

Reflections on *Healthy Chicago 2.0*

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Foreword

Healthy Chicago 2.0 is a landmark achievement in Chicago's struggle for health equity. In this *Center for Community Health Equity* working paper, we bring together perspectives from a range of academic disciplines – from geography to nursing to women's studies to preventive medicine – in an effort to nurture a reflexive conversation about *Healthy Chicago 2.0* and our collective next steps. I am thankful to the authors for contributing to this paper. [A copy of Healthy Chicago 2.0 can be found here.](#)

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Contributions

Reflection of Healthy Chicago 2.0

The Chicago Department of Public Health's recently released *Healthy Chicago 2.0: Partnering to Improve Health Equity* signifies a departure in the way in which the health of citizens of Chicago has been assessed, in terms of how the plan was developed and in how it presents health data. Whereas previous health planning efforts prioritized specific diseases or health conditions and strategized how a range of interventions might improve outcomes in those health areas, this plan emphasizes the role of social and structural determinants of health in its assessment of the city's health. Harnessing advances in how health-related data may be presented geographically, *Healthy Chicago 2.0* improves our understanding of how health and its determinants are distributed throughout Chicago, and how health inequities are shaped by the socioeconomic inequities in our highly segregated city. To its credit, CDPH has attempted to surmount the barriers that often separate the residents of the city, and has actively engaged diverse stakeholders in communities throughout the city in the development of the plan and the completion of this assessment phase. CDPH is to be lauded for its engagement with the city's communities in the plan's development, and hopefully this effort's momentum will continue in the implementation of strategies to address the disparities and inequities that the report highlights. The presentation and visualization of social/structural determinant data will continue to underscore the economic and

educational realities of the neighborhoods in which such strategies are to be planned, implemented, and evaluated.

Now comes the hard part.

The devolution of investment in the public's health over the past decades and increasing shortfalls in the City's budget limit CDPH's ability to do all of the "heavy lifting" necessary to meet these goals.

Increasingly, it will be up to communities to organize across the City with CDPH in order to put plans into action. The stakeholder model utilized in the development of the Healthy Chicago 2.0 assessment may indeed provide actionable plans to meet the targets that CDPH will monitor over the next 5 years. The targets that the plan has determined to monitor are well-informed indicators of individual-level health across a range of conditions, including infectious disease, maternal and child health, behavioral health and chronic disease, and in this way they resemble targets from previous plans. But are these the targets to which the social/structural determinant data in the assessment point? Without some fundamental changes in the ways that prevention is approached in Chicago, we may well witness in 2020 even greater disparities in health status, as well as economic hardship, child opportunity, and violence than we see today. Further strengthening multi-sector partnerships across communities may help to maximize access to assets and resources throughout this resource-rich but segregated city. Organized efforts to work on common goals and reverse the increasing inequities present in our city will need to focus on the social determinants that have brought us to this point, and encompass economics and investments, laws and law enforcement, education and jobs, politics and our elected officials, and above all how we as citizens hold elected officials, business leaders, and policy makers accountable for promoting the health of all.

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Reflections on and Suggestions for Healthy Chicago 2.0: Community-Based Healing and Health in Chicago

Healthy Chicago 2.0 identifies the reduction of violence as a top public health priority. At the outset, the report should be applauded for appropriately endeavoring to locate that violence within a broader context, seeking to understand interpersonal and community violence as impacted by a variety of social structures and inequalities that shape violence in different social contexts. For example, *Healthy Chicago 2.0* reports that “related to the unequal burden of violence and trauma is the problem of mass incarceration and disproportionate contact between police and communities of color.” This statement is important; indeed, the ways in which violence is defined matters. The report correctly incorporates episodes of gun violence and domestic within its definition of violence, but would be well-advised to also specifically identify systemic inequality as an element of violence that negatively impacts health outcomes – that is, racism and poverty, among other axes of inequality, need to be seen as forms of violence with powerful negative outcomes for individuals and communities. More specifically, there needs to be a commitment to interrogating the impacts of state-sanctioned violence, such as harsh disciplinary practices in schools and unjust policing practices. Effectively addressing and preventing violence in Chicago, therefore, must include focused attention not only on discrete episodes of violent action but also on our deeply embedded social patterns of violence and injustice.

