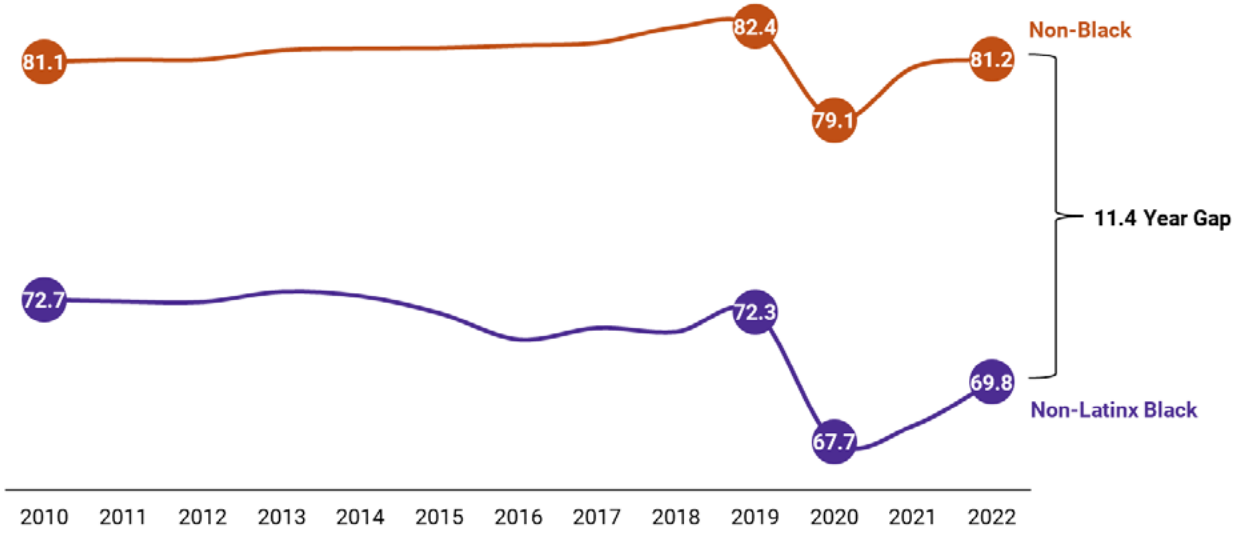
Starting at 84.7 years in 2010, life expectancy fluctuated just slightly over the following decade. In recent years, however, life expectancy among Latinx Chicagoans saw the most rapid decline and recovery. In 2020, the beginning of COVID-19, life expectancy dropped 6.3 years – the largest decline among all racial and ethnic groups in that year. Life expectancy began to recover, gaining 2.8 years in 2021 and 0.4 years in 2022. By 2022, life expectancy among the Latinx population was 81.4 years, still 3.1 years lower than pre-pandemic levels yet remains above the Latinx national average of 80.0 years[1].

Asian and Pacific Islander Chicagoans' Life Expectancy

Chicagoans identified as Asian and Pacific Islander (API) have historically experienced the highest life expectancy in the city and the United States overall. In 2010, life expectancy among this demographic was 86.7 years, compared to the Citywide average of 78 years. API life expectancy rose slightly from 2010-2019, before decreasing four years during the COVID-19 pandemic. In the years since, 2.3 years have been recovered, leaving the most recent life expectancy at 85.5 years.

[1]Centers for Disease Control and Prevention. (2023, November 29). Life Expectancy Increases, However Suicides Up in 2022. National Center for Health Statistics. https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2023/20231129.htm#:~:text=The%20Hispanic%20population%20had%20the,disease%2C%20cancer%2C%20and%20diabetes

Figure 3. Life expectancy in years among Black and non-Black Chicagoans, 2010- 2022.



Source: Illinois Department of Public Health, Division of Vital Records, Death Certificate Data Files, 2010-2022; U.S. Census Bureau, 2010 and 2020 Decennial Census.

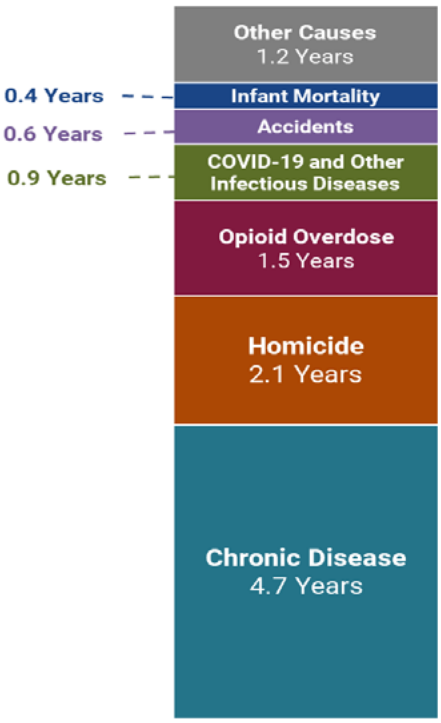
Contributors to the Racial Life Expectancy Gap

Drivers of the Gap

To effectively attenuate the life expectancy gap, we must first understand the differences in premature mortality. When a cause of death is disproportionately experienced by one population over another, it unequally contributes to years lost in life expectancy. This difference in life years leads to an overall disparity in life expectancy and creates 'gaps' between groups.

The life expectancy gap between Black and non-Black Chicagoans is largely driven by a few key contributors. Chronic disease contributes the greatest number of years towards the life expectancy gap with 4.7 years, accounting for 41% of the gap. Homicide, opioid overdoses, and infectious diseases including COVID-19 contribute 2.1, 1.5, and 0.9 years to the life expectancy gap respectively. Smaller contributors include accidents (0.6 years) and infant mortality (0.4 years) (Figure 4). The drivers that contribute the most years represent the highest potential for improvement if addressed deliberately. Black Chicagoans also experience 'other causes' and accidents more frequently; however, these causes require further consideration and collaboration with an array of stakeholders for mitigation and therefore are not addressed in CDPH's 2025 strategic plan.

Figure 4. Number of years contributed from each cause of death category to the life expectancy gap between Black and non-Black Chicagoans in 2022



Chronic disease (4.7 years): heart disease, cancer, stroke, diabetes, COPD, kidney disease, other circulatory diseases

Homicide (2.1 years): firearm and all-cause homicide

Opioid Overdose (1.5 years): fatal overdoses from substances including heroin, fentanyl, pain relievers, methadone

Infectious Diseases (0.9 years): syndemic infectious diseases including HIV and respiratory diseases including influenza, pneumonia, COVID-19

Accidents (0.6 years): motor vehicle accidents, non-opioid drug overdoses, unintentional injuries, etc.

Infant mortality (0.4 years): deaths before 1 year of age

Other (1.2 years): all other causes of death

Source: Illinois Department of Public Health, Division of Vital Records, Death Certificate Data Files, 2022; U.S. Census Bureau, 2020 Decennial Census.

Most Impacted People and Places

Life expectancy can be understood from multiple lenses including groups of people, and even by geographical places. As previously described, there is a significant racial inequity where Black Chicagoans live 11.4 years less than non-Black Chicagoans. When life expectancy is understood from a geographical perspective, there are inequities as well. Community areas on the West and South Sides of Chicago have life expectancies of 69 years or less, while community areas in the North Side have life expectancies in the range of 75 to 78.3 years (Map 1).

West Garfield Park, North Lawndale, and Englewood have the lowest life expectancies at 62.0, 63.9, and 64.3 years respectively. As such, these community areas have been identified as priority community areas for CDPH's 2025 Strategic Plan. West Englewood and East Garfield Park, which have below average life expectancies of 66.2 and 67.5 years respectively, have also been identified as priority communities due to their geographic proximity and colloquial combining with their neighboring communities which allows for maximization of current resources. Together, these five community areas will be prioritized for hyperlocal efforts to increase coverage and uptake of disease prevention and health promotion programs.

Table 1. Community areas with the lowest life expectancy, in years, Chicago, 2022

Community Area	Current (2022) Life Expectancy (years)
***West Garfield Park**	62
***North Lawndale**	63.9
***Englewood**	64.3
Burnside	65.6
Fuller Park	65.7
West Pullman	65.9
Auburn Gresham	66.2
***West Englewood**	66.2
South Chicago	66.7
Roseland	66.9

***Part of the five priority community areas for CDPH's 2025 Strategic Plan.**
Source: Illinois Department of Public Health, Division of Vital Records, Death Certificate Data Files, 2022; U.S. Census Bureau, 2020 Decennial Census.

Table 2. Community areas with the greatest change in life expectancy, in years, Chicago, 2010-2019

Community Area	Change in Life Expectancy from 2010 to 2019 (years)
***Englewood**	-3.30
***East Garfield Park**	-3.23
Washington Heights	-2.75
Pullman	-2.72
Calumet Heights	-2.68
Ashburn	-2.48
Fuller Park	-2.41
South Chicago	-2.28
South Deering	-2.04
Jefferson Park	-1.46

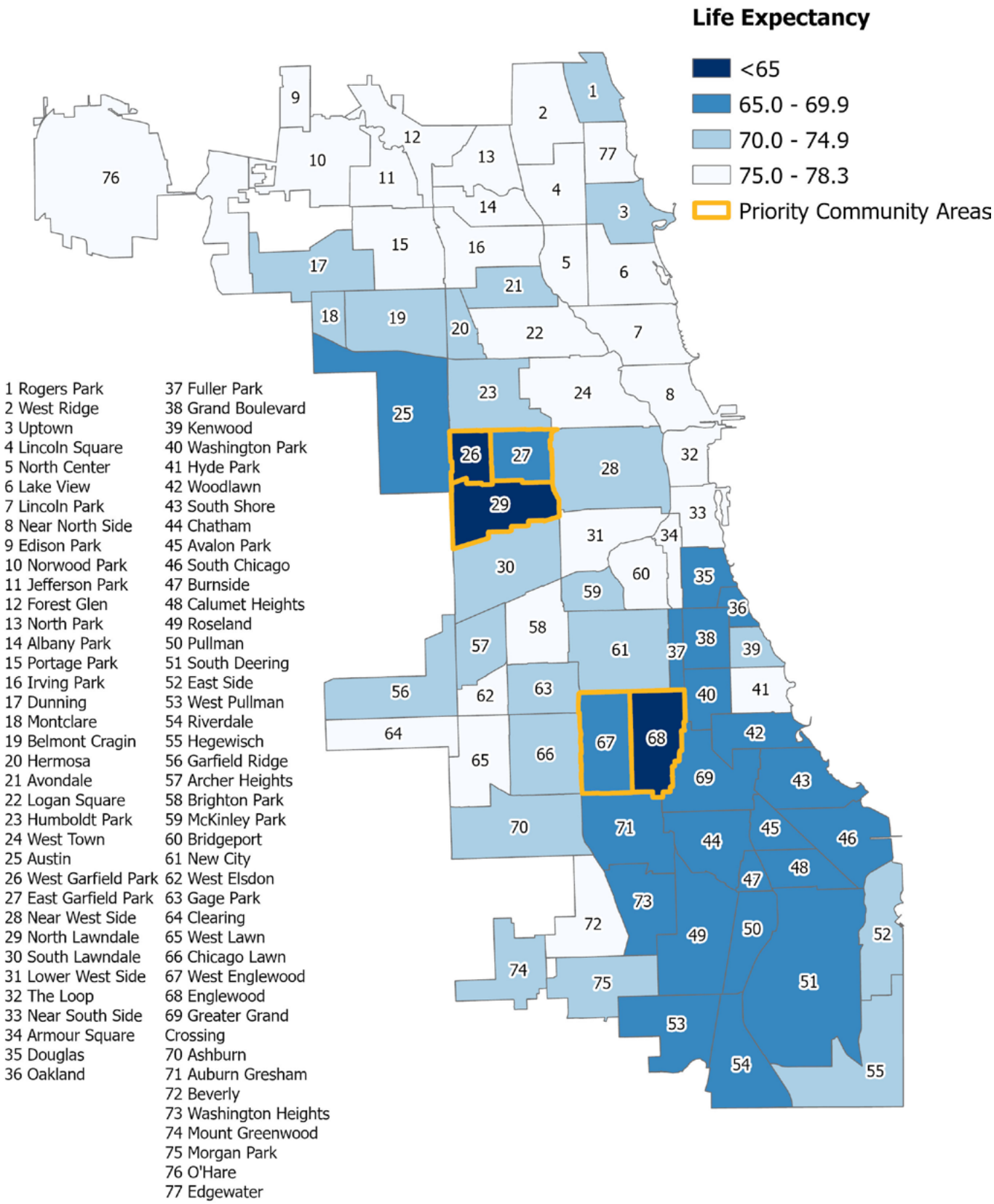
***Part of the five priority community areas for CDPH's 2025 Strategic Plan.**
Source: Illinois Department of Public Health, Division of Vital Records, Death Certificate Data Files, 2022; U.S. Census Bureau, 2020 Decennial Census.

Table 3. Community areas with the greatest change in life expectancy, in years, Chicago, 2019-2022

Community Area	Change in Life Expectancy (in years) Before and During COVID-19 Pandemic 2019-2022
***West Garfield Park**	-5.84
***North Lawndale**	-4.12
Grand Boulevard	-4.09
Kenwood	-3.6
South Shore	-3.1
Burnside	-3.06
Woodlawn	-2.99
Auburn Gresham	-2.77
Douglas	-2.65
West Pullman	-2.35

***Part of the five priority community areas for CDPH's 2025 Strategic Plan.**
Source: Illinois Department of Public Health, Division of Vital Records, Death Certificate Data Files, 2022; U.S. Census Bureau, 2020 Decennial Census.

Map 1. Life expectancy in years by community area in 2022



Source: Illinois Department of Public Health, Division of Vital Records, Death Certificate Data Files, 2022; U.S. Census Bureau, 2020 Decennial Census.

Root Causes

The life expectancy of a population fluctuates based on numerous factors including health threats, healthcare, education, nutritious food, neighborhood safety, environmental conditions, employment, physical activity, stable housing, among others. Small annual changes in population life expectancy are normal and not necessarily an indication of meaningful population-level change. However, consistent and prolonged exposure to these factors generates notable variations. In general, the greater access to and uptake of health-promoting resources creates opportunities for growth and the ability to foster wellbeing. When these resources and services are enjoyed at disparate rates, the totality of factors results in inequitable premature mortality. We therefore call these factors 'root causes' of the life expectancy gap, as they directly result in improved outcomes for some, and worsened outcomes for others.

Historically, due to long-term disinvestment and systemic racism, Black and Latinx Chicagoans have been systematically excluded from health resources. CDPH recognizes that institutions, including local public health departments, have contributed to this problem. This has resulted in poor and diminishing health for individuals and communities spanning generations. With this report, CDPH recalibrates our definition of 'health' and 'success' across all programs and initiatives by prioritizing populations that have long been in the margins. By confronting the primary drivers in the communities that have experienced the most disinvestment, CDPH aims to reverse the historic trend of divergent health outcomes and promote the wellbeing and prosperity of Chicago and all its residents.

Impact of COVID-19 and Lessons from a Hyperlocal Response

Although the significantly lower Black life expectancy was evident long before the emergence of COVID-19, the pandemic highlighted health disparities with a disproportionate rate of morbidity and mortality among historically marginalized Chicago communities. In 2020, the COVID-19 mortality rate among Latinx Chicagoans was the highest of any racial and ethnic group in the city at 221 deaths for every 100,000 people. Black Chicagoans also experienced a high rate of COVID-19 mortality with 167 deaths for every 100,000 people (Figure 5).

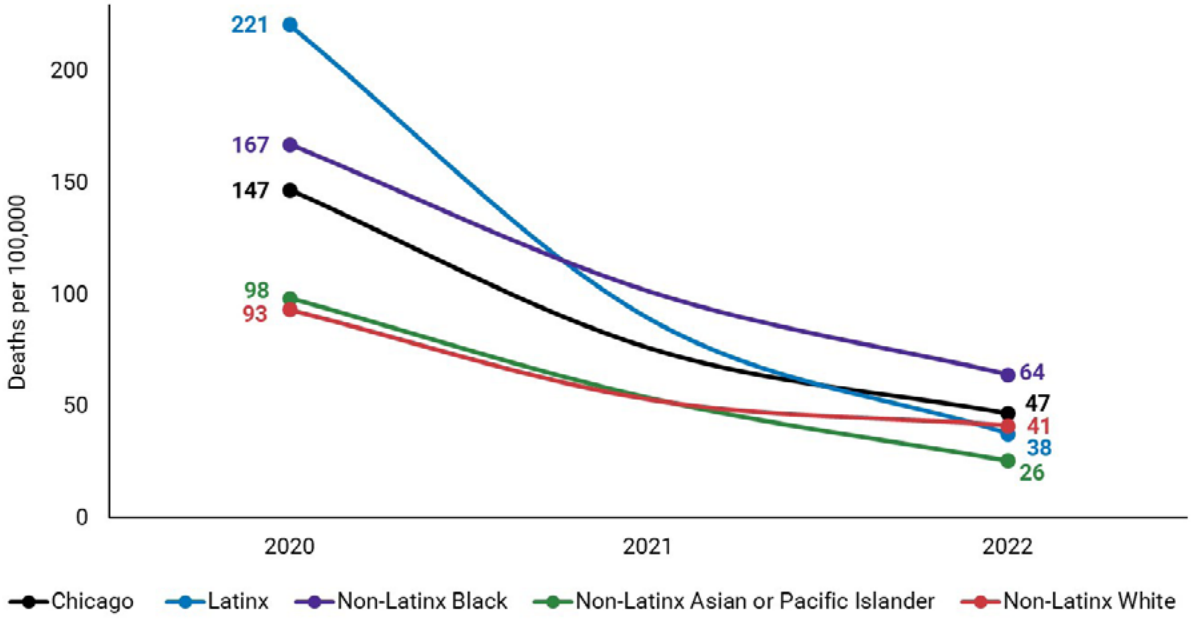
The COVID-19 pandemic had a profound impact on life expectancy globally, including a 3.6-year decline in overall life expectancy in Chicago. The Latinx population in Chicago had the largest decline in life expectancy with a 6.3-year reduction between 2019 and 2020. The Black population in Chicago had the second largest drop in life expectancy, with 4.6 years lost in a single year. In general, life expectancy does not fluctuate dramatically from year to year; multiyear losses of life expectancy between 2019 and 2020 are indicative of COVID-19's effect on our communities and highlights existing racial inequities.

In early April of 2020, CDPH released demographic data on COVID-19 diagnoses and death disparity by race and ethnicity, alongside a commitment to address health inequities driven by the pandemic. The plan outlined CDPH's dedication to collaborating with other government agencies and community partners to pool resources and expertise in developing rapid solutions. This led to the creation of the Racial Equity Rapid Response Team (RERRT). RERRT's efforts were data-driven, working closely with community-based organizations to identify effective strategies for the timely distribution of COVID-19 resources and information. These initiatives included hosting virtual town halls, distributing community personal protective equipment, conducting neighborhood canvassing, and more.

The first and largest peak of COVID-19 deaths in the spring of 2020 demonstrated the largest number of deaths among Chicagoans. Nearly 60% of COVID deaths among Black Chicagoans occurred among those aged 70 and older while 50% of Latinx COVID-19 deaths occurred among those aged

40-69. This higher rate of death among younger Latinx people is attributed to a larger proportion of individuals being classified as essential workers and therefore facing frequent workplace exposure which in turn put entire families at risk.

