Community Health Status Assessment Report

HEALTHY ILLINOIS 2028

State Health Assessment

Illinois Department of Public Health
IDPH
Protecting Health, Improving Lives

UIC Policy, Practice and Prevention Research Center

Illinois Public Health Institute

Contents

1 Executive Summary

Executive Summary

The results of examination of 67 measures for this Community Health Status Assessment (CHSA) are presented in this report. A summary table showing each of these measures for Illinois with comparable measures for the United States and/or Healthy People 2030 national benchmarks is provided. More detailed discussion and display of the data is present with comparison to demographic groups—by race/ethnicity, age, gender, and other social determinants, and geographic regions in Illinois—where possible.

Key among the findings of this assessment are:

- Illinois' population has become more diverse over time with increases in residents identifying as Asian or Hispanic or more than one race. The population is also aging with a growth of persons aged 65 years and older and a decrease in working age adults and children.
- Disparities exist in social determinants by race/ethnicity, especially for Black/African Americans and Hispanics, including lower frequency of high school and college graduation among Blacks, lower median household income, higher proportions living in poverty, and higher incidence of hate crimes and violence, including homicide and firearms-related events.
- Steady or slight decreases in annual mortality rates were seen for most leading causes of death from 2016 to 2019. However, decreases seen through 2019 for heart disease, cerebrovascular disease, and Alzheimer's disease were reversed with an uptick in these causes in 2020. Some of this increase may have been related to the COVID-19 pandemic. A rise in premature deaths overall, seen in increases in years of potential life lost before 75 years of age, was also evident in 2020 for all race/ethnicity groups, with the sharpest increases in Black/African Americans and Hispanics.
- Disparities in mortality were seen, particularly for Black/African Americans who had highest rates of death due to heart diseases, cancer, accident, diabetes, renal diseases, and violence-related causes. Similar inequities were seen in life expectancy among Black/African Americans.
- Key indicators of infant health—infant mortality, preterm and low birthweight births—remained relatively unchanged, however, Black/African American disparities persist for these measures.
- Prenatal care utilization remains below national benchmarks with Hispanic and Black/African American women more likely to not have adequate or early prenatal care.
- Childhood immunization coverage for most routine vaccine series were below national benchmarks.
- Childhood lead poisoning levels were at a 20-year low, however, Black/African American children experienced the largest burden of these exposures.
- Half of adults live with a chronic condition, regardless of race/ethnicity.
- Diabetes mellitus disproportionately affects Hispanic, Black/African Americans, nonurban, and those without a high school diploma.
- Obesity, high blood pressure, and high cholesterol are present in nearly one-third of the population with disparities among those by race/ethnicity and locale.
- Increases in mortality and nonfatal emergency department visits for drug and opioid overdose were seen in 2020.
- Binge drinking showed disparities by age and race/ethnicity with younger and White residents experiencing the highest prevalence.
- Smoking and tobacco use remained low at only 1 in 6 residents; higher prevalence was seen in older adults and those in nonurban areas.

- Suicide mortality disparities were evident by sex with males more than four times the female rate; Black/African American, Hispanic and other race groups showed increases in suicide rates.
- Poor mental health and depression impacts substantial proportions of residents with disparities by age, income, race/ethnicity, and locale.
- Nearly 75% of the state's residents visited their primary care provider in the past year with few disparities noted by race/ethnicity, income, or locale.
- Primary care related emergency department visit rates, as an indicator of access to care, showed higher rates of use for Black/African Americans for diabetes, hypertension, and asthma.
- Primary care health professional shortage areas were more prevalent outside of major metropolitan counties.
- Sexually transmitted infection rates, including chlamydia, gonorrhea, primary and secondary syphilis, and HIV diagnoses, demonstrate persistent disparity by race/ethnicity and age.
- COVID-19 mortality ranked as the third leading cause of death in 2020, with rates for Hispanics nearly twice that of the state's rate and Black/African Americans nearing or exceeding 50% higher over the overall state rate, respectively.

While improvements in some health indicators were seen for the period examined for this assessment, a common theme across many indicators is the persistent disparity/inequity in health status by race/ethnicity and among those with social determinants associated with lower income and opportunity—household income, educational attainment status, and access to health services, perhaps due to availability, distance, or other barriers (i.e., affordability or insurance status). For many of these, the inequities are long-standing and point to larger underlying structural and social conditions beyond those evident in the outcome measures presented here. Continued alignment of outcomes with the underlying causes is needed to effectively monitor and inform efforts to address the disparities in health status.

2 Introduction

The mission of public health is the fulfillment of society's interest in assuring the conditions in which people can be healthy (IOM 1988). To achieve this, the governmental public health is called upon to lead an engaged process to assess the health status of the population, including health outcomes and factors that contribute to health such as "upstream" social and structural determinants of health. This assessment serves to inform the identification of system-wide priorities related action plans to improve health and work toward achieving health equity. As part of Healthy Illinois 2028, the Illinois Department of Public Health (IDPH); the University of Illinois at Chicago School of Public Health (UIC-SPH) Policy, Practice, and Prevention Research Center (P3RC); the Illinois Public Health Institute; and practice and community representatives on the SHIP 2027 Partnership, engaged in a process of producing summary data for a set of leading health indicators to support the State Health Assessment (SHA) and State Health Improvement Plan (SHIP).

Pursuant to Illinois Public Act 102-0004, Illinois develops a SHA and SHIP every five years. A collaborative public/private cross-agency effort, the SHA and SHIP assesses and recommends priorities and strategies to improve the public health system, the health status of Illinoisans, reduce health disparities and inequities, and promote health equity.

IDPH is leading the SHA/SHIP process in collaboration with the appointed SHA/SHIP Partnership, which includes representatives from state agencies with public health responsibilities and a range of public, private, and voluntary sector stakeholders and participants in the public health system. IDPH is working with UIC-SPH P3RC and the Illinois Public Health Institute (IPHI) to facilitate the partnership and to complete the SHA/SHIP process.

SHA Framework

In 2021–2022, IDPH completed a comprehensive SHA using the Mobilizing for Action through Planning and Partnerships (MAPP) Process (Figure 1). MAPP utilizes four assessments to gain a comprehensive picture of community health.

Figure 1. The MAPP Process (NACCHO, 2013)

- The **Community Health Status Assessment (CHSA)** provides quantitative information on community health conditions.
- The **Community Themes and Strengths Assessment (CTSA)** identifies assets in the community and issues that are important to community members.
- The **State Public Health System Assessment (SPHSA)** measures how well different state public health system partners work together to deliver the Essential Public Health Services. The SPHSA is currently under revision from the National Association of County and City Health Officials (NACCHO). Therefore, IDPH, IPHI, and UIC developed an adaptation of the SPHSA focused on health equity (the Health Equity Capacity Assessment) to complete this component of the MAPP Process for the 2021–2022 SHA.
- The **Forces of Change Assessment (FOCA)** identifies forces that may affect a community and the opportunities and threats associated with those forces.

3 Community Health Status Assessment Framework

The Community Health Status Assessment is one of four assessments within the modified Mobilizing for Action through Planning and Partnerships (MAPP) framework developed by the National Association of County and City Health Officials (NACCHO). "The Community Health Status Assessment provides quantitative data on a broad array of health indicators, including quality of life, behavioral risk factors, and other measures that reflect a broad definition of health" (Source: NACCHO, 2008).

A key foundational principle of the NACCHO MAPP process, as outlined in the MAPP Evolution Blueprint (2020), is equity. Specifically, the process seeks to "encourage shared exploration of the social injustice, including structural racism, class oppression, gender oppression, which create and perpetuate inequities." This is reflected in this assessment's emphasis and examination of the following definitions and concepts.

Health Equity

"The attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities" (Healthy People 2030).

Racism Affects Health Status

Racism is defined as a "system of structuring opportunity and assigning value based on the social interpretation of how one looks... ("race"), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and undermines realization of the full potential of our whole society through the waste of human resources" (APHA, 2022). Increasing research and evidence has examined the ways in which racism negatively impacts health. "The persistence of racial inequities in health should be understood in the context of relatively stable racialized social structures that determine differential access to risks, opportunities, and resources that drive health" (Williams, D., 2019). Beyond behavioral risk factors (i.e., person's choices and actions) and social and structural causes, such as socioeconomic status or education and training, racism also "should be recognized as a fundamental cause of racial inequities in health" (Williams, D., 2019).

Social Determinants of Health

The social determinants of health (SDOH) are the non-biological and nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems.

The SDOH have an important influence on health inequities—the unfair and avoidable differences in health status seen within and between populations. Addressing SDOH is fundamental for improving health and reducing long-standing inequities in health.

This assessment presents health outcomes and highlights SDOH where possible. However, data relating to SDOH are often not collected in surveillance of behaviors, risk factors, and outcomes. Critical to the understanding of health disparities presented in this report is acknowledgment that these

are most often not related to group differences but to undocumented, systemic factors and conditions—the underlying SDOH, that serve as root causes of these inequities (Adapted from WHO, 2022).

Demographic Group Differences by Race and Ethnicity

Race and ethnicity are dynamic, shaped by geographic, cultural, and sociopolitical forces. Race and ethnicity are social constructs and with limited utility in understanding medical research, practice, and policy. However, the terms may be useful as a lens through which to study and view racism and disparities and inequities in health, health care, and medical practice, education, and research.

Although race and ethnicity have no biological meaning, the terms have important, albeit contested, social meanings. Neglecting to report race and ethnicity in health and medical research disregards the reality of social stratification, injustices, and inequities and implications for population health, and removing race and ethnicity from research may conceal health disparities. Thus, inclusion of race and ethnicity in reports of medical research to address and further elucidate health disparities and inequities remains important at this time (Flanigan, 2021).

For this report, race and ethnicity descriptors are used in an unlinked manner. Race categories refer only to race. Ethnicity is dichotomized as Hispanic or non-Hispanic and is independent of race meaning that individuals from a variety of races are represented in Hispanic and non-Hispanic categories. As a result, data influenced by a single respondent may impact both a racial group and the ethnicity categories.

4 Notes On Interpretation

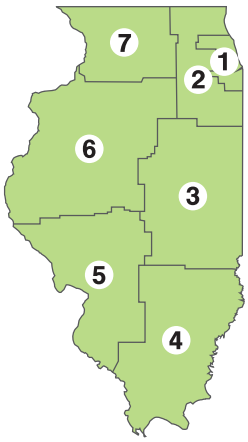
The measures presented in this Community Health Status Assessment (CHSA) report represent results from various forms of public health forms of community health surveillance—from birth and death registries, mandated reporting of communicable diseases, health service utilization, data from the decennial census, and sample surveys conducted by the U.S. Census Bureau as well as local and national surveys conducted by IDPH and the federal government, such as the Behavioral Risk Factor Surveillance System (BRFSS) survey. While these methods apply sound methodological principles and design, there are limitations in terms of response and completeness, accuracy related to classification and self-reporting, and the ability to detail smaller geographic or demographic groups.

In most cases, for an area with a population as large as Illinois, these limitations remain fairly consistent from year to year, allowing for assessment of health status changes over time or between groups. However, these measures represent annual or multiyear estimates as summary measures and don't reflect seasonal or cyclic variations in these measures. While this is useful for planning purposes, some caution in interpretation is needed as determining differences between groups and trends in these estimates requires statistical procedures that are not included here.

As the data used in developing this report consist of secondary sources of data—obtained from IDPH data stewards and other agencies—data categories were largely defined by these sources. Every attempt was made to apply consistent definitions across the measures. Some variation in age groupings between measures are present, due to the manner in which the data were categorized by the data owner. For race, category labels for White, Black/African American, Asian, Native American, Other Race, or Two or More Races, represent these race classifications and ethnicity as "non-Hispanic." Similarly, categorization of ethnicity as "Hispanic" refers to persons of Hispanic origin of any race identity. No further differentiation of ethnicities was possible.

IDPH Regions

IDPH divides the state geographically into seven administrative regions. The regions and region names correspond to the locations of the IDPH regional offices, which are led by regional health officers. For this assessment, regional data are presented by these with the exception of HIV/AIDS, which uses a different regional categorization. The IDPH regions are listed with corresponding counties in the table below and shown geographically in the map.



Several indicators in the report present measures by IDPH region. These values were calculated using county-level data within a given region for the time period specified. In general, the median regional rate or measure across counties for a region is presented with a range of values representing the highest and lowest values among counties in that region. This allows some interpretation of differences between regions as well as identification of the range of variability in the indicator across counties in a region.

REGION 1 (COOK)	REGION 2 (WEST CHICAGO)	REGION 3 (CHAMPAIGN)	REGION 4 (MARION)		REGION 5 (EDWARDSVILLE)	REGION 6 (PEORIA)		REGION 7 (ROCKFORD)
Cook	DuPage	Champaign	Alexander	Lawrence	Christian	Adams	Mason	Boone
	Grundy	Clark	Clay	Marion	Coles	Brown	McDonough	Carroll
	Kane	Cumberland	Clinton	Massac	Greene	Bureau	Menard	DeKalb
	Kankakee	DeWitt	Crawford	Perry	Jersey	Calhoun	Mercer	Jo Daviess
	Kendall	Douglas	Edwards	Pope	Macoupin	Cass	Peoria	Lee
	Lake	Edgar	Effingham	Pulaski	Madison	Fulton	Putnam	Ogle
	McHenry	Ford	Fayette	Richland	Monroe	Hancock	Rock Island	Stephenson
	Will	Iroquois	Franklin	Saline	Montgomery	Hardin	Schuyler	Whiteside
		Livingston	Gallatin	Union	Morgan	Henry	Stark	Winnebago
		Macon	Hamilton	Wabash	Pike	Knox	Tazewell	
		McLean	Henderson	Wayne	Randolph	LaSalle	Warren	
		Moultrie	Jackson	White	Sangamon	Logan	Woodford	
		Piatt	Jasper	Williamson	Scott	Marshall		
		Shelby	Jefferson		St. Clair			
		Vermilion	Johnson		Washington			

5 Indicator Overview and Summary

For this assessment, a broad set of indicators was used across several domains in order to provide a more detailed picture of the state's health status. Data were organized across the following domain groupings:

- Population
- Social Determinants of Health (SDOH)
- Mortality Indicators
- Maternal and Child Health
- Chronic Diseases and Conditions
- Behavioral and Mental Health
- Access to Health Care
- Injury and Violence
- Communicable Diseases

The following tables present summary indicators for Illinois from those reviewed for this assessment. For comparison purposes, where available, recent measures for the United States are provided. Healthy People 2030 benchmarks are also noted, where applicable. Unless noted, U.S. measures are for comparable years as those presented for Illinois. U.S. and HP2030 source references are presented in the Core Summary Reference Table in the Reference Section of this report. Sources for Illinois indicators are referenced in the narrative section of this report.

Core Indicator Summary Table

INDICATOR	MEASURE	YEAR(S)	ILLINOIS	U.S.*	HP2030*
Social Determinants of Health (SDOH)					
High School Diploma	Percent	2015-2019	26.0%	28.1% (2019)	
Bachelor's Degrees	Percent	2015-2019	21.1%	22.5% (2019)	
Median Income	Annual Household	2015-2019	$65,886	$69,560 (2019)	
Population Living in Poverty	Percent	2015-2019	12.5%	10.5%	
Unemployment	Percent	2015-2019	5.9%	3.6% (2019)	
Homeless Population	Count	2020	10,431	580,466	
Medicaid Adults	Percent	2015-2019	21%	14.7% (2016-2020)	
Medicaid Children	Percent	2021	37.1%	39.7% (2016-2020)	
Non-English Primary Language	Percent	2015-2019	23.2%	21.5%	
Less than Well English Fluency	Percent	2015-2019	8.6%	8.2%	
Homicide Mortality	Age-Adjusted Rate per 100,000	2016-2020	9.1	6.0	5.5
Firearms Mortality	Age-Adjusted Rate per 100,000	2016-2020	11.5	13.6 (2020)	

INDICATOR	MEASURE	YEAR(S)	ILLINOIS	U.S.*	HP2030*
Mortality Indicators					
Life Expectancy at Birth	Years	2017-2019	78.6	77.0	78.6
Life Expectancy at Age 65 Years	Years	2017-2019	20.0	19.6	
Premature Death – Years of Potential Life Lost <75 Years	Cumulative Years	2020	835.7	6968.6 (2016)	
Mortality – Diseases of the Heart	Age-Adjusted Rate per 100,000	2016-2020	163.8	211.5	
Mortality – Ischemic Heart Disease	Age-Adjusted Rate per 100,000	2020	81.7	88.0	71.1
Mortality – Malignant Neoplasms	Age-Adjusted Rate per 100,000	2016-2020	153.4	146.2	122.7
Mortality – Female Breast Cancer	Age-Adjusted Rate per 100,000	2016-2020	20.1	19.4	
Mortality – Prostate Cancer	Age-Adjusted Rate per 100,000	2020	18.9	18.0	
Mortality – Lung Cancer	Age-Adjusted Rate per 100,000	2020	33.9	34.8	
Mortality – COVID-19	Age-Adjusted Rate per 100,000	2020	99.2	91.5	
Mortality – Accidents	Age-Adjusted Rate per 100,000	2016-2020	44.4	49.3 (2019)	
Mortality – Cerebrovascular Disease (Stroke)	Age-Adjusted Rate per 100,000	2016-2020	38.7	37.0	33.4
Mortality – Alzheimer's Disease	Age-Adjusted Rate per 100,000	2016-2020	25.4	233.8	
Mortality – Diabetes Mellitus	Age-Adjusted Rate per 100,000	2016-2020	18.7	553.4	
Mortality – Kidney Diseases	Age-Adjusted Rate per 100,000	2016-2020	16.8	12.9	
Mortality – Influenza and Pneumonia	Age-Adjusted Rate per 100,000	2016-2020	15.4	12.3	
Motor Vehicle Crash Mortality	Age-Adjusted Rate per 100,000	2016-2020	9.3	11.1	
Maternal and Child Health					
Infant Mortality	Per 1000 live births	2019	5.6	5.8 (2017)	5.0
Preterm Births (< 37 weeks)	Percent	2015-2019	10.4%	10.1% (2020)	
Low Birthweight Births	Percent	2015-2019	8.4%	8.2% (2020)	
Adequate Prenatal Care	Percent	2015-2019	74%	76.7%	80.5%
Maternal Mortality (Pregnancy-Associated Mortality)	100,000 live Births	2016-2017	58.0	17.1	15.7
Breastfeeding Prevalence	Percent	2015-2019	81.5%	83.2%	

INDICATOR	MEASURE	YEAR(S)	ILLINOIS	U.S.*	HP2030*
Teen Birth Rate	Birth Rate per 1000 Female Population	2019	8.2	16.7	
Immunization Coverage Age 24 Months – 7 Vaccine Series	Percent	2018-2020	70.6%	69.7%	
Childhood Lead Poisoning Prevalence (>5 mg/dl)	Percent	2018	2.6%	2.6%	
Chronic Diseases and Conditions					
Prevalence of Adults Living with a Chronic Condition	Percent	2015-2019	49.9%	51.8% (2018)	
Arthritis Prevalence	Percent	2017-2019	24.7%	25.6%	
Disability Prevalence	Percent	2015-2019	23.7%	26.0%	
Diabetes Prevalence	Percent	2017-2019	11.3%	10.8%	
Asthma Prevalence	Percent	2017-2019	8.7%	9.5%	
Obesity Prevalence	Percent	2017-2019	31.6%	34.9%	
Hypertension Prevalence	Percent	2015, 2017, 2019	32.2%	31.8%	
High Cholesterol Prevalence	Percent	2015, 2017, 2019	32.5%	34.2%	
Behavioral and Mental Health					
Drug Overdose Mortality	Age-Adjusted Rate per 100,000	2019	21.9	28.3 (2020)	
Opioid Mortality	Age-Adjusted Rate per 100,000	2017-2020	23.1	17.8 (2020)	
Substance Misuse Emergency Department Visit Rate	Rate per 10,000	2018-2020	33.9	NA	
Alcohol Misuse Emergency Department Visit Rate	Rate per 10,000	2018-2020	56.8	39.3 (2021)	
Marijuana Use	Percent	2017-2019	12.0%	18.0% (2019)	
Binge Drinking	Percent	2017-2019	19.9%	16%	
Tobacco Use Prevalence	Percent	2017-2019	15.2%	12.5% (2020)	
Suicide Mortality	Age-Adjusted Rate per 100,000	2016-2020	10.9	13.9	12.8
Poor Mental Health Prevalence	Percent	2017-2019	12.4%	8.2%	3.4
Depression Prevalence	Percent	2015-2019	17.7%	18.4%	
Access to Health Care					
No Personal Doctor or Health Care Provider	Percent	2017-2019	18.8%	20.1%	
Diabetes Emergency Department Visit Rate	Rate per 10,000	2018-2020	345.5	NA	
Hypertension Emergency Department Visit Rate	Rate per 10,000	2018-2020	43.4	29.5	27.7
Asthma Emergency Department Visit Rate	Rate per 10,000	2018-2020	34.5	54.9 (2013-2015)	44.0
Ambulatory Care Sensitive Emergency Department Visit Rate	Per 10,000	2018-2020	1499.8	NA	

INDICATOR	MEASURE	YEAR(S)	ILLINOIS	U.S.*	HP2030*
Communicable Diseases					
Chlamydia Incidence Rate	Rate per 100,000	2016-2020	679.1	483.1 (2020)	
Gonorrhea Incidence Rate	Rate per 100,000	2016-2020	203.9	206.5 (2020)	
Primary and Secondary Syphilis Incidence Rate	Rate per 100,000	2016-2020	10.7	12.7 (2020)	
HIV Diagnosis Rate	Rate per 100,000	2020	10.9	12.6 (2019)	
AIDS Prevalence	Rate per 100,000	2020	147.4	162.3	
COVID-19 Mortality Rate	Rate per 100,000	2020	99.1	91.5	

*U.S. and HP2030 source references are presented in the Core Summary Reference Table in the Reference Section of this report.

Note: Sources for Illinois indicators are referenced in the narrative section of this report.

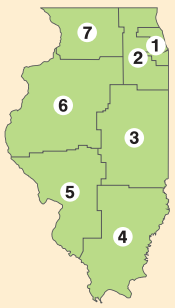
6 Illinois Health Status Indicators

Population

Between 2010 and 2020 Illinois' population decreased by 0.1 percent to 12,812,508. The state's ranking dropped from the fifth to the sixth most populous state.

In 2020, nearly 70% of the state's population resided in the Chicago metropolitan area (Region 1 [Cook] and 2 [West Chicago]). These regions each saw growth of slightly under 2%. Other regions of the state experienced population decrease in the last decade of between 2.6% and 4.5%.

REGION	NAME	2010	2020	CHANGE
1	Cook	5,194,675	5,275,541	1.6%
2	West Chicago	3,400,223	3,462,229	1.8%
3	Champaign	782,233	761,647	-2.6%
4	Marion	587,112	560,815	-4.5%
5	Edwardsville	1,076,316	1,034,977	-3.8%
6	Peoria	1,101,680	1,054,090	-4.3%
7	Rockford	688,393	663,209	-3.7%
Illinois		12,830,632	12,812,508	-0.1%



Illinois' population is aging with the median age increasing from 36.3 years in 2010 to 38.3 years in 2020. The largest increase in population by age was among those 65 years and older with a 25.3% rise from 12.5% to 15.7% of the population. Proportions of both working age adults and children under 18 years of age decreased during this period. Similar patterns were seen by sex, with the proportion of males 65 years of age and older rising the most from 10.8% to 13.9%, a 28.7% increase.