At the same time, to meet its articulated goal of developing a comprehensive approach to addressing interpersonal violence – in particular teen dating and domestic violence – *Healthy Chicago 2.0* needs to avoid too narrow of a focus on violence only within particular communities. Rather, the report’s emphases should recognize that these forms of relationship violence are epidemic in all communities, those characterized by poverty and urban disinvestment as well as more economically prosperous and well-resourced areas. For instance, although rates of teen dating violence vary based on how the variable is defined and what age group is being studied, by any measure it is found to be common and widespread among adolescents. Several studies have suggested that physical aggression occurred in one of every three teens’ dating relationships (Centers for Disease Control and Prevention, 2010 National Intimate Partner and Sexual Violence Survey). Furthermore, a recent longitudinal analysis involving retrospective reports of over 700 college-aged students found that fully 64.7% of females (and 61% of males) reported dating violence victimization between the ages of 13 and 19, with a majority reporting multiple occurrences (Bonomi et al., 2012). A study by the American Association of University Women Educational Foundation (2001) found that 81% of high school youth reported sexual

harassment from peers. And studies on sexual victimization have indicated that 15-20% of high school females reported experiencing forced sexual activity. These interpersonal violence issues also are prevalent on college campuses. Public awareness of the sexual violence issue at universities – and in particular inadequate institutional responses on college campuses -- was brought into sharp focus recently with the release of a report by the White House Task Force formed by President Obama in January 2014 (Not Alone: The First Report of the White House Task Force to Protect Students from Sexual Assault, April 2014). *Healthy Chicago 2.0* needs to recognize the widespread nature of relationship violence and not fall prey to conceptualizing this violence as a deficit only in marginalized urban communities.

Moving forward, I see a need to more fully theorize the connections among many of the priorities laid out in *Healthy Chicago 2.0*. In particular, the connections among trauma, behavioral health, education inequities, and violence warrant further development. Theorizing these connections more fully can create a foundation upon which the city can continue to build. The goals and objectives articulated in *Healthy Chicago 2.0* are no doubt important and ambitious. Over time, however, I would hope to see more integrated, creative, multi-layered, and youth-led responses to emerge.

One way in which to begin to more fully understand these connections is to highlight community voice as the city moves forward in working toward articulated goals. *Healthy Chicago 2.0* talks about community engagement, but does so primarily in terms of outreach to educate community members. Community outreach and education is of course important, but I suggest also creating a focus on policy makers' learning from community members themselves. A full collaborative approach in which the strengths and assets of community members are foregrounded to inform intervention and policy agendas has great potential. For example, the city could consider implementing participatory evaluation research models as they work toward evaluating progress made toward meeting currently articulated goals and objectives. A participatory action research approach can be defined as political use of research by community members to better understand and improve issues of importance to their own communities. In practice, this means teaming with multiple members of a community or communities to develop a research effort – conducting research, interpreting data, and ultimately using the work to inform and advocate for needed change

I further suggest generating increased opportunities for youth involvement, decision-making, and leadership as the city works toward health equity, particularly in terms of eradicating violence in Chicago. If we create spaces for youth to talk about issues affecting their lives, to generate ways to raise public awareness, to speak out against violence, and to advocate for change in their communities, we can empower young people to partner effectively with adults to become community leaders and active participants in the movement to end violence. Such youth-adult partnerships hold great potential in terms of moving Chicago toward a vision for a city in which all youth and adults use their power to achieve health and well-being in their own lives and for their communities.