Figure 5. Age-adjusted COVID-19 mortality rate per 100,000 people by race and ethnicity, 2020-2022



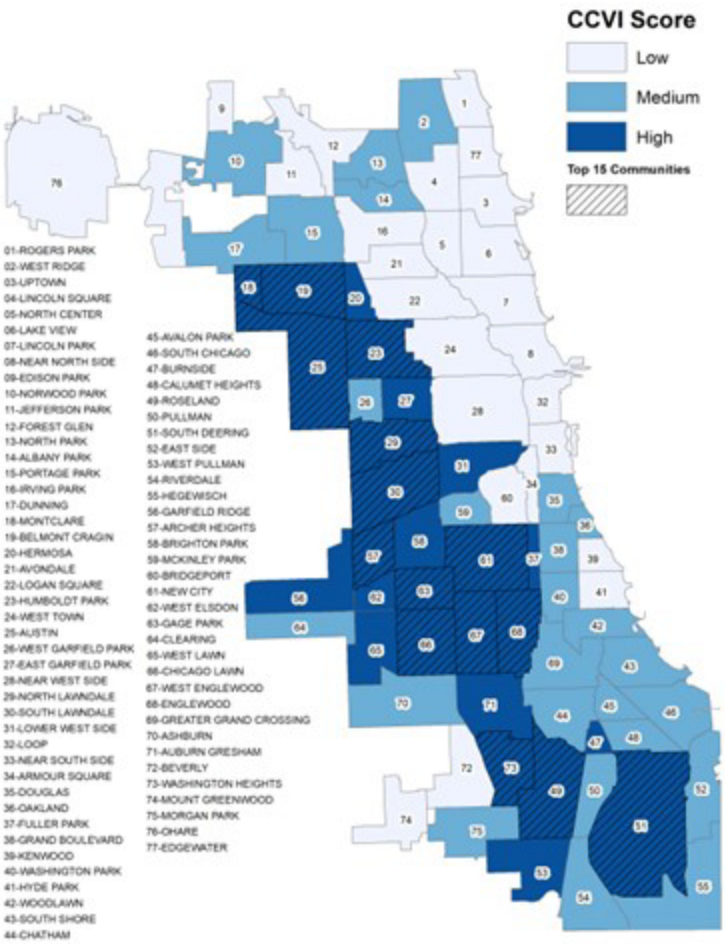
Source: Illinois Department of Public Health, Division of Vital Records, Death Certificate Data Files, 2020-2022. U.S. Census Bureau, 2020 Decennial Census.

Identifying trends beyond just race and ethnicity moved the health department to develop a more robust measure of health vulnerability. The Chicago COVID-19 **Community Vulnerability Index** (CCVI) was developed to determine community-level vulnerability to adverse COVID-19 outcomes based on several different factors. This practice allowed CDPH to quickly identify the communities that were highly vulnerable to the adverse effects of COVID-19 and strategize around equitable vaccination and education campaigns. Twenty-six community areas were determined to have a high vulnerability score; all these communities are comprised of predominantly Black and Latinx populations. The EmPOWER Project, also utilized in New York City and Los Angeles, additionally allowed CDPH to identify the top 10% most vulnerable Chicagoans through analysis of the Central Medicare System (CMS) data. These individuals were systematically contacted via phone and, through motivational interviewing techniques, were offered at-home COVID-19 vaccinations to help mitigate vaccination refusal due to distrust.

About the Chicago COVID-19 Community Vulnerability Index (CCVI)

The CCVI incorporated 18 indicators grouped into 10 components to account for sociodemographic, epidemiological and occupational factors, as well as cumulative COVID-19 burden. These variables were weighted and synthesized to generate a single composite weighted score to categorize all 77 communities as low, medium, or high vulnerability to COVID-19 morbidity and mortality.

Map 2. Chicago COVID-19 Community Vulnerability Index (CCVI) Score with Top 15 Community Area Overlay



Source: Chicago Department of Public Health, 2021

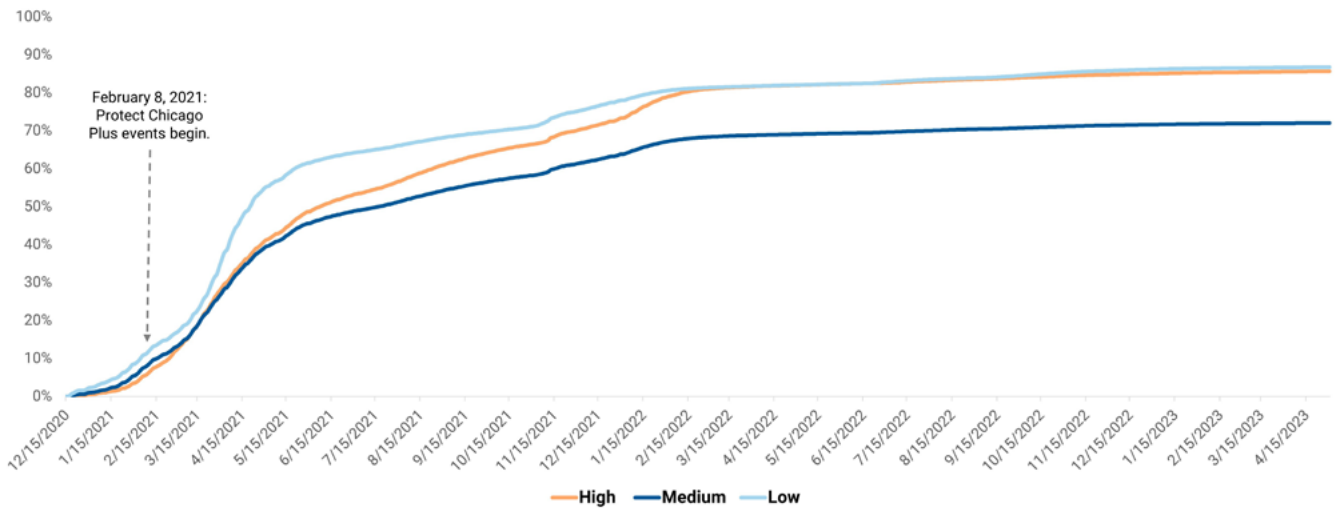
In February 2021, Chicago launched **Protect Chicago Plus** (PCP), the first citywide initiative aimed at equitable COVID-19 vaccine distribution. This plan was designed to effectively reach individuals in the 15 top CCVI priority communities by layering City expertise and resources with community-advocacy and access. Efficient collaboration with community partners led to the establishment of both the COVID-19 Contact Tracing Corps, which employed over 600 community residents across 31 Community Based Organizations (CBOs) who served the hardest hit communities, as well as the **Healthy Chicago Equity Zones** (HCEZs). HCEZ is a program which allowed CDPH to fund networks of community-based organizations to promote equity in COVID-19 vaccine access and treatment by addressing disease risk factors and barriers to care at a hyperlocal level. The goal was to dedicate resources to the community areas with high CCVI scores to ensure they would not fall behind in protection against COVID-19 and reduce the early observed inequities in COVID-19 diagnoses and deaths.

Protect Chicago Plus Efforts to Promote Vaccine Equity

- Set up 11 temporary clinics in priority CCVI neighborhoods
- Phone and text banking for residents in CCVI neighborhoods
- Collaborated with large employers of essential workers to conduct workplace education and vaccination
- Canvassed at grocery stores, taquerías, currency exchanges, health fairs, and more to share information about the vaccine and help individuals make appointments
- Hosted 27 special events over the first 3 months specifically for seniors, essential workers, immigrants, and non-English speakers
- Partnered with Uber, Americans with Disabilities Act (ADA) paratransit, Chicago Transit Authority (CTA), and Pace to offer transportation assistance for seniors to and from the United Center mass vaccination site
- Launched a free Vaccine Ambassador Course that provided free online training to educate people to become trusted vaccine education ambassadors in their communities. In partnership with community organizations, door-to-door canvassing teams were trained through this program
- Canvassing teams conducted home visits in communities with high CCVI and low vaccination uptake to answer questions and increase vaccine acceptance
- Data captured by canvassing teams was used to schedule hyperlocal and pop-up vaccination events in areas of greatest need and demand and identify those in need of at-home vaccination
- Worked with community partners to identify pop-up event locations where vaccine uptake remained low. Events took place at parks, beaches, farmers markets, churches, schools, food pantries, CTA locations, Aldermanic offices, and more

As a result of Protect Chicago Plus, from early February through early May 2021, the percentage of adults with at least one dose of a COVID-19 vaccine in the 15 initial communities grew from six percent to nearly 50 percent (Figure 6). Additionally, we saw first dose vaccine coverage among high CCVI community areas surpass the percentage of medium CCVI vaccine coverage. Subsequently, the vaccine uptake for the high vulnerability group continued to rise and eventually matched the percentage of vaccine coverage seen among the low vulnerability group.

Figure 6. Cumulative first-dose vaccine coverage by Chicago COVID Vulnerability Index (CCVI) level, Chicago, December 15, 2020 – April 30, 2023.



Source: Illinois Comprehensive Automated Immunization Registry Exchange (I-CARE), 2023

The coverage gap in vaccines was eliminated by March 2022 which resulted in the flattening of the COVID-19 mortality curve (Figure 5). Increasing coverage of vaccines and the uptake of preventive measures led to a notable and sustained decrease in mortality for all. As of 2022, all racial and ethnic groups have growing life expectancies and through this COVID-19 response, the city learned that with intense targeted intervention, disparate rates in mortality can be reversed. This example of utilizing a data-driven, asset-based, and layered approach was a successful practice that CDPH intends to apply again, beginning with this 2025 Action Plan.

CDPH's 2025 Strategic Plan

Goal

In response to the persistent racial life expectancy gap, CDPH will pilot a collective impact model in five priority communities in 2025. This strategy requires synergy between programs that influence the primary drivers of the racial life expectancy gap to provide layered programmatic coverage to the people and places most acutely impacted by declining life expectancy. Therefore, the primary goal of the 2025 Strategic Plan is to systematically address each of the leading causes of disproportionate mortality and the underlying factors of the racial life expectancy gap through implementation of a hyperlocal approach.

Development of the CDPH 2025 Strategic Plan

The development of this department-wide strategic plan involved four steps that followed a theory of change model to ensure focused and impactful approaches across bureaus. The 2025 Strategic Plan consists of seven distinct programmatic action plans.

Step 1: Reframing *the Life Expectancy Gap*

In *Healthy Chicago 2025*, Chicago's latest Community Health Improvement Plan, CDPH centered its goals around closing the racial life expectancy gap between Black and white Chicagoans. With this report, the department is shifting focus to closing the racial life expectancy gap which compares Black Chicagoans' life expectancy to that of all other Chicagoans, "non-Black Chicagoans". With this change, CDPH moves away from centering white health outcomes as the standard or goal, and

instead toward reaching health equity for all people.

Step 2: Focus on Long Term Trends

CDPH must focus on long-term trends in the life expectancy gap between Black and all non-Black Chicagoans rather than annual or short-term changes. Although the COVID-19 pandemic plays a part in the decline of life expectancy for all racial groups, Black life expectancy was consistently lower than all other racial and ethnic groups and already declining even prior to the pandemic. CDPH's actions will be targeted at reversing these unacceptably negative trends.

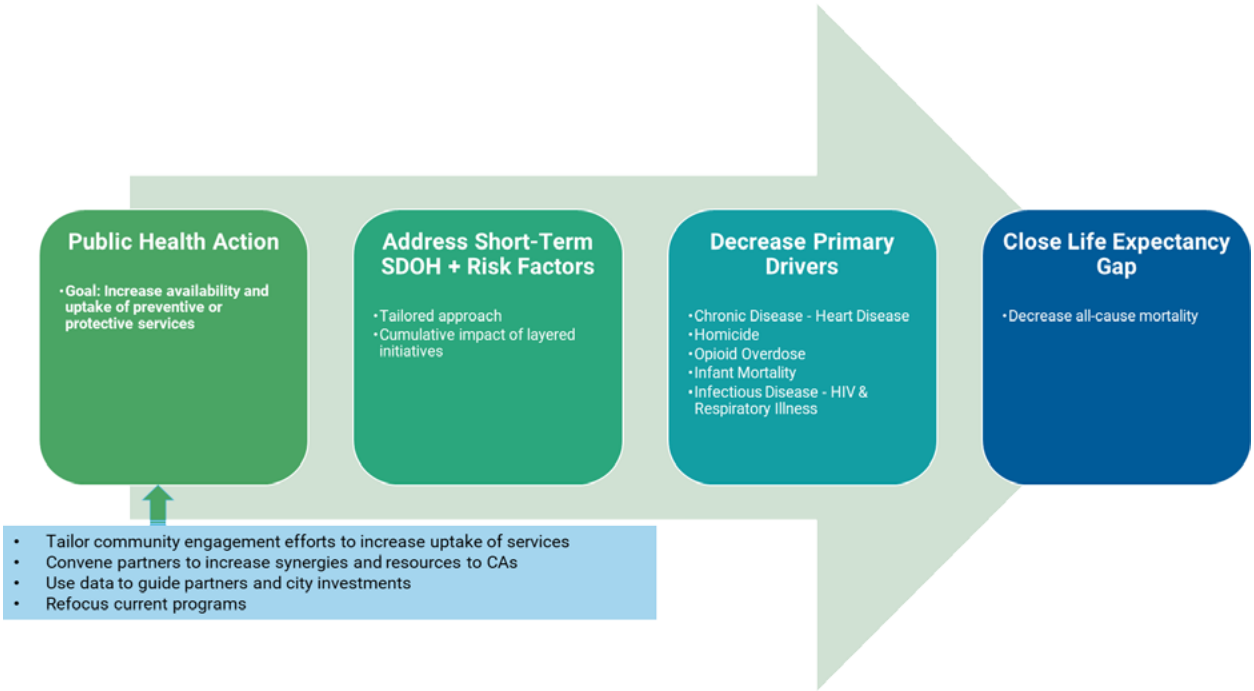
Step 3: Prioritize Most Impacted People and Places

The history and persistence of residential segregation in the city of Chicago limits access to resources in certain communities. Consequently, CDPH will redirect focus to five Chicago neighborhoods on the south and west sides where lower life expectancy is concentrated and where most life years have been lost. These neighborhoods are: East Garfield Park, West Garfield Park, North Lawndale, Englewood, and West Englewood.

Step 4: Focus on Primary Drivers of the Black non-Black Life Expectancy Gap

There are five main preventable causes of death, or drivers, that occur at disproportionately higher rates within the Black population – these include chronic disease, homicide, opioid overdose, infectious disease, and infant mortality. Unmet mental health needs must also be discussed as a leading cause of underlying morbidity which contributes to mortality across all drivers. This is largely due to reduced access to social, economic, and environmental supports such as healthcare, education, and financial opportunities and increased exposure to harms such as pollution, predatory advertising, and disinvestment. Many of these drivers may take years or even decades to address, but CDPH remains committed to addressing the inequitable experiences of premature mortality.

Theory of Change



Note: *With the actions put forth in this report, CDPH will commence efforts where the need is greatest. As progressed is realized, CDPH will continue to assess and expand priority populations and geographies. The programmatic actions discussed below are a starting point - a steppingstone to accomplish health equity with ultimately broader reach across the city.*

CDPH has developed action plans for the following programmatic areas:

- Chronic Disease – Heart Disease
- Violence Prevention
- Substance Use
- Infectious Disease – Respiratory and Syndemic
- Infant and Maternal Health
- Mental Health
- Partnership

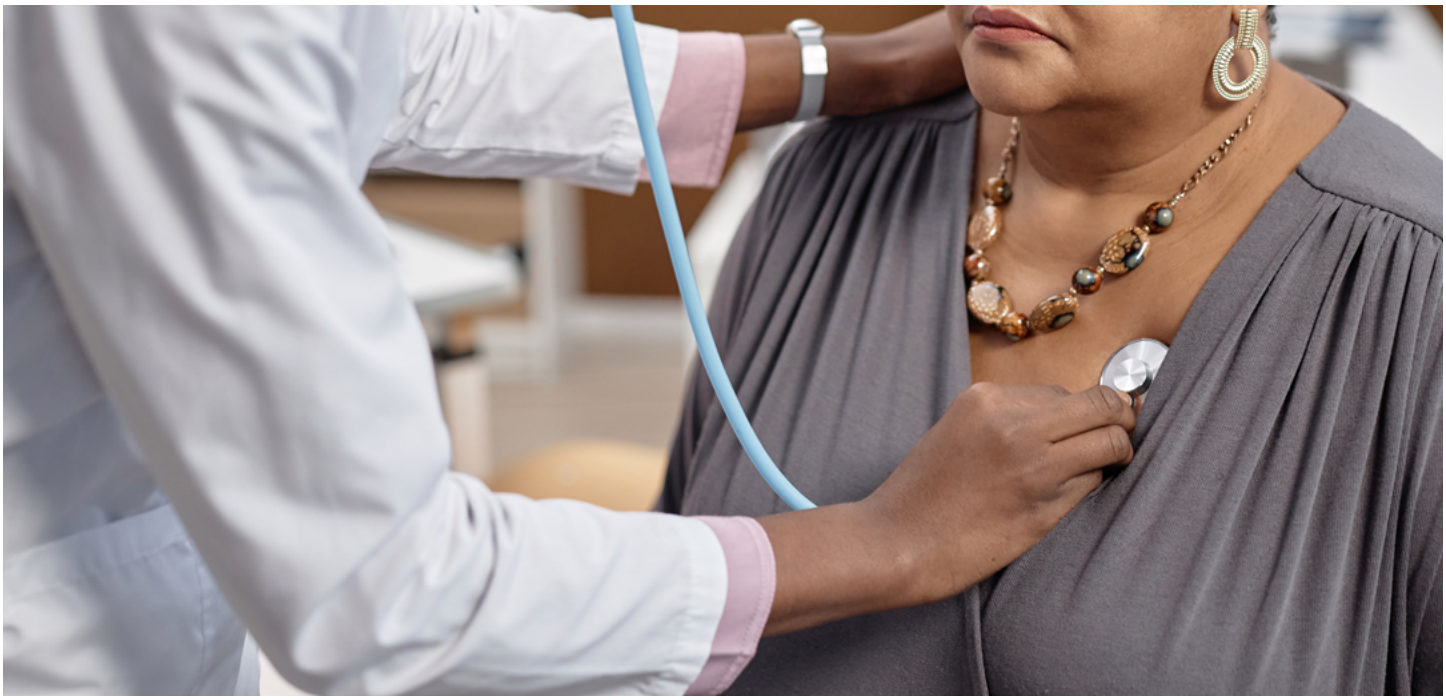
While most of these action plans are directly tied to the drivers of the life expectancy gap, two additional plans were added to more comprehensively address the underlying causes of inequity created by gaps in services and systems.

Additional Action Plans

1. As there is an inextricable link between physical, social, and mental wellbeing, the Mental Health Action Plan is included to combat unmet mental health needs that make it difficult to care for oneself and loved ones.
2. Additionally, CDPH aims to work in synergy with communities, augmenting the work and stretching it further to reach a greater audience. To grow meaningful partnerships and prevent opposing or duplicative initiatives and services, a Partnership Action Plan will be implemented.

Programmatic Action Plans

Chronic Disease Action Plan: Heart Disease

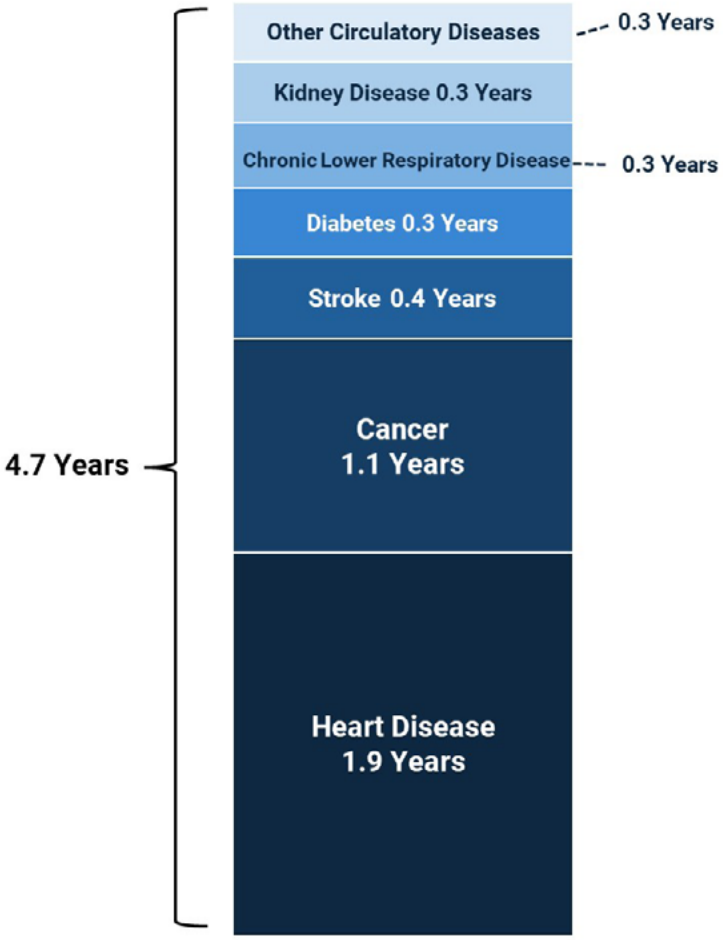


Theory of Change

Background Data & Community Profiles

As an aggregated category, Chronic Disease is the largest contributor to the racial life expectancy gap, contributing 4.7 years. Heart disease alone accounts for 1.9 of these 4.7 years (Figure 7), making it the leading contributor to chronic disease death.