The shifts in the population's age are reflected in the increase in the Dependency Ratio, which measures the relationship between those 18 to 64 years of age, ostensibly those of working age, to those both younger than 18 years of age and those 65 years of age and older. For Illinois in 2020, there are only 61.6 persons between 18 to 64 years of age for every 100 persons in the population from the other two age groups combined.

AGE*	2010	2020
<18	24.4%	22.5%
18-64	63.1%	61.9%
65+	12.5%	15.7%
Median Age	36.6	38.3
Dependency Ratio	58.6	61.6

AGE BY SEX**	FEMALE		MALE	
	2010	2020	2010	2020
<18	23.4%	21.6%	25.4%	23.3%
18-64	62.3%	61.1%	63.8%	62.8%

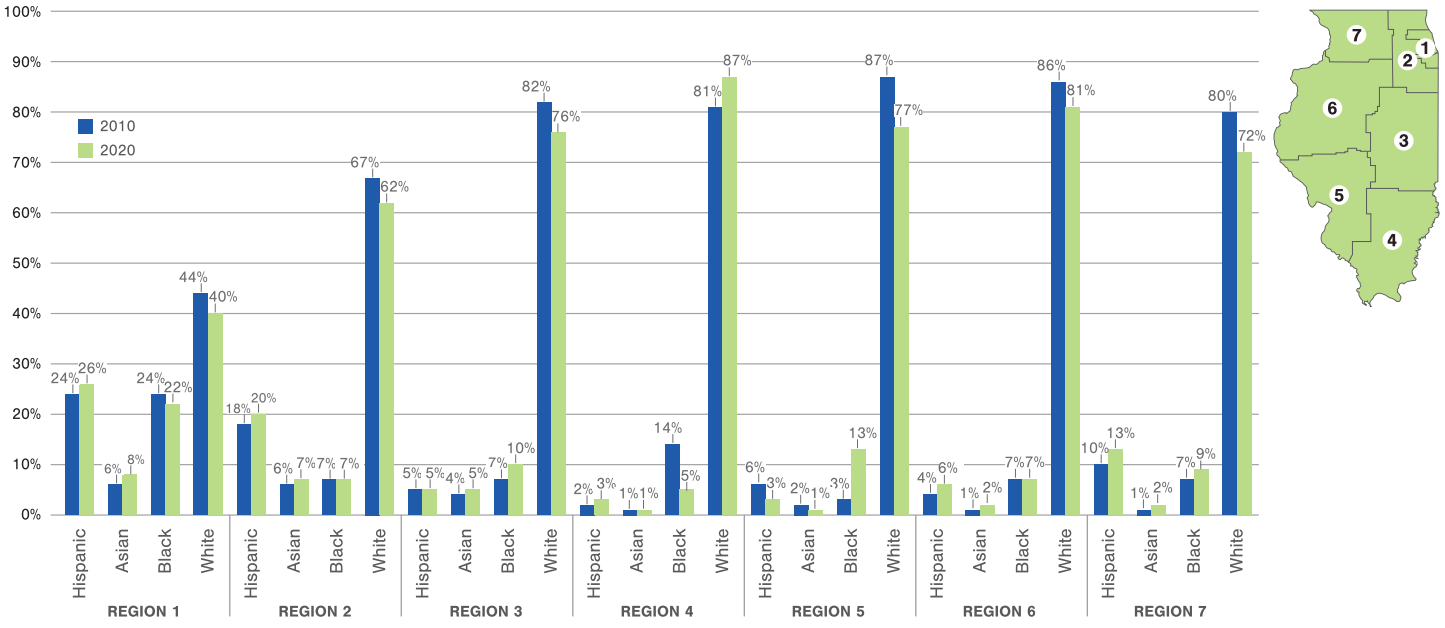
*2020 Decennial Census (US Census Bureau, 2022)
**ACS 5 Year Estimates (US Census Bureau, 2022)

Illinois' population was more diverse in 2020, with slightly more than 4 in 10 identifying as Black, Indigenous, or Persons of Color (BIPOC). This is reflected most in a growing Hispanic population, which increased by 15.3%. In addition, people identifying as being of More than 1 Race or Other Race saw the greatest change—more than doubling in the last 10 years. In contrast, populations

identifying as White (-8.5%), Black or African American (-3.1%), and American Indian/Alaska Native (-12.1%) showed decreases in population.

RACE/ETHNICITY	2010 COUNT	2010 PERCENT	2020 COUNT	2020 PERCENT	% CHANGE
American Indian/Alaska Native	18.849	0.1%	16,561	0.1%	-12.1%
Asian/Pacific Islander	583,563	4.5%	747,280	5.8%	28.1%
Black or African American	1,832,924	14.3%	1,775,612	13.9%	-3.1%
Hispanic	2,027,578	15.8%	2,337,410	18.2%	15.3%
White	8,167,753	63.7%	7,472,751	58.3%	-8.5%
Other Race	16,008	0.1%	45,080	0.4%	181.6%
More than 1 Race	183,957	1.4%	414,855	3.2%	125.5%
Total Population	12,830,632		12,812,508		-.1%

These patterns are similar across most of the state's regions. Decreases were seen in the proportion of the White population in all regions except for Region 4 (Marion), which increased from 81% to 87%. Hispanic populations increased in all regions, except Region 5 (Edwardsville), which decreased from 6% to 3%. The largest increase in Hispanic population was seen in Region 7 (Rockford), which increased from 10% to 13%. Black or African American populations increased in Region 3 (Champaign) and in Region 5 (Edwardsville) from 3% to 13%, respectively. The Black or African American population decreased the most in Region 4 (Marion) from 14% to 5%. Asian populations increased slightly or remained stable in most of the regions.



7 Social Determinants of Health

Social Determinants of Health

- Educational Attainment
- Household Income and Poverty
- Homelessness and Housing
- Unemployment
- Health Insurance
- Language Diversity
- Discrimination and Racism
- Violence and Safety
- Toxic Stress and Adverse Childhood Experiences (ACEs)

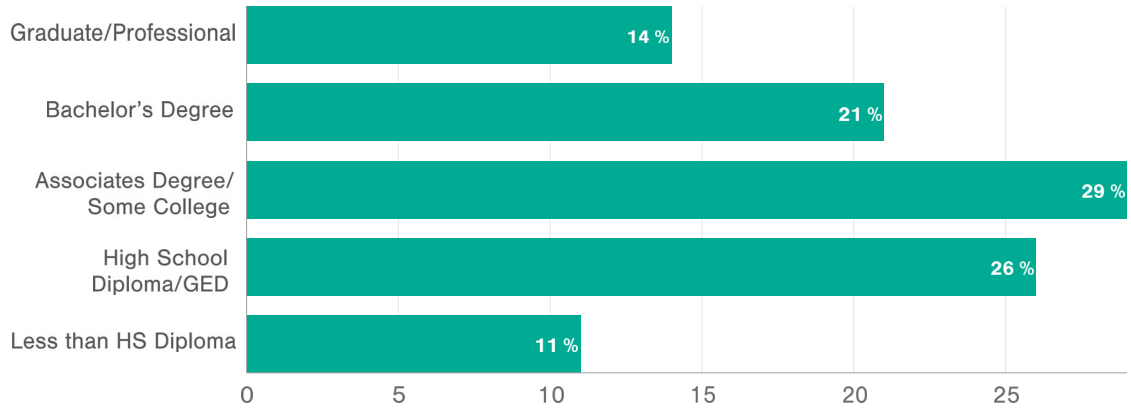
Social Determinant: Educational Attainment

Educational attainment, the highest level of education an individual has achieved, is a key social determinant of health that is positively associated with income and negatively associated with health outcomes. In Illinois for the period 2015 to 2019, 10.8% or nearly 1 in 10 residents lacked a high school diploma. Only slightly more than 1 in 5 residents (21.1%) had a bachelor's degree.

Hispanic and Other Race adult residents were most likely to lack a high school diploma or equivalent, with almost 1 in 3 (30.8%) Hispanics and 37.1% of those of Other Race not achieving this milestone.

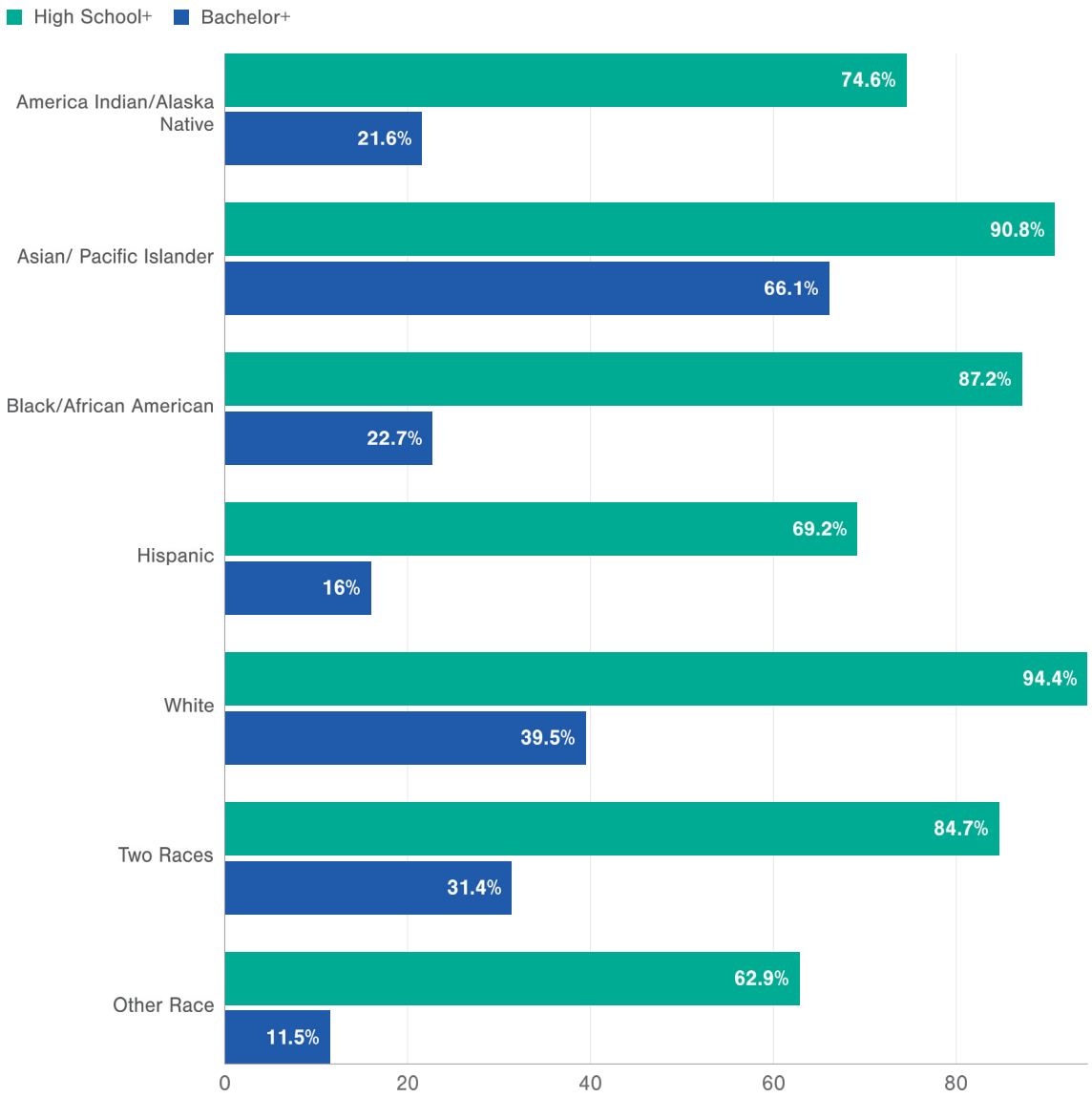
Black/African American, Hispanic, American Indian/Alaska Native, Other Race, and mixed-race adults were less likely to be college graduates compared to White or Asian/Pacific Islander adults. Asian/Pacific Islanders were 2 to 3 times more likely to have completed a bachelor's degree than all other groups.

Educational Attainment by Age 25 Years Illinois (2015–2019)



Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimate

Educational Attainment by Race/Ethnicity Illinois (2015–2019)



Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimate

Social Determinant: Household Income and Poverty

For the period 2015 to 2019, the median income among Illinois households stood at $65,886. This is more than the median income for the U.S. for this period ($62,843).

Disparities in household income are apparent by race/ethnicity with Black/African American households below the state median by $27,313. Only Asian and White households had median incomes above the state figure.

In 2018 for the U.S., 11.8% of the population lived below the federal poverty level. For the period 2015 to 2019 in Illinois, the proportion of the population in poverty was higher at 12.5%.

RACE/ETHNICITY	MEDIAN HOUSEHOLD INCOME	DIFFERENCE FROM ILLINOIS MEDIAN
Illinois	**$65,886**	
Asian	$90,278	$24,392
White	$73,686	$7,800
Two or more races	$59,451	-$6,435
Hispanic	$55,836	-$10,050
Some other race	$52,832	-$13,054
American Indian and Alaska Native	$49,634	-$16,252
Native Hawaiian and Other Pacific Islander	$46,023	-$19,863
Black or African American	$38,573	-$27,313

	% BELOW POVERTY LEVEL
Illinois	**12.5%**
Race/Ethnicity	
White alone	9.4%
Black or African American alone	26.1%
American Indian and Alaska Native alone	16.4%
Asian alone	10.8%
Native Hawaiian and Other Pacific Islander alone	12.6%
Some other race alone	17.5%
Two or more races	16.0%
Hispanic or Latino origin (of any race)	16.1%
White alone, not Hispanic or Latino	8.4%

Source: U.S. Census Bureau, 2016–2020 American Community Survey 5-Year Estimate

Black/African American prevalence of living below the federal poverty level, at 26.1%, was more than twice that of the overall Illinois proportion of the population living in poverty (12.5%). Asian and White residents living in poverty were below the state average at 10.8% and 8.4%, respectively.

Social Determinant: Homelessness and Housing

Homelessness is a root cause of the poor health status of both those directly impacted and the community. Estimates of homelessness in Illinois in 2020 indicated that on any given day approximately 10,431 citizens experienced homelessness. More than 1 in 10 of these are family households and 2 in 10 are chronically homeless.

ILLINOIS HOMELESS STATISTICS 2020	(AVERAGE DAILY COUNTS)
Illinois Residents	10,341
Family households	1,063
Veterans	736
Unaccompanied young adults (18-24 years)	671
Chronic homeless persons	2,305
Homeless Students in Public School	54,237
Nightime residence: Unsheltered	337
Nightime residence: Shelters	5,093
Nightime residence: Hotel/motel	2,217
Nightime residence: Double up	42,647

Source: US Interagency Counceil on Homelessness, 2022

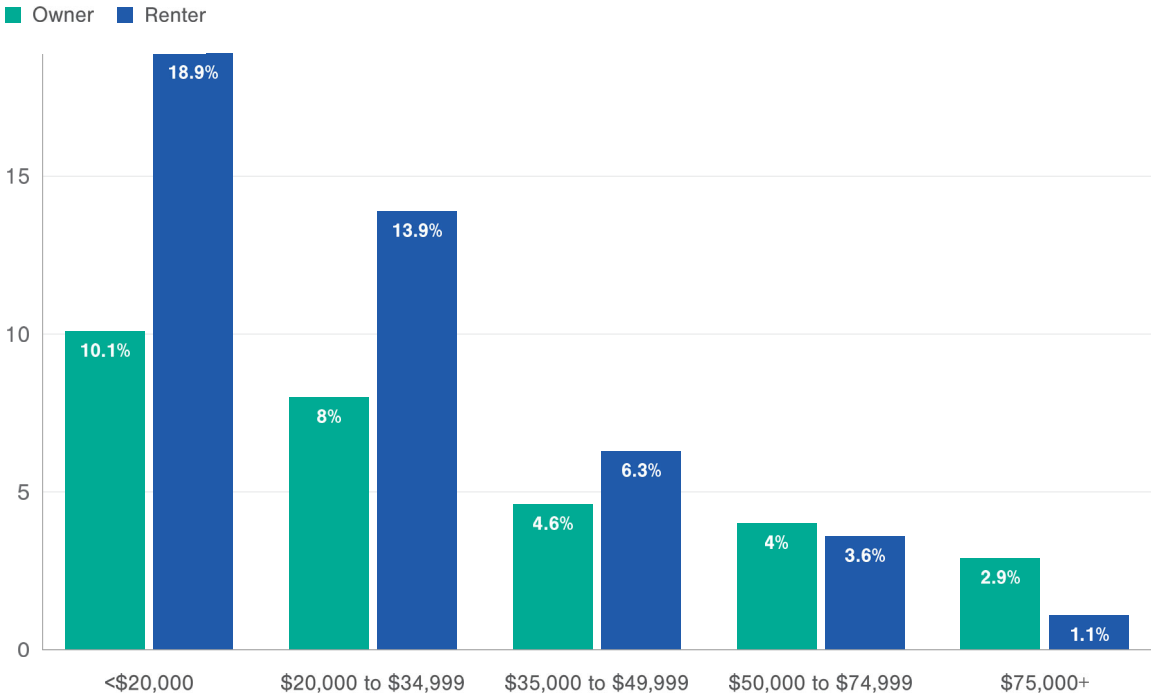
Homelessness' burden on children's education is indicated by more than 54,000 public school students being homeless. These youth and their families have a variety of temporary living conditions, including nearly 1 in 10 in shelters and the vast majority (78.6%) "doubling up" with friends, neighbors, or relatives.

Households spending more than 30% of monthly income on housing—either rent or mortgage—may be considered at financial risk for homelessness. In 2020, poorer households showed a higher

prevalence of housing related financial risk with nearly 1 in 5 paying more than 30% of their monthly income for rent or mortgage.

Housing financial risk in the two lowest income groups was seen between 3 and 7 times more frequently than in the housing of the two highest income groups.

Illinois – 5 Year Estimates – 2020 Housing Financial Risk – Percentage of Households with Monthly Housing Cost Over 30% of Income by Annual Income and Housing Ownership

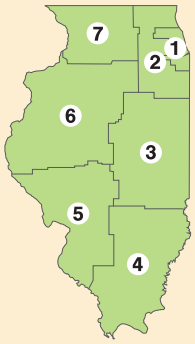


Source: U.S. Census Bureau, 2016–2020 American Community Survey 5-Year Estimate

Social Determinant: Unemployment

Percent Unemployed – Illinois, Regional Median and County Range (2015–2019)

	REGION	MEDIAN	COUNTY RANGE MIN	MAX
	Illinois	**5.9%**		
1	Cook	7.0%	NA	NA
2	West Chicago	4.8%	4.1%	6.6%
3	Champaign	5.0%	3.0%	9.5%
4	Marion	5.6%	2.6%	15.7%
5	Edwardsville	5.5%	2.5%	7.1%
6	Peoria	5.1%	2.6%	7.7%
7	Rockford	5.6%	3.5%	8.1%



Source: U.S. Census Bureau, 2015–2019 American Community Survey 5-Year Estimate

Prior to the COVID-19 pandemic, the median unemployment rate for the U.S. for 2015-2019 was 4.4%. During the same time period, Illinois' rate was higher at 5.9%. Region 1 (Cook) had a rate

higher than the rest of the state at 7.0% and Region 2 (West Chicago) had a median lower than the state at 4.8%. Rates varied widely within regions, with Region 4 (Marion) experiencing the widest variation between counties—from 2.6% to as high as 15.7%. For regions 2 through 7, the regional county median unemployment rates varied little, however, there was considerable variation in rates by county within regions.

Employment disparities by race/ethnicity mirror household income indicators. Black/African Americans experienced a median unemployment rate for the period 2015 to 2019 of more than twice the Illinois rate and three times higher than Whites and Asians.

Percent Unemployment – Illinois and by Race/Ethnicity (2015–2019)

RACE/ETHNICITY	PERCENT
Illinois	**5.9%**
Black/African American	14.1%
American Indian/Alaska Native	9.0%
Two or more races	8.9%
Hispanic	6.4%
Some other race	6.3%
Native Hawaian/ Pacific Islander	5.2%
White	4.3%
Asian	4.2%

Source: U.S. Census Bureau, 2015–2019 American Community Survey 5-Year Estimate

Social Determinant: Health Insurance

Lacking health insurance coverage is another key social determinant that has a notable impact on health outcomes. Communities with high rates of uninsured experience poorer health status due to lack of access to affordable health care. For the period 2015 to 2019 in the U.S., an annual median estimate of 8.7% of the population was uninsured. In comparison, Illinois estimates for the same period were lower at 6.8%. However, disparities exist by race/ethnicity with Hispanic residents (16.0%) and those with some other race (20.3%) uninsured at more than double the state rate and almost 4 to 5 times higher than the White population (4.1%).

Percent Uninsured – Illinois and by Race/Ethnicity (2015–2019)

RACE/ETHNICITY	PERCENT
Illinois	**6.8%**
Some other race	20.3%
Hispanic	16.0%
Native Hawaiian and Other Pacific Islander	14.5%
American Indian/Alaska Native	11.3%
Black/African American	7.7%
Asian	6.6%
Two or more races	5.7%
White	4.1%

Medicare and Medicaid Insurance – Illinois and by Age and Sex (2015–2019)

AGE/SEX		PERCENT
Medicaid	**Age Group**	**Percent**
Illinois	**<65 years**	**21.0%**
Males	<19 years	36.8%
	19-64 years	12.0%
Females	<19 years	37.4%
	19-64 years	17.1%
Medicare	**Age Group**	**Percent**
Illinois	**65+ years**	**95.3%**
Males	65+ years	94.9%
Females	65+ years	95.7%

In Illinois, 1 in 5 residents under the age of 65, had health care coverage by Medicaid. Among these, more than one-third of children of both sexes had health insurance through Medicaid. Among adults under 65 years of age, 17.1% of females and 12.0% of males were covered by Medicaid for their health care services.

Among those 65 years of age and older, there were high rates of coverage by Medicare. Overall, 95.3% of seniors in Illinois had Medicare coverage. These rates varied little by sex.