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Reflections on and Suggestions for Healthy Chicago 2.0: Behavioral health across Chicagoland

Quality of life and overall wellness are built upon a foundation of behavioral health. For Chicagoans and their communities, behavioral health represents an apron that ties together all Healthy Chicago 2.0 outcomes including preventing and controlling chronic disease. For example, a Chicagoan cannot fully participate in physical health efforts including exercise while binge drinking or experiencing poor mental health for weeks at a time. Indeed, behavioral health outcomes may require the most continuous attention and dedicated resources in comparison to other Healthy Chicago 2.0 outcomes. Challenges to

improving behavioral health outcomes may seem insurmountable when considering limited resources allocated to behavioral health, barriers to access including transportation, the stigma oftentimes associated with mental health issues, and the lack of patient-seeking of behavioral health services within many minority communities. In order to truly improve behavioral health among Chicagoans, behavioral health needs to be a priority for stakeholders representing every level including government (local and State), providers, researchers, community leaders, and laypeople.

For Healthy Chicago 2.0 to tackle the issue of behavioral health through articulating two goals and related strategies indicates that the City of Chicago is committed to achieving behavioral health equity for all of its residents. Overall, three issues need to be simultaneously understood and acted upon when addressing mental health: 1) patient activation; 2) the creation of new and the identification of existing interventions; and 3) ensuring access to services. Healthy Chicago 2.0 explicitly addresses leveraging and creating resources. Healthy Chicago 2.0 strategies plan to fill a CDPH-based behavioral health leadership role, organize a leadership council to coordinate behavioral health services across Chicagoland, and implement specific interventions such as Mental Health and Psychological First Aid Training. While strategies that address resources are required to move behavioral health forward in Chicagoland, strategies may benefit from a level of specificity; for example, precise and transparent selection of leadership council members. Transparency allows an understanding of who and what are shaping behavioral health services for Chicagoans. In a similar vein, Healthy Chicago 2.0 must be careful to not “reinvent the wheel” regarding interventions, assessments, and the resource inventory; and to be sure to ascertain whether or not any existing iterations of interventions are currently underway in Chicago. By expanding on existing and effective interventions and services, Healthy Chicago 2.0 may preserve limited resources such as costs, time on behalf of stakeholders, and speedier relief of behavioral health challenges experienced by Chicagoans.

Healthy Chicago 2.0 also clearly addresses the issue of access. The use of current technologies to facilitate access to behavioral health services is a productive step forward for Chicagoans. The development and use of telehealth will bring mental health into the present and offer consumers easier access to services. Telehealth may also lead to more convenient mental healthcare (e.g. easier to fit into everyday schedules) for consumers. However, how will stakeholders ensure that the most vulnerable patients are able to access telehealth services? Perhaps a starting point is to clearly define telehealth services as they encompass many modes of communication (e.g. telephone conversation or text

messaging) between providers and patients. Once stakeholders establish a definition of what constitutes telehealth services, Healthy Chicago 2.0 can enact concrete and measurable access-related outcomes.

What is seemingly missing is an explicit focus on patient activation regarding patient-seeking of behavioral healthcare and openness to available mental health services. While Healthy Chicago 2.0 plans to create and implement an anti-stigma campaign, I believe more needs to be done in order to address patient activation. The first step of the behavioral health process begins with the individual – recognizing a problem and mobilizing to address the problem – requires considerable attention from the individual filling the CDPH behavioral health leadership position and members of the leadership council. While it is likely easier to describe an issue such as patient deactivation than developing effective solutions, it is a worthy effort on behalf of Healthy Chicago 2.0. Perhaps crosscutting outcomes pertaining to mental health, child and adolescent health, and chronic disease in terms of continuous patient education and detection of mental health challenges is a starting point.

Overall, Healthy Chicago 2.0 identifies and plans to act upon key areas in behavioral health. Two of the strategic highlights being: 1) advocating that insurance companies cover trauma services; and 2) reducing emergency department utilization for mental health purposes. Emergency department utilization for behavioral chief complaints continue to financially drain the healthcare system and deny continuous disease management to patients. Additionally, Chicagoans suffer from disproportionately high levels of traumatic experiences. Insurance coverage for trauma services will relieve unnecessary and additional financial stress for patients and allow a smoother facilitation of recovery. Securing coverage for trauma services and reducing emergency department utilization for behavioral issues would indicate success for Healthy Chicago 2.0 and all Chicagoans. However, Healthy Chicago 2.0 may benefit from: 1) specificity in the identification of interventions and other services (e.g. are all selected interventions evidence-based?); 2) expansion of existing and effective interventions and strategies (e.g. if interventions are evidence-based, how are they already being employed across Chicagoland); 3) precision in the selection of outcome measures (e.g. is 10% a significant increase in primary care utilization by individuals with serious mental illness); 4) transparency of leadership (e.g. who will serve in leadership positions and what is his/her commitment level?); and 5) the development and implementation of strategies addressing patient activation. In sum, Healthy Chicago 2.0 mobilizes the City of Chicago in the correct direction and addresses the issue of behavioral health that affects us all.