Figure 7. Chronic disease causes of death and the number of years contributed to the life expectancy gap between Black and non-Black Chicagoans, 2022

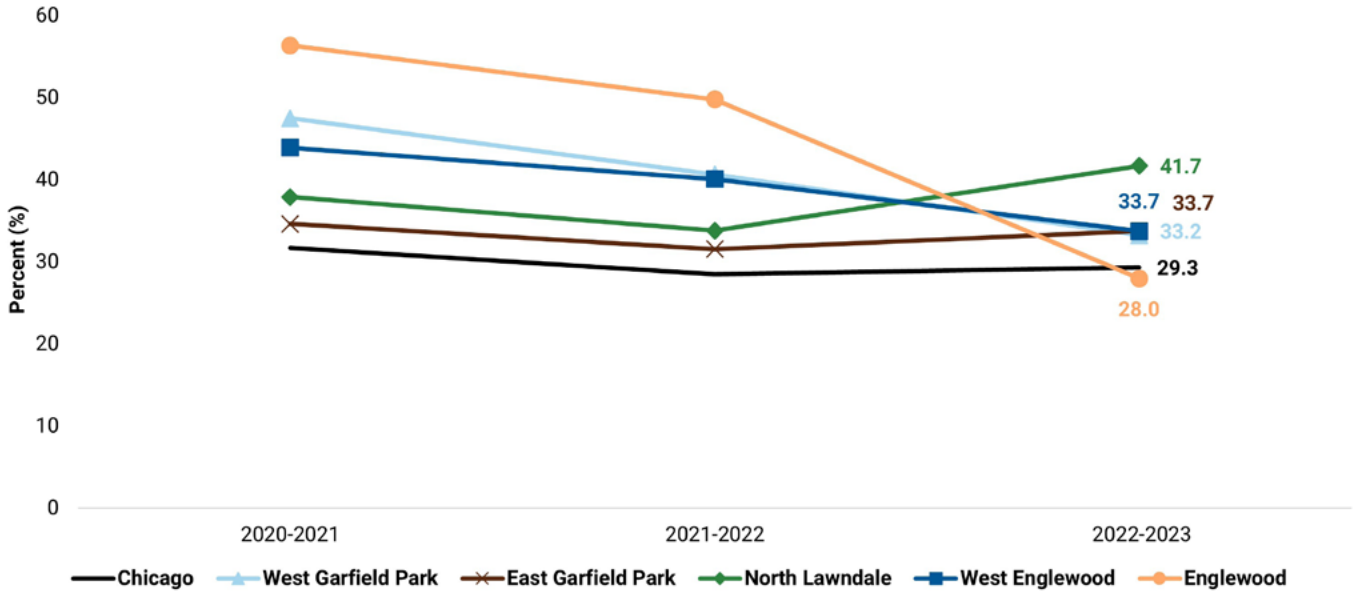


Source: Illinois Department of Public Health, Division of Vital Records, Death Certificate Data Files, 2022; U.S. Census Bureau, 2020 Decennial Census.

Heart disease is the umbrella term for many cardiovascular conditions affecting the heart and blood vessels. Unhealthy foods, tobacco use, and low physical activity can lead to higher rates of hypertension and cardiovascular disease. Therefore, community interventions on diet, exercise, and tobacco cessation are intended to reduce rates of heart disease.

Hypertension is a condition of the blood vessels. When someone's blood pressure is too high for a sustained period of their life, it can lead to further heart and blood vessel damage. For this reason, community interventions on hypertension are intended to help residents get connected and remain adherent to appropriate care to prevent the downstream impacts of serious heart disease and stroke.

Figure 8. Percent of adults reporting a health professional has diagnosed them with hypertension (high blood pressure) by priority community areas, Chicago, 2020-2023.

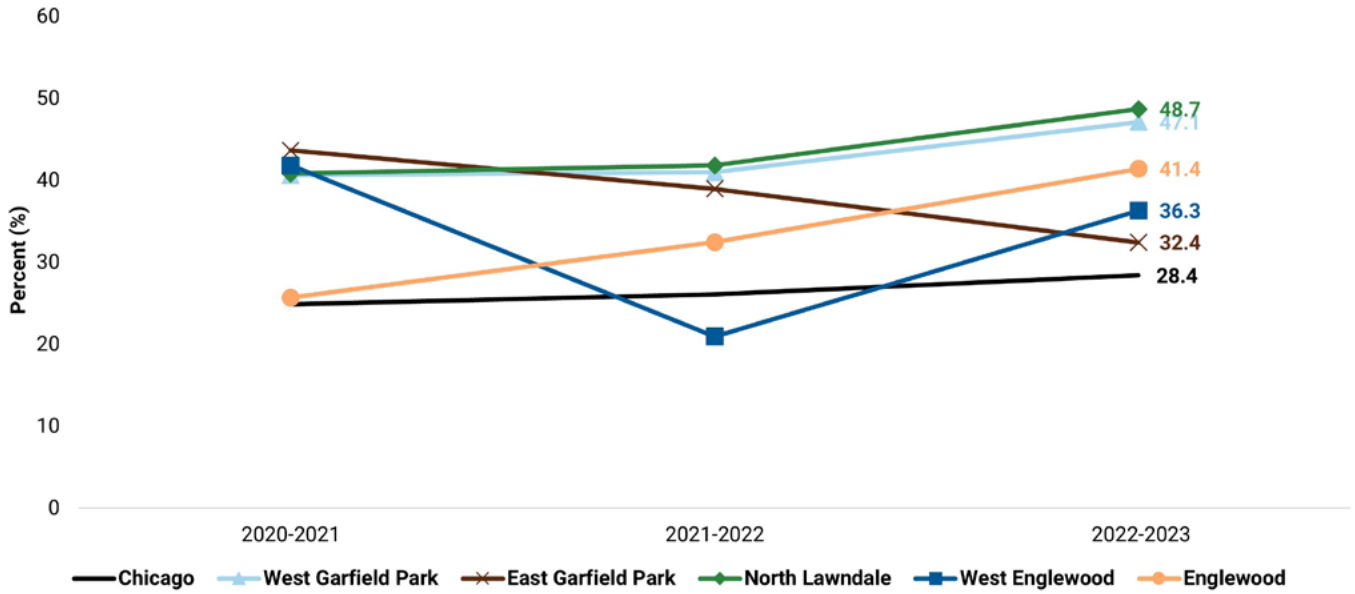


Source: Healthy Chicago Survey, 2020-2023.

Englewood had the highest percentage of adult residents reporting being diagnosed with hypertension in the 2020-2021 and 2021-2022 time periods at 56% and 50% respectively. During the 2022-2023 period, the rate of reported hypertension dropped drastically to 28%, sitting below all of the other priority community areas and even exceeding the citywide average. During this same time period, North Lawndale's rate of reported hypertension among adult residents increased to 42%, replacing Englewood as the highest rate citywide (Figure 8). CDPH will focus efforts on reducing risk factors for heart disease with the aim of reducing the rates of hypertension, diabetes, obesity, and tobacco use in Chicago. Mitigating these risk factors has been proven to help prevent cardiac and stroke-related mortality.

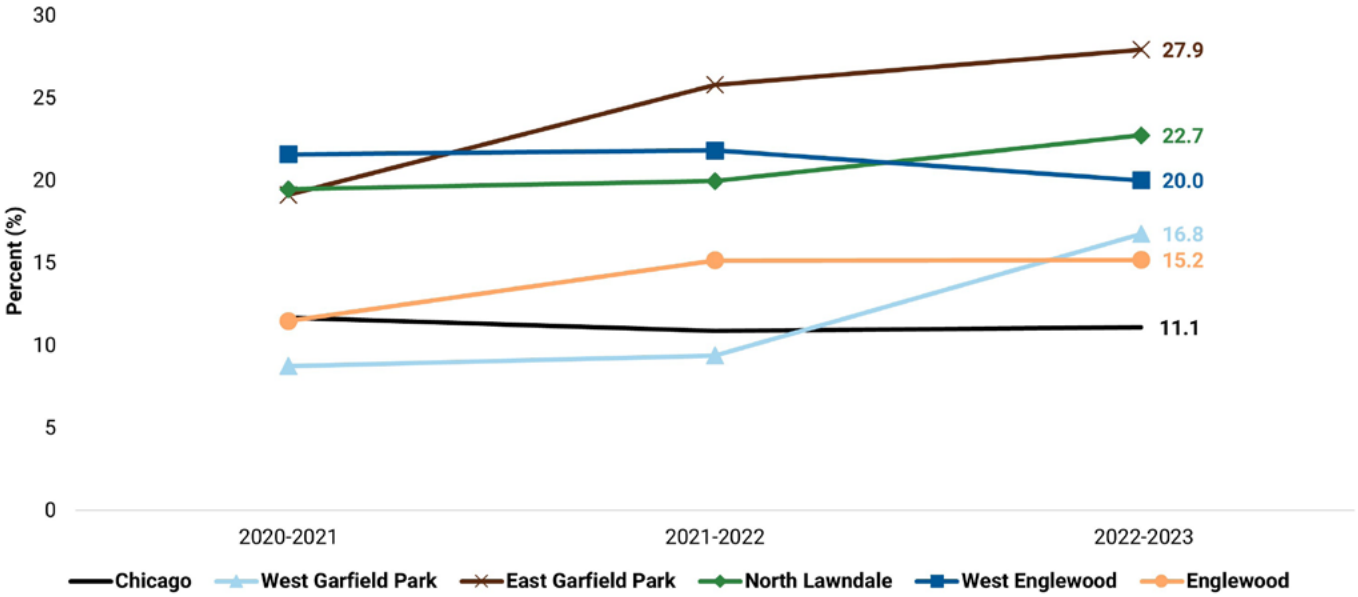
In Chicago, the highest rates of heart disease and heart disease-related risk factors are seen on Chicago's South and West sides. All five of the priority communities are within the top ten highest rates of heart disease mortality and are among the top ten lowest for socioeconomic status in Chicago. Additionally, while 28.4% of all Chicago adults are physically inactive, nearly half of adults in West Garfield Park and North Lawndale are inactive (Figure 9). Similarly, the rate of adults in East Garfield Park, North Lawndale, and West Englewood who report smoking cigarettes is nearly double or more than the citywide average (Figure 10).

Figure 9. Percent of adults who reported not participating in any physical activities or exercises in the past month by priority community areas, Chicago, 2020-2023.



Source: Healthy Chicago Survey, 2020-2023.

Figure 10. Percent of adults who reported having smoked at least 100 cigarettes in their life and reported that they now smoke cigarettes every day or some days by priority community areas, Chicago, 2020-2023.



Source: Healthy Chicago Survey, 2020-2023.

Many social determinants of health influence how people maintain their health and prevent early conditions from progressing. CDPH will focus efforts for the 2025 Strategic Plan on the modifiable risk factors to reduce chronic disease mortality: food access, physical activity, and tobacco prevention and cessation.

Chronic Disease Action Plans

1. Increase engagement around tobacco prevention and cessation through community partnerships
2. Tailor the PlayStreets initiative to increase youth and adult physical activity
3. Support food resource navigation and increase food access
4. Increase hypertension prevention and treatment by increasing health literacy and promoting risk reduction resources

As part of the programmatic response, CDPH will deploy a Community Health Response Corps to promote chronic disease prevention in priority areas. CDPH will delegate services to community-based organizations who will staff Community Health Workers (CHWs) to promote health in the priority areas.

The Response Corps will engage Chicago residents from priority communities through two primary methods: CHWs may make direct contact through canvassing or at community events, or by using phone communication through the Resource Coordination Hub, a hotline that connects individuals and families to community health and social services. All residents can access the Resource Coordination Hub by calling 312-746-4835 to receive referrals to services and information about local resources. CHWs utilize UniteUs, a social service and resource connection tool, to promote these resources and keep resource lists current. This health resource hotline will be amplified through public health marketing efforts and through strengthening partnerships with the 211 and 311 platforms. These efforts will allow CHWs to serve as trusted messengers to increase awareness of available resources and health protective behaviors in the communities overburdened by chronic disease.

1. **Increase engagement around tobacco prevention and cessation through community partnerships**
   CHWs in the Community Health Response Corps will be trained on tobacco cessation programming and practices in order to share resources with residents of priority communities. By engaging with community, CHWs will aim to build trust with youth and adults, deterring them from smoking or encouraging them to take the next steps towards quitting, such as contacting the Illinois Tobacco Quitline at 1-866-784-8937. Two Tobacco Community Coalition models will be piloted in 2025. The first model will be primarily led by a CDPH regional partner on the Far South Side. The partner organization will convene other community organizations, retailers and enforcement agencies who collectively disseminate information on tobacco cessation and nicotine products. The regional lead will also collate community feedback for ongoing process improvement and opportunities for deeper engagement. The second model will be led by CDPH staff who will convene a network of community partners from the five priority areas with interest and expertise in the tobacco cessation space. This coalition will gather to share insights, engagement techniques, and relevant materials that are tailored to priority populations and topics. Menthol and smokeless tobacco will also be included as focus areas for this initiative. CDPH personnel will cultivate meaningful relationships with schools, retailers, and elected officials within the priority community areas to tailor messaging to the respective audiences and get the resources into the hands of the individuals most at risk for

becoming new users and for the users most at risk of adverse health outcomes. Materials and resources developed in each Tobacco Community Coalition may be channeled through the network of partners for greater dissemination to increase cessation attempts. CDPH personnel will serve as a liaison between these two models to assess successes and challenges with both structures to guide further expansion.

2. **Tailor the PlayStreets initiative to increase youth and adult physical activity**
   PlayStreets is moving to an equity-based model in 2025 by prioritizing events in eight community areas with the poorest chronic disease health indicators and outcomes. To be more impactful and prescriptive about PlayStreets' activations, CDPH will focus on working with eight CBOs in 2025. This will allow for more tailored interventions which seek to attract a greater number of participants to each activation. Further, the PlayStreets' Activity Guide will be edited to strengthen the requirements around the length of time that moderate to vigorous physical activity is offered at all PlayStreets events. The Chronic Disease team also will collaborate with the Chicago Park District to develop trainings for CBOs on the hosting of heart health activities.

3. **Support food resource navigation and increase food access**
   CDPH will leverage knowledge from prior assessments to increase our attention to systems development to minimize gaps and increase access to food resources for community members most in need of nutrition support. Other priorities for 2025 include mapping food-related assets and needs within the five priority community areas and identifying partnerships for collaboration in both the rescue and distribution of food. The Community Health Response Corps will augment food access efforts in the priority areas by promoting the Resource Coordination Hub to share information and connect residents to local food resources. Additionally, CDPH plans to develop nutritional standards for food and beverage offerings at all PlayStreets events.

4. **Increase hypertension prevention and treatment by increasing health literacy and promoting risk reduction resources**
   The Community Health Response Corps CHWs will receive training in health literacy and how to provide hypertension risk reduction resources. This will allow the CHWs to tailor their approach to the communities that they serve by implementing culturally appropriate messaging. CHWs in the Response Corps will participate in blood pressure screenings in priority communities. Residents who are at risk of cardiovascular disease will be referred to health preventive resources as appropriate to safeguard their health.

Violence Prevention Action Plan

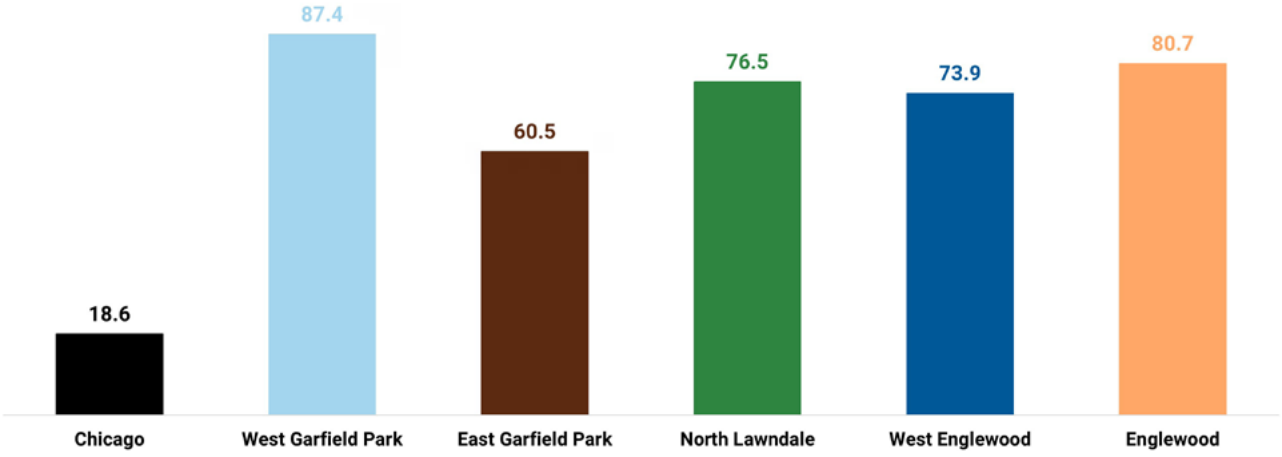
Theory of Change

Background Data & Community Profiles

In July of 2024, the U.S. Surgeon General declared firearm violence to be a public health crisis in America. Gun-violence and related homicide has long been known to be a major contributor to injury, hospitalization, and death in Chicago, accounting for 2.1 years of the current racial life expectancy gap. Recent crime data highlights the disparity in experiences of gun violence across the city and

the aftereffects which can ripple for generations. Black Chicagoans account for over 80% of the firearm-related homicides with a mortality rate of roughly 63 per 100,000 in 2022. Violence is highly concentrated in Chicago with generally over 60% of the homicides and non-fatal shootings occurring within just 15 of the city's 77 community areas in any given year. The five priority communities of East and West Garfield Park, North Lawndale, Englewood and West Englewood are consistently included in these 15 most violent communities. Most notably, West Garfield Park experiences a gun violence victimization rate over six times the citywide average and a homicide rate almost five times the citywide average (Figure 11).

Figure 11. Average annual age-adjusted firearm-related homicide rate per 100,000 people by priority community areas, Chicago, 2018-2022.



Source: Illinois Department of Public Health, Division of Vital Records, Death Certificate Data Files, 2018-2022.

With decades of unaddressed systemic racism, disinvestment, and lack of social services, trust in local government and law enforcement has led to the reliance on policing as the primary solution, which ultimately has failed to reduce violence-related mortality. Violence must therefore be addressed through a public health approach which focuses on ameliorating risk factors and promoting protective factors through equity-building and evidence-based strategies. Experiencing low socioeconomic status and opportunity, food insecurity, housing insecurity, an inferior built environment, and lack of community activation are known factors associated with higher rates of neighborhood violence. Violence is often viewed as a complex problem to solve due to the need for interventions at the individual, group, and societal levels that simultaneously target social, economic, environmental, educational, psychological, among other factors. CDPH works to interrupt cycles of violence through our people-based and place-based initiatives. People-based initiatives include Street Outreach and Victims Services initiatives to reach individuals directly impacted by violence, while place-based initiatives promote greater development of social, economic, and environmental infrastructure to generate opportunity and foster community empowerment.

The five priority community areas have some of the highest number of vacant lots in the city, with Englewood and West Englewood having the greatest numbers, and therefore largest proportions at 12.7% and 9.3% respectively (Table 4).