Social Determinant: Language Diversity

		PERCENT SPEAK ENGLISH ONLY OR SPEAK ENGLISH "VERY WELL"	PERCENT SPEAK ENGLISH LESS THAN "VERY WELL"
Illinois			
Population 5 years of age and over		91.4%	8.6%
Speak only English	76.8%	NA	NA
Speak a language other than English	23.2%	62.7%	37.3%
Chicago			
Population 5 years of age and over		85.3%	14.7%
Speak only English	64.0%	NA	NA
Speak a language other than English	36.0%	59.3%	40.7%

Source: U.S. Census Bureau, 2015–2019 American Community Survey 5-Year Estimate

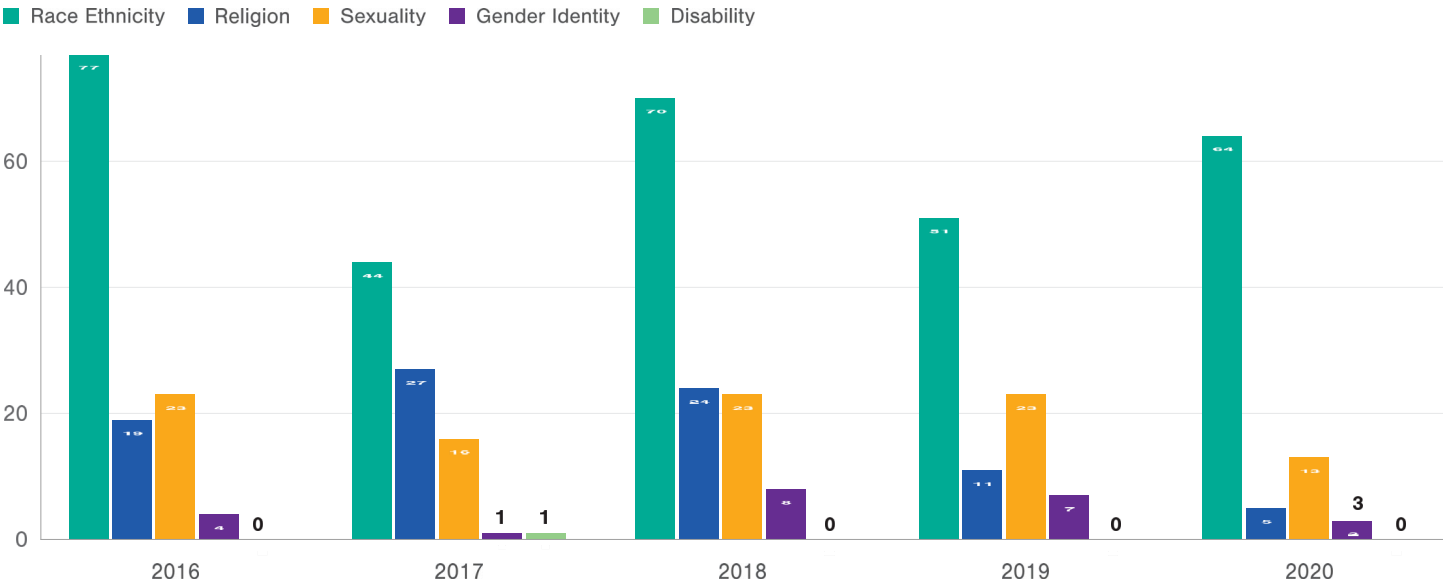
Illinois' diversity is reflected in language diversity among its residents. Those residents who might not be fluent in English may be challenged to access needed services due to language barriers or may become linguistically isolated. Nearly one-quarter (23.2%) of Illinois residents speak a language other than English. Among these, more than one-third (37.3%) speak English less than "very well." In Chicago, more than 1 in 3 (36.0%) residents speak a language other than English. Of these, 2 in 5 (40.7%) speak English less than "very well."

Social Determinant: Discrimination and Violence

Crimes documented as "hate crimes" remain low in Illinois with fewer than 150 convictions. However, these do highlight that while other forms of discrimination and "hate-related" events do occur, racial/ethnicity related crimes form the majority of these events. It should be noted that these do not represent all instances related to discrimination based on race/ethnicity (racism), religion, sexuality, or gender identity.

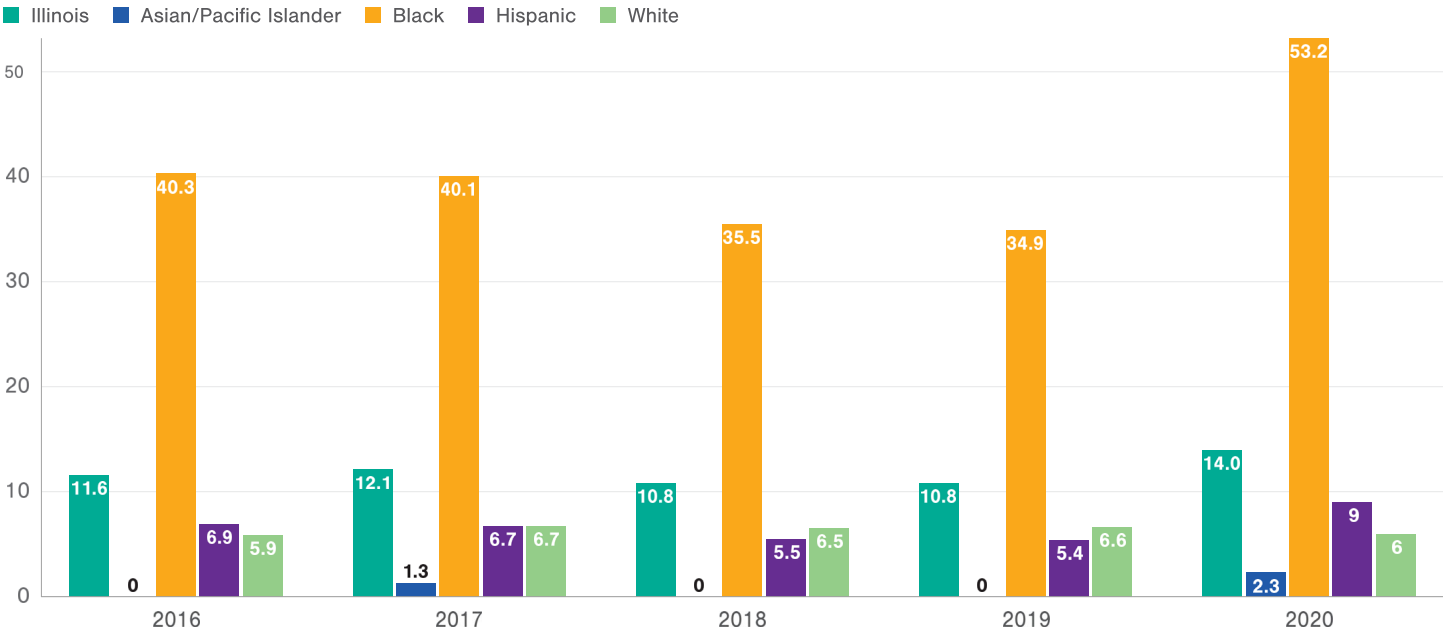
Few other direct quantitative measures of discrimination and racism are available for this assessment. Despite limited direct data it is known that the effects of discrimination and racism are reflected in the disparities in health outcomes and other social determinants of health.

Hate Crimes – Illinois (2016–2020)



Source: Crime in Illinois Uniform Crime Report, 2016-2020

Firearms-related Mortality – Age-Adjusted per 100,00 Population Illinois and by Race/Ethnicity (2016–2020)

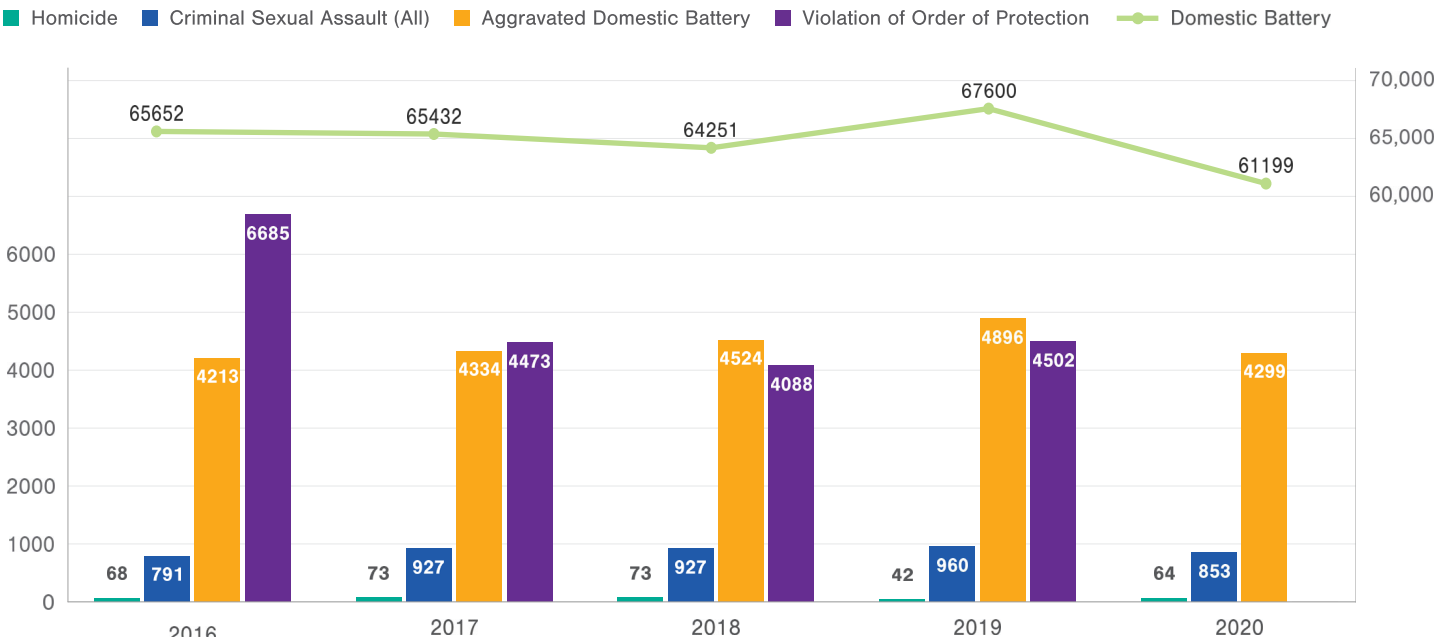


Firearm-related mortality remained stable between 2016 and 2019. In 2020, firearm mortality increased in Illinois overall and in most race/ethnicity groups. A 52.4% increase was seen in Black/African American mortality due to firearms between 2019 and 2020. There is an ongoing disparity in this indicator in Illinois, where Black/African American firearm-related mortality has consistently remained more than three times greater than the overall Illinois rate and five times that of other race/ethnicity groups from 2016 to 2020.

Social Determinant: Violence and Safety

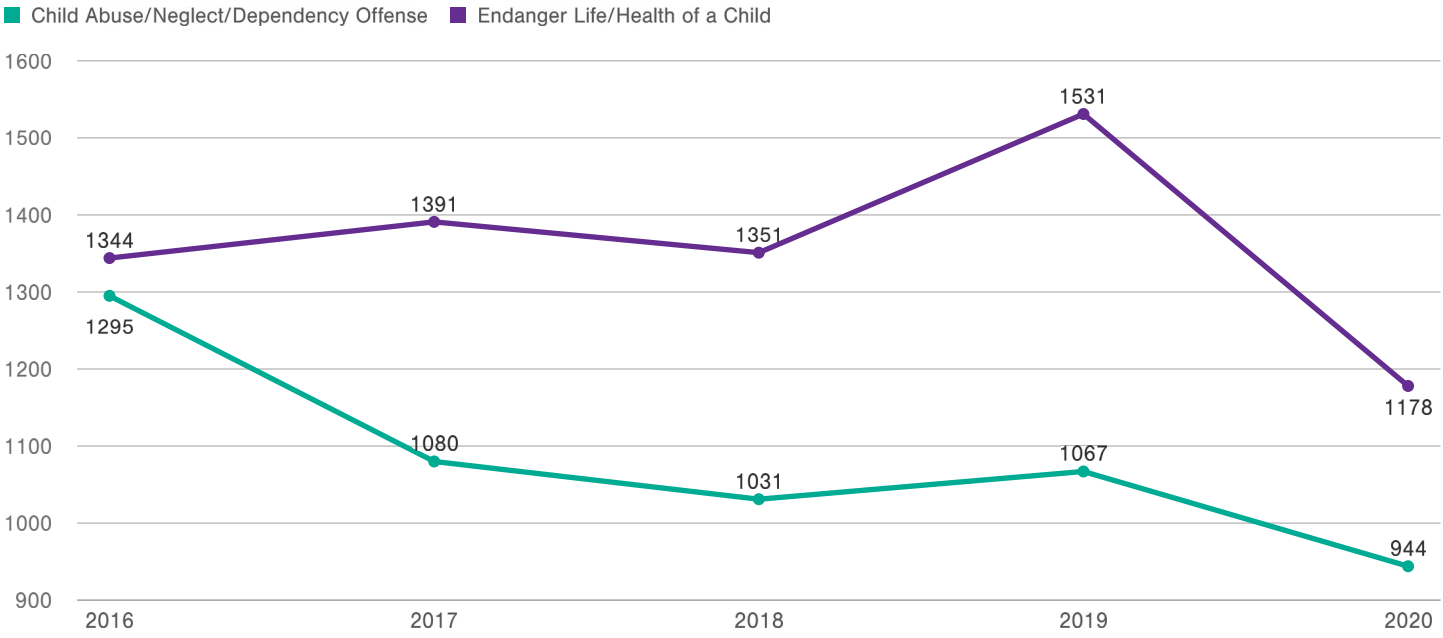
Intimate partner violence and child abuse are sources of trauma that impact health and wellbeing. For 2016 to 2020, domestic crimes of all types remained stable during the period with domestic battery and aggravated domestic battery the most common form of this violent offense. Domestic battery and aggravated domestic battery crimes were slightly higher in 2019 but declined in 2020.

Domestic Crime (2016–2020)



Source: Crime in Illinois Uniform Crime Report, 2016-2020

Domestic Crime Against Children (2016–2020)



Source: Crime in Illinois Uniform Crime Report, 2016-2020

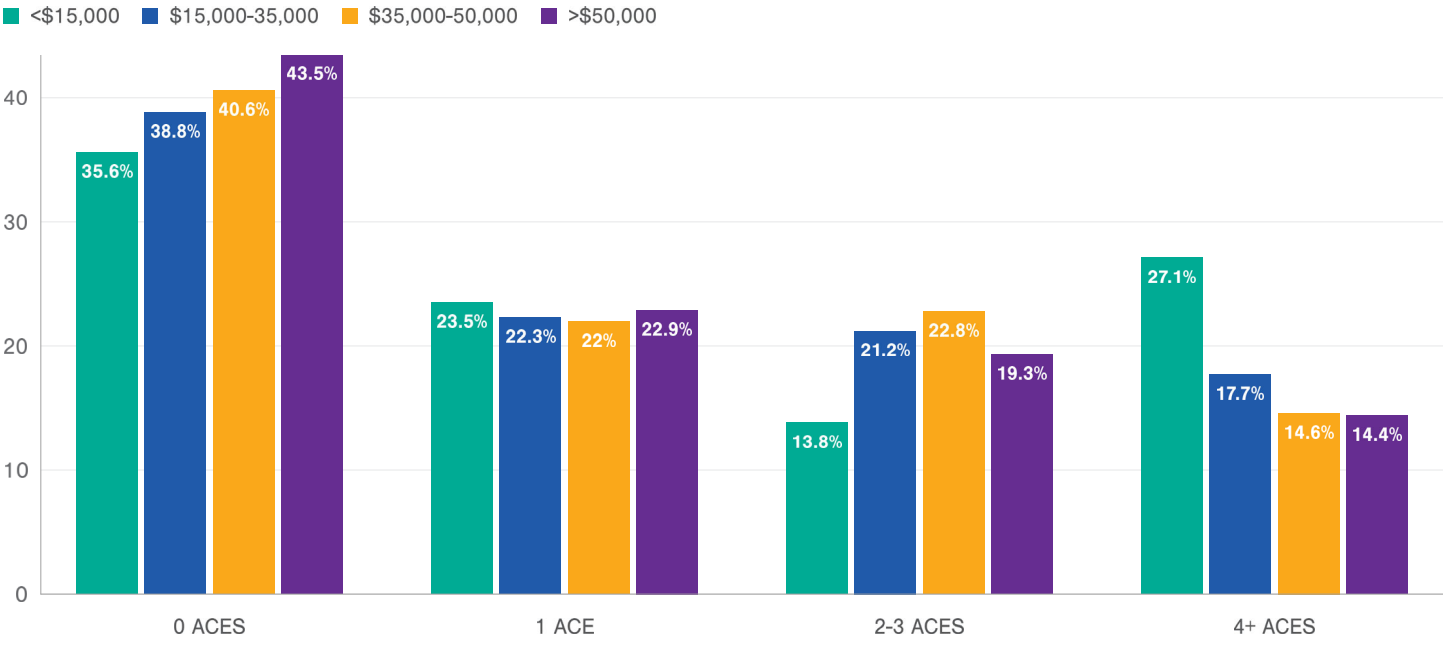
Similar to domestic crime, crimes against children—child abuse or neglect and endangering the life/health of a child—is a source of trauma for children. For 2016 to 2020, child abuse crimes declined each year, except for 2019, which was followed by a reduction in 2020. In contrast, child endangerment remained level prior to 2018 with a notable increase in 2019, but then declined in 2020.

NOTE: Data for 2020 may reflect impacts of COVID-19 mitigation activities on judicial activity and court operations.

Social Determinant: Toxic Stress and Adverse Childhood Experiences (ACES)

Adverse childhood experiences (ACEs) are traumatic events that can include violence, abuse, and growing up in a family with mental health or substance use problems. Toxic stress from ACEs can change brain development and affect how the body responds to stress. ACEs are linked to chronic health problems, mental illness, and substance misuse in adulthood (CDC, 2022).

Adverse Childhood Experiences – Prevalence by Household Income – Illinois (2017)

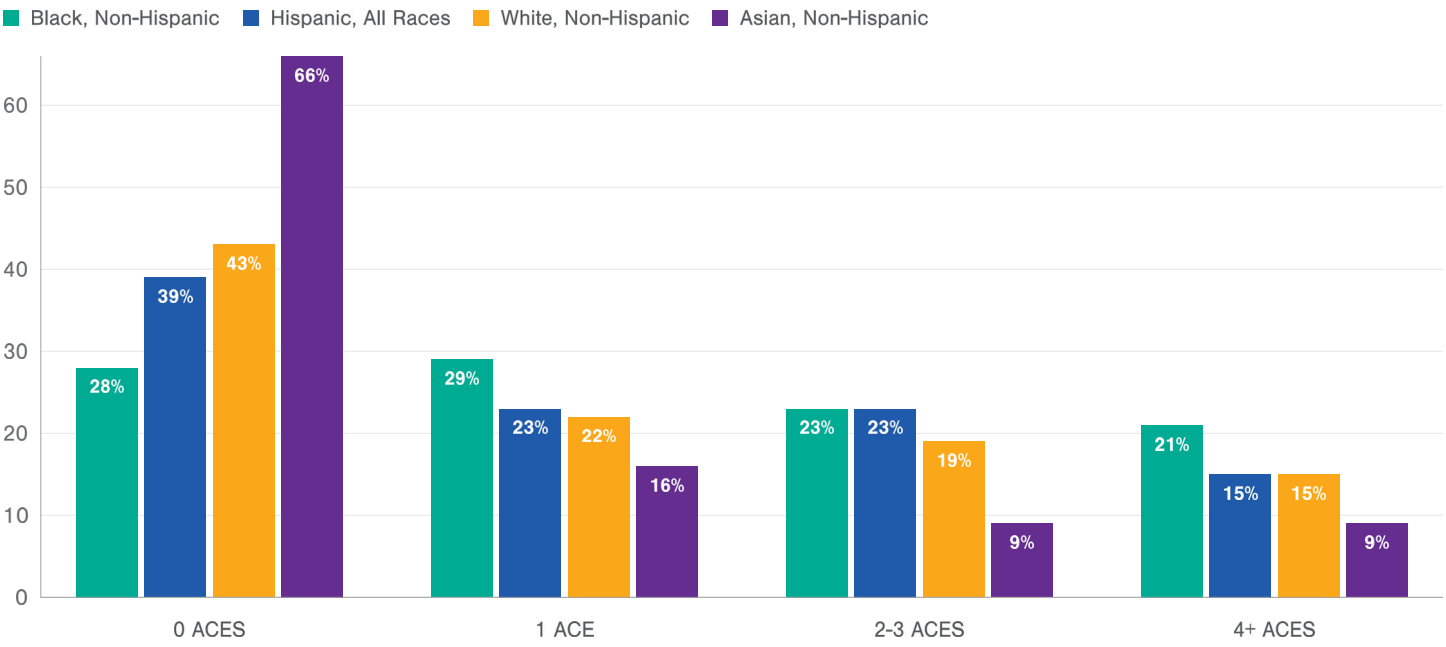


Source: Illinois BRFSS, IDPH, 2017

Data from the 2017 Illinois Behavioral Risk Factor Surveillance System survey showed persons in lower income groups reported experiencing four or more ACEs—nearly double that of the highest income group. Conversely, the latter also had the highest prevalence of not experiencing any ACEs, while the lowest prevalence was seen in the low-income group (44% vs. 36%, respectively).

By race/ethnicity, 21% of Black/African American respondents reported experiencing four or more ACEs, while only 9% of non-Hispanic Asian respondents reported the same. Most non-Hispanic Asian respondents (66%) reported experiencing zero ACEs.

Adverse Childhood Experiences – Prevalence by Race/Ethnicity – Illinois (2017)



Source: Illinois BRFSS, IDPH, 2017

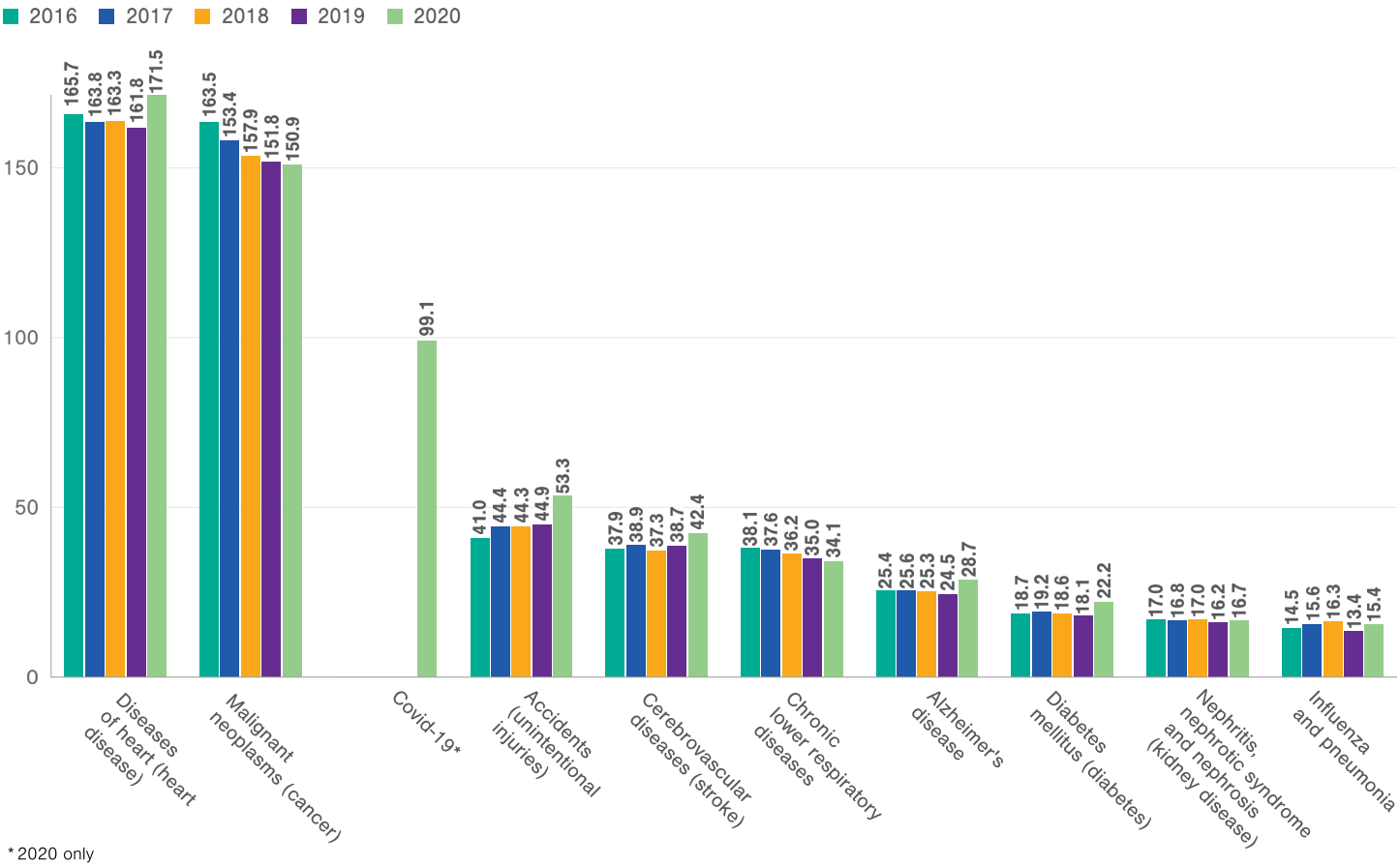
8 Mortality Indicators

Mortality Indicators: Leading Causes of Death

For 2016-2020, the top leading causes of death in Illinois were diseases of the heart (heart disease) and malignant neoplasms (all cancers). Age-adjusted heart disease mortality rates remained stable with an annual average rate of 165.7 deaths per 100,000 population. This is lower than the U.S. rate of 211.5 per 100,000. In 2020, heart disease deaths did increase to 171.5 per 100,000. For cancers, mortality rates declined during the period from 163.5 per 100,000 in 2016 to 150.9 per 100,000 in 2020, a decrease of nearly 8%.