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A Geographical Perspective

A short essay in *Science* recently recognized a “spatial turn in health research” as advances in geographic information systems (GIS) technology enable multiple data sets to be visualized in layers and depicted on maps (Richardson, et al. 2013). Although *Healthy Chicago 2.0* makes little mention of the power of GIS to offer such new analyses of health inequalities, it is evident throughout the report that this specifically spatial visualization of ‘big data’ has impacted how the authors perceive Chicago’s public health needs. The numerous maps in the report (generated using GIS) starkly display neighborhood disparities through a range of intersecting aspects from transit access and economic hardship, to unemployment and educational attainment, to more traditional measures of health outcomes such as blood lead levels, infant mortality, infection and obesity rates. The result is a holistic revisioning of Chicago as an urban ‘healthspace’ that puts place at the center of the debate about public health and how to achieve equity of health outcomes across the city.

This geographic data enables us to envision the city and its neighborhoods anew (indeed, this is also being done nationally, see Irwin and Bui, 2016). Yet reliance on such assessments risks a pernicious new data-driven environmental determinism, namely an understanding that place determines behavior, life chances, health, and social progress; in short, one’s fate. Environmental determinists of the nineteenth century argued that factors of climate and landscape caused human behavior. While seemingly intuitive that the local environment shapes people, environmental determinism led (and leads) to problematic science that naturalized imperial and racial hierarchies. For example, proponents understood cooler northern latitudes as conducive to higher mental capabilities; warmer tropics, in contrast, were believed to create people fit only for physical labor. Such a reading of the world conflated spatial location with causality. While today the overlapping and co-located factors influencing health and life outcomes are recognized as produced by humans, rather than by the natural environment, the danger of presuming location as cause remains. It is somewhat problematic, therefore, to maintain that “When it comes to health, your zip code matters more than your genetic code” (Iton, quoted on p.14). The reason that ‘zip

code matters,' (i.e. the spatial location of an individual's place of residence), is not because of anything intrinsic or causal about the location itself. Rather, the health inequalities that are observable from neighborhood to neighborhood in the cartographic data visualizations in *Healthy Chicago 2.0* are the outcomes of systemic disinvestment in urban amenities and services in low income (predominantly non-white) communities for over a generation. Chicago's geographical distribution of highly polluting industries, for example, finds them concentrated in areas that are low income; protected bike lanes and bike sharing services, despite expansion over the past five years, remain few and far between in the lowest income neighborhoods, which are also places where homicides and violence impact the lives of so many. Thus, although in Chicago in 2016, "the built environment influences health by providing or preventing opportunities for physical activity, adequate transportation and social connectedness," (p.16) it is imperative to understand that the places in which we live do not determine health outcomes. The resulting challenge, therefore, is to produce a new Chicago, reversing policies that have produced an urban landscape in which "residents do not have equitable access to the systems and opportunities that contribute to good health" (p.15).

At the heart of the *Healthy Chicago 2.0* plan is a commitment to equitable community development. The Plan recognizes, in its second Action Area, that the city needs to work on "improving social, economic and community conditions" (p.2). For a plan that is ostensibly about improving health outcomes, it is a positive development that the City identifies community development and urban planning as critical pathways towards improving the health of all Chicagoans. A related issue, therefore, is the equitable distribution and provision of services that provide healthful outcomes (from transit provision and lead-free housing, to access to health care services and preventive care). These still overwhelmingly favor wealthier communities and, if provided in lower income communities, have the tendency to accelerate gentrification and displacement of low income residents, further exacerbating inequalities. "Access to affordable, safe and healthy housing is crucial for supporting people's health," maintains the report (p.20), and, concomitantly, "Lack of affordable housing can restrict where people live and the quality of the places in which they live" (p.20). The importance of providing geographical equity to resources, services, economic development and housing and, therefore, a genuine commitment to improving Chicago's health outcomes for all, necessitates challenging and changing the existing system that sees some neighborhoods vastly over-served and others with few amenities.