*Table 4. Number and proportion of City owned vacant lots (n=9,966) by priority community areas, Chicago, 2023**

Community Area	Number of Vacant Lots	Proportion of Vacant Lots to City Total
Englewood	1,262	12.7%
West Englewood	929	9.3%
New City	860	8.6%
North Lawndale	827	8.3%
Grand Boulevard	531	5.3%
West Pullman	473	4.7%
East Garfield Park	426	4.3%
Washington Park	425	4.3%
South Chicago	400	4.0%
Austin	378	3.8%
West Garfield Park	374	3.8%
Chicago Total	**9,966**	**100.0%**

*As of July 14, 2024.
Source: Chicago Data Portal.

Priorities & Action Plans

Violence Prevention Action Plans

1. Develop a proactive 2025 summer violence prevention plan based on a 2024 summer after-action report
2. Invest in community greenspace by cleaning vacant lots and promoting tree plantings
3. Implement hospital-based violence interventions

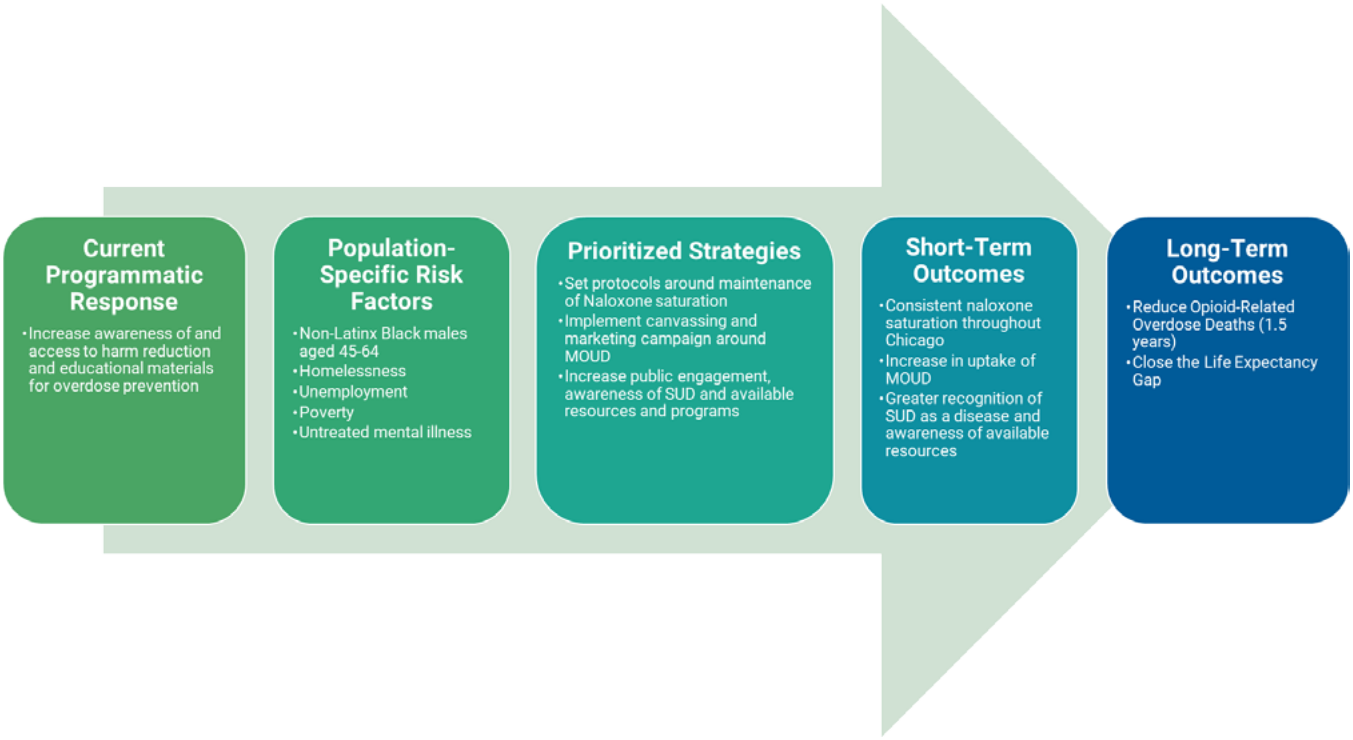
1. **Develop a proactive 2025 summer violence prevention plan based on a 2024 summer after-action report**
   CDPH will improve the effectiveness of our current violence prevention programming by developing a proactive violence prevention plan for summer 2025. By conducting an analysis of the 2024 violence prevention efforts in Chicago, the Office of Violence Prevention will be required to systematically assess best practices to adopt for 2025. This after-action review will analyze patterns in community violence and investigate key events to identify details such as dates (e.g. holiday weekends and death anniversaries) and places, (e.g. 'hot' blocks and activity of organized groups) that may drive future violence. Further reflection on successes and failures of programmatic activity based on community response and shifts in violence will help CDPH prepare for the upcoming year. The proactive 2025 violence prevention plan will discuss critical insights and strategies for mobilizing resources ahead of time to ward off violent incidents prior to occurrence.

2. **Invest in community greenspace by cleaning vacant lots and promoting tree plantings**
   CDPH currently invests in community greenspace by funding and coordinating two initiatives. The 'cleaning and greening' of vacant lots is one such initiative where CDPH partners with the **Department of Streets and Sanitation** (DSS) and **Greencorps Chicago** to clean blocks by removing natural and manmade debris and revitalizing the land with grass, gardens, and sometimes fences. Overgrown and littered lots offer places to hide illegal guns and locations for undesirable activity to transpire. CDPH also supports the **Our Roots** initiative which utilizes partnerships to expand the tree canopy in Chicago. The city works with externally funded Tree Ambassadors from the communities who educate residents on the importance of trees and submit requests for tree plantings in ideal locations. Improving the built environment creates an area that feels cared for, thus increasing community pride and reducing the physical disorder which makes it less attractive to criminal behavior, including violence. CDPH will continue its role in these initiatives while placing greater focus on the communities prioritized in this Strategic Plan with the goal of preventing community violence. Englewood and West Englewood alone have nearly 2,200 of the city's 10,000 vacant lots. CDPH will evaluate these vacant lots, determine their desirability for cleaning and greening, and expedite their revitalization. CDPH will also increase tree equity awareness by building new connections with community partners to attract more Tree Ambassador program applicants from the priority areas. Through partnerships, CDPH can generate a larger number of planting requests from the communities that can benefit most.

3. **Implement hospital-based violence interventions**
   As an improvement upon the Street Outreach initiative, CDPH will implement a new hospital-based violence intervention portfolio. This opportunity allows hospitals or community organizations to apply for funding to serve gunshot-wound victims with wraparound services while still in the hospital. This early contact allows for higher likelihood of interrupting retaliatory violence while also improving the health outcomes for the victim. Physical and mental health care recovery services as well as social supports such as housing and trauma-reduction funding may be available earlier to a victim and their family, helping to start the healing process and turn away from continued violence.

Substance Use Action Plan

Theory of Change

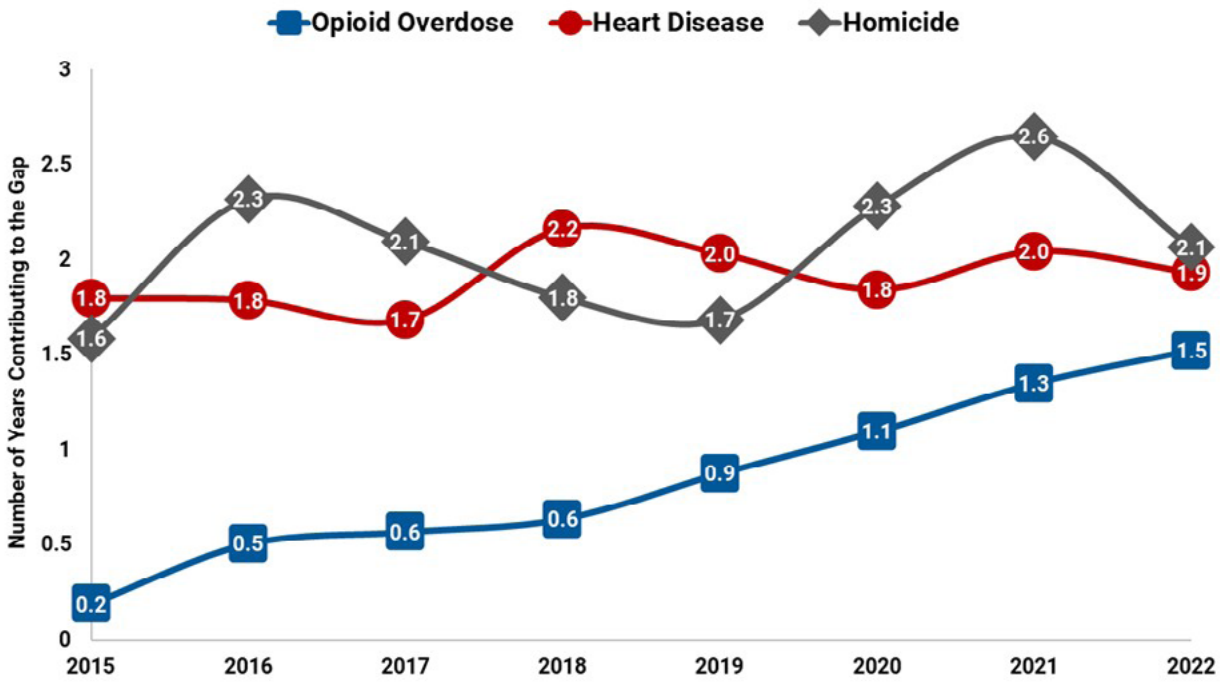


Background Data & Community Profiles

Opioid-related overdose mortality is the third leading cause of the Black-non-Black life expectancy gap and is the only one of the top three drivers that is experiencing a steadily growing racial disparity (Figure 12). The opioid overdose fatality rate among Black Chicagoans is now three times greater

than the rate among non-Black Chicagoans.

Figure 12. Number of years homicide, heart disease, and opioid overdoses contribute to the life expectancy gap between Black and non-Black Chicagoans, 2015-2022.



Source: Illinois Department of Public Health, Division of Vital Records, Death Certificate Files, 2015-2022; U.S. Census Bureau, 2010 and 2020 Decennial Census.

According to data from the **Chicago Fire Department** (CFD), opioid-related Emergency Medical Services (EMS) responses in Chicago increased from under 3,000 responses annually in 2015 to over 10,000 in 2023, with a peak of 13,794 in 2020. The number of fatal overdoses in Chicago also continues to rise. Per the **Cook County Medical Examiner**, preliminary data indicates over 1,300 opioid-related overdose fatalities and over 1,500 fatal drug overdoses in 2023. Thus, each year, there are more opioid-related overdose deaths in Chicago than there are homicides and traffic crash fatalities combined.

Certain populations face a significantly higher risk of overdose. Individuals recently returning from jail or prison are particularly vulnerable, with a 40-129 times elevated risk of fatal opioid overdose compared to the general public[2]. Additionally, research has shown that many individuals leaving supervised withdrawal ("detox") or abstinence-based treatment facilities resume drug use shortly after discharge, which heightens their risk of overdose[3]. Individuals who have just given birth are also at increased risk of experiencing an overdose, particularly in the period soon after giving birth[4]. Finally, individuals who have nonfatally overdosed in the past are at heightened risk of overdosing again[5].

In Chicago, certain demographic groups experience significantly elevated rates of fatal overdose.

[2]Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007). Release from prison—a high risk of death for former inmates. New England Journal of Medicine, 356(2), 157-165.

[3]Strang J, McCambridge J, Best D, Beswick T, Bearn J, Rees S, Gossop M. Loss of tolerance and overdose mortality after inpatient opiate detoxification: follow up study. BMJ. 2003 May 3;326(7396):959-60. doi: 10.1136/bmj.326.7396.959. PMID: 12727768; PMCID: PMC153851.

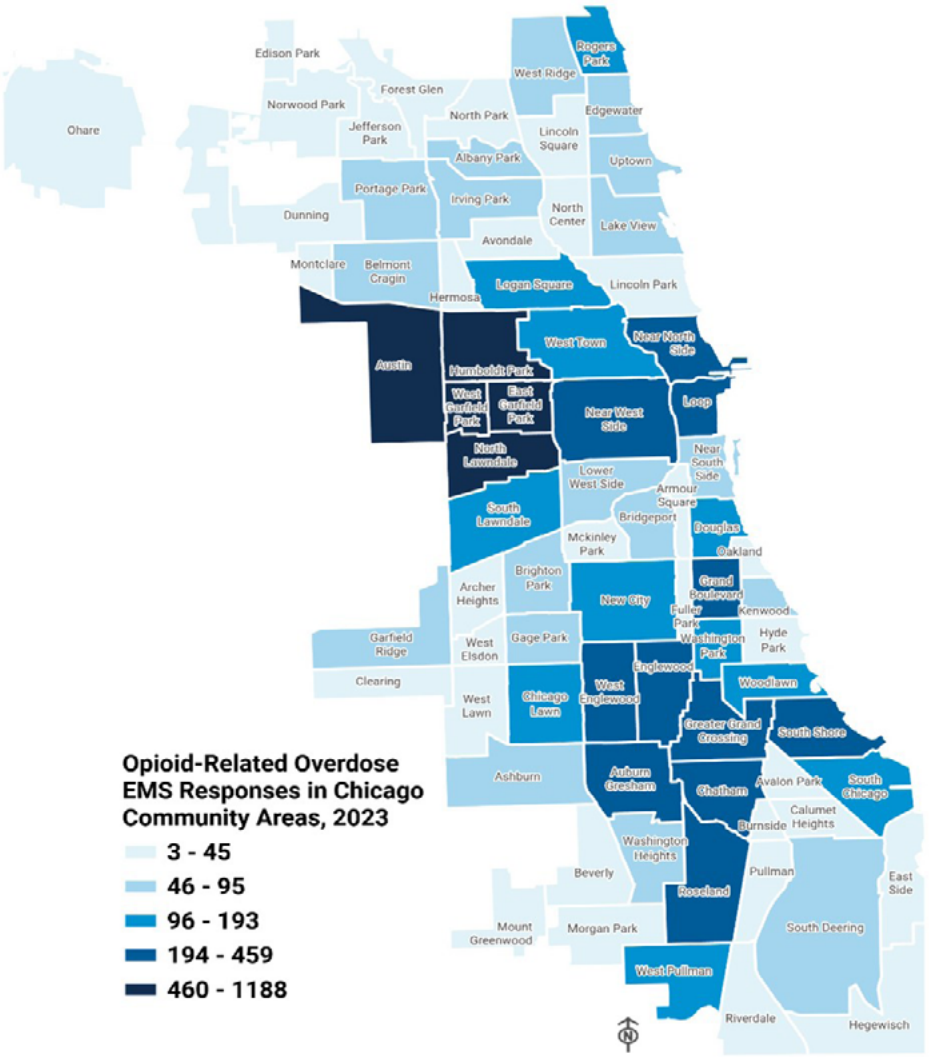
[4]Bruzelius E, Martins SS. US Trends in Drug Overdose Mortality Among Pregnant and Postpartum Persons, 2017-2020. JAMA. 2022;328(21):2159–2161. doi:10.1001/jama.2022.17045

[5]Caudarella, A., Dong, H., Milloy, M. J., Kerr, T., Wood, E., & Hayashi, K. (2016). Non-fatal overdose as a risk factor for subsequent fatal overdose among people who inject drugs. Drug and alcohol dependence, 162, 51-55.

Males, Black Chicagoans, individuals aged 45-64, and people living in communities of high economic hardship are most heavily impacted by fatal opioid overdose in Chicago. Research has shown that individuals experiencing homelessness and housing instability have increased rates opioid overdoses, as well as individuals who have a history of overdose or a Substance Use Disorder (SUD). In 2020, the opioid-related overdose death rate among Black males aged 45-64 years was six times higher than the rate among White males of the same age group.

Moreover, while overdose occurs in all 77 of Chicago's community areas, some communities have a significantly elevated overdose burden. The West Side community areas consistently account for the greatest number of opioid-related overdoses in the city (Map 3) while East Garfield Park, West Garfield Park, North Lawndale, and Englewood all rank among the top 5 for the highest opioid-related overdose mortality rate in Chicago.

Map 3. 2023 opioid-related overdose EMS responses in Chicago by community area



Source: Chicago Fire Department, Emergency Medical Services (EMS), 2023

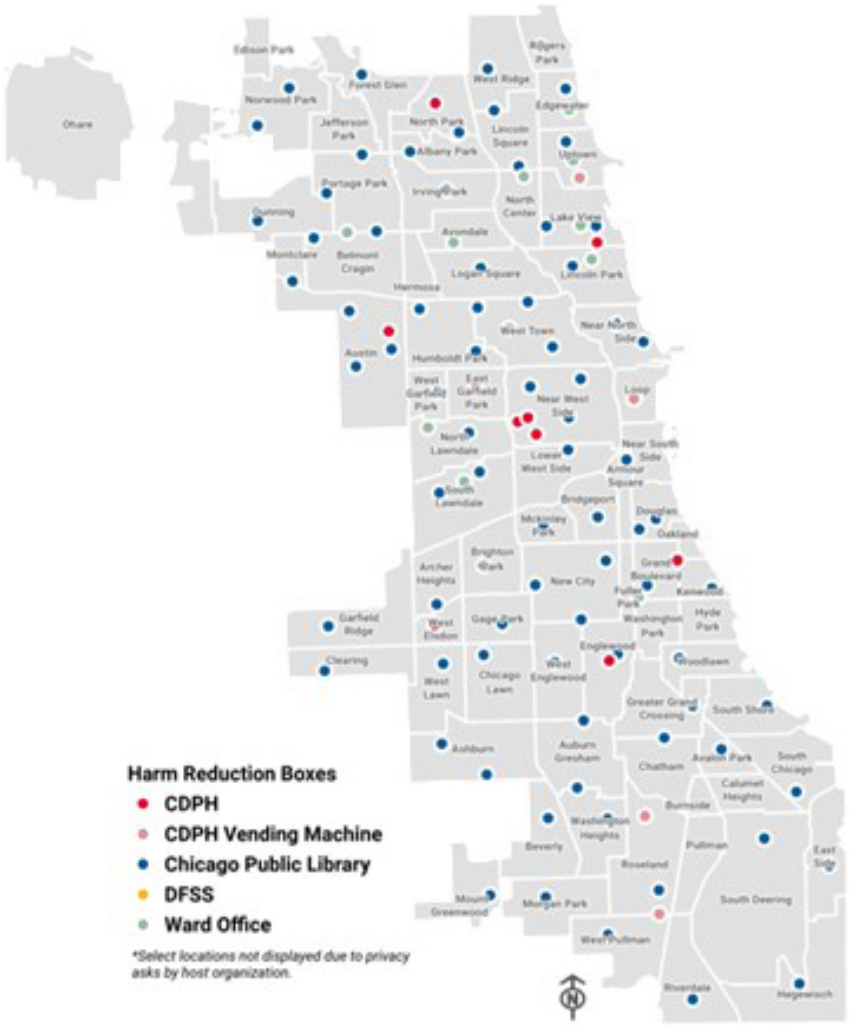
Priorities & Action Plans

Substance Use Action Plans

1. Set protocols around monitoring and maintenance of naloxone saturation
2. Conduct canvassing and develop a marketing campaign to increase uptake of Medications for Opioid Use Disorder (MOUD)
3. Increase public engagement and awareness of Substance Use Disorder (SUD) and available resources programs

1. **Set protocols around monitoring and maintenance of naloxone saturation**
   CDPH's **Office of Substance Use** will set protocols around the monitoring and maintenance of naloxone (Narcan) saturation throughout the city of Chicago. 'Saturation' refers to the amount of naloxone doses available in a specific geographic area that is needed to effectively reduce the rate of overdose deaths. The Office of Substance Use will develop a system to monitor saturation and use this data to inform hyperlocal distribution strategies. Consistent and efficient distribution should ensure enough Narcan is always available where people need it most. CDPH stocks public-access Narcan at numerous locations across Chicago including public libraries, public health vending machines, and some aldermanic offices. As 44% of adults who utilized the public health vending machines reported ever witnessing an overdose, it is vital that life-saving drug reversal agents are easily available at public locations, especially on the city's West Side. Monitoring usage and maintaining saturation in the high priority communities will be essential to reducing inequitable overdose outcomes.