For 2020, COVID-19 became the third leading cause of death with 99.1 deaths per 100,000 population. This was more than two times greater than for each of the remaining seven leading causes in 2020.

Trend in Illinois Leading Causes of Death – Age-Adjusted Death Rate per 100K Population (2016–2020)



*2020 only

Source: Illinois Death Registry, IDPH 2022

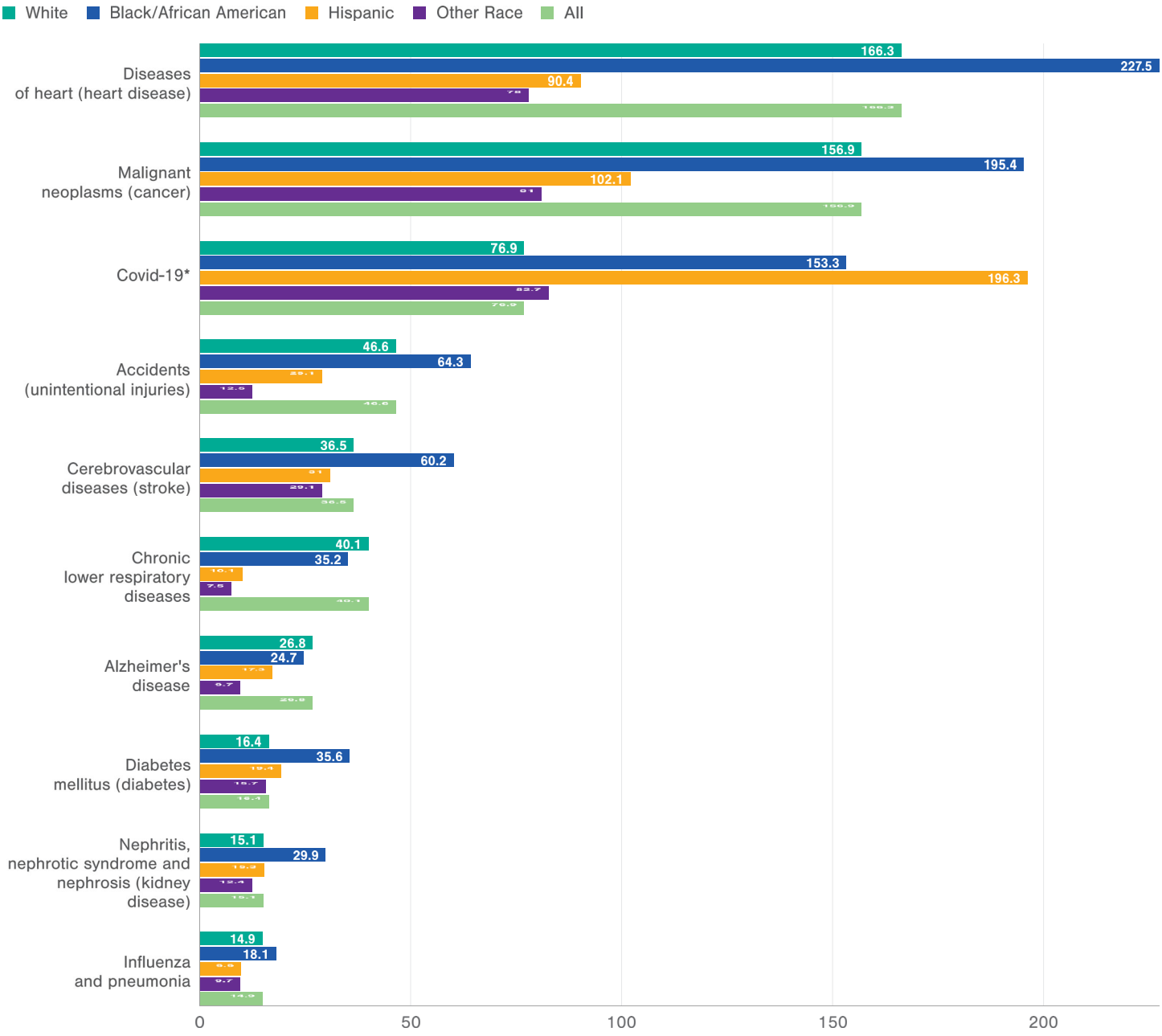
Other leading causes of death showed fairly stable rates during the period 2016 to 2020. Increases were seen in 2020 for accidents (19%), cerebrovascular disease (stroke) (9%), Alzheimer's disease (7%), and diabetes mellitus (23%). It is unclear as to whether these increases are true increases due to these conditions alone or due to these in combination with the impacts of the COVID-19 pandemic.

By race/ethnicity, disparities in these specific rates become evident. Black/African American mortality rates showed elevated rates of mortality for 8 of the 10 leading causes of death for 2016 to 2020.

Five-year median mortality rates for Black/African Americans were higher than the corresponding Illinois population rate for heart diseases (1.4 times higher), cancers (1.3 times higher), unintentional injuries (accidents, 1.4 times higher), cerebrovascular diseases (stroke, 1.6 times higher), diabetes mellitus (1.9 times higher), kidney disease (1.8 times higher), and influenza and pneumonia (1.2 times higher).

For COVID-19 related deaths in 2020, Black/African Americans experienced a death rate 1.5 times higher than the overall Illinois rate. This higher rate, however, was not the highest in Illinois. The rate among Hispanic residents was twice the overall Illinois rate for the year at 196.3 per 100,000 population. For other leading causes of deaths, Hispanic mortality rates were either lower or not substantially different from the Illinois rates.

Illinois Leading Causes of Death – Median Age Adjusted Rate per 100K Population by Race/Ethnicity (2016–2020)



Source: Illinois Death Registry, IDPH 2022

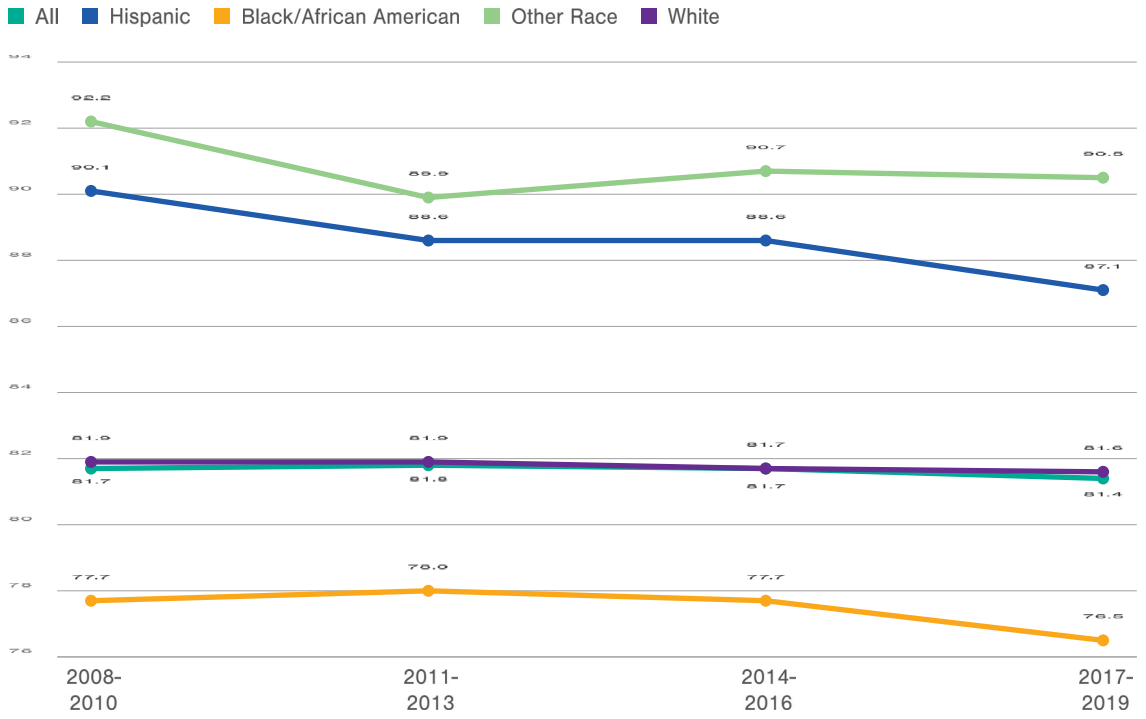
* 2020 only

Mortality rates among White residents were only slightly higher than the overall Illinois five-year median for chronic lower respiratory diseases (10% higher) and for Alzheimer's disease (5% higher).

Life Expectancy at Birth

Three-year average life expectancy at birth was examined for the periods 2008-2010, 2011-2013, 2014-2016, and 2017-2019. Among all females, life expectancy at birth was essentially un-changed overall across the periods with a median of 81.6 years. This is essentially no different than life expectancy for White females. All other female racial ethnic groups showed some decline in life expectancy from 2008 to 2010 to the most recent period (2017-2019). Hispanic females showed the biggest decline— three years. Black/African American females had the lowest life expectancy with a median of 77.7 years. This is nearly 13 years lower than the median for Other Race females with a median of 90.7 years.

Illinois Female Life Expectancy at Birth – Overall and by Race/Ethnicity – 3 Year Averages



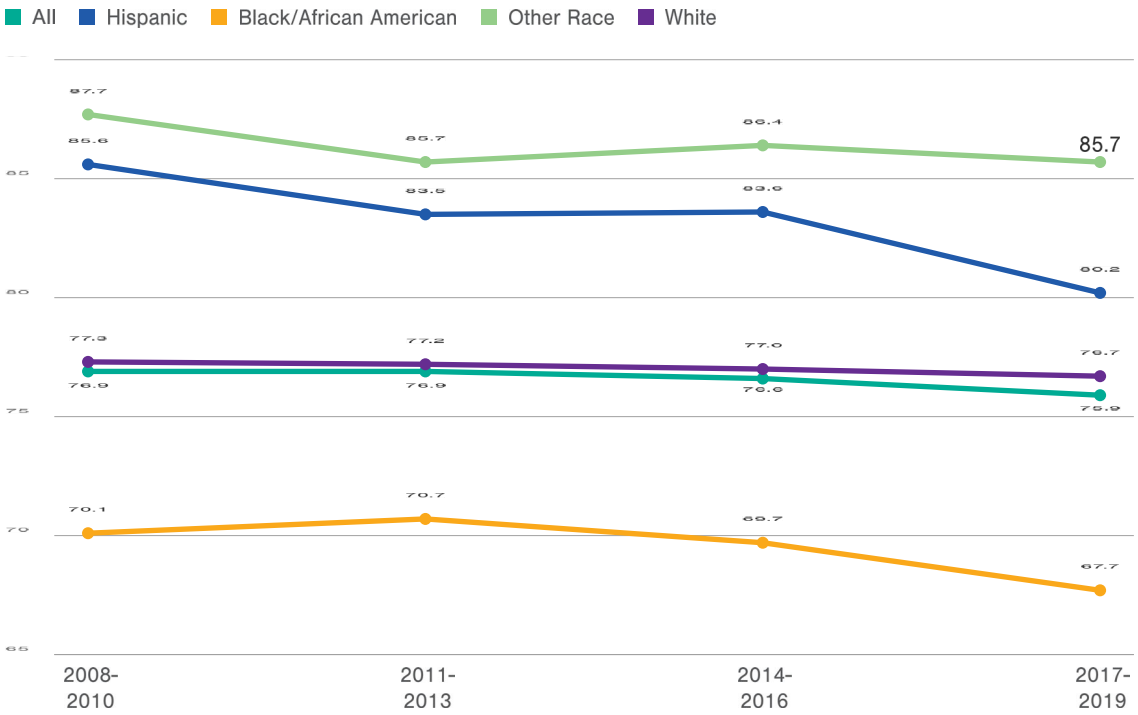
Source: Illinois Death Registry, IDPH 2022

2020	FEMALE	MALE
All	80.1	74.2
Hispanic	84.2	76.2
Black/African American	74.5	64.7
Other Race	88.3	83.5
White	80.6	75.6

Among all males, life expectancy declined slightly beginning in 2014-2016 and falling to 75.9 years for 2017-2019. Life expectancy for White males remained relatively level with a slight decline in the final period to 76.7. Similar to females, life expectancy for all race/ethnicity groups declined across the periods. Hispanic males experienced the largest drop of 5.4 years. Black males had the lowest life expectancy with a median of 67.7 years, which is 18 years lower than that of the highest group, Other Race at 85.7 years. For 2020, life expectancy at birth declined

overall and for all race/ethnicity and sex categories, reflecting the impact of the pandemic. Hispanic and Black males saw the greatest decrease from 2017-2019 with a drop of four years and three years each, respectively.

Illinois Male Life Expectancy at Birth – Overall and by Race/Ethnicity – 3 Year Averages

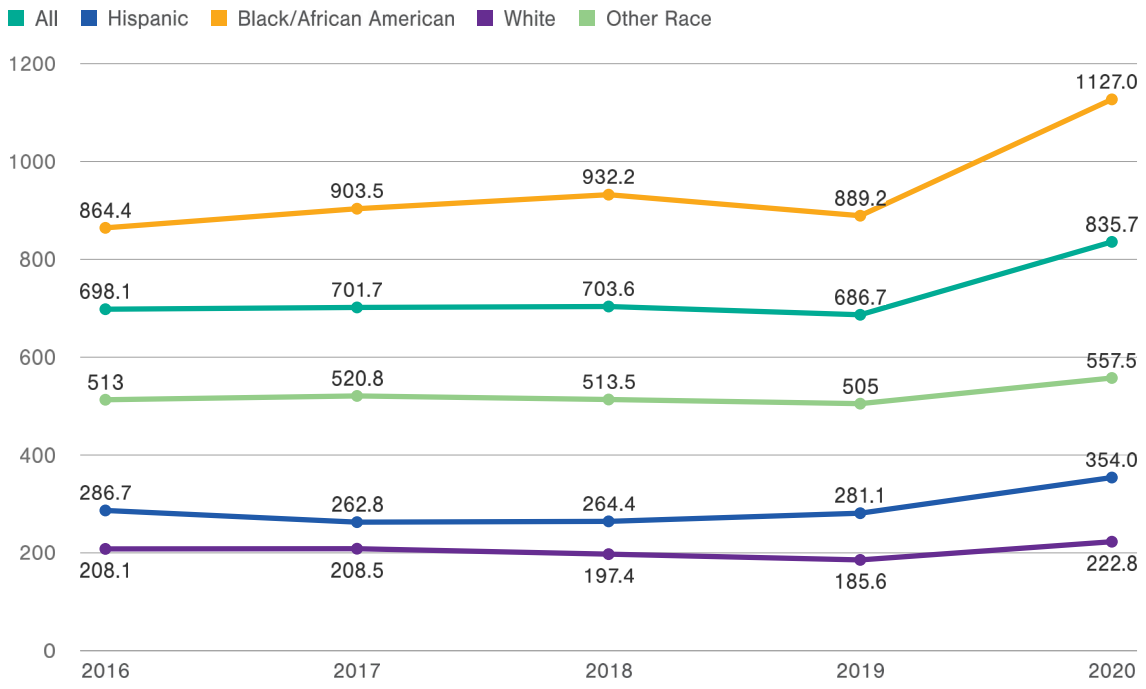


Source: Illinois Death Registry, IDPH 2022

Premature Mortality: Years of Potential Life Lost

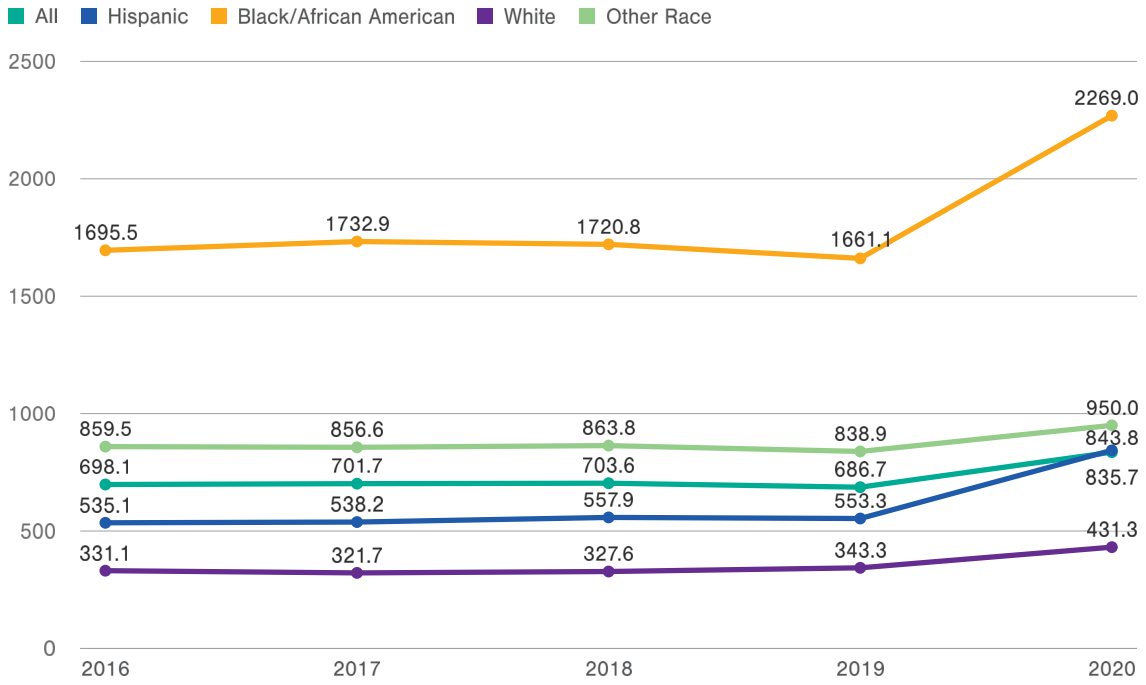
Years of potential life lost (YPLL) is a measure of premature mortality. It is calculated for each death prior to an endpoint, such as 75 years, counting the difference between that endpoint and the age of death. These values are then summed up. The result is total years of potential life lost. Overall, in Illinois, the YPLL was relatively stable for 2016 to 2019. In 2020 YPLL increased from 686.7 to 835.7 years.

Illinois Premature Mortality: Females – Total Years of Potential Life Lost Before Age 75 Years Overall and by Race/Ethnicity (2016–2020)



Source: Illinois Death Registry, IDPH 2022

Illinois Premature Mortality: Males – Total Years of Potential Life Lost Before Age 75 Years Overall and by Race/Ethnicity (2016–2020)



Source: Illinois Death Registry, IDPH 2022

Examining this measure for females in Illinois shows that overall and for all race/ethnicity groups YPLL remained stable from 2016 to 2019. In 2020, these values increased, potentially related to impacts of the COVID-19 pandemic. By race/ethnicity, the largest increases were seen in Black/African American females and Hispanic females.

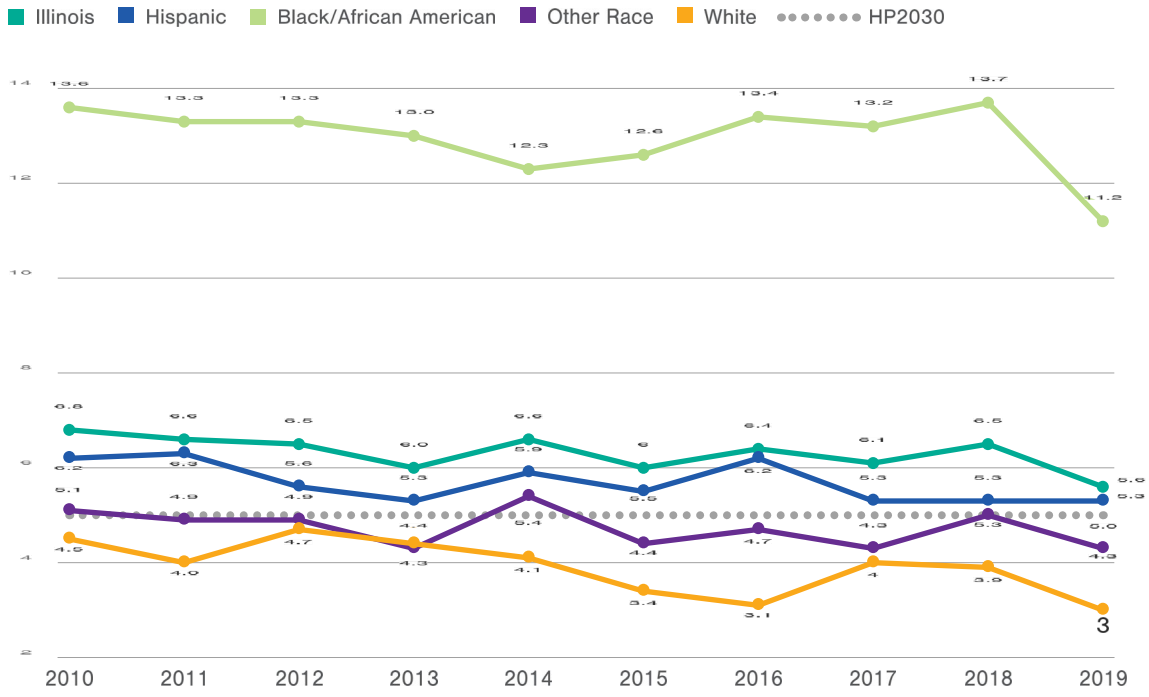
Among males in Illinois, a similar pattern was seen with stable YPLL counts for 2016 to 2019. Again, for 2020, the YPLL increased overall, going from 686.7 to 835.7 years. The largest increases were seen in Black/African American and Hispanic males. Note that since total YPLL is not adjusted for changes in the population denominator for each group, trends and differences should be interpreted with caution.

9 Maternal and Child Health

Infant Mortality and Preterm Births

Infant mortality rates remained relatively unchanged since 2010 with Illinois rates consistently above the national Healthy People benchmark of 5.0 deaths per 1,000 live births. In 2020, infant death rates showed declines overall and in all race/ethnicity groups. The infant mortality rate among Black/African American infants remained more than two times the overall Illinois rate.