Goal 5, for example, demands a strategy to “Preserve affordable and supportive housing units... [and] Create a structure to develop a more balanced portfolio of housing that is safe, healthy, accessible and affordable” (p.23), yet there is no discussion in the report regarding how this is to be attained. Further, where in Chicago will this affordable housing be found? As public housing is demolished and replaced by housing vouchers, and once low-income neighborhoods gentrify, the places where affordable housing is located in Chicago are arguably fewer and more isolated than at any time in the city’s history. The private market has little interest in providing affordable housing, and certainly not in the high revenue real estate markets that circle the Loop in a 3-5mile radius. Yet, as the report makes clear, neighborhood and housing affordability must be a part of any public health advances for Chicago.

As for existing housing, will the City fund lead remediation for all? Will it bear the costs of replacing century-old plumbing and paint in the city’s most disadvantaged neighborhoods? Will the city and CTA, as the report demands, “Support improvements to the built environment through transportation and land use policies, plans and projects that enable safe and routine walking, biking and transit use for daily travel” (p.48)? If, as Mayor Emanuel rightly contends when introducing the report that a healthy Chicago is one in which, “every child raised in Chicago, regardless of neighborhood and background, has the resources and opportunities to live a healthy life,” it is evident from this report that the city needs to intervene to ensure affordable housing. Practices like rent control and property tax reform are two possibilities, as are stricter rules on speculative development and programs like Boston’s ‘linkage fees’ that see developers pay into an affordable housing trust in return for construction permits. Beyond these specific policies, there is an international movement to build 21st Century “8 to 80” cities (i.e. cities built recognizing the needs of people aged eight through eighty (see 880cities.org)), or “4 season” cities that cater year round to people of all ages, abilities and needs. Chicago must begin to engage with these initiatives.

In sum, *Healthy Chicago 2.0* recognizes that place matters, but it is problematic to equate outcome with cause. Location alone does not determine individual behaviors or fates. Indeed, in many cases, the factors shaping one zip code’s ‘healthspace’ are rooted in changes taking place elsewhere, or at a different scale. Even today’s sophisticated big data models and GIS visualizations, therefore, require critical, thoughtful analysis about causation so that a contemporary technological determinism does not come to resemble the environmental determinism of the past. By recognizing Chicago’s existing geographical patterns of health disparity, *Healthy Chicago 2.0* demands a robust urban planning

approach to creating a livable, healthy city for all. This means that health policy must be urban policy, and a healthy city is one in which a resident's zip code has no bearing on personal health outcome. It is a vision of Chicago which demands fundamental changes to how we live in, govern, plan and build our city.

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Reflections on Healthy Chicago 2.0: Strengthening Child & Adolescent Health

Healthy Chicago 2.0 (HC 2.0) is a four year community health improvement plan that was developed through partnerships between public and private stakeholders. The goal is to develop and implement actionable strategies to improve the health and wellbeing of Chicagoans. One of the 6 key action areas targeted by HC 2.0 is to strengthen child and adolescent health, thereby increasing opportunities for children to live healthy lives. According to HC 2.0 nearly three-hundred thousand children between the ages of 0-17 are living in Chicago neighborhoods that are constrained by low or very low child opportunity (HC2.0, 2016). Acevedo-Garcia et al. (2014) define neighborhood-based opportunities within three domains: (1) educational opportunities such as quality early childhood education, (2) health and environmental opportunities such as the availability of healthy food, and (3) social and economic opportunities, such as poverty levels. In Chicago, disparate numbers of neighborhood based child opportunity are evident by race and neighborhood, with children of color currently facing the likelihood that they will grow up within the context of the lowest child opportunity. In fact, over half of African American and Hispanic children live in low child opportunity areas compared to 2% of white children. Thus race and children's neighborhoods transect to undermine child opportunity for far too many

children in Chicago. In order to address child opportunity, HC 2.0 proposes to strengthen child and adolescent health by focusing on factors that close the health-gap for children of all ages.