Map 4. Public-access Narcan locations in Chicago



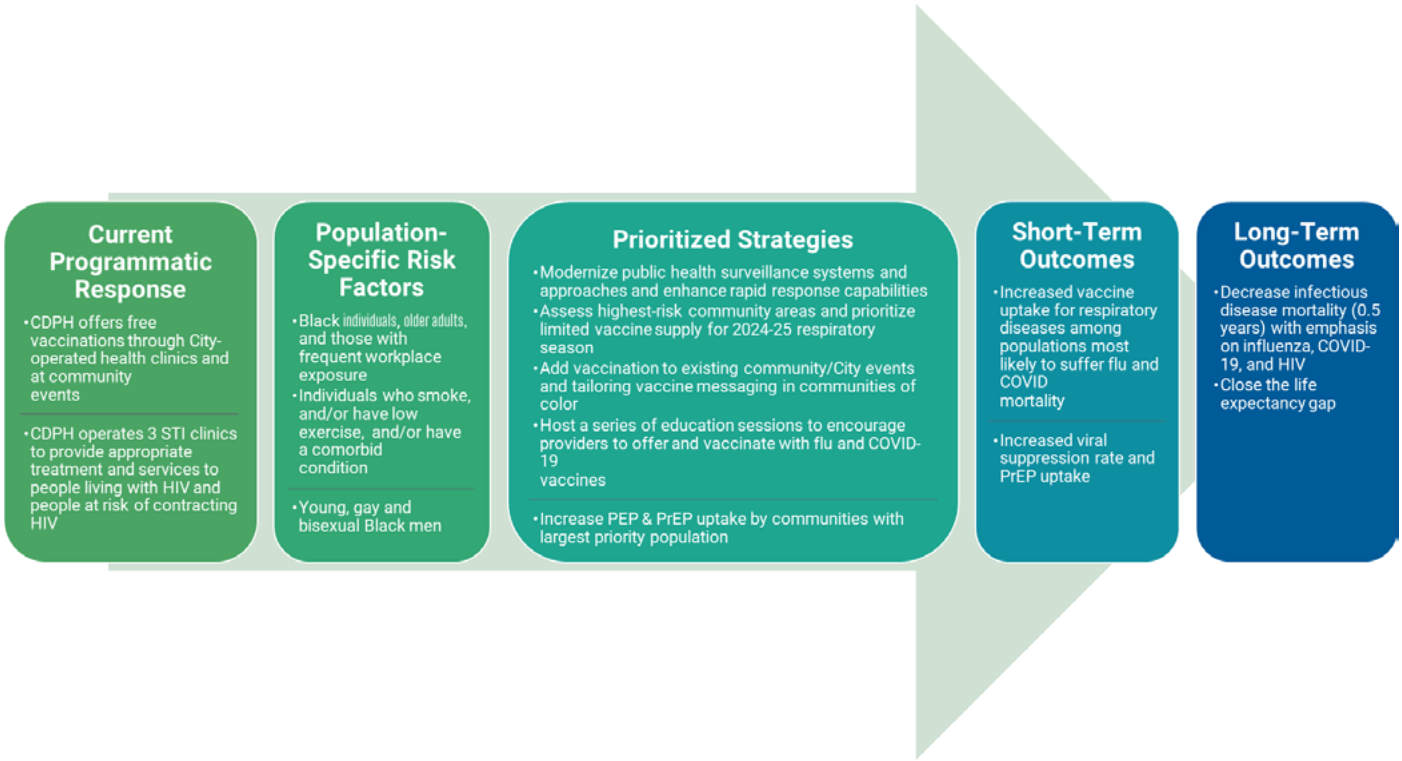
2. **Conduct canvassing and develop a marketing campaign to increase uptake of Medications for Opioid Use Disorder (MOUD)**

   CDPH will canvass priority communities with the highest number of overdose-related EMS calls to assess current knowledge, perception, and utilization of Medications for Opioid Use Disorder (MOUD) and barriers and facilitators to uptake. MOUD is an evidence based effective treatment and harm reduction intervention for people with an Opioid Use Disorder (OUD) to help individuals quit substance use by minimizing withdrawal symptoms and reducing the likelihood of overdose-related death. The Office of Substance Use in partnership with CDPH's Public Information Office (PIO) will utilize the learnings from community canvassing to develop a hyperlocal MOUD marketing campaign to be rolled out in summer of 2025. This campaign will aim to increase awareness and accessibility of MOUD which can be prescribed over the phone through the MAR NOW hotline at 833-234-6364. The campaign will locate information and resources where people are on a neighborhood-by neighborhood-basis, targeting priority individuals with advertisements on social media, at bus stops and train stations, in libraries and homeless shelters, near local eateries and high-traffic roadways, and other places frequented by residents.

3. **Increase public engagement and awareness of Substance Use Disorder (SUD) and available resources programs**
   An additional informational campaign will be launched to spread broader awareness of SUD as a disease rather than a moral failing. The campaign will focus on reducing stigma and equip all individuals with information regarding resources and programs available to help prevent overdose-related mortality. This campaign will have physical deliverables as well, including a talking guide and printable resources to be utilized by community partners and city staff at community events. These resources will be culturally appropriate and targeted geographically at high-impact settings within our priority communities.

Infectious Disease Action Plan

Theory of Change



Background Data & Community Profiles

Respiratory Infectious Disease

In 2022, communicable diseases contributed nearly one year (0.9 years) to the 11.4-year life expectancy gap between Black and non-Black Chicagoans. Within this category, COVID-19 contributed 0.4 years, and pneumonia and influenza contributed 0.2 years. Mirroring national trends, influenza-associated hospitalization rates are highest among Blacks and experience worse COVID-19 outcomes compared to other racial and ethnic groups.

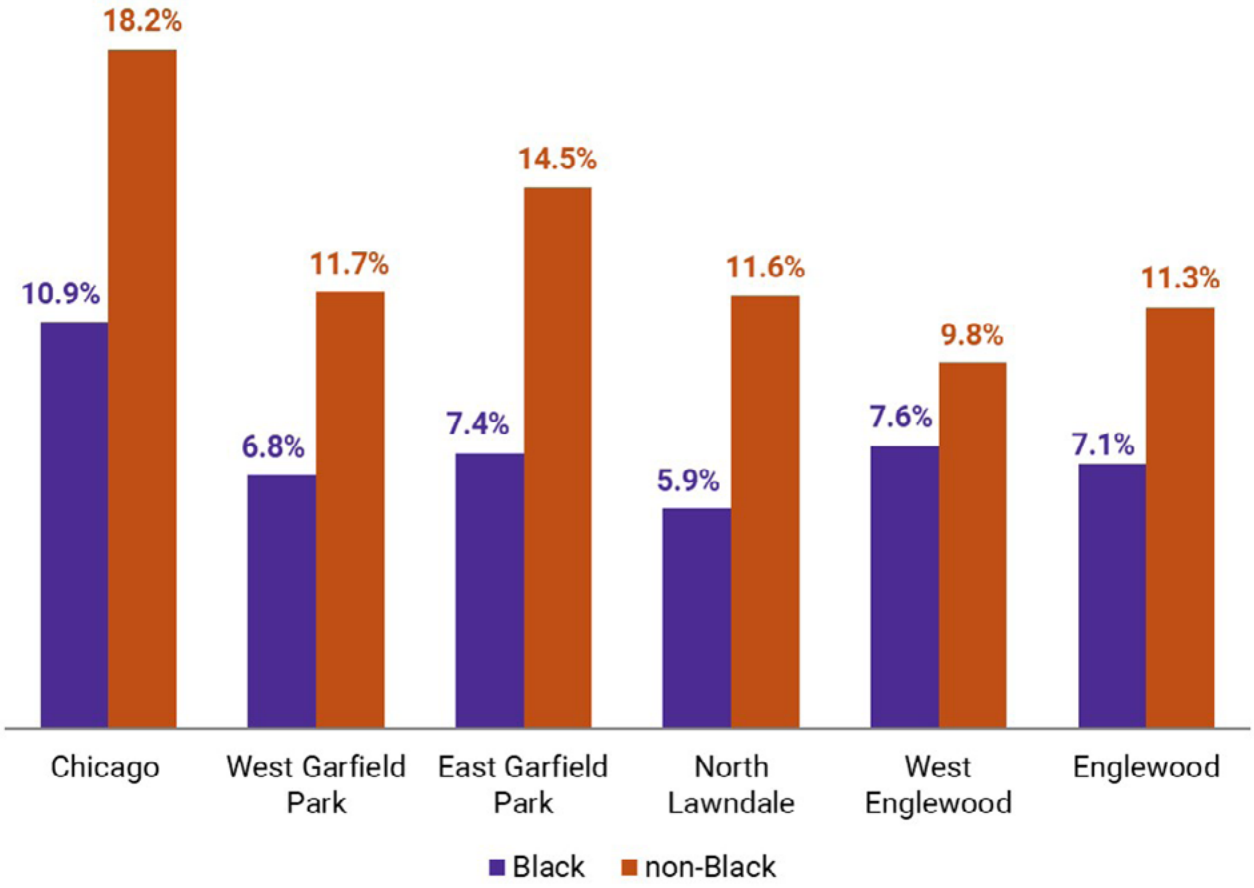
The Vaccine-Preventable Diseases (VPD) Surveillance Program at CDPH regularly analyzes data from the Illinois immunization registry to estimate COVID-19 and influenza vaccination coverage rates across the city. During the 2023-24 respiratory season, vaccine uptake among Black Chicagoans continued to lag behind that of non-Black Chicagoans. COVID-19 and influenza vaccination coverage among Black Chicagoans was 10.9% and 18.2% respectively, while vaccination rates among non-Black Chicagoans were 18.8% and 31.5% respectively (Figures 13 and 14).COVID-19 vaccination coverage among Black residents within the five priority communities was amid the lowest citywide: North Lawndale (5.9%), West Garfield Park (6.8%), West Englewood (7.6%), East Garfield Park (7.4%), and Englewood (7.1%) (Figure 13). Many of these community areas similarly had low influenza vaccine coverage as well, though coverage rates were higher than the COVID-19 coverage rates across the board (Figure 14).

Despite the wide availability of highly effective vaccines for both influenza and COVID-19, longstanding disparities in vaccine coverage across racial and ethnic groups persist both locally and nationally. Since the start of the COVID-19 pandemic, the COVID-19 vaccine has been free to all people regardless of insurance status. Even during the 2023-24 respiratory season when the COVID-19 vaccine was commercialized, the Centers for Disease Control and Prevention's (CDC) Bridge Access Program provided free COVID-19 vaccines to adults without health insurance and to adults whose insurance did not cover all COVID-19 vaccine-related costs. After the Bridge Access Program ended in August 2024, CDPH will continue to provide free vaccines to adults that do not have medical insurance.

The VPD Surveillance Program also tracks influenza-associated Intensive Care Unit (ICU) hospitalizations to assess illness severity. Over the past decade, the rate of influenza-associated ICU hospitalizations in Black Chicagoans was the highest among all racial and ethnic groups, an average of 2.25 times higher than that of White Chicagoans. This trend has been worsening over time, with Black Chicagoans having an ICU hospitalization rate 3.2 times greater than White Chicagoans throughout the 2022-23 respiratory season. During the most recent respiratory seasons, influenza ICU hospitalizations occurred more frequently in community areas with lower vaccine coverage. Communities of color often experience the highest rates of morbidity and mortality from respiratory illness due to underlying elevated rates of chronic disease. These comorbid chronic conditions are reflected throughout the life-expectancy gap analysis and significantly predispose individuals to worse clinical outcomes after respiratory virus infection[6]. Increasing vaccination rates within the priority communities can effectively help mitigate the risk of infectious disease death by reducing the rate of seasonal respiratory infection.

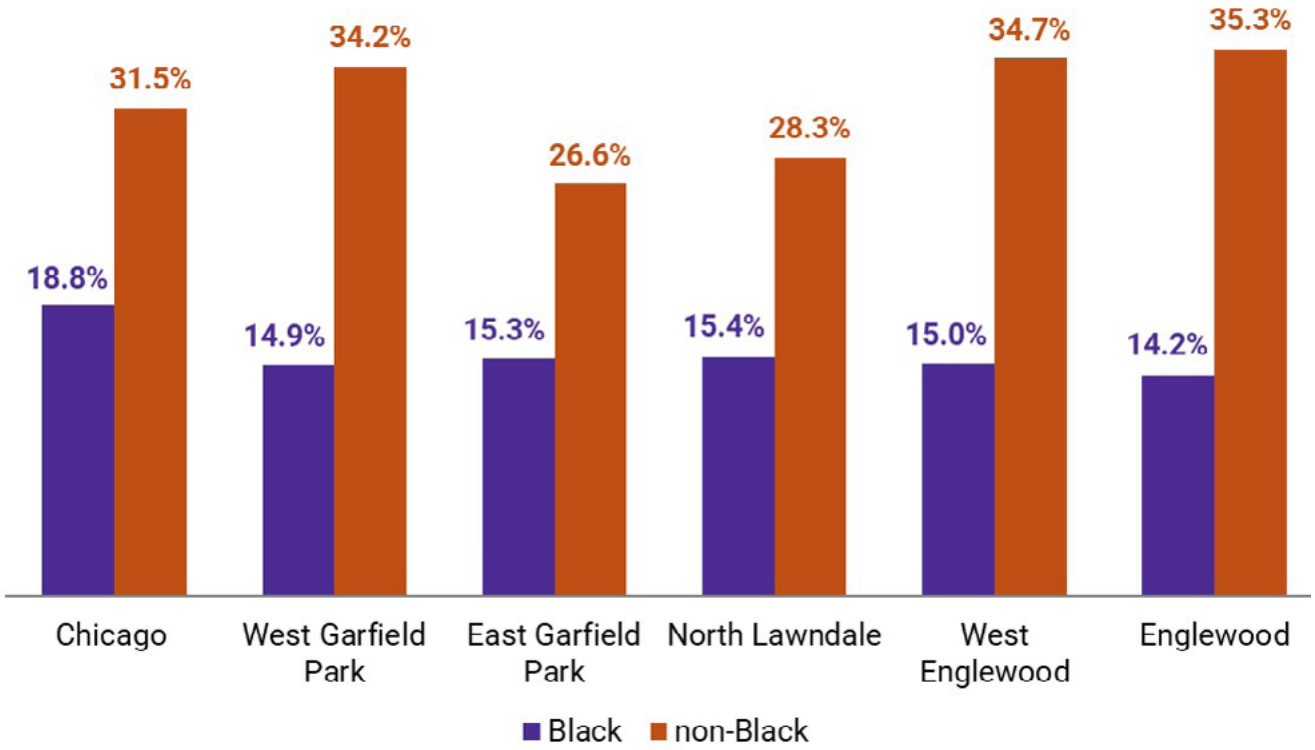
[6] Centers for Disease Control and Prevention. (2024, January 26). People with chronic medical conditions continue to account for the majority of flu hospitalizations this season. Influenza (Flu). https://www.cdc.gov/flu/whats-new/2023-2024-higher-risk-hospitalizations.html#:~:text=Overall%2C%20among%20people%20hospitalized%20with,they%20have%20chronic%20medical%20conditions.

Figure 13. COVID-19 vaccination coverage among Black and non-Black Chicagoans by Chicago priority community areas, 2023–2024



Source: 2023-2024 formula COVID-19 vaccinations reported to the Illinois Comprehensive Automated Immunization Registry Exchange (I-CARE). Excludes patient records with unknown race-ethnicity.

Figure 14. Influenza vaccination coverage among Black and non-Black Chicagoans by Chicago priority community areas, 2023–2024



Source: 2023-2024 formula influenza vaccinations reported to the Illinois Comprehensive Automated Immunization Registry Exchange (I-CARE). Excludes patient records with unknown race-ethnicity.

Syndemic Infectious Disease

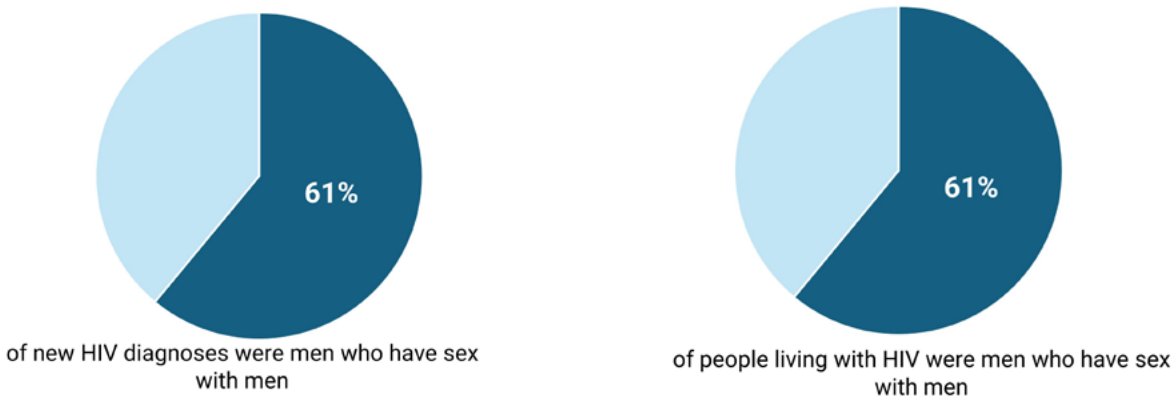
The term 'syndemic' is a combination of 'synergy' and 'epidemic', where synergy is the interaction of two or more agents that produces a combined effect greater than the sum of their separate efforts. Thus, a syndemic is a combination of two or more overlapping epidemics connected through behavior, biology, and social conditions, resulting in an exacerbated health burden across a population. Poverty, unstable housing, low uptake of adequate healthcare, limited access to sufficient and nutritious food, generational trauma, poor environmental conditions, a lack of opportunity and education, and other factors create conditions for clustering and lead the residents of priority communities addressed in this strategic plan to be left vulnerable to worse health outcomes. These syndemic drivers may present opportunities for interventions with broad applications.

Human Immunodeficiency Virus (HIV) is a common syndemic disease because it is sometimes diagnosed in conjunction with other diseases due to sociodemographic, behavioral, and biological factors. Sexual behavior and injection drug use are primary behaviors associated with HIV as well as other Sexually Transmitted Infections (STIs), Mpox, and Hepatitis B and C. Through biological mechanisms, HIV weakens the immune system and leaves an individual susceptible to opportunistic infections as well, including Tuberculosis (TB). Black Chicagoans make up about 30% of the City's population, however 50% of all infectious disease deaths occur among the Black population. Over the past decade, there have been roughly 1,000 HIV-related deaths in the City of Chicago, the majority were Black males. As of 2022, cisgender males who engage in male-to-male sexual contact accounted for roughly 61% of the prevalent HIV cases and 61% of the 633 new HIV diagnoses (Figure 15). The CDPH Syndemic Infectious Disease team promotes cross-program collaboration to address the common risks of syndemic diseases and integrates funding to create comprehensive programs

for patient-level service integration across health conditions. By developing robust systems of care for HIV, health literacy, screening, counseling, linkage to care, and wraparound supportive services may all be provided at a single point of care. These integrated systems have been proven to result in higher quality care, demonstrated by 80% of people newly diagnosed with HIV linked to healthcare and supportive services within 30 days of diagnosis in 2022 (Figure 16).

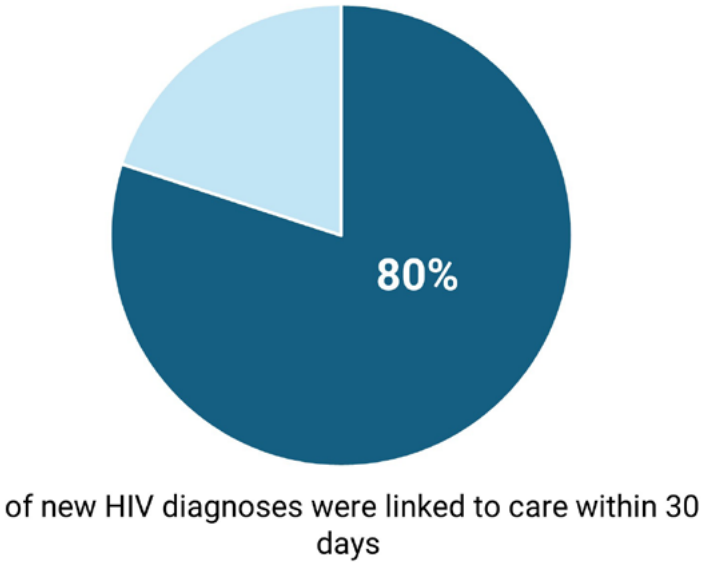
However, there are still notable inequities seen in HIV prevention and care services, new and early diagnoses, and adherence to treatment across demographics. The expansion and adaptation of existing HIV surveillance, epidemiology, and public health interventions will aim to better serve gay and bisexual men and injection drug users in our priority community areas who are disproportionately affected by HIV and other common syndemic diseases to achieve health equity.