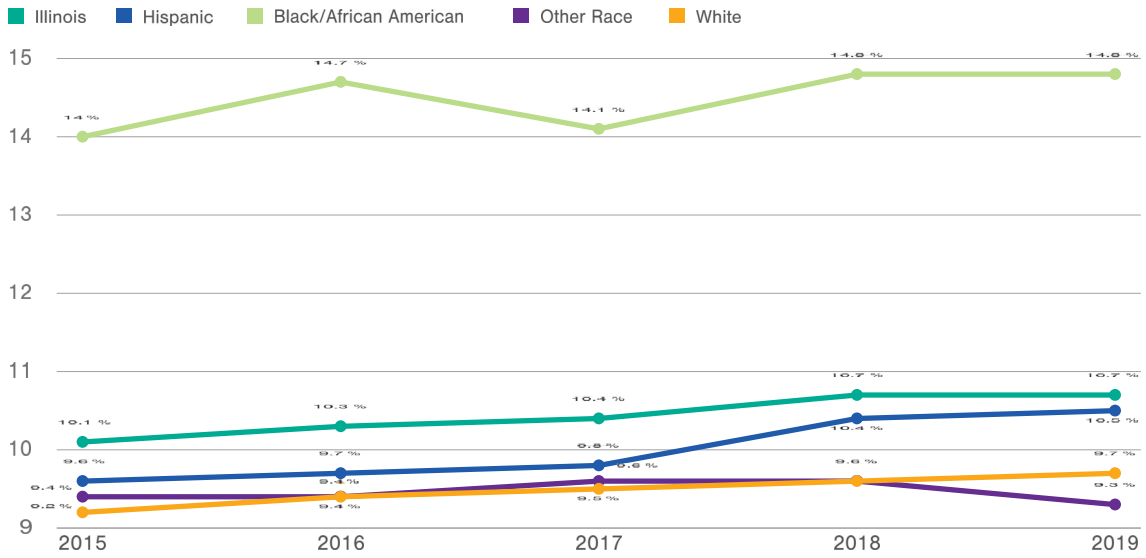
Illinois Infant Mortality Rate (Infant Deaths per 1,000 Live Births) – Overall and by Race/Ethnicity (2010–2019)



Source: Illinois Birth Certificates, IDPH 2022

In Illinois from 2015 to 2019, the proportion of preterm births showed a slow but significant increase. Similar increases were also seen for Hispanic births and White births. Black/African American births did not show an increase but remained 40% higher than the U.S. proportion of 10.1% for 2020 and the state median for the period.

Percent of Preterm Births (<37 Weeks) – Illinois and by Race/Ethnicity (2015–2019)

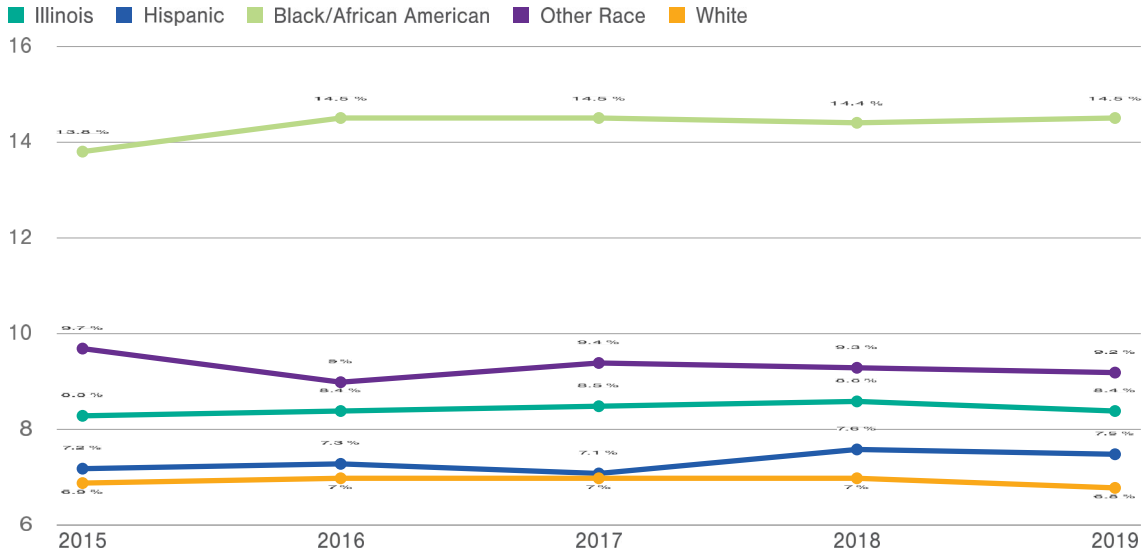


Source: Illinois Birth Certificates, IDPH 2022

Low Birthweight Births and Prenatal Factors

Low birthweight births (<2,500 gm) comprised an average of 8.5% of all births between 2015 and 2019. This was marginally higher than the U.S. rate of 8.2 % in 2020. In general, the proportion of low birthweight births remained stable across the period. Black/African American births continue to experience a significant disparity in the proportion of low birthweight births with rates more than 70% higher than Illinois as a whole and more than double the lowest rate group (White, median 7.0%). Births to Other Race mothers also saw higher proportions of low birthweight births with a median of 9.3% for the period.

Percent of Low Birthweight Births (<2,500 gm) – Illinois and by Race/Ethnicity (2015–2019)



Source: Illinois Birth Certificates, IDPH 2022

Percent of Births with Pregnancy Outcome Preventive and Risk Factors Illinois and by Race/Ethnicity – 5-Year Median Percent of Birth (2015–2019)

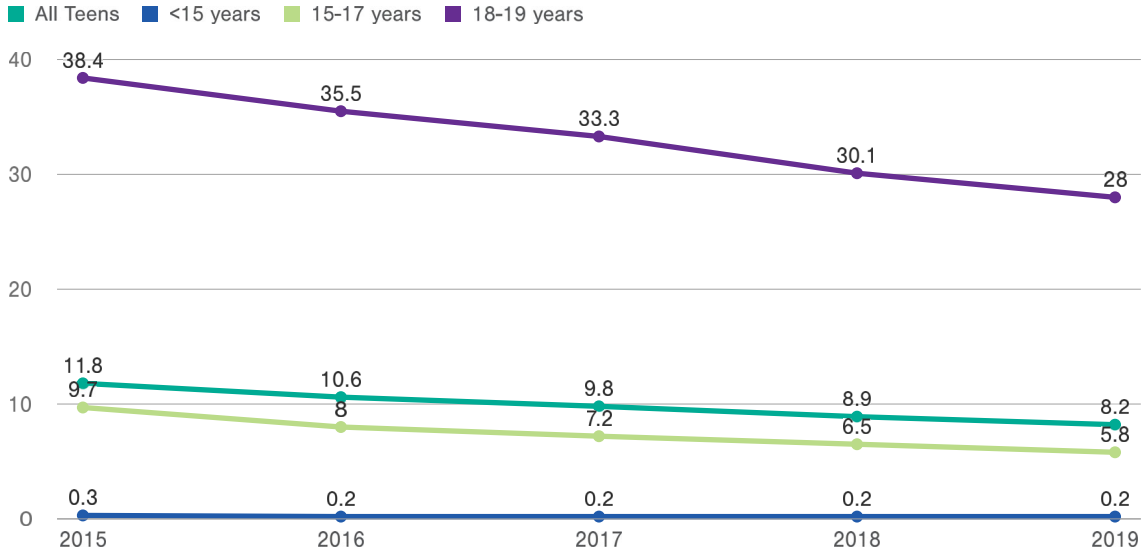
	PREVENTIVE FACTOR			RISK FACTOR	
	ADEQUATE PRENATAL CARE	PRENATAL CARE BEGAN IN THE 1ST TRIMESTER	MOTHER WAS A WIC PARTICIPANT	MOTHER SMOKED DURING 3RD TRIMESTER	MOTHER DRANK ALCOHOL DURING PREGNANCY
Illinois	74.0%	74.7%	30.3%	5.3%	0.5%
Hispanic	67.7%	68.1%	48.6%	1.1%	0.3%
Black/African American	57.6%	61.0%	51.3%	6.0%	0.6%
Other Race	75.8%	74.2%	13.8%	0.4%	0.3%
White	80.9%	81.9%	18.6%	7.4%	0.4%
*HP2030 ** US (2020)	80.5%*	77.7%!		4.4%**	

Preventive factors for pregnancy outcome showed that only 3 of 4 mothers did not receive adequate prenatal care or begin prenatal care in the first trimester—below national benchmarks. This varied by race/ethnicity with Black/African American and Hispanic mothers more likely to have not received care as recommended. Half pregnant Black/African American and Hispanic mothers participated in the Special Supplement Nutrition Program for Women, Infants, and Children (WIC), a protective factor for infant mortality. Overall, smoking and alcohol use were low with only 1 in 20 women smoking and 0.5% using alcohol during pregnancy.

Births to Teens

Birth rates for teens by age and by race/ethnicity declined steadily throughout the period from 2015 to 2019, decreasing among all teens by 30%, from a high of 11.8 per 1,000 females in 2015 to 8.2 per 1,000 females in 2019. Among younger teens, age 15 to 17 years, there was a 40% decline in the rate between 2015 and 2019.

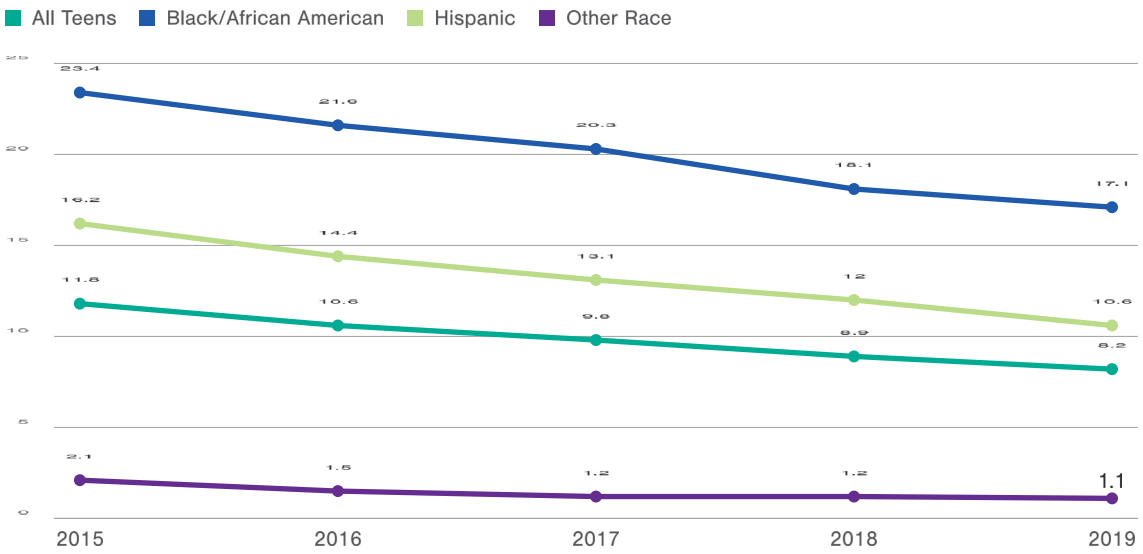
Teen Birth Rate per 1,000 Female Population – Illinois and by Age of Mother (2015–2019)



Source: Illinois Birth Certificates, IDPH 2022

By race/ethnicity, teen births saw declines in all groups. Black/African American teen birth rates declined by 27% from 23.4 per 1,000 females in 2015 to 17.1 per 1,000 females in 2019. Similarly, Hispanic teen births fell by 35% from 16.2 per 1,000 females to 10.6 per 1,000 females during the period. Despite these declines, Black and Hispanic teens still experience disparity in teen birth rates with the Black/African American rate nearly double and the Hispanic rate nearly 1.3 times above the state rate in 2019.

Teen Birth Rate per 1,000 Female Population – Illinois and by Race/Ethnicity (2015–2019)



Source: Illinois Birth Certificates, IDPH 2022

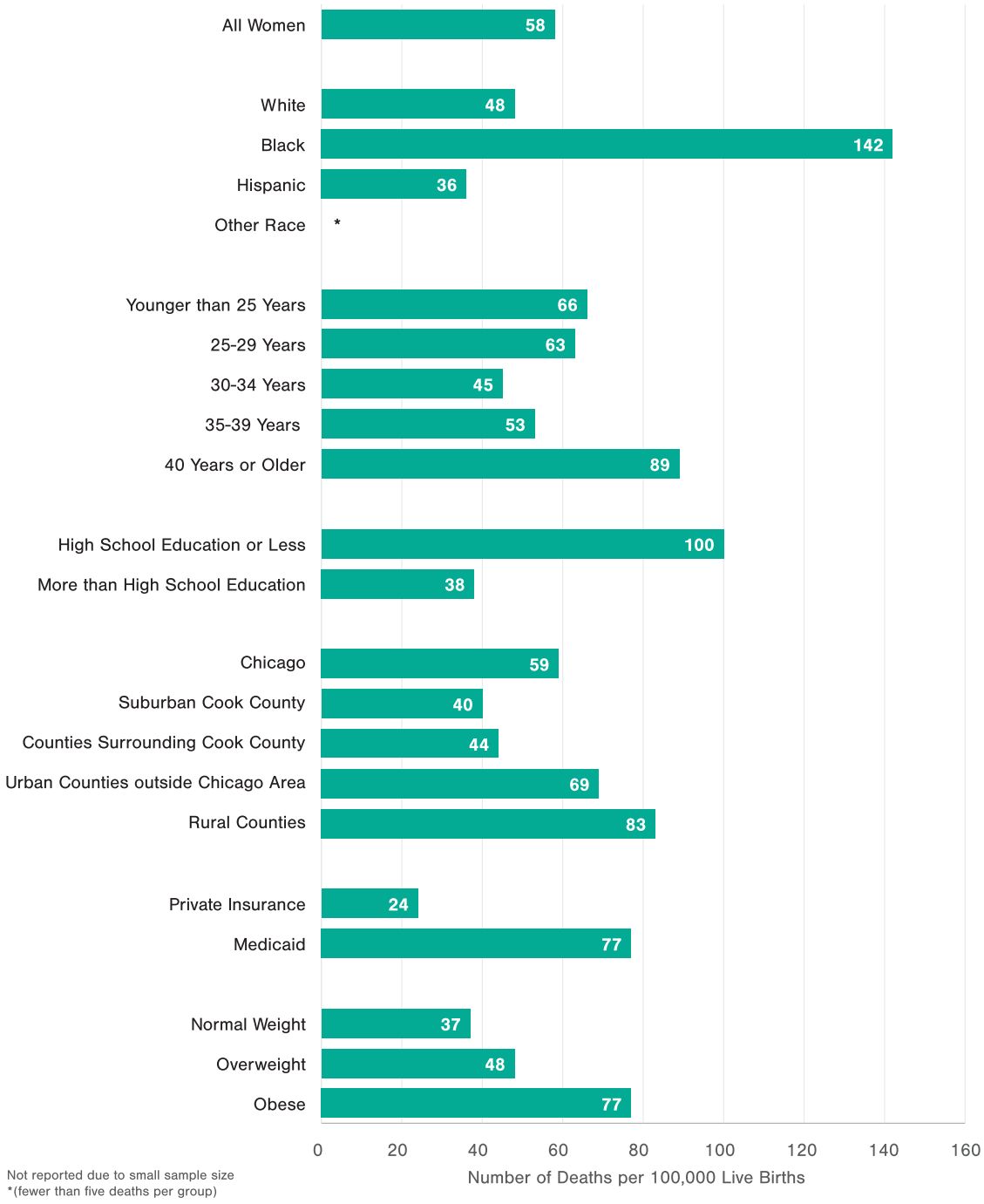
Maternal Mortality

Maternal mortality for this assessment is defined as pregnancy associated mortality—"maternal death while pregnant or within one year of pregnancy." For 2016 to 2017, the period for which most recent data are available, there were 754 deaths among Illinois women for a pregnancy-associated mortality ratio (PAMR) of 58 per 100,000 live births. For the same period, the highest PAMR was seen in Black women at 142 per 100,000 live births or nearly 2.5 times the Illinois rate. Higher rates were also seen for older women—those 40 years or older (89 per 100,000 live births) and those with a high school education or less (100 per 100,000 live births)—almost double the Illinois rate.

Regionally, the highest PAMR rates for the period were seen outside of the Chicago area with those in urban counties (69 per 100,000 live births) and rural counties (83 per 100,000 live births) experiencing rates elevated above the state rate.

Finally, PAMR rates in obese women were more than twice those of normal weight women (77 per 100,000 live births and 37 per 100,000 live births, respectively).

Pregnancy-Associated Mortality Ratio (PAMR), By Demographics, Illinois (2016–2017)



Not reported due to small sample size
*(fewer than five deaths per group)

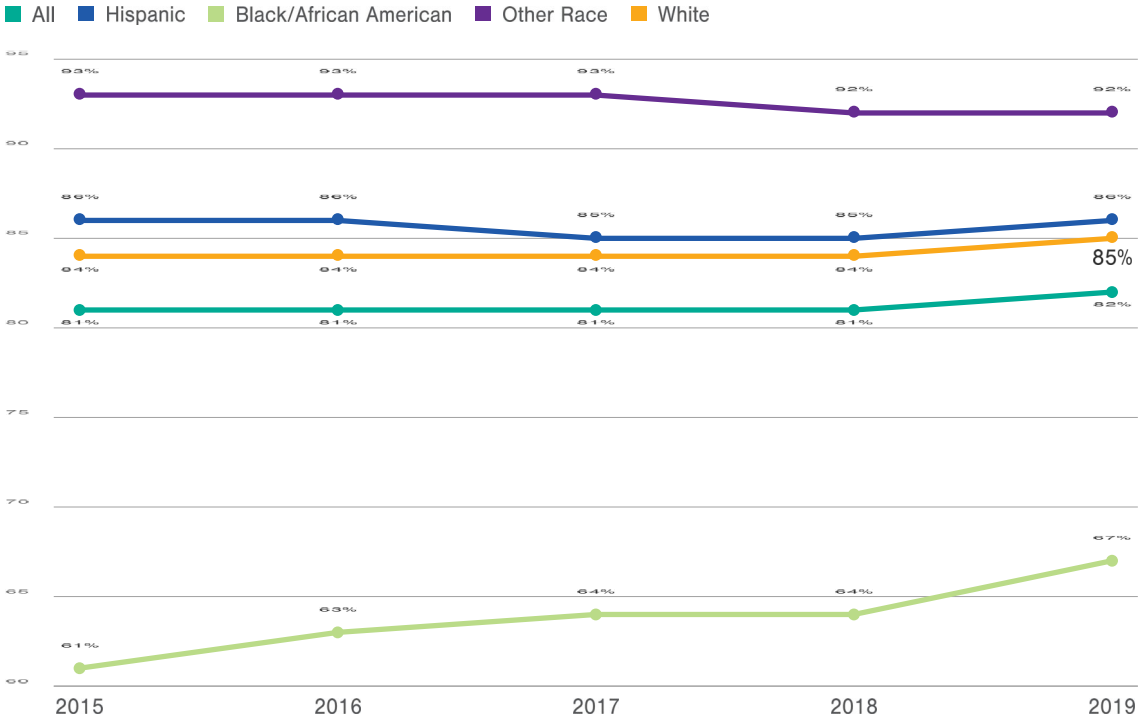
Source: Illinois Maternal Morbidity and Mortality Report 2016-2017 (IDPH, 2021)

Infant Breastfeeding Prevalence

Breastfeeding is critical to infant health. HP2030 has set a goal to have 42.4% of infants breastfed exclusively through 6 months of age. In Illinois overall, slightly more than 80% of newborns are breastfed at the time of leaving the hospital after birth. However, attrition in breastfeeding is seen in other surveillance data. Data from the Pregnancy Risk Assessment Monitoring System (PRAMS) identified that for this same period, only 68% of newborns were still being breastfed at 8 weeks of age. (CDC, PRAMS, 2022)

Within the overall high rate of breastfeeding initiation, significant disparities remain. While there was a steady increase for these mothers across the period 2015 to 2019, Black/African American new mothers were 25% less likely to be breastfeeding at discharge.

Illinois Percent of Infants Being Breastfed* by Race/Ethnicity (2015–2019)



*At time of discharge.

Child and Adolescent Mortality

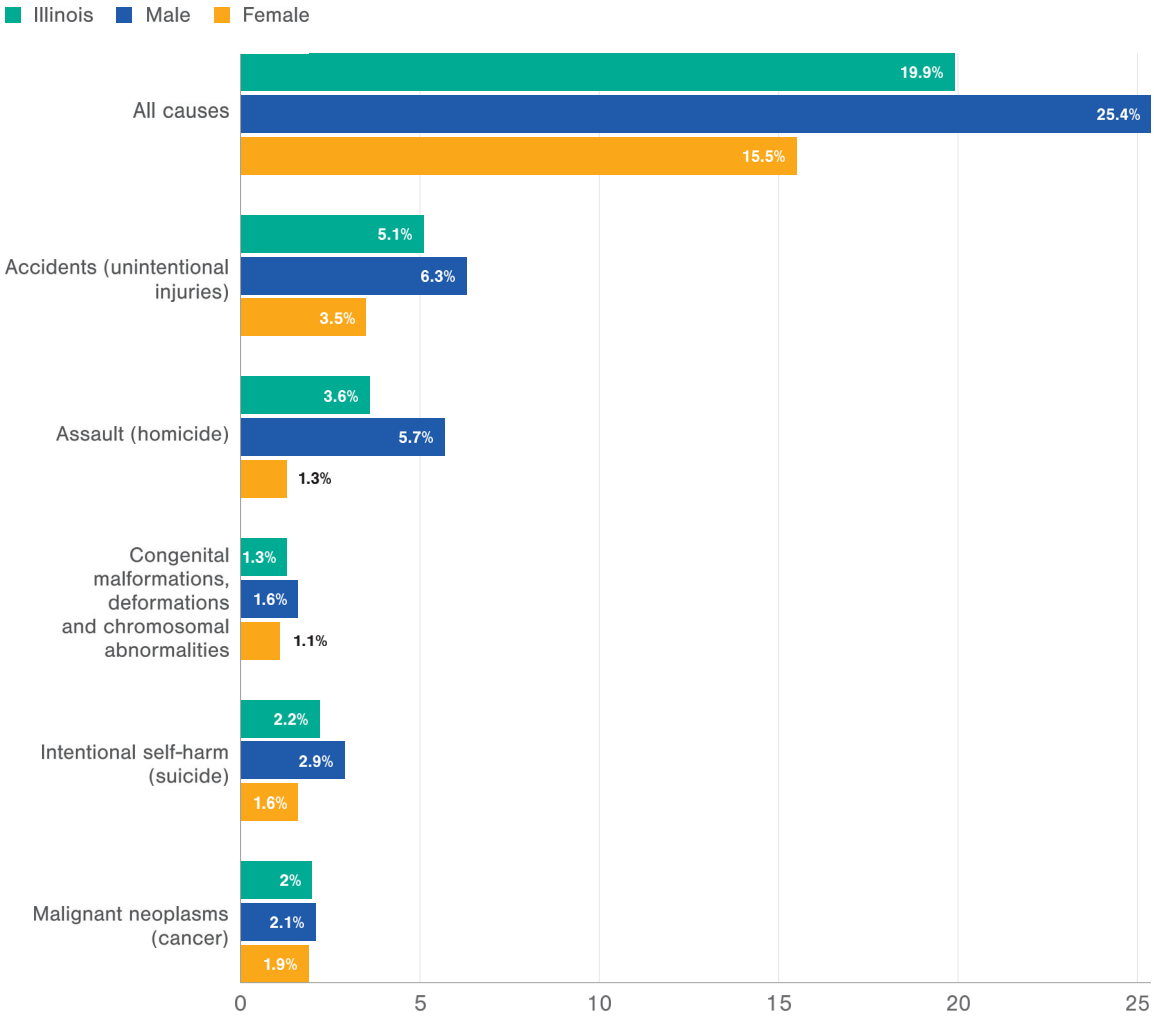
Among children and adolescents under 18 years of age, the leading cause of death for 2016 to 2020 was accidents (unintentional injuries) with five-year median rates of 5.1 per 100,000 population (1 to 17 years of age). This was followed by homicide (3.6 per 100,000) and suicide (2.2 per 100,000). For these leading causes, male rates were higher than female rates. Male homicide rates were over four times the female rate.