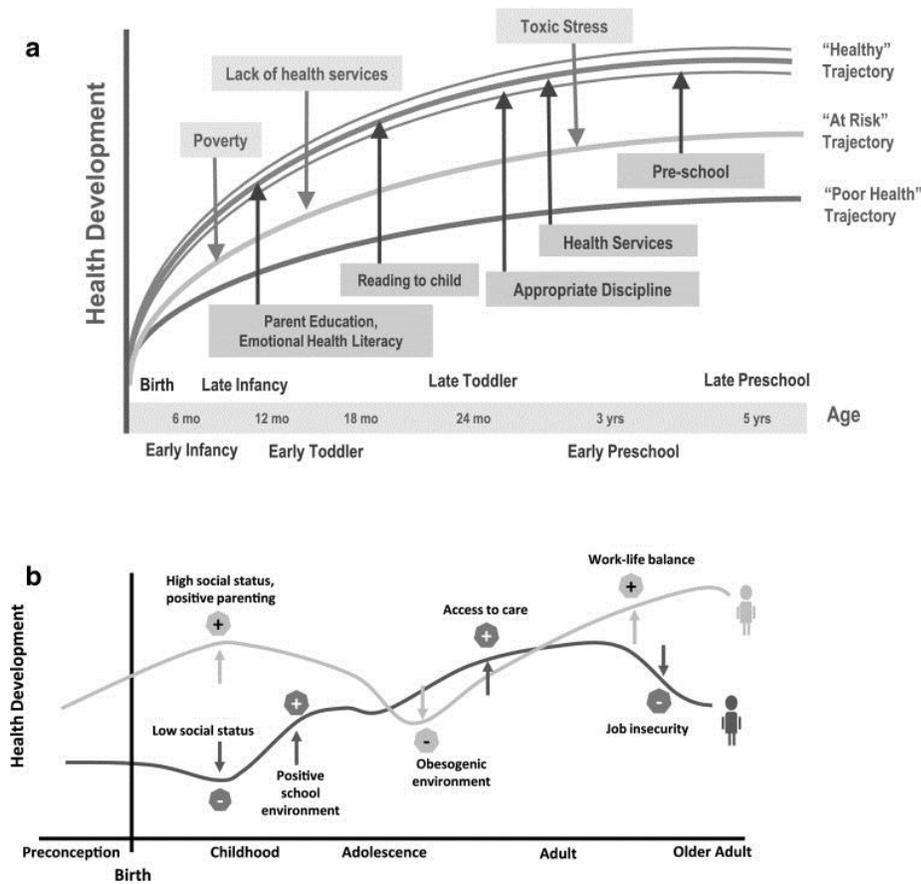
Determinants of Health Disparities

The determinants of youth health disparities include poverty, unequal access to health care, poor environmental conditions and educational inequities (Allensworth, 2011). The most prominent of these determinants is poverty, and the impact of poverty on children has an early onset, is multifaceted and enduring (Fiscella, 2010; Lempinen, 2012). Poor families have a greater likelihood of exposure to adverse experiences that intersect with poverty to further diminish child health (Freiberg, Homel, & Lamb, 2007). Furthermore, poverty can negatively influence health across the entire life span (i.e. from infancy to adulthood) and contribute to health disparities (Adler & Stewart, 2010) in adults who experience low SES as children. Further exacerbating the challenges of lifelong low SES, is the likelihood that poor and minority children will have more health problems, and less access to quality health care, which can then contribute to school absenteeism. Absenteeism can affect academic achievement, which can then, in turn damage future earnings potential and long-term health and wellbeing. Therefore, healthcare and education sectors must join forces with municipalities in order to address health and education disparities in consort (Crosnoe, Wu, Bonazzo & Maholms, 2012).