Figure 15. Proportion of new and prevalent HIV diagnoses who are men who have sex with men.



Source: Chicago enhanced HIV/AIDS reporting system (eHARS) (data as of 12/27/2023).

Figure 16. Linkage to care within 30 days of HIV diagnosis, 2022.



Source: Chicago enhanced HIV/AIDS reporting system (eHARS) (data as of 12/27/2023).

Priorities & Action Plans

Infectious Disease Action Plans

1. Modernize public health surveillance systems and approaches and enhance rapid response capabilities
2. Perform in-depth analysis to assess highest-risk community areas and prioritize limited vaccine supply for 2024-25 respiratory season
3. Plan and execute 2024-2025 flu/COVID-19 campaign by adding vaccination to existing community/City events and tailoring vaccine messaging in communities of color
4. Host a series of provider education sessions to encourage providers to offer and vaccinate with the 2024-2025 flu and COVID-19 vaccines
5. Fund and promote the uptake of the HIV Services Portfolio to provide linkages to care and supportive, wraparound services
6. Design an advertising campaign to increase PrEP uptake
7. Implement Low-Barrier Care (LBC) for persons living with HIV through its Population Centered Health Homes

Repiratory Infectious Disease

CDPH selected five community areas to be targeted by the respiratory disease action plans. Although these communities have incomplete overlap with the departmentwide priority communities, they all have predominantly Black or Latinx populations with high incidence of influenza and COVID-19 morbidity. The priority areas for this initiative are Burnside, West Garfield and West Englewood for Black community areas as well as Hermosa and McKinley Park.

1. **Modernize public health surveillance systems and approaches and enhance rapid response capabilities**
   In coordination with the Epidemiology and Laboratory-based Surveillance Programs, the Vaccine Preventable Disease (VPD) and Immunizations Programs will leverage capacity brought on during the COVID-19 pandemic to modernize public health surveillance systems and approaches and enhance rapid response capabilities. CDPH will build internal-facing views within the Disease Control Bureau's Surveillance for Emerging and Novel Threats and Reportable Illnesses and Injuries (SENTRII) system, which facilitates automated processing, summarization, visualization, and analysis of data from multiple disparate sources to support decision-making. This system can facilitate more rapid detection and assessment of infectious disease threats in Chicago. Further, we will deploy Rapid Response Testing Teams to help mitigate healthcare access issues and more rapidly detect, diagnose, and respond to public health crises. Additionally, we will narrow disease reporting gaps resulting from lack of healthcare access and other disparities by using data collected through wastewater testing and indoor air sampling technology, which don't rely on clinical testing results. The infectious disease team will introduce predictive analytic capabilities into our surveillance processes by informing the development of compartmental and agent-based models by contracted partners at **Argonne National Laboratory**. This will allow CDPH to estimate the effectiveness of proposed interventions on specific populations before they are implemented. Finally, as accurate and efficient data exchange provides us the information required to respond in a timely and appropriate manner, the Disease Control Bureau will support efforts by the CDPH Informatics Program to establish a more efficient data exchange with healthcare sites, particularly those serving vulnerable populations.

2. **Perform in-depth analysis to assess highest-risk community areas and prioritize limited vaccine supply for 2024-25 respiratory season**
   The CDPH Vaccine-Preventable Disease (VPD) Surveillance Team analyzed disease surveillance data to assess highest-risk community areas and develop a 2024-25 respiratory season vaccination plan that prioritizes vaccination among people and places with greatest vulnerability to flu and COVID-19 related mortality. Flu-associated Intensive Care Unit (ICU) admissions and COVID-19 hospitalizations which were required to be reported in Illinois through Illinois National Electronic Disease Surveillance System were used as a proxy for severe disease and mortality. The incidence of flu ICU admissions during two previous respiratory seasons (2021-22 and 2023-24) and the incidence of COVID-19 hospitalizations during the last respiratory season (2023-24) was estimated among Black residents by community area. Community areas with high rates of flu ICU hospitalizations and COVID-19 hospitalizations among Black residents, including West Garfield Park and West Englewood were prioritized for the 2024-25 respiratory season community vaccine events.

3. **Plan and execute 2024-2025 flu/COVID-19 campaign by adding vaccination to existing community/City events and tailoring vaccine messaging in communities of color**
   The CDPH Immunization Team will host a series of provider education sessions to encourage providers to offer and vaccinate patients with the 2024-2025 flu and COVID-19 vaccines. CDPH will work with the **Illinois Chapter of American Academy of Pediatrics** and the **Illinois Department of Public Health** to plan a provider webinar series on fall 2024-2025 seasonal flu and COVID-19 vaccines. We will host these on-going team meetings with relevant stakeholders and work with them to schedule vaccination events for most vulnerable

populations.

4. **Host a series of provider education sessions to encourage providers to offer and vaccinate with the 2024-2025 flu and COVID-19 vaccines**
   The CDPH Immunization Team will plan and execute a 2024-2025 flu/COVID-19 campaign by adding vaccination to existing community and City-led events and tailoring vaccine messaging in communities of color. A series of planning meetings with City personnel, health, and community-based partners will help provide a landscape of potential events to layer with CDPH vaccination. After consideration, a schedule of vaccination campaign clinic events will be determined with an emphasis on serving communities with the lowest COVID-19 vaccination uptake in the 2023-2024 season, least access to vaccine, highest uninsured rates, and worst health outcomes.

Syndemic Infectious Disease

5. **Fund and promote the uptake of the HIV Services Portfolio to provide linkages to care and supportive, wraparound services**
   CDPH's Syndemic Infectious Disease team will continue to fund and promote uptake of the HIV Services Portfolio to serve people living with and at risk of contracting HIV with appropriate care. This calls for the ongoing operation of four CDPH Healthcare Access Programs: Population Centered Health Homes, HIV Medical Services, Essential Supportive Services, and HIV Medical Case Management. These programs offer low-barrier HIV and STI screenings and linkage to treatment, PrEP prescription and linkage to treatment, and an array of wraparound supportive services including food, transportation, legal, mental health, oral health, and substance use services to people living with HIV.

6. **Design an advertising campaign to increase PrEP uptake**
   The Syndemic Infectious Disease team will work to increase PrEP uptake among residents of the priority communities of Greater Garfield Park, Greater Englewood, and North Lawndale through an advertising campaign. This will expand the geographic reach of CDPH's HIV prevention work as the current primary focus is within the South Shore and Austin community areas due to their largest number of new HIV diagnoses. A hyperlocal strategy of PrEP advertising through social media, sex-seeking sites, and local providers aims to drive connection to treatment specifically among gay Black men at risk for HIV. This will include a combination of advertising and print materials to achieve multiple touchpoints and increase likelihood of uptake.

7. **Implement Low-Barrier Care (LBC) for persons living with HIV through its Population Centered Health Homes**
   CDPH will implement Low-Barrier Care (LBC) for persons living with HIV through its Population-Centered Health Homes. LBC prioritizes individuals with complex behavioral and/or medical conditions that compromise one's ability to consistently attend medical care appointments and take HIV medications. To serve these high-vulnerability individuals, LBC will offer walk-in access to medical care and intensive supportive services and incentives to motivate sustained engagement in care. These services will be available to persons living with unsuppressed HIV in the five priority community areas to reduce HIV-related mortality.

Infant and Maternal Health Action Plan

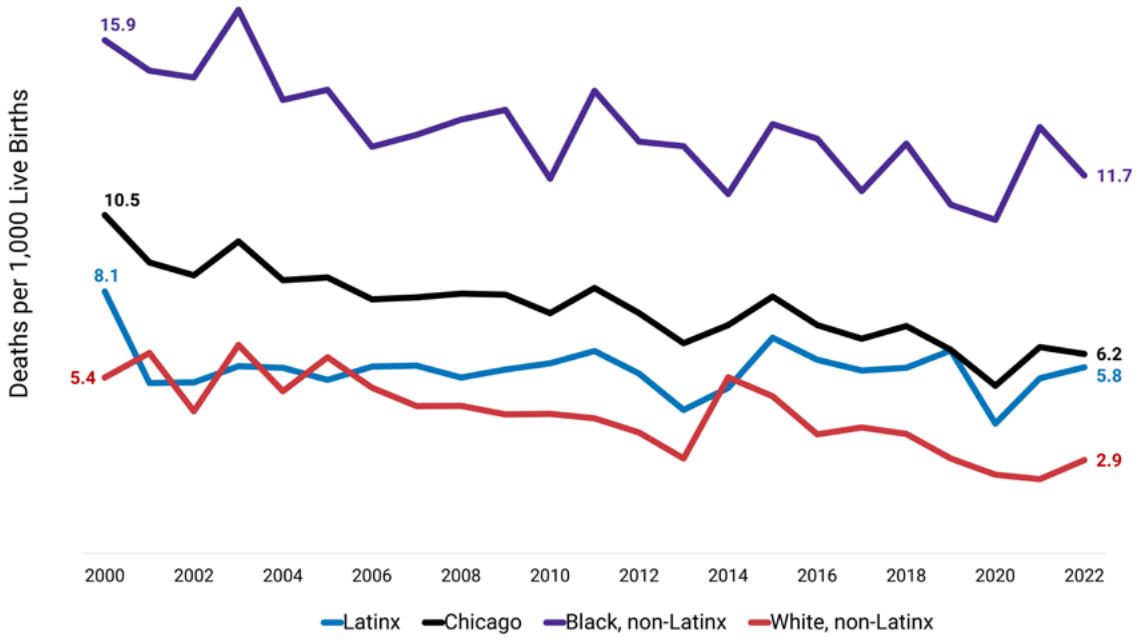
Theory of Change

Background Data & Community Profiles

In 2022, infant mortality contributed 0.4 years to the racial life expectancy gap between Black and non-Black Chicagoans. From 2020-2021, Black infants were five times more likely, and Latinx infants were twice as likely, to die before their first birthday compared to White infants (Figure 17). While

infant mortality among all Chicagoans has decreased citywide by 41% since 2000, the gap has widened as infant mortality rates decreased 47% among White infants during this period but only 32% among Black infants. Fifteen community areas in Chicago have an infant mortality rate that is double the national goal of 5 infant deaths per 1,000 births. All 15 of these community areas are located on the South and West sides and include both the Greater Englewood and the Greater Garfield Park communities. Englewood has the highest infant mortality rate in the city at 17.3 per 1,000 live births, nearly triple the city's overall rate of 6.3 deaths per 1,000.

Figure 17. Infant mortality rate by race and ethnicity, Chicago, 2000-2022



Source: Illinois Department of Public Health, Division of Vital Records, Birth Certificate Data Files, 2000-2022; Illinois Department of Public Health, Division of Vital Records, Death Certificate Data Files, 2000-2022

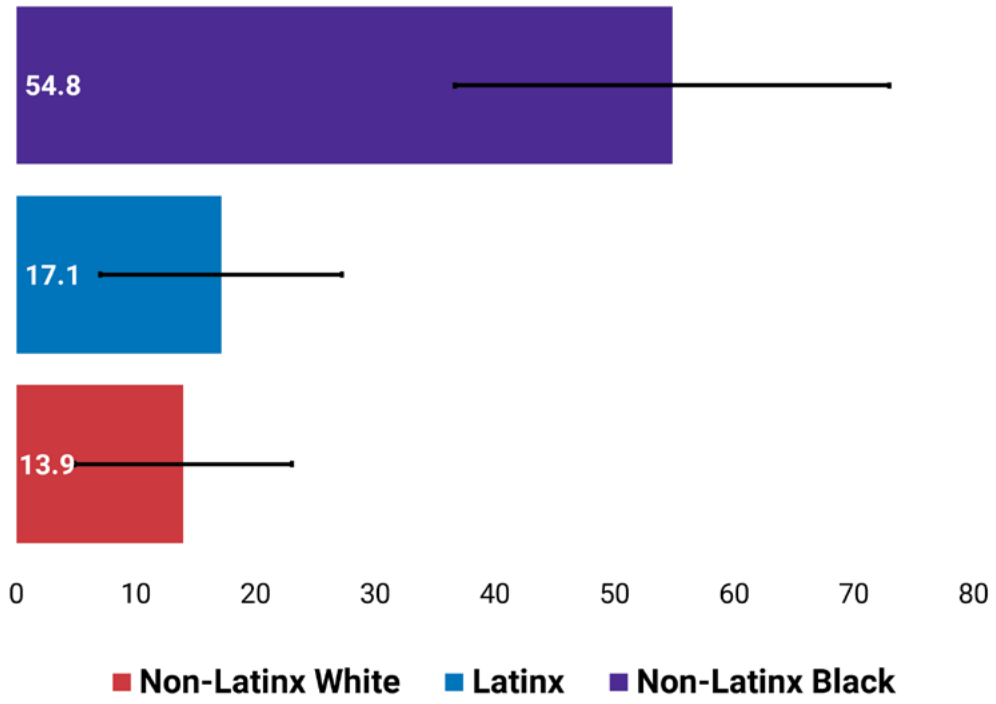
The top causes of infant death in Chicago are, in order of incidence, prematurity and low birth weight, sudden unexpected infant death (SUID), and congenital anomalies and disorders. Across all three categories, Black infants have the highest rate of death. From 2018-2022, while Black infants were about twice as likely to die from congenital anomalies or low birth weight than non-Black infants, they were seven times more likely to experience a SUID. As 99% of sleep-related deaths in Cook County happen in an unsafe sleep environment[7], most SUIDs are preventable with adequate community and social support for safe sleep. Further contributing to disparity, infants exposed to prenatal smoking were 2.3 times more likely to die in the first year of life than non-exposed infants. Though the citywide rate of smoking during pregnancy is 1.1%, in West Garfield Park, this value is 8.2%. Therefore, reducing prenatal and postnatal exposure to smoking is essential, as this risk factor contributes to 10% of all SUIDs.

Maternal morbidity and mortality are also a priority concern for CDPH. While maternal mortality alone is not a leading driver of the racial life expectancy gap, it is essential to improve the health of both birthing persons and infants as the health outcomes for both groups are inextricably linked. In Chicago from 2015-2020, Black women were four times more likely to die from pregnancy-related

[7]Cook County Medical Examiner's Office; Rush University Medical Center. (2022). Sudden Unexpected Infant Death. Cook County Report 2020-2021. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.rush.edu/sites/default/files/media-documents/suid-report-20-21.pdf

causes than non-Black women[89]. (Figure 18). Among Black women, 89% of pregnancy-related deaths were preventable had there been adequate community, medical, or social support. In addition, the rate of severe maternal morbidity for Black women from 2018-2022 was nearly twice the race for non-Black women and is particularly concentrated around Greater Garfield Park on the West Side and Greater Englewood on the South Side.

Figure 18. Pregnancy-related mortality ratio per 100,000 live births by race and ethnicity, Chicago, 2015-2020.



Black lines indicate 95% confidence intervals

Source: Illinois Department of Public Health, Maternal Mortality Review Committee; Illinois Department of Public Health, Division of Vital Records, Birth Certificate Data Files, 2015-2022.

Poverty, preterm birth, and lack of early and adequate prenatal care are the greatest risk factors for infant mortality. In Chicago, 43% of Black children under five live in poverty, nearly double the citywide average. Similarly, 14% of Black infants were born preterm and 15% were born with a low birth weight, again double the citywide average. These disproportions appear even prior to birth, with 82% of White pregnant women receiving early and adequate prenatal care compared to only 58% of Black pregnant women. One in nine infants who died within the first year of life were born to pregnant people who received no prenatal care. The priority communities of Englewood, North Lawndale, and West Garfield Park account for three of the five lowest rates of prenatal care utilization among the 77 community areas citywide. Consequently, CDPH operates numerous programs, most notably the Special Supplemental Nutrition Program for Women, Infants, and Children and **Family Connects Chicago** to help combat these inequities. The work of CDPH's MICAH aims to ensure all birthing people and

[8]Illinois Department of Public Health. (2024, October 23). 2023 maternal morbidity and mortality report. Maternal morbidity and mortality. https://dph.illinois.gov/content/dam/soi/en/web/idph/publications/idph/topics-and-services/life-stages-populations/maternal-child-family-health-services/maternal-health/mmmr/maternal-morbidity-mortality-report2023.pdf

[9]Illinois Department of Public Health (2023). 2022 birth statistics. Vital statistics. https://dph.illinois.gov/content/dam/soi/en/web/idph/publications/idph/topics-and-services/life-stages-populations/maternal-child-family-health-services/maternal-health/mmmr/maternal-morbidity-mortality-report2023.pdf

parents in Chicago have the medical and social support they need to have healthy pregnancies and raise healthy babies. The challenge now is to ensure program quality, community acceptance, and participant uptake for these life-saving supportive resources.

Priorities & Action Plans

Infant and Maternal Health Action Plans

1. Hyperlocal outreach to promote safe sleep practices
2. Complete a community assessment to understand facilitators and barriers to prenatal care and roll out an educational media campaign
3. Modernize the Women, Infants, and Children (WIC) program through various strategies to maximize utilization
4. Increase Family Connects Chicago participation by increasing awareness and facilitating access

1. **Hyperlocal outreach to promote safe sleep practices**
   CDPH will coordinate hyperlocal community outreach to provide education and resources that promote safe sleep practices in priority communities and other community areas with the highest rates of infant mortality related to SUID. This will require partnering with CBOs to deliver safe sleep education and resources at fairs, parent groups, libraries, schools, churches, neighborhood festivals, community baby showers, small businesses and other places where parents and those who support them gather.

2. **Complete a community assessment to understand facilitators and barriers to prenatal care and roll out an educational media campaign**
   CDPH will complete a comprehensive community assessment to understand both the facilitators and barriers to prenatal care. The findings will be used to design a tailored outreach and education campaign to promote access to early, adequate and risk-appropriate prenatal care in priority communities with the lowest rates of prenatal care. The assessment will include a complete literature review, quantitative data analysis, and analysis of insights gathered through interviews and focus groups with pregnant or recently pregnant people. Following the discovery phase, CDPH's MICAH team will develop data and evidence-informed prenatal health literacy tools and educational materials. These materials will include messaging and culturally appropriate engagement tactics informed by the data and literature. Finally, hyperlocal dissemination of the information through community and individual level engagement activities and media campaigns will be initiated, leveraging Family Connects Chicago community alignment, the WIC program, and other maternal child health partners.