By race/ethnicity, child and adolescent mortality showed substantial disparities with Black/African American mortality more than double the state rate and more than 2.5 times the White and Hispanic rates for 2016 to 2020.

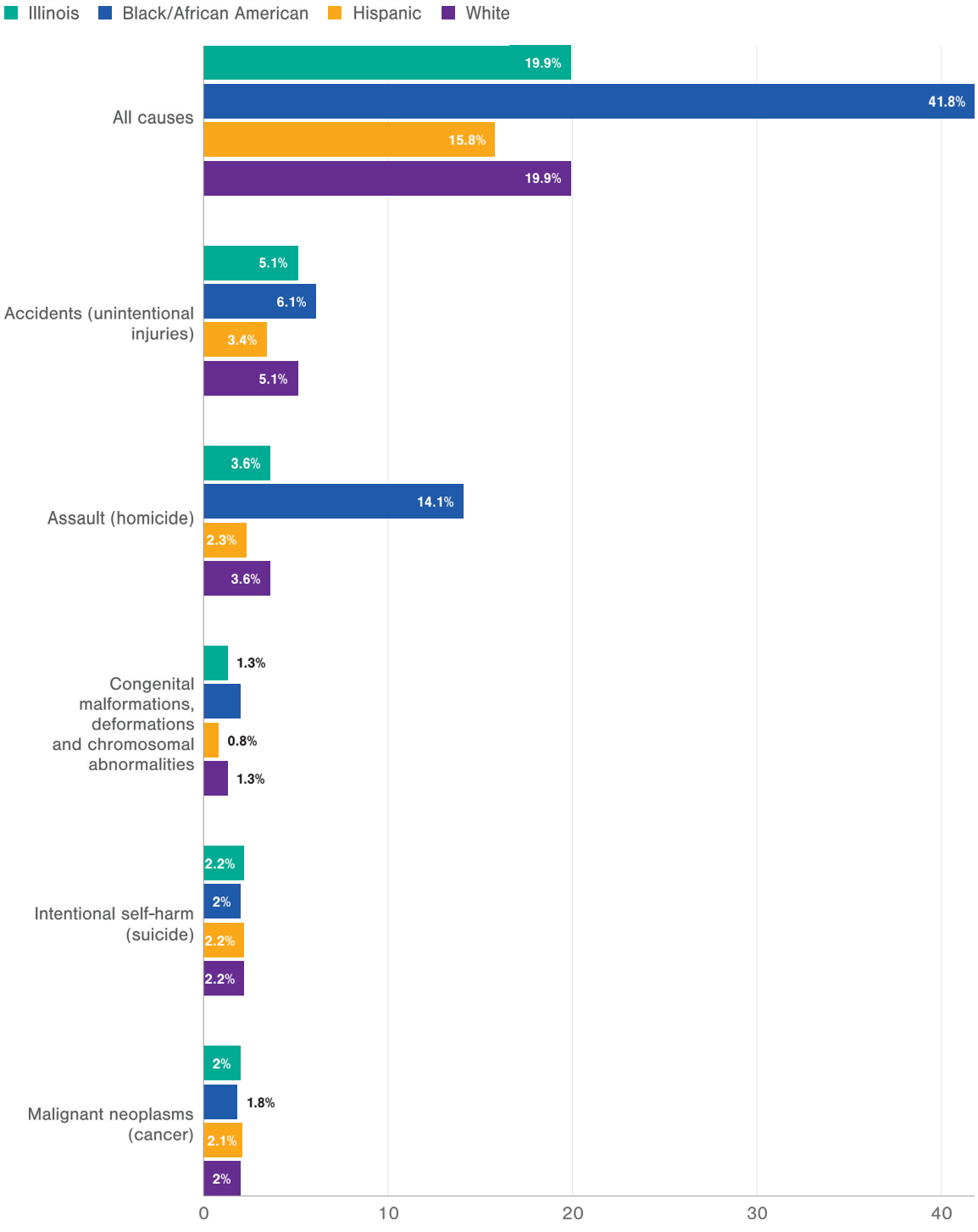
Most striking were homicide rates among Black/African American children and adolescents with a rate of 14.1 per 100,000 population—nearly four times higher than the Illinois rate for the period.

Unintentional injury death rates showed the lowest five-year median rates among Hispanics (3.4 per 100,000 population) compared to other groups. Black/African American (6.1 per 100,000) and White (5.9 per 100,000) had death rates due to accidents above the state average.

Child and Adolescent Mortality by Sex – All and Leading Causes
Age Specific (1–17 years) Rate per 100,000 Population (5 Year Median 2016–2020)



Child and Adolescent Mortality by Race/Ethnicity – All and Leading Causes
Age Specific (1–17 years) Rate per 100,000 Population (5 Year Median – 2016–2020)



Immunizations

Immunization coverage rates for 2017-2018 met the HP2030 goal of 90.8% for at least one dose of MMR by 24 months of age for Illinois (91.4%), Chicago (93.2%) and the rest of state (90.8%). However, for DTaP, the percentage of children up to date remained below HP2030's goal of 90%. Only 7 of 10 children were fully vaccinated by age 2 for the recommended seven vaccine series.

Among teens, vaccination levels for DTaP and for meningitis vaccine exceeded, or were near, 90%. Lower levels of coverage have been noted for HPV vaccine with all below the HP2030 benchmark of 80%. Chicago had the highest completion of the HPV vaccine with 72.3% compared to 63.1% for Illinois and 61.2% for the rest of state.

Estimated Vaccine Coverage 24 months of age

	PERCENT COMPLETE/UTD		
IMMUNIZATION	ILLINOIS	CITY OF CHICAGO	REST OF STATE
MMR >1 dose*	91.4	93.2	90.8
Dtap (>4 doses)**	81.6	83.8	81.0
Hep B (birth dose)	77.5	79.9	76.8
Hep A (>1 dose)	84.6	90.3	82.9
Hep A (>2 doses by age 35 months)	71.5	77.3	70.1
Rota Virus	84.6	84.6	84.6
Influenza(>2 doses)	62.9	65.7	62.0
Combined 7 vaccine Series	70.6	74.2	69.5

* HP203090.8% **HP203090%

Source: National Child Immunization Survey 2018-2020

Estimated Vaccine Coverage: Teens (13–17 years)

	PERCENT COMPLETE/UTD		
IMMUNIZATION	ILLINOIS	CITY OF CHICAGO	REST OF STATE
≥1 Tdap	91.4	88.2	92.1
≥1 MenACWY	92.5	89.7	93.0
≥1 HPV	75.9	86.3	73.7
HPV UTD	63.1	72.3	61.2

Source: NHS 2020

Childhood Lead Poisoning

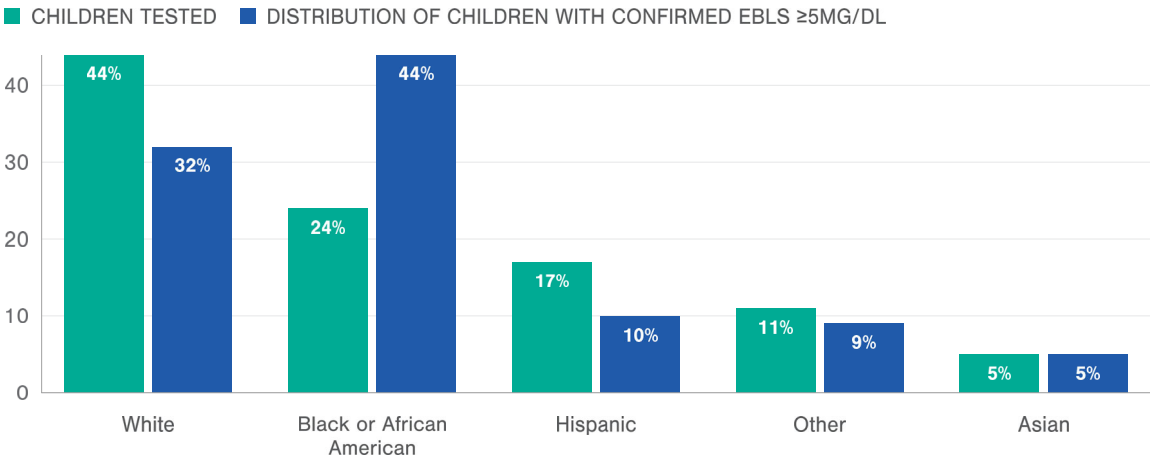
Childhood lead poisoning is associated with older housing, often in poorer communities. Children under 5 years of age living in these conditions and communities are recommended to be screened by a blood test. Childhood lead poisoning screening surveillance showed that the number of children with positive blood lead levels (>5mg/dl) was at the lowest level in 20 years. Despite this, however, more than 7,000 children still have elevated blood lead levels. By race/ethnicity, disparities are evident in both lower levels of screening with only 1 in 4 screened and higher proportions testing positive for elevated blood lead (44%).

Illinois Children Tested at Different Intervention Across Time: (1997–2019)

	1997	2008	2012	2019
≥40 µg\dL	654	152	85	87
≥30 µg\dL	1,985	376	201	202
≥25 µg\dL	3,820	619	334	294
≥10 µg\dL	43,683	5,126	3,035	1,896
≥5 µg\dL	135,197	49,571	29,160	7,135

Source: Illinois Department of Public Health – Healthy Homes and Lead Poisoning Surveillance (HHLPSS) Database, 2019.

Distribution of Children Tested with Confirmed EBLS ≥5mg/dl



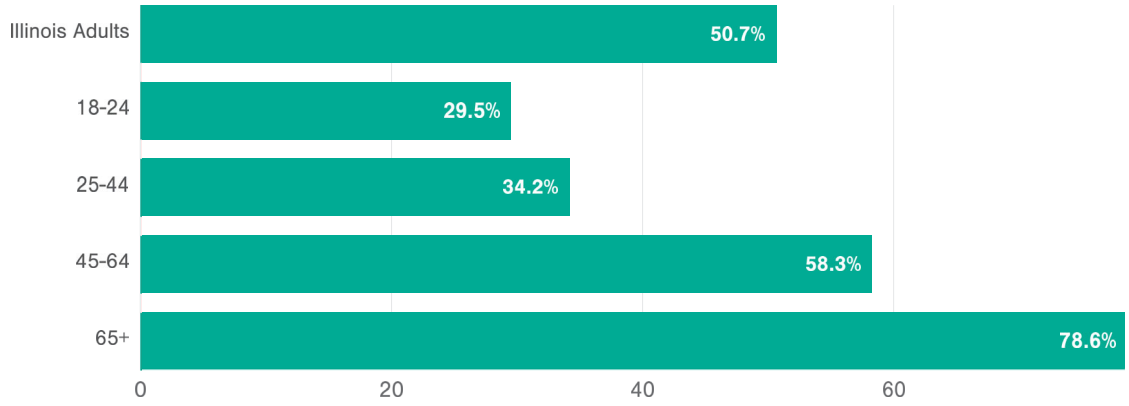
SOURCE: Illinois Department of Public Health – Healthy Homes and Lead Poisoning Surveillance (HHLPSS) Database, 2019.

10 Chronic Diseases and Conditions

Chronic Disease Prevalence

Chronic conditions include issues related to chronic diseases as well as functional disabilities and other conditions. An increase in the prevalence of chronic conditions is not unexpected in an aging population. This was reflected in prevalence estimates from the Illinois BRFSS survey conducted annually. For the period 2017 to 2019, more than half of Illinois residents report living with at least one chronic condition. This increases with age where 58.3% of persons 45 to 64 years of age and more than three-quarters (78.6%) of residents 65 years of age and older are living with a chronic condition.

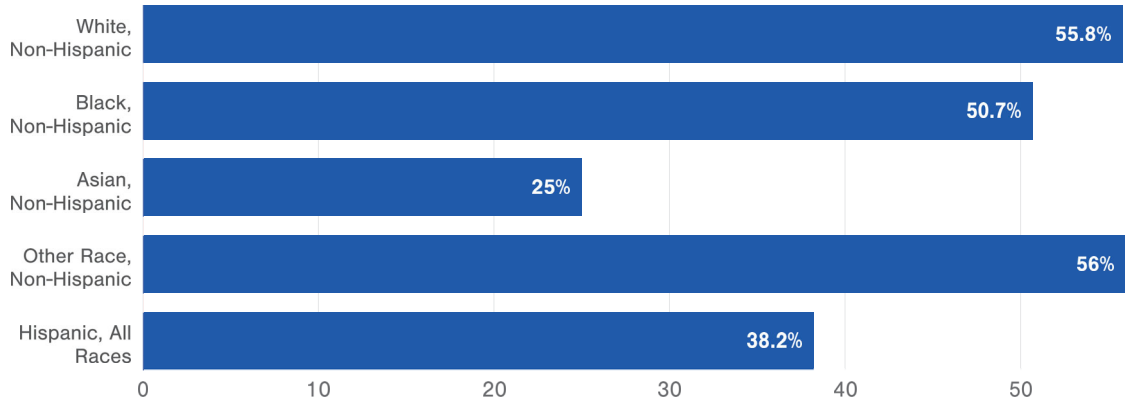
Lives with a Chronic Condition – Illinois and by Age Group (2017–2019)



Source: Illinois BRFSS, 2017, 2018, 2019. IDPH

An analysis of BRFSS chronic condition prevalence by race/ethnicity showed that more than half of Black (50.7%), White (55.8%), and Other Race (56.0%) residents reporting living with at least one condition. Much lower prevalence was seen for Hispanics (38.2%) and Asians (25.0%) for 2017 to 2019.

Lives with a Chronic Condition – by Race/Ethnicity (2017–2019)



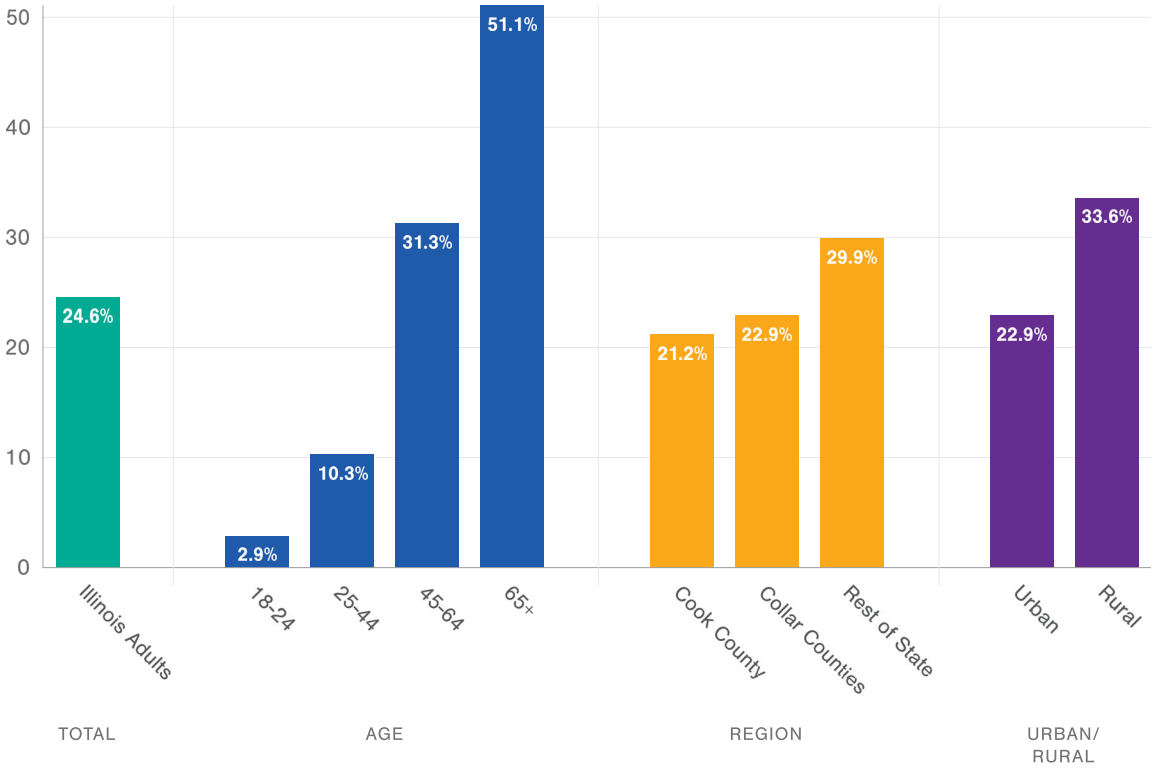
Source: Illinois BRFSS, 2017, 2018, 2019. IDPH

Arthritis and Functional Disability Prevalence

Illinois BRFSS survey data from 2017 to 2019 showed that nearly one-quarter (24.6%) of residents report having been diagnosed with arthritis. This compares to a U.S. prevalence of 24.6% for the same period. This measure increases with age with nearly one-third of 45- to 64-year-olds and more than half of those 65 years of age and older reporting having arthritis.

By region, slightly higher arthritis prevalence is seen in areas outside of the Chicago metropolitan area, with 29.9% (rest of state) and 33.6% in rural areas with reporting an arthritis diagnosis.

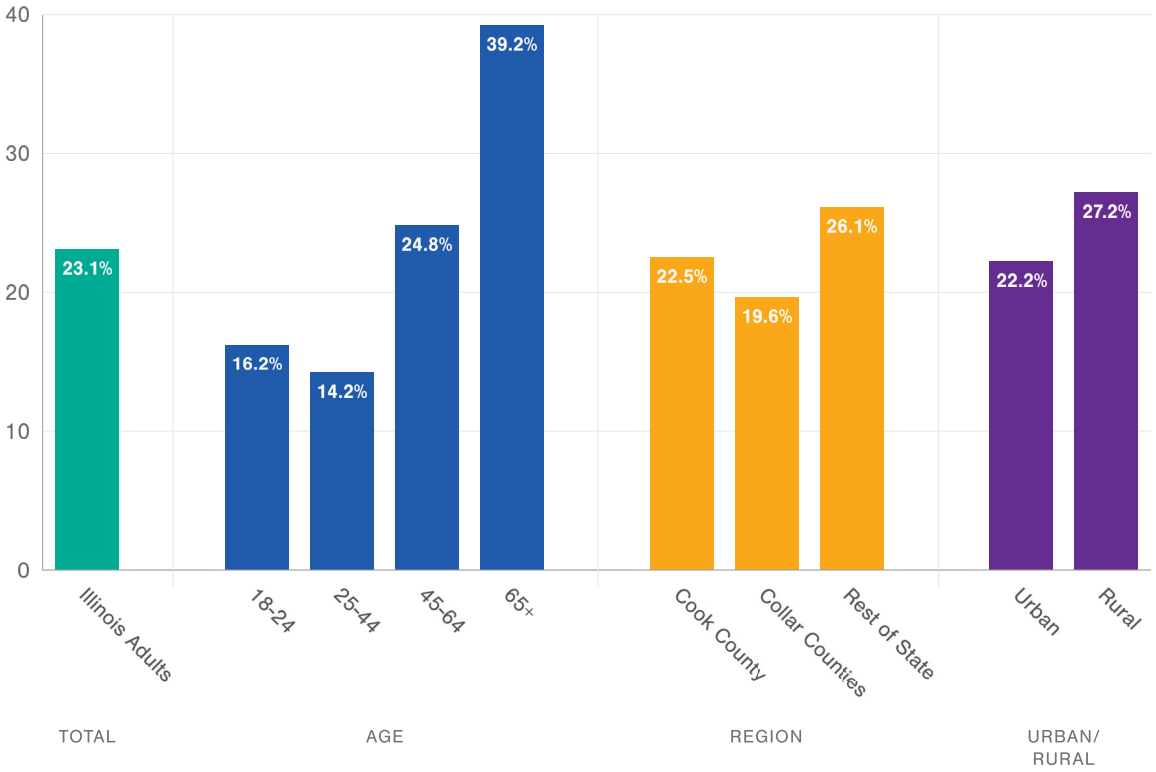
Arthritis Prevalence – Illinois, Age, Region (2017–2019)



Source: Illinois BRFSS, 2017, 2018, 2019. IDPH

Similar to arthritis, nearly one-quarter of Illinoisans reported living with a functional disability. Also similar, prevalence of this condition increases with age with 1 in 4 persons 45-64 years of age and nearly 40% of those 65 years of age and older with a functional disability. A somewhat higher prevalence was seen in areas outside of the Chicago metropolitan areas (26.1%) and in rural areas (27.2%).

Functional Disability Prevalence – Illinois, Age, Region (2017–2019)



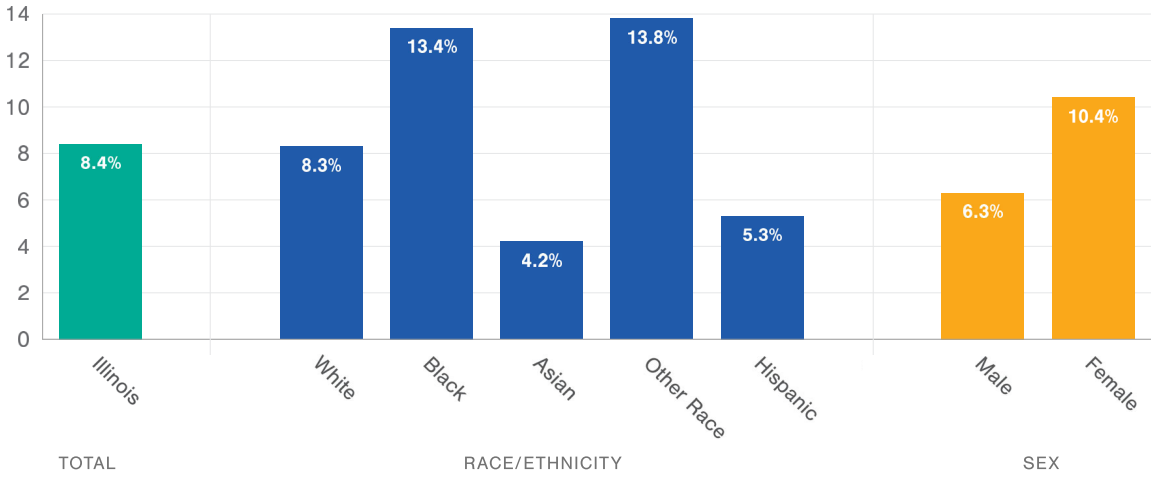
Source: Illinois BRFSS, 2017, 2018, 2019. IDPH

Asthma Prevalence

Prevalence of adult asthma for 2017 to 2019 stood at 8.4% percent for Illinois. This compares to a U.S. prevalence of 9.5% for the same period. Race/ethnicity disparities were seen in Black/African Americans at 13.4% and Other Race at 13.8%—both more than 60% higher than the Illinois measure. Females had much higher prevalence than males (10.4% vs 6.3%, respectively).