Potential Solutions/Opportunities

Parenting within the context of poverty is stressful, which can contribute to poor self-regulation, executive function, and deficits when children enter school (Blair, 2015). Therefore, in order to bolster the well-being of children living in poverty, parent and teacher education must be prioritized. Parental engagement, aimed at addressing disparities in early brain function in young children must start at birth by teaching parents and caregivers the enduring importance of talking and reading to children, among other developmentally vital strategies (Lempinen, 2012). Teachers can be supported in their essential roles with coaching by mental health consultants to improve the emotional climate of the classroom, decrease peer to peer conflict in children, and decrease teacher stress (Morris, Mattera, Castells, Bangser, Bierman, & Raver, 2014). Solutions for improving the health and well-being of children and adolescents that are proposed in HC 2.0 will take years to come to fruition. Economic changes will take time and a huge shift in public policy and resources. Housing and educational changes will take time and commitment, yet to be realized. Nevertheless, there is something that we can do now while we work towards attainment of more complex solutions. We can give immediate attention to addressing

child health. The LCHD model offers an approach to child health that posits that we can start with mothers and infants. The following principles are at the heart of the LCHD framework. Healthy development is: emerging and develops over the lifespan; multifaceted, and nonlinear; influenced by environmental experiences; adaptive and resilient in the contexts of adverse environmental challenges (see figure 1). Finally healthy development is impacted at molecular, physiological, behavioral, societal and cultural levels (Halfon, Larson, Lu, Tullis & Russ, 2013).



Prioritizing Family Child Health

The LCHD model sought to explain how health develops over an individual’s lifetime (see figure 1). Attention is focused on the impact of risk and protective factors early in the lifespan, promoting effective prevention and intervention strategies that optimize healthy development, rather than focusing on treatment in the later stages of disease. The LCHD model suggests that investments in the maternal-child health (MCH) population by adopting a whole child, whole family and whole community approach, are likely to result in the significant long term health development. And yet, despite the

proposed focus of the LCHD model on the whole family, fathers are rarely considered within the context of MCH, and are in fact often relegated to the margins of MCH services. Extension of the model to be more inclusive of the role of fathers in MCH—thereby prioritizing family and child, rather than mother and child, is warranted.

Plans such as HC 2.0 cannot immediately address the root cause of poverty and disparities in child opportunity. Nevertheless, we do not have time to waste. We must begin to work with families, across many diverse conceptualizations of family, to foster the health and well-being of children and adolescents. Adoption of the Life Course Health Development framework with mothers, fathers and children is an appropriate place to begin.

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Reflection of Health Chicago 2.0: Addressing the Need for Evaluation of Chronic Disease Prevention and Control among Older Population

In 2011, the Chicago Department of Public Health (CDPH) developed a four-year public health plan known as “Healthy Chicago” aimed to reduce the disparities and to improve health for all individuals living in the Greater Chicago Area. Twelve priority areas, including: (1) Tobacco Use; (2) Obesity Prevention; (3) HIV Prevention; (4) Adolescent Health; (5) Cancer Disparities; (6) Heart Disease & Stroke; (7) Access to Health Care; (8) Healthy Mothers & Babies; (9) Communicable Disease Control & Prevention; (10) Healthy Homes; (11) Violence Prevention; and (12) Public Health Infrastructure, were identified according to Leading Health Indicators in the Healthy People 2020¹. To keep reducing remaining health disparities, another four-year plan, known as the Health Chicago 2.0, was launched in March, 2016 to continuously improve health and well-being throughout Chicago communities. Based on the results from a comprehensive community health needs assessment carried out by the CDPH, Healthy Chicago 2.0 details a broad spectrum of strategies for ten priority areas, including (1) Expanding Partnerships and Community Engagement; (2) Improving Social, Economic and Community Conditions; (3) Improving Education; (4) Increasing Access to Health Care and Human Services; (5) Promoting Behavioral Health; (6) Strengthening Child and Adolescent Health; (7) Preventing and Controlling Chronic Disease; (8) Preventing Infectious Diseases; (9) Reducing Violence; and (10) Utilizing and Maximizing Data and Research².