3. **Modernize the Women, Infants, and Children (WIC) program through various strategies to maximize utilization**
   CDPH will advance strategies to increase participation in WIC services among pregnant people and new parents in priority community areas through program innovation and enhanced outreach. This innovation and outreach will be informed by improved access to programmatic and citywide data on utilization of WIC services. CDPH will participate in a pilot to mobilize WIC services and resources in the communities that are underserved. This effort will be enhanced through partnerships with the Greater Chicago Food Depository and Illinois Public Health Institute to support widespread outreach. Additionally, CDPH will implement technology-

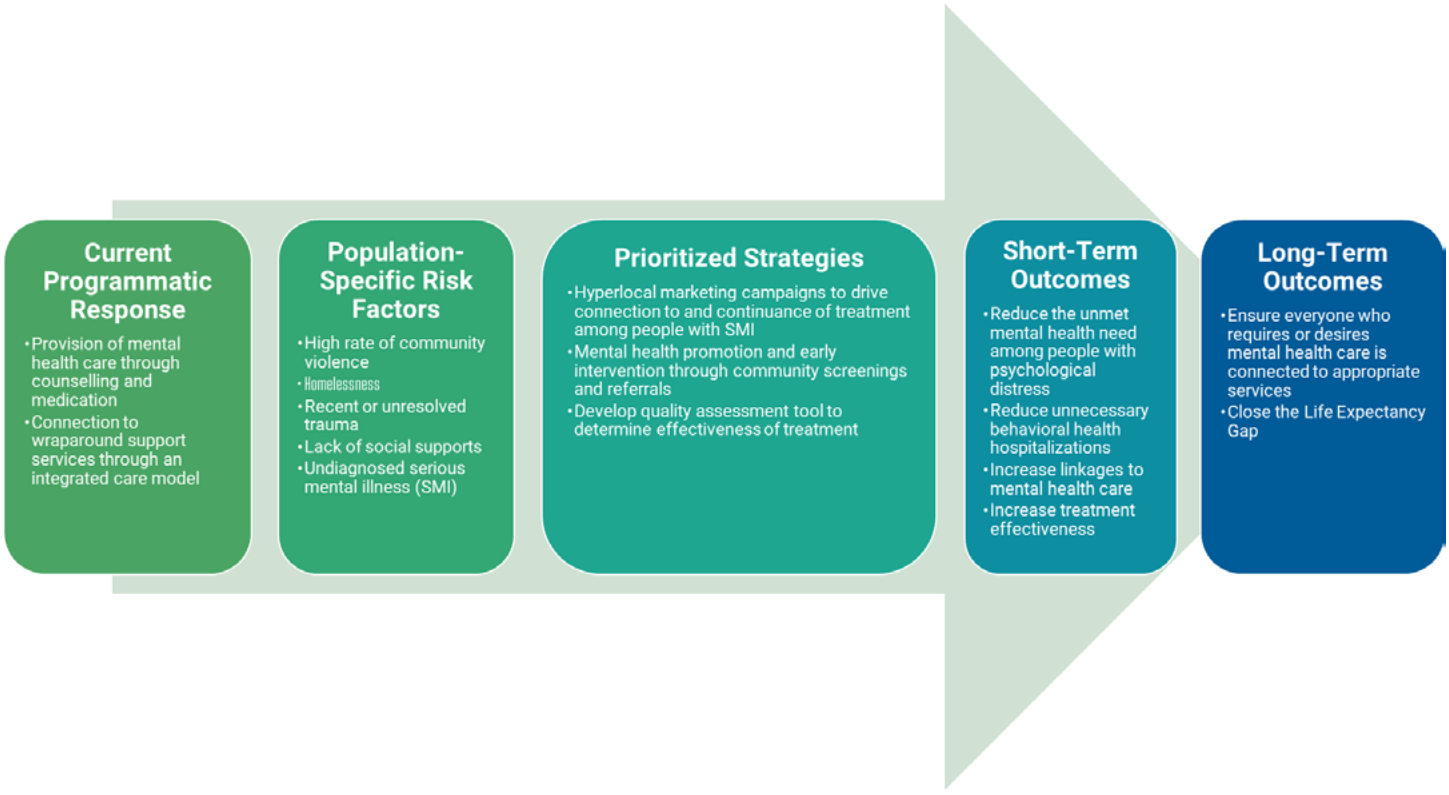
based solutions to enhance WIC clinical service delivery and streamline and track referrals to wraparound services. With the aim of improving rates of breastfeeding initiation and duration, CDPH will expand WIC services by hiring a breastfeeding coordinator and getting clinical staff certified in breastfeeding/lactation support. All of these efforts will be most effective at improving infant and maternal health outcomes if initiated early. Thus, CDPH plans to expand partnerships with prenatal providers and organizations serving pregnant people to promote enrollment in WIC earlier and during pregnancy.

4. **Increase Family Connects Chicago participation by increasing awareness and facilitating access**

   Family Connects Chicago (FCC) is an evidence-based, universal program that provides in-home visits from a nurse to all families with newborns. These visits include health assessments of the birth parent and newborn and connection to community services to meet the whole family's needs. As this voluntary program expands citywide, there is a need to normalize this service as the way we care for all families and to improve participation rates, particularly in communities experiencing the greatest inequities in maternal and infant health outcomes. To achieve this, CDPH and its partners in FCC will implement an integrated strategy that includes three pillars.
   a. Quality improvement activities will be implemented with nurses and partner hospitals on practices to improve service introduction, scheduling and visit completion with new parents.
   b. Community engagement specialists in FCC Regional Community Alignment Boards will conduct outreach to pregnant people, families and organizations that serve them (e.g. prenatal care providers, social service organizations, churches, etc.) to raise awareness about FCC.
   c. Hyperlocal marketing campaigns that promote program awareness will also be initiated with greater intensity to grow program utilization.

Mental Health Action Plan

Theory of Change



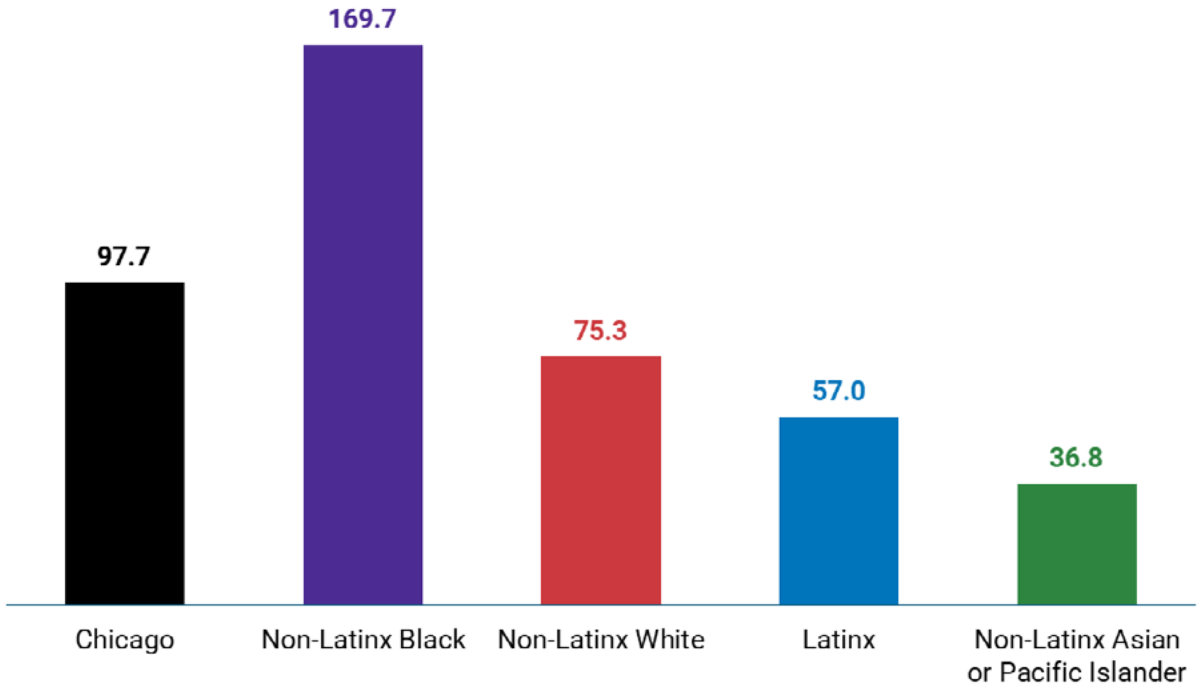
Background Data & Community Profiles

To fully realize wellbeing, physical, mental, and social health must all be addressed concurrently. Although mental health does not directly contribute to the 11.4-year life expectancy gap between Black and non-Black Chicagoans as a standalone driver, the disparity in mental health outcomes mirrors what we see for the primary drivers of this gap. This indicates that mental health is

inextricably linked with these physical health outcomes.

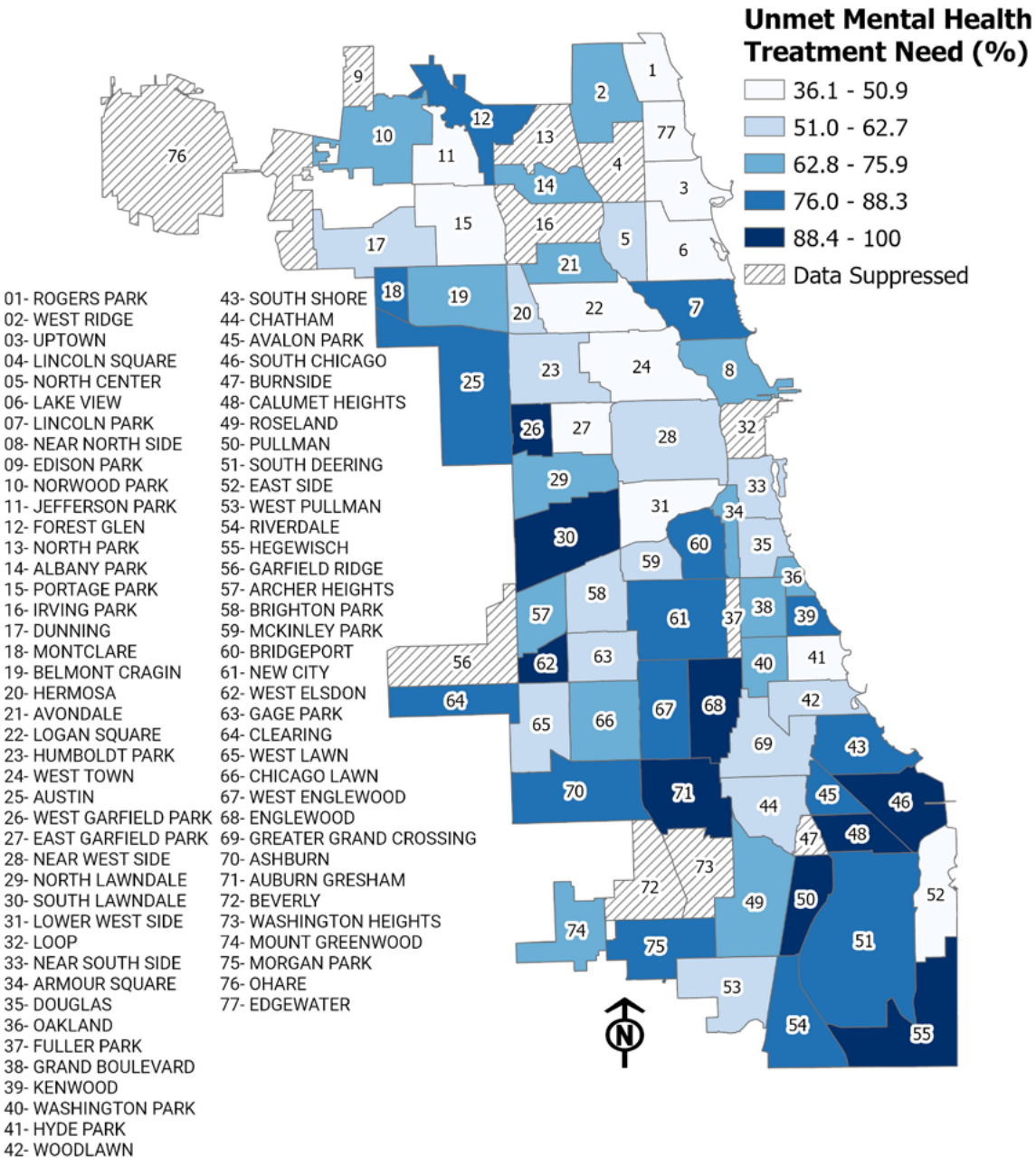
In recent years, over 80% of adult Black Chicagoans who reported having moderate or serious psychological distress did not take medication or receive treatment from a health professional for their condition. Further, despite declining citywide since 2016, the rate of behavioral health hospitalizations is consistently more than two times higher among Black Chicagoans compared to non-Black Chicagoans, while the rate of uncontrolled Serious Mental Illness (SMI) and mood disorders such as schizophrenia is more than five times higher among this group (Figure 19). These disparities are not biological in nature, rather they reflect the inequitable distribution of unmet mental health needs in this city (Map 5).

Figure 19. Age-adjusted behavioral health hospitalization rate per 10,000 by race and ethnicity, Chicago, 2022



Source: Illinois Department of Public Health, Hospital Discharge Data, 2022.

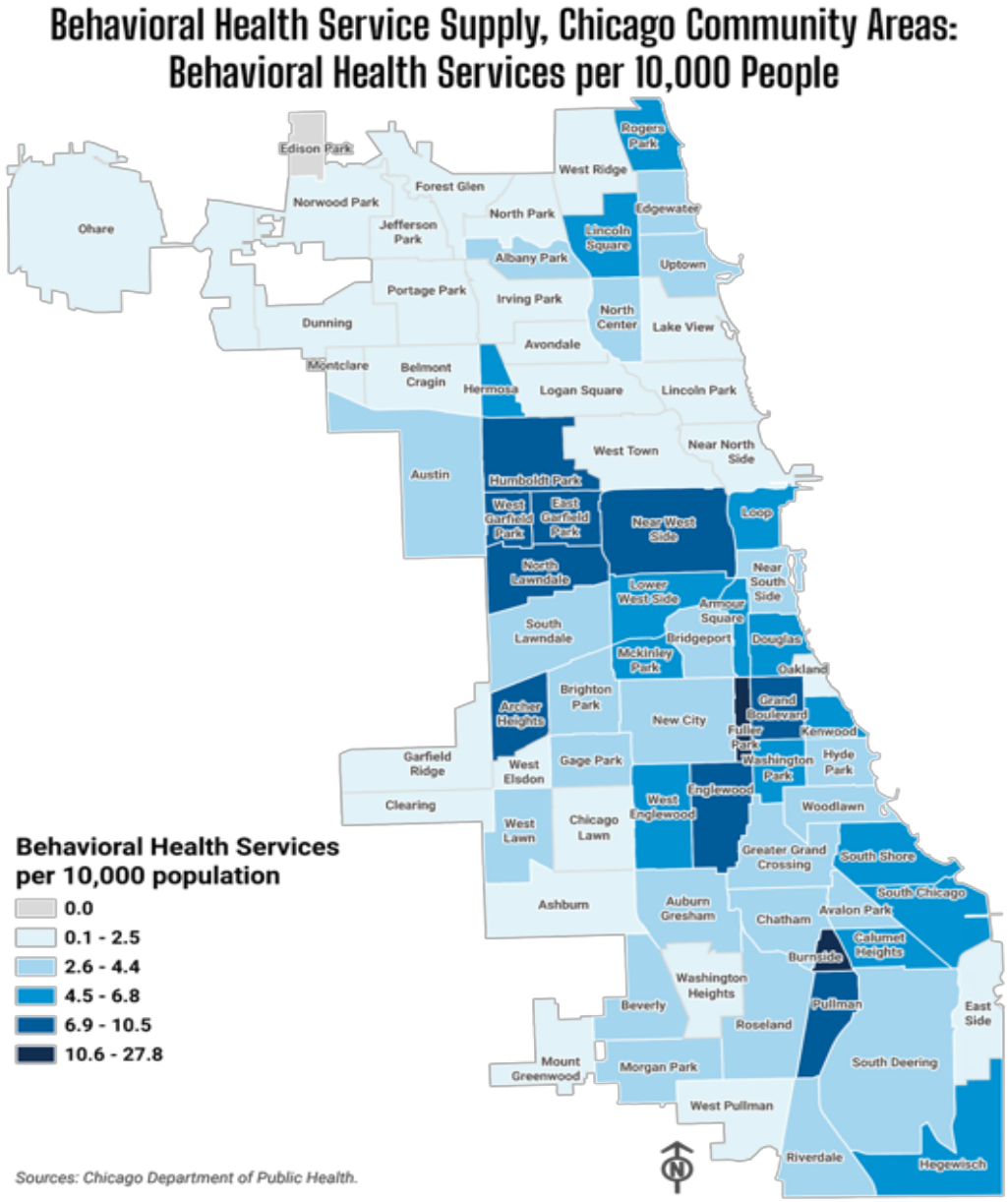
Map 5. Rate of unmet mental health treatment need among people with serious psychological distress by community area, 2022-2023



Source: Healthy Chicago Survey, 2022-2023

Individuals who have a SMI are more likely to use cannabis, experience food insecurity, be heavily rent burdened, frequently witness violence, live under 200% of the federal poverty level, and report feeling isolated. In Englewood, 97.4% of the adults who report serious psychological distress have unmet mental health needs. Research has shown that the number of and proximity to providers is not the primary barrier to care. In fact, the priority South Side and West Side communities have a higher rate of providers per 10,000 residents than most of the communities across Chicago (Map 6). There are other factors at play that prevent residents from seeking the care they need; it is CDPH's responsibility to uncover the key hindrances in each of our priority communities and successfully mitigate them to achieve better healthcare management.

Map 6. Behavioral health service providers by Chicago community area per 10,000 population



Source: Chicago Department of Public Health, 2024

Priorities & Action Plans

Mental Health Action Plans

1. Implement continuous quality improvement plans for Mental Health Equity Network and CARE
2. Develop housing to recovery continuum of care for people experiencing unsheltered homelessness and comorbid behavioral health conditions
3. Facilitate upstream capacity building and mental health promotion through free, no-barrier, evidenced-based training offered by CDPH workforce and funded partners

1. **Implement continuous quality improvement plans for Mental Health Equity Network and CARE**

   At the end of 2024, CDPH will operate 7 direct service mental health centers and fund a robust network of mental health safety net providers through the Mental Health Equity Initiative (MHEI). In addition, the CARE team will relaunch in 7 Chicago Police Districts as a 9-1-1 alternate response model as well as reserve 1 team for citywide activation. CDPH also utilizes a data-informed approach to triage mental health services to Chicago communities that experience disparities and hyperlocal stressors. By leveraging CDPH direct services and partnerships with organizations, stakeholders, and government entities across violence prevention, substance use, and mental health sectors, CDPH will continuously evaluate and improve short and long-term mental health outcomes. The aims of continuous quality improvement will be for both MHEI and CARE to:

   - Maximize service utilization through ongoing monitoring of units of services delivered and timely service delivery
   - Utilize mapping and community-driven tools to increase the efficiency of systems coordination
   - Improve patient outcomes through tracking performance indicators with prioritization around the management of SMI (e.g., schizophrenia, schizoaffective disorder, bipolar disorder)
   - Enhance integration with citywide resources through tracking referrals to city partners and longitudinal outcomes through available data sources
   - Establish a tiered approach to working with funded partners and potential external partners
   - Drive interagency partnerships with city agencies such as Chicago Public Schools, Parks, Libraries, Cook County, and the state to ensure cohesive coordination is occurring across government

2. **Develop housing to recovery continuum of care for people experiencing unsheltered homelessness and comorbid behavioral health conditions**

   CDPH has coordinated healthcare for people experiencing unsheltered homelessness who simultaneously experience behavioral health conditions across several fronts including shelter-based care, a stabilization housing pilot program, and supporting Department of Family and Support Services (DFSS) in outreach to encampments. These programs and services can be integrated into a care and recovery continuum that adopts a principle of “housing first and not housing only” for people experiencing the highest burdens of SUD and BH comorbid conditions.

3. **Facilitate upstream capacity building and mental health promotion through free, no-barrier, evidenced-based training offered by CDPH workforce and funded partners**

   CDPH recognizes the importance of mental health promotion activities through culturally responsive training to build mental health awareness, literacy, and skill. CDPH is building infrastructure to provide free and accessible training on suicide prevention (Question, Persuade, Refer or QPR), harm reduction, trauma-informed care, psychological first aid, and wellness. CDPH emphasizes community building and engagement to increase awareness of the CDPH’s behavioral health resources that are immediately available and to coordinate where and when to train. CDPH aims to reduce the number of new cases of mental health disorder by preventing it from occurring in the first place through its portfolio of training and community engagement strategies.