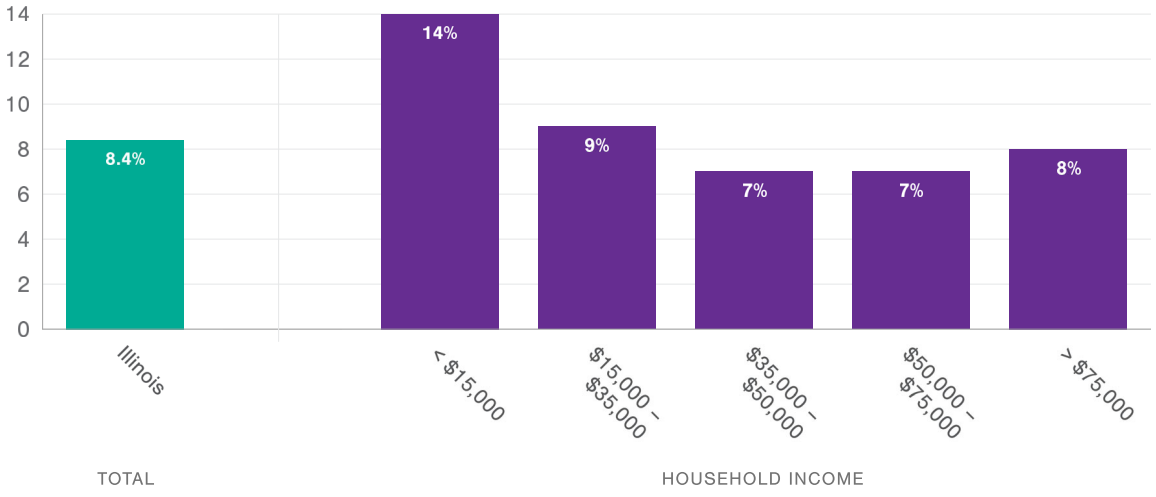
In general, prevalence of asthma for 2017 to 2019 was highest among the lowest income groups. Prevalence of adult asthma in households earning less than $15,000, at 13.6%, was more than double that of the lowest level seen among income groups for the period (6.5%, $50,000-$75,000). The second highest level was seen in households with income between $15,000 and $35,000 at 9.4%, still above the state prevalence of 8.4%.

Adult Asthma Prevalence – Illinois and by Race/Ethnicity and Sex (2017–2019)



Source: Illinois BRFSS, 2017, 2018, 2019.

Adult Asthma Prevalence – Illinois and by Household Income (2017–2019)



Source: Illinois BRFSS, 2017, 2018, 2019.

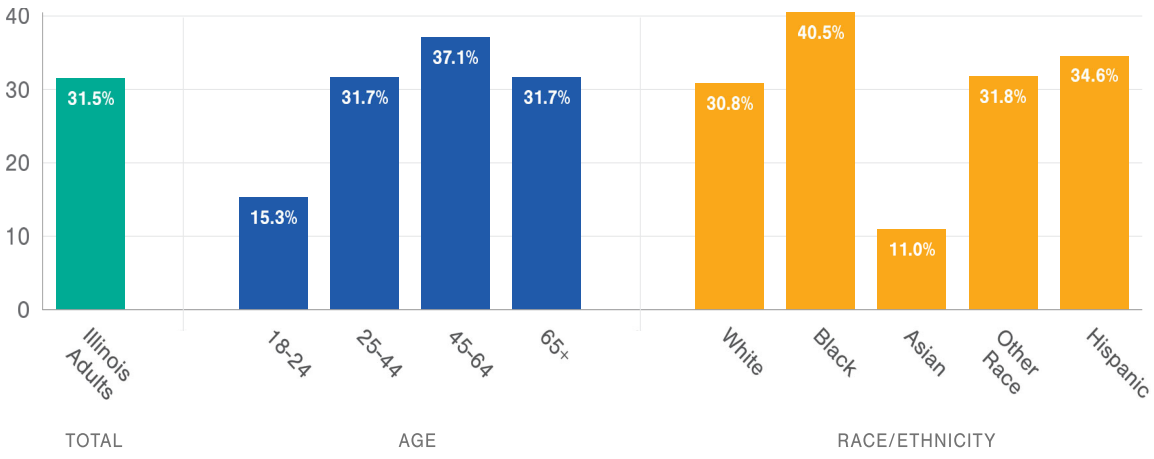
Obesity Prevalence

For 2017-2019, nearly 1 in 3 (31.5%) Illinoisans were obese, with a BMI of 30 or greater. This is lower than the U.S. level at 34.9% for the same period By age group, similar prevalence of obesity was seen among age groups above 24 years of age. The obesity frequency was highest among the 45- to 64-year-old age group at 37.1%.

Disparities in race/ethnicity see much higher prevalence among Black/African Americans (40.5%) compared to other population groups. Asians had the lowest proportion with only 11.0% reported as obese.

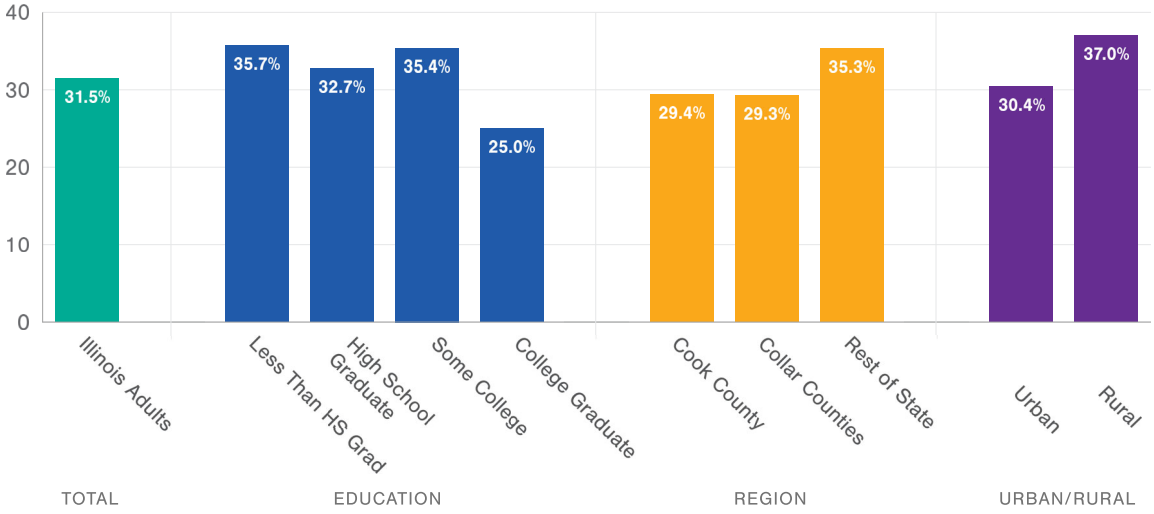
Examination by education level showed that only college graduates (25.0%) had obesity prevalence below the state level. By region, a higher prevalence of obesity was seen outside of the Chicago metropolitan region with 35.3% for the rest of state and 37.0% in rural areas.

Obesity Prevalence – Illinois, Age and Race/Ethnicity – (2017–2019)



Source: Illinois BRFSS, 2017, 2018, 2019. IDPH

Obesity Prevalence – Illinois, Educational Attainment and Region – (2017–2019)

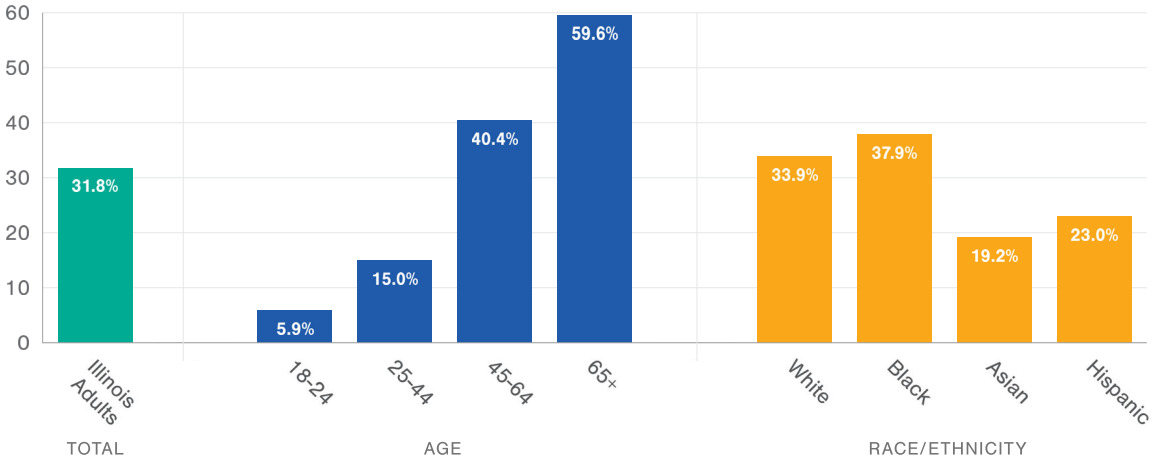


Source: Illinois BRFSS, 2017, 2018, 2019. IDPH

Hypertension Prevalence

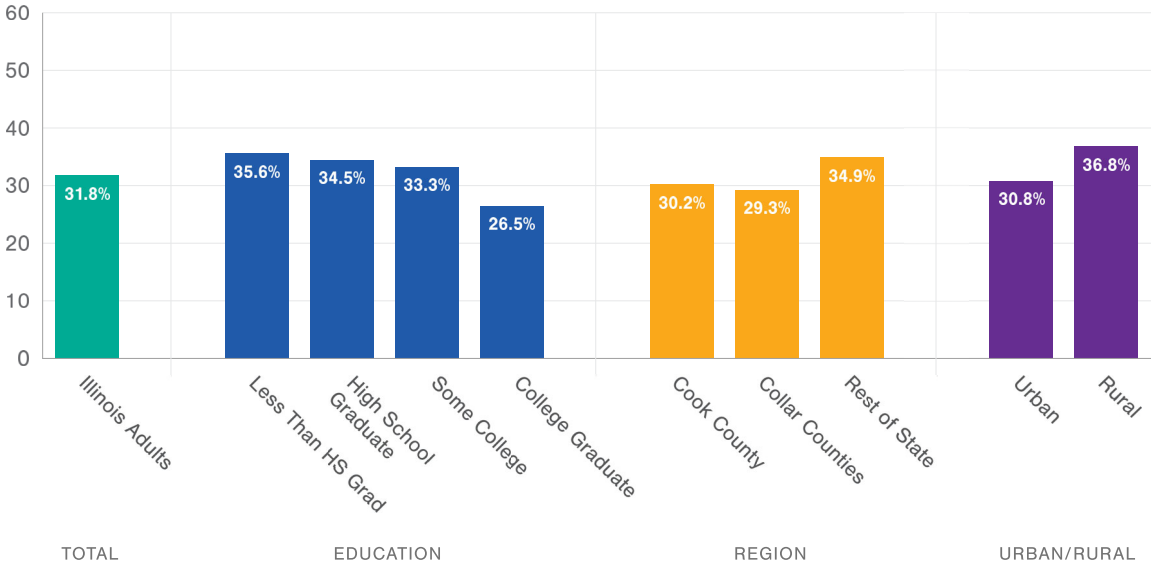
From BRFSS data available for 2015, 2017, and 2019, an average of nearly 1 in 3 (31.8%) Illinoisans have hypertension (high blood pressure). This is equal to the comparable average seen across the same years for the U.S. (31.8%). Hypertension prevalence increased with age. Those 65 years of age and older had the highest levels—6 in 10 residents, or 59.6%, were diagnosed with hypertension. By race/ethnicity, highest proportions were seen in Black/African Americans (37.9%) followed by Whites (33.9%). Prevalence in Hispanics (23.0%) and Asians (19.2%) were below state levels.

Hypertension Prevalence – Illinois, Age and Race/Ethnicity (2015, 2017, 2019)



Source: Illinois BRFSS, 2017, 2018, 2019. IDPH

Hypertension Prevalence – Illinois, Educational Attainment and Region (2015, 2017, 2019)



Source: Illinois BRFSS, 2017, 2018, 2019. IDPH

By education level, a distribution similar to that seen for obesity was present with only college graduates (26.5%) with a level below the state prevalence of 31.8%. This pattern continued by region with higher obesity rates in rural areas (36.8%) and outside of the Chicago metropolitan region—rest of state (34.9%/).

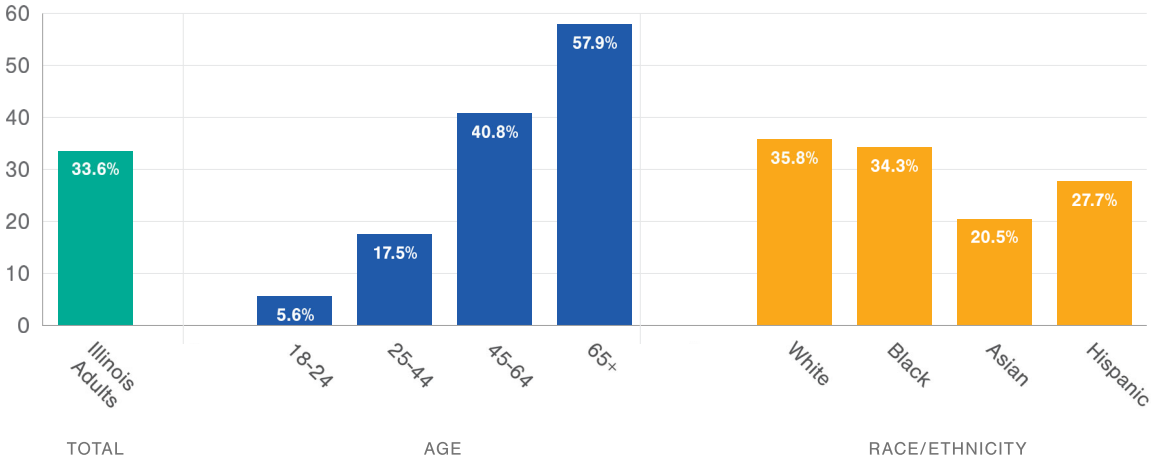
High Cholesterol Prevalence

Hypercholesterolemia, or high cholesterol prevalence, showed patterns similar to hypertension. For the available years of 2015, 2017, and 2019, slightly more than one-third of Illinois residents (33.6%) were told they have elevated cholesterol. This is slightly lower than the average U.S. prevalence for the same years of 34.2%. Similar to obesity and hypertension, high cholesterol prevalence was seen to increase with age. Those 65 years of age and older had the highest levels of this indicator at 57.9%. By race/ethnicity, Whites (35.8%) followed by Black/African Americans (34.3%) showed higher proportions with this condition compared to Hispanics (27.7%) and Asians (20.5%).

Educational attainment data saw decreasing prevalence with increasing levels of education. Those with college degrees had the lowest at 29.0% rate and were well below the state rate at 29%.

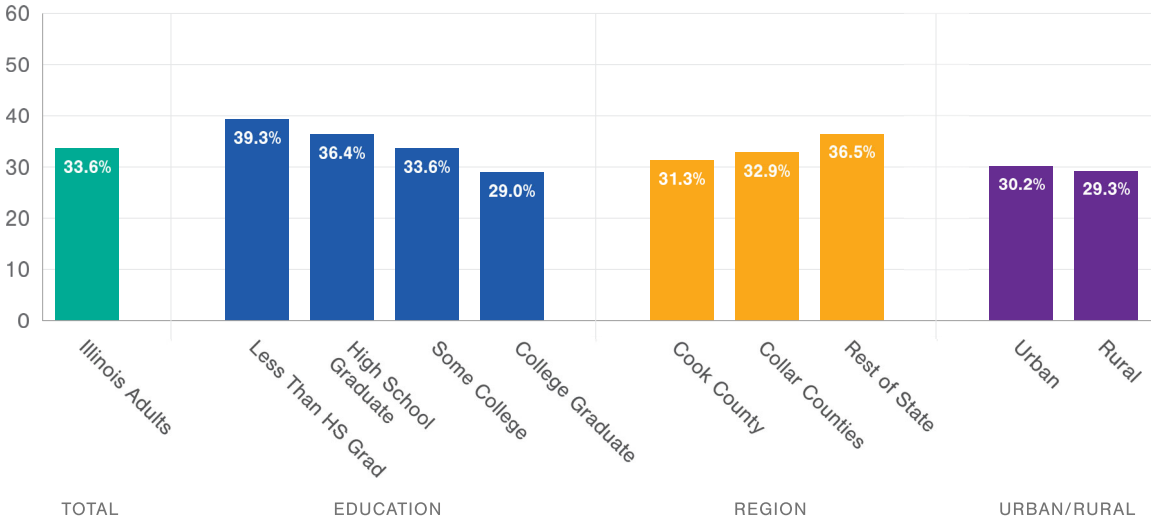
Regional data showed similar patterns to obesity and hypertension with higher prevalence seen in rural (39.0%) and areas in the rest of state (36.5%)—outside of Cook and the collar counties.

High Cholesterol Prevalence – Illinois, Age and Race/Ethnicity (2015, 2017, 2019)



Source: Illinois BRFSS, 2017, 2018, 2019. IDPH

High Cholesterol Prevalence – Illinois, Educational Attainment and Region (2015, 2017, 2019)



Source: Illinois BRFSS, 2017, 2018, 2019. IDPH

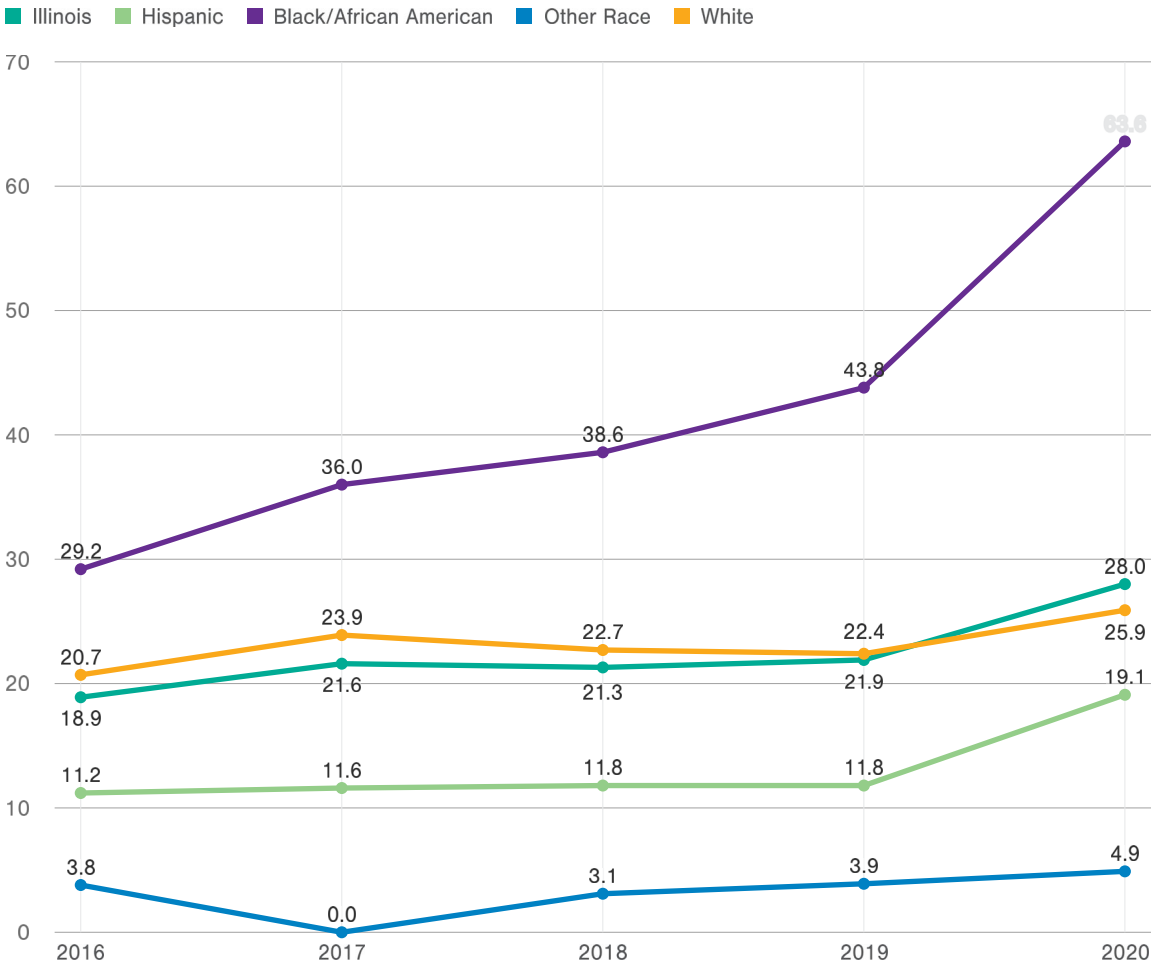
11 Behavioral and Mental Health

Substance and Opioid Overdose Mortality

Substance overdose mortality showed level rates for the period 2017 to 2019, but rates increased in 2020. In Illinois, overdose mortality rose to 28.0 deaths per 100,000 population. This is comparable to the U.S. rate for 2020, which stood at 28.3 per 100,000. Across race/ethnicity groups, significant disparity exists among Black/African Americans with increasing rates through the period 2016 to 2020. Mortality for substance overdose among Black/African Americans rose sharply in 2020 to 63.6 deaths per 100,000 population. This is more than twice the Illinois rate and nearly 13 times that of the group with the lowest rate (Other Race at 4.9 deaths per 100,000).

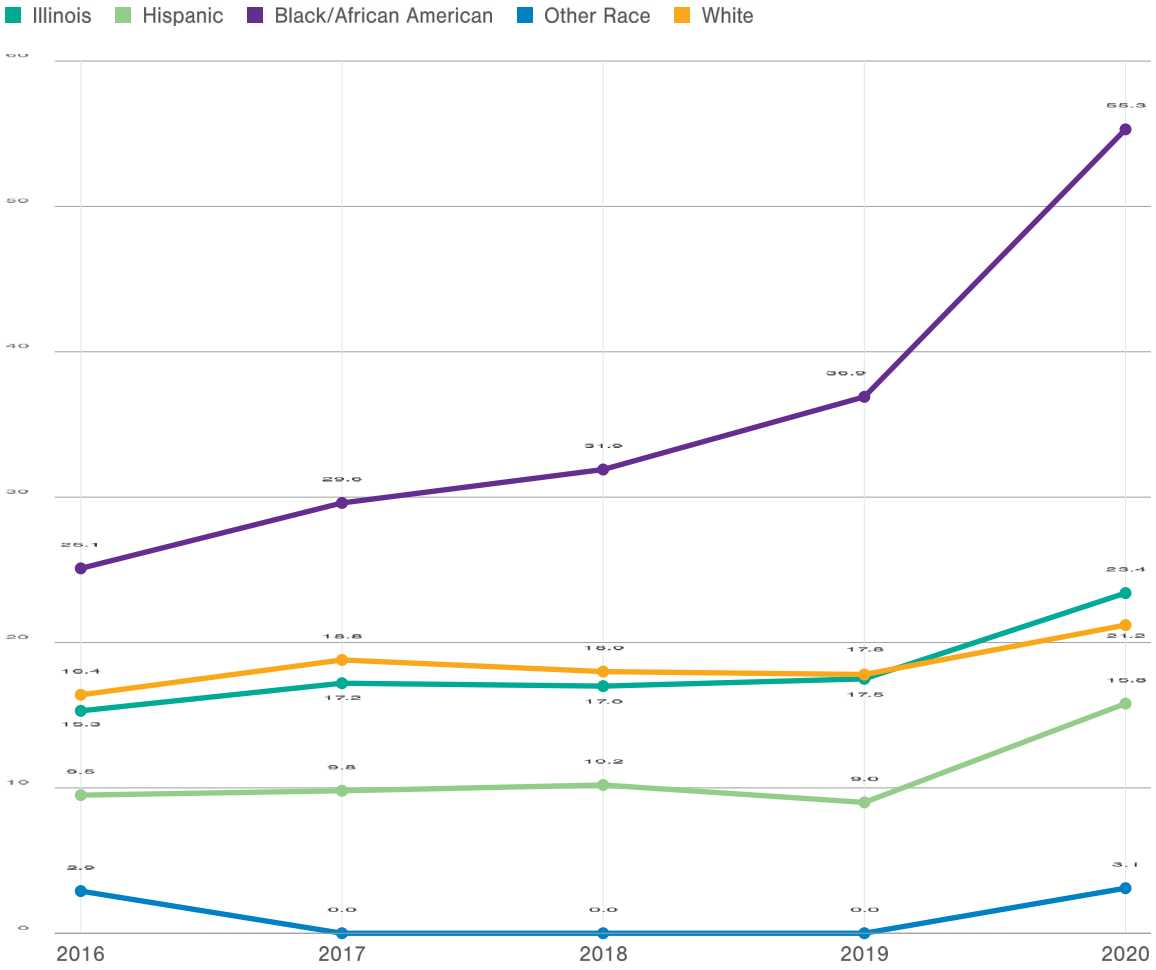
Since opioids make up the majority of substance overdose related deaths in the last several years, not surprisingly, the pattern for opioid overdose mortality mirrors the overall substance overdose rates. The Illinois mortality for opioid overdose was stable for 2017 to 2019 but increased in 2020 to 23.4 deaths per 100,000 population. This was higher than the U.S. rates for that year at 17.8 per 100,000. Black/African American opioid overdose mortality increased across the period, rising dramatically from 36.9 per 100,000 in 2019 to 55.3 per 100,000 in 2020, a 50% increase.