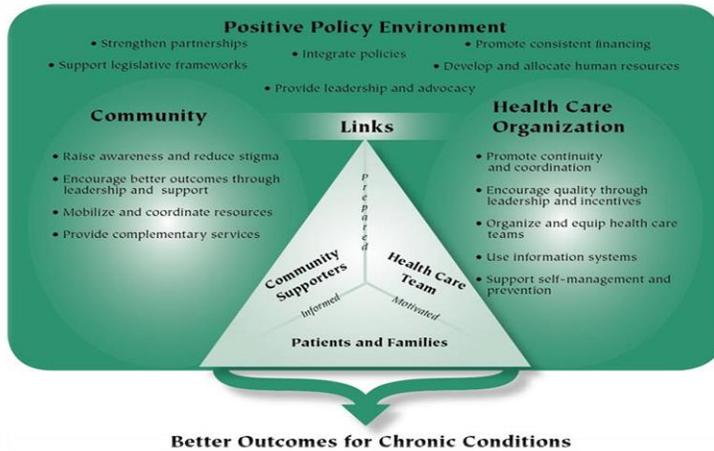
Healthy Chicago 2.0 has a special focus on addressing disparities and inequities among vulnerable populations such as people living in economic hardship or youth living in areas with low opportunity for healthy development². Other vulnerable population subgroups include: a specific race-ethnicity, age, housing status, lesbian, gay, bisexual, and transgender (LGBT) group. Regarding the age population subgroup, Healthy Chicago 2.0 emphasizes much on health outcomes on child and adolescent

population as well as their long-term health as they enter adulthood². However, less emphasis was put on older population. Today the world population is aging. There are about 600 million people aged 60 and over around the world. It is estimated that the total of older population will double by 2025 and will increase to two billion by 2050³. In Chicago, the Department of Family and Support Services-Chicago Area Agency on Aging (DFSS- Chicago Area Agency on Aging) also indicated that the estimated number of older population (65-84 years) is expected to double by 2040 in the Chicago metropolitan area⁴. As a result of the rapidly increasing number of older Chicagoans, the burden of chronic diseases (e.g., diabetes, heart diseases, stroke, cancer etc.) is expected to be increasing in Chicago. It is important for CDPH to (1) Assess the incidence and prevalence of chronic conditions among older people, (2) Assess health care needs among older people with chronic diseases, (3) Evaluate the availability of resources (e.g., health promotion, chronic disease prevention interventions) for chronic diseases prevention and control at community level, (4) implement evidence-based chronic disease management strategies at health care organization level, and (4) establish the partnership between health care organization, community organization, and patients and their family. Therefore an overall situation analysis of chronic disease prevention and control efforts at Chicago is needed.

The well-known “Innovative Care for Chronic Conditions framework (ICCC)” (Figure 1) developed by the World Health Organization⁴ can be used as an analytical framework for the situation analysis. The ICCC comprises of Macro-level (policy environment), Meso-level (health care organization and community), and Micro-level (patient & family interaction) to improve care for chronic conditions. Better outcome for chronic conditions can be achieved when each level works effectively and interacts well with other levels. First, a positive policy environment will optimize health care for chronic diseases and reduce the burden of chronic diseases. Within the Macro-level, all policy activities happened in the City of Chicago (e.g., legislation, leadership, policy integration, partnerships, financing, and allocation of human resources on chronic diseases prevention and control) need to be identified. Second, appropriate, sufficient, and timely care and services provided by health care organizations will improve the health condition of older people with chronic diseases. Additionally, most older people with chronic diseases spend their majority of time living in the community. Comprehensive community resources are vital to the management of chronic diseases. Within the Meso-level, various activities for chronic diseases prevention and control that occur in health care organizations and communities in Chicago should be evaluated. At the Micro-level, patient interactions include the activities between patients and families, healthcare teams, and community partners must be enhanced. Finally, the results from the situation

analysis at Chicago can be used to develop the guideline of making effective strategies for chronic disease prevention and control to improve health among older people living in the Greater Chicago Area.

Figure 1. Innovative Care for Chronic Conditions framework (ICCC)



References

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