Partnership Action Plan

Background

CDPH is a convener of many partnerships across its bureaus and programs. These partnerships are established through various avenues, including Requests for Proposals (RFPs), Memorandums of Understanding (MOUs), direct engagement with community members, and ongoing collaboration with community-based organizations, advocacy groups, academic institutions, and other governmental agencies. These partnerships are fundamental to advancing CDPH's mission and fostering health improvements across Chicago's diverse neighborhoods. Cross-sectional partnerships allow for the integration of expertise, resources, and strategies from different sectors – public health, healthcare, education, housing, social services, etc. – to address complex health and social challenges that no one entity alone can solve. By merging diverse community voices and institutional knowledge, CDPH can more effectively address the social determinants of health that are at the root of the disparities seen in health outcomes. These collaborations also help to ensure that interventions and activations are tailored to the specific needs of the communities and are co-designed with input from residents and local organizations. The benefit of cross-sectional partnerships extends far beyond immediate programmatic outcomes, as these collaborations also provide increased facilitation of knowledge exchange, increased community trust, and create alignment that allow for more comprehensive and sustainable interventions over time. Under the CDPH's 2025 Strategic Plan, by centering health equity and meaningful community engagement in its cross-sector partnerships, CDPH aims to build upon these existing collaborations within the five priority community areas.

Every five years, CDPH works with our communities and partners to review data on Chicago's public health issues, better understand the strengths and needs of our neighborhoods, and build a collective plan to improve the health and well-being of all Chicagoans. CDPH is the anchor institution for the Partnership for Healthy Chicago (P4HC), a coalition of over 40 organizations representing the broad spectrum of Chicago's public health system, which leads the city's community health assessment and improvement planning cycle. By working together with cross-sector partners, CDPH aims to strengthen the health system's capacity to serve all Chicagoans. Maximizing public health interventions through a layered approach requires consistent collaboration to reinforce a clear mission while minimizing duplication so that Chicagoans in the most marginalized communities have increased access and utilization of health promoting resources.

Priorities & Action Plans

Partnership Action Plans

1. Community-level asset mapping
2. Conduct all-partner briefing of CDPH priorities and plans
3. Host recurring community engagement meetings for partner collaboration

1. **Community-level asset mapping**
   CDPH's Inclusion Diversity Equity and Access (IDEA) team will complete the asset mapping for all five priority communities. These asset maps will result in the build-out of a full list of CDPH partners, both contracted and not, across all bureaus.

2. **Conduct all-partner briefing of CDPH priorities and plans**
   The IDEA bureau will then coordinate the gathering of all CDPH partners and CDPH programmatic teams to present the department's 2025 Strategic Plan and community

priorities. This will serve to inform partners of CDPH's shift in strategic operations and recenter the goal of reducing the racial life expectancy gap. This convening will seek to establish buy-in so that all partners are aligned in mission and reinvigorated for ongoing collaboration to mitigate the largest contributors to the life expectancy gap.

3. **Host recurring community engagement meetings for partner collaboration**
   The IDEA bureau will also be responsible for hosting bimonthly community engagement meetings throughout 2025 to keep partners informed of upcoming events, collaborative opportunities and collective progress on each initiative. CDPH will also hear from the community about which strategies are working, and which are not to guide process improvement efforts. These engagements will be smaller than the initial large gathering in that each meeting will be specific to a single community area to reinforce the hyperlocal approach. One IDEA staff member will be assigned per community area to manage and facilitate the engagements throughout the year. These consistent engagements will allow for better internal synchronization to layer interventions and generate greater synergy between the city and the community to address community needs in a culturally appropriate manner.

Next Steps

Community Baselines

While developing the programmatic action plans, mortality data was reviewed to determine the greatest health burdens in each community area. The action plans will utilize this data to prioritize action and further tailor the approach based on each community's most pressing needs. The following health outcomes serve as a mortality baseline and CDPH will attempt to reduce the disparities and improve the citywide averages in the coming years.

*Table 5. Baseline health outcome data for Chicago and the five priority community areas**

Indicator	Citywide	West Garfield Park	East Garfield Park	North Lawndale	West Englewood	Englewood
Heart Disease Mortality Rate (2018-2022) per 100,000 people	177.2	255.7	293	264.9	267.2	308.5
Infant Mortality Rate (2018-2022) per 1,000 live births	6.3	15.2	11.2	9.9	14.3	17.3
Homicide Mortality Rate (2018-2022) per 100,000 people	20.9	98.9	70	81.3	77	96.7
Opioid-Overdose Mortality Rate (2021) per 100,000 people	40.1	225.6	147.7	119.9	77.5	115.8
Unmet Mental Health Need Rate (2022-2023) % of people with moderate or serious psychological distress	72.9%	83.7%	74.3%	83.1%	94.0%	87.5%
Flu & Pneumonia Mortality Rate (2018-2022) per 100,000 people	14.7	15.8	15.9	22.8	26.9	21
HIV Mortality Rate (2018-2022) per 100,000 people	2.3	9.9	0	9.1	2.3	Suppressed

*All mortality rates are age-adjusted with the exception of infant mortality rate.

Source: Illinois Department of Public Health, Division of Vital Records, Death Certificate Data Files, 2018-2022; Illinois Department of Public Health, Division of Vital Records, Birth Certificate Data Files, 2018-2022; Cook County Medical Examiner, 2021; Healthy Chicago Survey, 2022-2023.

As morbidity inherently precedes mortality, CDPH will also monitor the indicators in the table below. These values represent various social determinants of health, health behaviors, and health conditions which correlate with premature mortality. CDPH will continue to monitor these indicators as intermediary outcomes throughout the implementation of programmatic action plans to gauge initial success. If no change or negative change is indicated, CDPH will utilize the data to course-correct and amend programmatic approaches.

Table 6. Baseline health indicator data for Chicago and the five priority community areas

Indicator	Citywide	West Garfield Park	East Garfield Park	North Lawndale	West Englewood	Englewood
Adult Hypertension Rate (2022-2023) % of adults	29.3%	33.2%	33.7%	41.7%	33.7%	28.0%
Adult Smoking Rate (2022-2023) % of adults	11.1%	16.8%	27.9%	22.7%	20.0%	15.2%
Food Insecurity Rate (2020) % of people	21.3%	35.7%	37.7%	33.8%	36.4%	40.3%
Adult Physical Inactivity Rate (2022-2023) % of adults	28.4%	47.1%	32.4%	48.7%	36.3%	41.4%
Adult Daily Soda Consumption Rate (2022-2023) % of adults	25.4%	42.9%	34.8%	29.8%	39.8%	40.1%
Smoking During Pregnancy Rate (2018-2022) % of births	1.0%	6.7%	5.1%	6.0%	3.3%	4.9%
Sudden Unexpected Infant Death Rate (2023) per 1,000 births	1.2	4.8	3.7	2.5	3.2	6.2
Family Connects Reach Rate (2023) % of eligible births	39%	30%	48%	37%	39%	42%
Perceived Neighborhood Violence Rate (2022-2023) % of adults	32.4%	69.8%	52.1%	47.6%	46.1%	59.1%
Gun Violence Victimization Rate (2023) per 10,000 people	10.9	66.4	51.2	51.8	43.3	49.4
Opioid-Related EMS Calls (2023) count of calls	47 (median)	646	602	523	443	262
Moderate or Serious Psychological Distress Rate (2022-2023) % of adults	47.5%	48.7%	36.2%	40.3%	48.1%	54.2%
Adult Flu Vaccination Rate (2022-2023) % of adults	35.0%	31.3%	29.9%	27.2%	29.6%	17.8%
PrEP Uptake (2023) Count of people	17,572	36	61	78	35	28
Viral Suppression Rate (2023) % of people living with HIV	58%	46%	49%	47%	49%	53%

Source: Healthy Chicago Survey, 2022-2023; Chicago Health Atlas; Illinois Department of Public Health, Division of Vital Records, Birth Certificate Data Files, 2018-2022; CDC Sudden Unexpected Infant Death (SUID) Case Registry, 2023; Chicago Department of Public Health; Chicago Fire Department, Emergency Medical Services (EMS), 2023; Illinois Department of Public Health, Enhanced HIV/AIDS Reporting System (eHARS), 2023.

Monitoring and Evaluation

While this report only details the commitments of CDPH through year-end 2025, the metrics outlined below will be used to assess progress and success toward reducing the impact of the primary drivers on the Black non-Black life expectancy gap. Historic trends have been mapped to establish a baseline and one-year targets will be established accordingly. Internal data trackers and dashboards will capture programmatic outputs and health outcomes to allow for continuous evaluation of reach and impact by community area. Evaluation will ultimately serve to hold CDPH accountable to the actions set forth herein and determine the effectiveness of a cumulative impact model strategy on improving health in Chicago.

Metrics to be tracked during the 2025 calendar year include both outputs and outcomes citywide and for the five priority community areas. Programmatic outputs will be measured on monthly cadences, and health outcomes that will be assessed following year end 2025 through the **Healthy Chicago Survey**. Intermediate outcomes will include Social Determinants Of Health (SDOHs) that are associated with morbidity and mortality from the key contributors to the life expectancy gap. Social determinants of health apply to entire populations and include factors such as education, employment, and food stability that are not under the direct control of the health department and therefore may not be changed at the population level in a single year. However, as SDOHs are known to influence overall human health, meaningful changes in SHOHs are expected prior to population health improvements and will be monitored to measure incremental progress. In parallel, CDPH will continue to monitor long term outcomes by focusing on rates of cause-specific mortality by population.

Chronic Disease

Programmatic outputs include:

- Number of events where tobacco cessation information is offered
- Number of people engaged with blood pressure information by CHWs
- Number of people engaged with tobacco information by CHWs
- Number of PlayStreets participants per priority community area (youth/adults)
- Number of people referred to food resources
- Pounds of rescued food directed to priority communities

Health outcomes include:

- Heart disease mortality rate
- Percentage of adults tobacco use
- Percentage of adults with hypertension
- Percentage of population food insecure
- Percentageof adults with easy access to fruits and vegetables

Violence Prevention

Programmatic outputs include:

- Number of de-escalation events
- Number of lots cleaned and greened
- Number of trees planted through the Our Roots Chicago program
- Number of individuals engaged through hospital-based violence intervention

- Percentage of eligible individuals/families connected to a Victim Services organization upon hospital discharge

Health outcomes include:

- Homicide rate
- Gun-violence victimization rate
- Perceived neighborhood violence

Substance Use

Programmatic outputs include:

- Number of Narcan distributed per 100,000 Chicagoans per month
- Number of individuals who are prescribed MOUD
- Number of individuals who use MOUD (calculated by pharmacy pickup)
- Number of individuals who engage with IL helpline

Health outcomes include:

- Opioid-overdose mortality rate
- Number of opioid-overdose related EMS calls

Infectious Disease

Programmatic outputs include:

- Percentage viral suppression among people living with HIV (PLHIV)
- Number of people prescribed PrEP through CDPH-funded or administered programs
- Number of vaccine-related outreach events
- Percentage Influenza vaccination coverage
- Percentage COVID-19 vaccination coverage
- Percentage of CDPH responses initiated within 24 hours of a reported disease outbreak
- Number and percentage of immediate notifiable diseases reported to CDPH within the *Control of Communicable Disease Code of Illinois* timeframe
- Number and percentage of 24-hour notifiable diseases reported to CDPH within the *Control of Communicable Disease Code of Illinois* timeframe
- Number and percentage of 3-day notifiable diseases reported to CDPH within the *Control of Communicable Disease Code of Illinois* timeframe

Health outcomes include:

- HIV mortality rate
- Number of new HIV diagnoses
- Flu and pneumonia mortality rate

Infant and Maternal Health

Programmatic outputs include:

- Number of safe sleep community education events
  - Number of people engaged through these events
- Number of prenatal community education eventsNumber of people engaged through these events
  - Participation rates in Women, Infants, and Children (WIC) clinics

- Participation rates in Family Connects Chicago (FCC)

Health outcomes include:

- Infant mortality rate
- Maternal mortality rate
- Rate of early and adequate prenatal care
- Sudden unexpected infant death (SUID) rate
- Smoking during pregnancy rate

Mental Health

Programmatic outputs include:

- Number of unique clients served through Mental Health Equity Initiative (MHEI)
- Number of incidents responded to by CARE
- Percentage of patients served by MHEI and CARE with Serious Mental Illness (SMI)
- Number of clients served through CDPH housing to recovery continuum
- Number of evidence-based MH trainings received through CDPH

Health outcomes include:

- Unmet mental health needs

Partnership

Programmatic outputs include:

- Number of partner coordination meetings
- Number of partner organizations included in CDPH partnership collective

Outcomes include:

- Number of collaborative community health events with partners

Preparing for CHA/CHIP 2025

Through transparency and the fostering of public-private partnerships, CDPH will be accountable for prioritizing the health and wellbeing of Black Chicagoans in Greater Garfield Park, Greater Englewood, and North Lawndale who have been most impacted by declining life expectancy.

The next iteration of Chicago's Community Health Assessment (CHA) and Improvement Plan (CHIP) will incorporate learnings from this one-year pilot. Analysis of the above key performance indicators (KPIs) will reveal both successes and shortcoming which will be considered as CDPH continues to hone public health strategies to maximize benefit from health-promoting services.
CDPH's mission, vision, and values will remain central in all efforts to improve health equity in 2025. To achieve this, the department strives to prevent premature mortality, protect quality of life, and promote the health and wellbeing of current and future Chicagoans through meaningful collaboration and data-informed decision making.

Appendix

Ongoing Efforts with CDPH Support

The action plans put forth in this document reflect the work to be led by CDPH alone. There are numerous other endeavors led by the City of Chicago that impact health and wellbeing which CDPH does and will continue to support. The following are initiatives grown under the administration of Chicago Mayor Brandon Johnson with progress achieved through the City's efforts throughout the first year of tenure.

Economic Vitality & Equity

Goal: Make strategic investments in people, businesses, and neighborhoods:

- Secured $1.25 billion to invest in housing, business and job growth, and cultural and community assets on the South and West Sides
- Launched the Cut the Tape initiative to streamline City development processes to reduce barriers while establishing subsidy selection criteria to prioritize investments in historically disinvested communities
- Hired a Process Improvement Director to implement the Cut the Tape Initiative
- Issued $2.7M in small business grants to 15 community organizations to help fill vacant storefronts
- Re-launched the Guaranteed Income Advisory Group

Education

Goal: Strengthen our education system and invest in our youth:

- Expanded One Summer Chicago program, employing ~28,000 youth in 2024, up 32% from previous admin. Working to double youth employment in the first term
- Extended Citywide Broadband & Digital Equity Initiative and Chicago Connected Program, serving +40K CPS students
- Expanded the Mayor's Youth Commission and named new Chicago Public Schools (CPS) Board members, nearly all whom are parents
- Continued support of CPS and City Colleges of Chicago (CCC) collaborations for dual credit & early college enrollment
- Ended student-based budgeting and shifted focus toward investing in neighborhood schools
- On the verge of ending the School Resource Officer (SRO) program in schools in school year 24-25

Environmental Justice (EJ)

Goal: Protect Chicagoans affected by environmental racism:

- Re-established the Department of Environment
- Released the City's Cumulative Impact Assessment to monitor and address the impacts of environmental harm
- Released the EJ Action Plan to address the impacts from cumulative exposures on marginalized communities
- Introduced the Clean and Affordable Buildings Ordinance setting decarbonization measures for all newly constructed or majorly renovated buildings

- Awarded $6M to 22 small business & nonprofits through the **Climate Infrastructure Fund** to improve neighborhood resiliency

Health and Human Services (HHS)

Goal: Redefine approaches to mental health emergencies:

- Launched the **Mental Health System Expansion** initiative and report to implement the promises of the Treatment Not Trauma campaign and ordinance, dedicated to improving and expanding City-run mental health services
- Reopening the public mental health clinic in Roseland, expanding mental health services to the Lower West/Pilsen clinic, and co-locating mental health services at **Legler Regional Library**
- Shifting toward alternate mental health crisis response model to free CPD and CFD to do their primary roles
- Expanded the **Emergency Supplemental Victims Fund** (ESVF) program to 10 additional communities most impacted by violence

Housing

Goal: Affirm housing as a human right:

- Allocated $360-390M of the $1.25B housing & economic development bond towards new affordable housing
- Appointed the City's first Chief Homelessness Officer
- Committed $250M to services and support for unhoused Chicagoans
- Completed 100 affordable units since May 2023 (700 more under construction)
- Added $10M to support homeowners with repairs and modifications
- Allocated an additional $5M towards flood relief

Human Rights, Equity and Inclusion

Goal: Affirm equity as a core governing principle:

- Launched Co-Governance Steering Committee to guide approaches to government-community partnerships
- Established **Black Reparations Task Force** to support strategy & implementation of reparations for Black Chicago

- Codified the **Office of Equity & Racial Justice** and role of Chief Equity Officer into City law to provide oversight & guidance for the systematic reform of government processes, practices, and functions to advance equity
- Published **Equity Statement of Principles** & 1st **Annual Equity Report** on status of City efforts to institutionalize equity
- Engaged **Chicago Therapy Collective** to assess City hiring policies, address employment barriers for Transgender and Gender Nonconforming (TGNC) individuals, and provide training for hiring managers

Public Safety

Goal: Engage Chicagoans to reimagine public safety:

- Invested over $100M in strategies to prevent & reduce violence
- Launched the **People's Plan for Community Safety** to invest in people & communities historically left behind, starting in Austin, Englewood, Little Village & West Garfield Park
- Allocated $5M to create an **Office of Reentry** to support returning residents & disrupt the cycles of incarceration
- Added ~400 CPD civilian positions & created 200 new promotional opportunities within Bureau of Detectives to improve clearance rates without adding to total sworn staff
- Created funding opportunities for hospital-based violence intervention programming for the first time in the City's history to disrupt the cycles of violence & provide trauma-informed care for individuals at high risk of repeat violent injury

Transportation

Goal: Invest in equitable public transportation:

- Released the **Meeting the Moment** report card to evaluate the effectiveness of investments to improve safety and security on the transit system
- On track to hire 200 bus drivers and rail operators to enhance service outside of rush hours by the end of the year
- Collected data on ticket dismissal rates to ensure equitable fines and fees
- Advanced **SMART Streets** ticketing, which is on track for **City Council** approval

Workers' Rights and Labor

Goal: Establish Chicago as the most pro-worker city in the nation:

- Passed the most generous paid time off policy in the country, doubling paid leave for +1.38M workers
- Phased out the sub-minimum wage for 100,000 tipped workers
- Increased the number of staff at the **Office of Labor Standards** that is responsible for enforcing our labor ordinances
- Worked with CPS and **Chicago Teachers Union** (CTU) to land agreement to expand paid parental leave for school employee

Life Expectancy Methodology

CDPH uses the following sources of data to calculate life expectancy:

1. Death certificate data provided by the **Illinois Department of Public Health**. This includes death certificate data for all Chicago residents. A death certificate is a legal document issued by a doctor or a government institution confirming that a person has died. Depending on the circumstances of death, physicians, medical examiners, and/or coroners are responsible for determining the cause of death and recording this in a temporary death certificate. The first funeral director to take custody will use this information to file a permanent death certificate to the **Illinois Vital Records System**. Death certificates include demographic information about

the decedent including their name, age, address, race, ethnicity, and occupation. Information is obtained from the best available source which may include medical records or reported by next of kin. All life expectancy calculations use the age of death recorded on the death certificate. Some calculations will use more information, such as the person's sex, race, place of birth, or their cause of death.

2. **Census data** about the number of people in the population. For years corresponding to a decennial census, such as 2010 or 2020, the census population is used in life expectancy calculations. For intercensal years, a linear interpretation is performed to estimate the population for that year.

CDPH calculates life expectancy using a method published by Dr. Chin Long Chiang for the **World Health Organization**[10]. In brief, life expectancy is estimated by first calculating a separate risk of death, or a death rate, in each age group using the actual population and death data for Chicago. These age specific death rates are then applied to a standard population, for example a population of 100,000 people. The average age of death in that standard population is then calculated to estimate life expectancy. The use of a standard population allows for comparisons of life expectancy between different times, places, and people.

The analysis of the standard life expectancy can be expanded, as it was for this Action Plan, to identify which groups have a higher risk of death at younger ages. Information about the cause of death from the death certificate is used to calculate the death rate in each age group by these causes of death. This allows for the identification of the health problems causing the most deaths in each age group, known as the contributors of the life expectancy gap in this report.

[10]Chiang CL. Life table and mortality analysis [Internet]. Geneva: World Health Organization; 1979 [cited 2024 Nov 12]. Available from: https://digitallibrary.un.org/record/125059