Substance Overdose Mortality – Age-Adjusted Rate per 100,000 Population Illinois and by Race/Ethnicity (2016–2020)



Source: Illinois Death Registry, IDPH 2022

Opioid Overdose Mortality – Age-Adjusted Rate per 100,000 Population Illinois and by Race/Ethnicity (2016–2020)

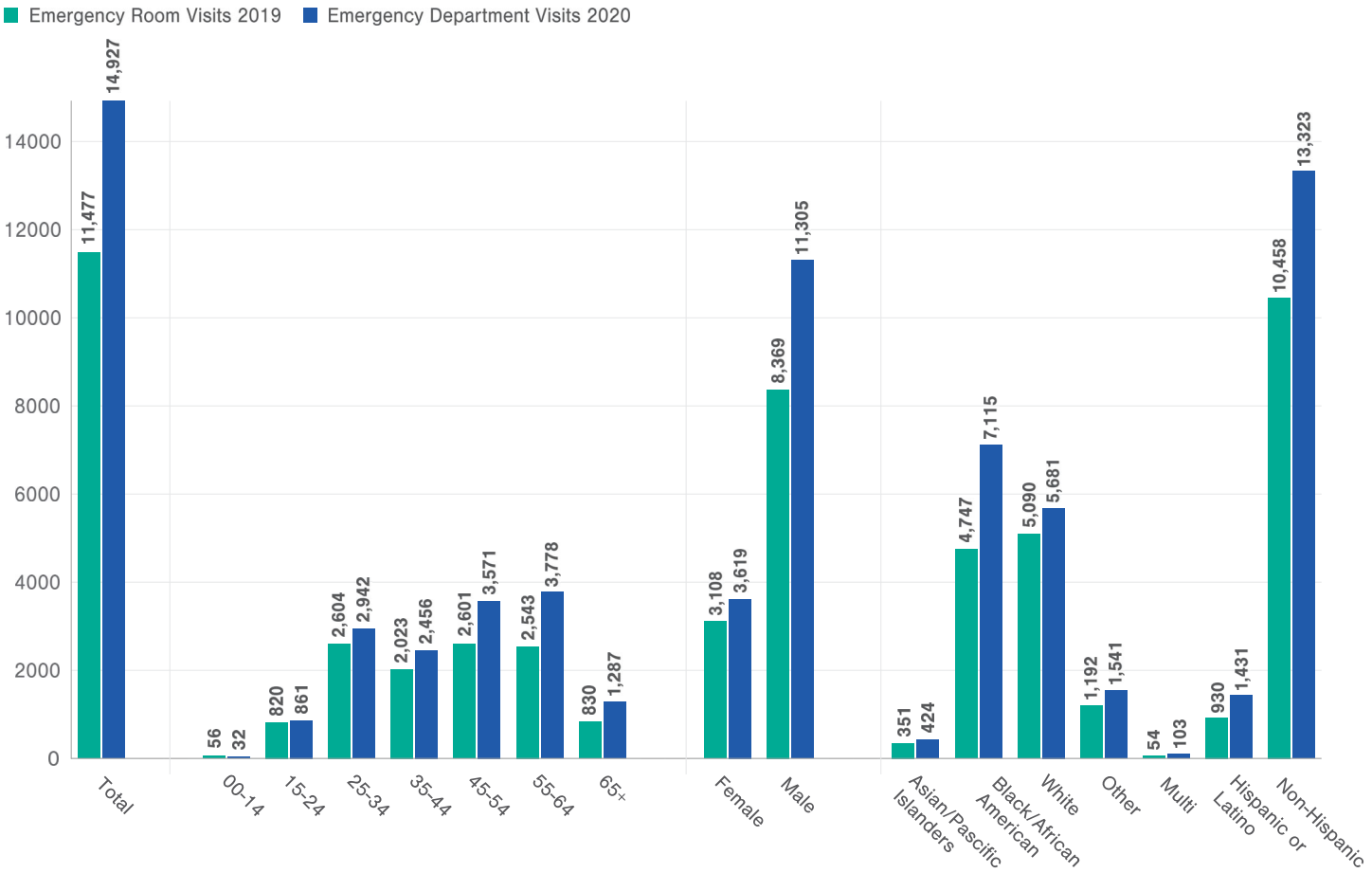


Source: Illinois Death Registry, IDPH 2022

Nonfatal Opioid Events: Emergency Department Visits

Aligned with the increase in substance and opioid overdose mortality rates seen between 2019 and 2020, a review of emergency department (ED) visits for nonfatal opioid events shows similar increases in the state. The number of ED visits for nonfatal opioid events increased by 30% from 11,477 in 2019 to 14,927 in 2020. The largest increases in visits involved males, up 35% from 8,369 visits in 2019 to 11,305 in 2020 and among visits involving Black/African Americans from 4,747 visits to 7,115 visits—a 50% increase. Smaller increases were seen across all other groups as well.

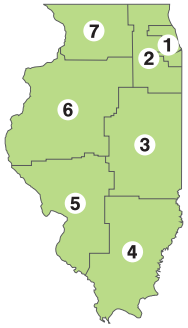
Nonfatal Opioid Emergency Department Visits (Counts) (2019–2020)



Substance and Alcohol Misuse

Emergency Department Visits – Rate Per 10,000 Population – Illinois, Race/Ethnicity, and IDPH Region (2019–2020)

SUBSTANCE USE	RATE PER 10,000 POPULATION
Illinois	33.9
Black	98.8
Hispanic	17.7
White	21.6



ALCOHOL	RATE PER 10,000 POPULATION
Illinois	56.8
Black	95.7
Hispanic	51.5
White	47.7

SUBSTANCE USE	REGION	COUNTY	
IDPH REGION	MEDIAN	MIN	MAX
Region 1	50.8	NA	NA
Region 2	19.4	15.7	29.7
Region 3	17.7	10.4	43.1
Region 4	19.0	9.9	30.0
Region 5	20.8	4.3	28.3
Region 6	21.6	7.9	33.4
Region 7	17.2	6.7	37.0

ALCOHOL	REGION	COUNTY	
IDPH REGION	MEDIAN	MIN	MAX
Region 1	71.99	NA	NA
Region 2	45.6	37.2	73.9
Region 3	31.8	10.5	58.4
Region 4	34.0	19.2	39.0
Region 5	27.0	18.5	66.8
Region 6	32.5	15.6	107.3
Region 7	40.8	17.2	66.5

Source: IDPH, 2021

Disparities in substance and alcohol use related emergency department visits become evident when population-based rates are examined. For substance misuse including overdose and nonfatal visits, Black/African Americans with 98.8 visits per 10,000 population, had a rate nearly three times the Illinois rate of 33.9 per 10,000 population. Rates varied by region for this measure with the highest visit rate in Region 1 (Cook) more than double the regional median rate in other regions across the state. Other regions saw similar median rates ranging from 17.2 per 10,000 in Region 7 (Rockford) to 21.6 in Region 6 (Peoria).

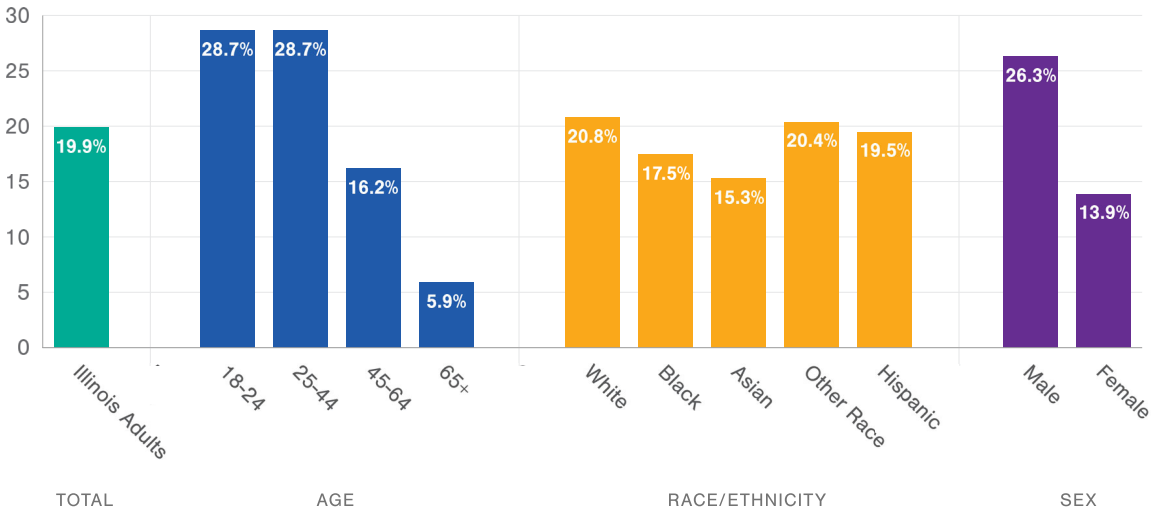
As alcohol use is more common as a “legal” drug, alcohol misuse measures for emergency department visits are higher across the state. Overall, for Illinois in 2019 to 2020, there were 56.8 visits per 10,000 population. This was 68% higher than the substance use visit rate for the state. The visit rate among Black/African Americans was 1.6 times greater than the state’s rate. Whites (47.7 per 10,000) and Hispanics (51.5 per 10,000) had similar rates. Regional data showed the highest rates were in Region 1 (Cook) (about 72.0 per 10,0000) followed by Region 2 (West Chicago) (45.6 per 10,000). Within regions, county rates varied with a high of 107.3 per 10,000 in Region 6 (Peoria).

Alcohol Use: Binge Drinking

Binge drinking is defined by the Centers for Disease Control and Prevention (CDC) as "drinking five or more drinks on an occasion for men or four or more drinks on an occasion for women in the past 30 days." For 2017 to 2019, binge drinking prevalence showed that 1 in 5 residents (19.9%) engaged in binge drinking. This is higher than the comparable U.S. rate of 16.0%. By age, younger adults—those 18 to 24 years of age and 25 to 44 years of age are more likely to binge drink with a level of 28.7% each. Binge drinking rates were lowest among Asians (15.3%) followed by Black/African Americans (17.5%). All other race/ethnicity groups had a similar prevalence. Males were nearly two times more likely to engage in binge drinking than females.

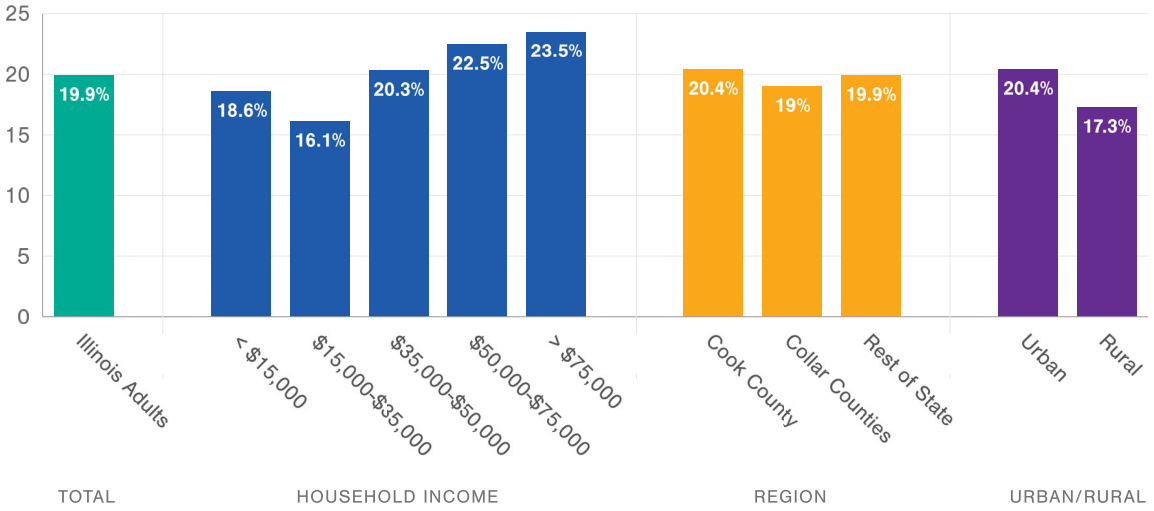
Binge drinking prevalence generally rose with increasing income with the highest value in households with more than $75,000 in annual income at 23.5%. The pattern of binge drinking by region showed little variation. A moderately higher prevalence was seen in urban (20.4%) compared to rural (17.3%) areas.

Binge Drinking Prevalence – Illinois, Age, Race/Ethnicity, and Sex (2017–2019)



Source: Illinois BRFSS, 2017, 2018, 2019. IDPH

Binge Drinking Prevalence – Illinois, Income and Region (2017–2019)



Source: Illinois BRFSS, 2017, 2018, 2019. IDPH

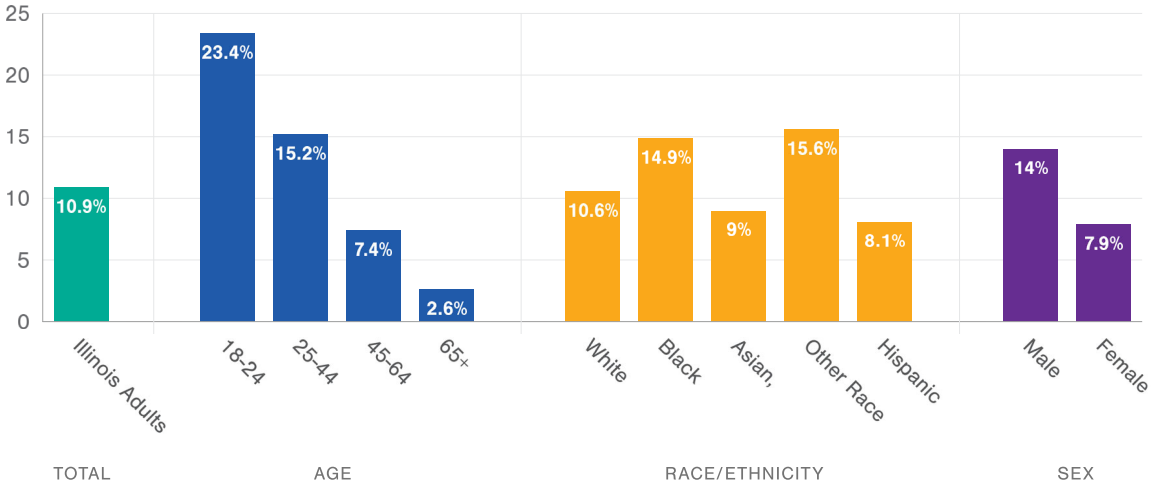
Marijuana Use

Self-reported marijuana use from 2018 and 2019 BRFSS in Illinois showed slightly more than 1 in 10 residents have used marijuana. This is lower than the 18.0% reported for the U.S. Use varied by age with the highest proportions in the 18- to 24-year-old age group; rates declined with increasing age. By race/ethnicity, prevalence was higher in those of Other Race (15.6%) and Black/African Americans (14.9%) compared to others. Male prevalence was nearly double that of females (14.0% vs. 7.9%, respectively).

Examining prevalence by income shows similar levels across all household income categories with slightly higher figures in the poorest group (under $15,000 at 12.4%) and a lower value in the highest income group (>$75,000 at 9.5%).

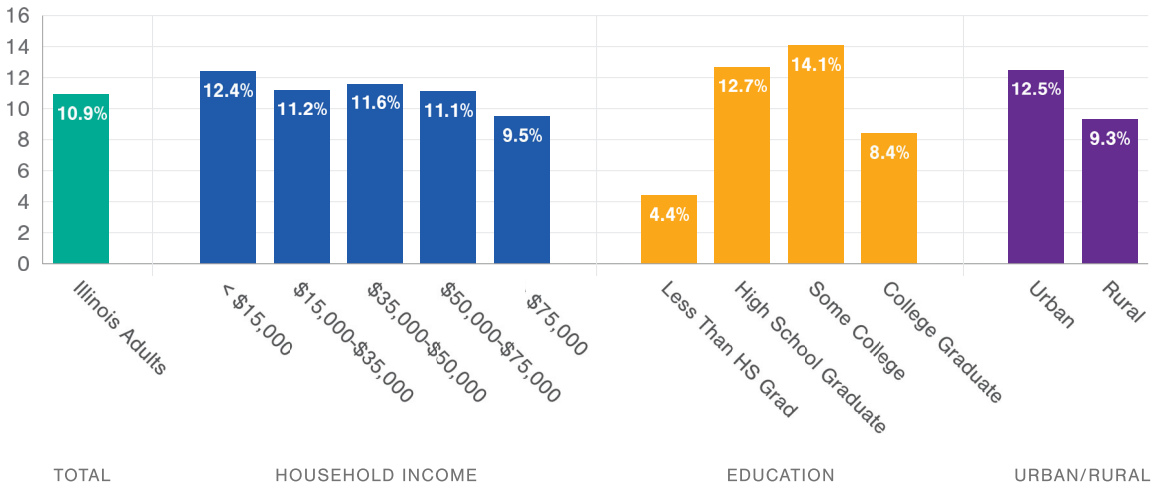
Marijuana use varied by education level. Highest use (14.1%) was seen in those with Some College followed by High School Graduates (12.7%). Those without a high school diploma were much less likely to report use (4.4%). Use was more frequent in urban (12.5%) than rural (9.3%) areas.

Marijuana Use Prevalence – Illinois, Age, Race/Ethnicity, and Sex (2018–2019)



Source: Illinois BRFSS 2018, 2019. IDPH

Marijuana Use Prevalence – Illinois, Income, Education and Region (2018–2019)



Source: Illinois BRFSS, 2018, 2019. IDPH

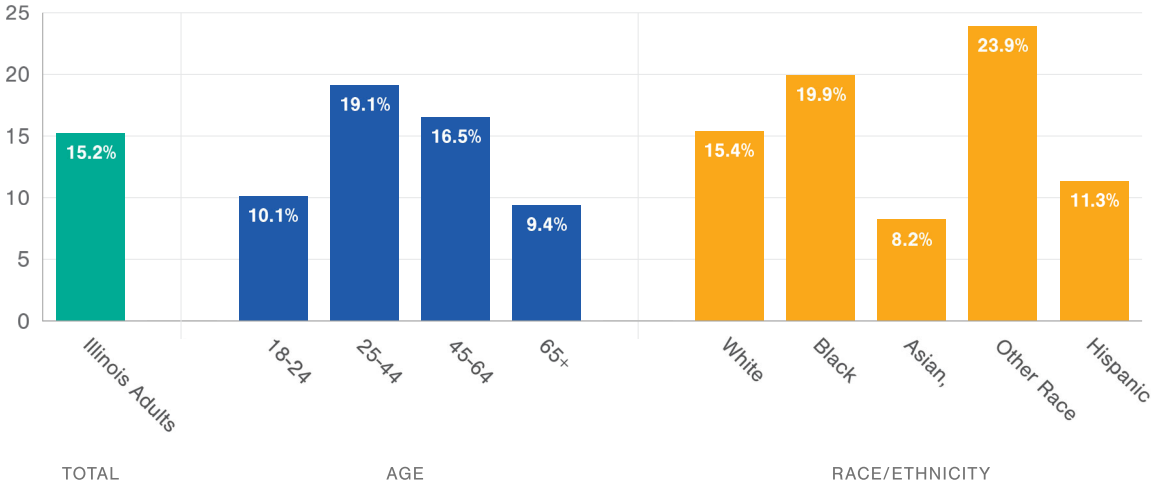
Smoking: Tobacco and E-Cigarette Use

Between 2017 and 2019, tobacco use prevalence was 15.2% in Illinois or about 1 in 6 residents. This compares to a national prevalence of 12.5% . By age, smoking was highest among those 25 to 44 years of age at 19.1% or nearly 1 in 5 persons. People 18 to 24 years of age and those 65 years of age and older were least likely to smoke with proportions below the national level (10.1% and 9.4%, respectively). Tobacco use was most frequently reported by those of Other Race (23.9%) followed by Black/African Americans (19.9%). Hispanics (11.3%) and Asians (8.2%) were lower than the national rate.

Tobacco use declined with increasing household income. Among those at lower income levels, slightly more than 1 in 4 residents in households with income less than $15,000 smoked compared to 9.7% of those in households with income greater than $75,000. By region, tobacco use prevalence was highest outside of the Chicago metropolitan area (rest of state) with 19.1% and in rural areas (20.5%).

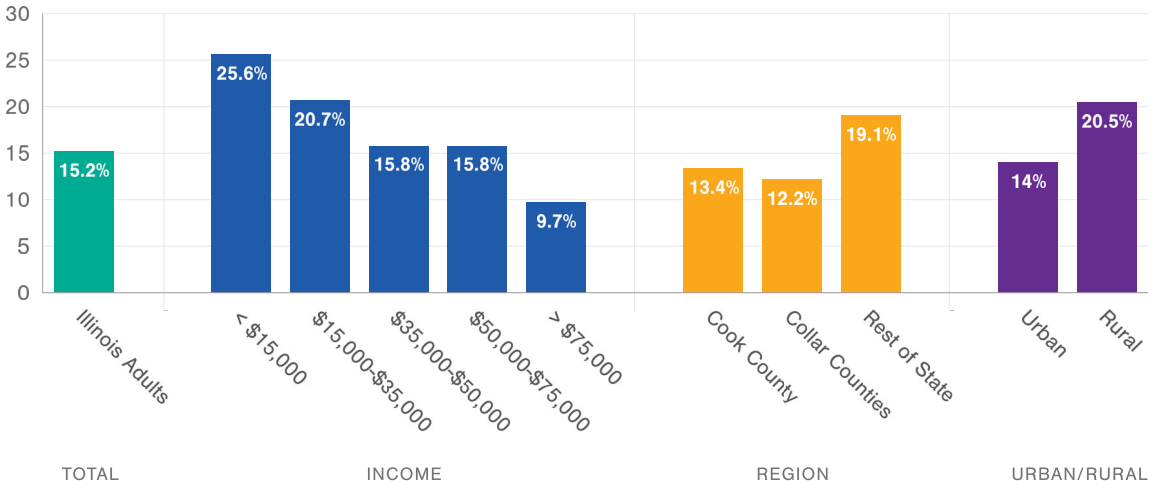
Electronic cigarette prevalence was relatively low at 4.9% for 2106 to 2018. Persons 18 to 24 years of age had the highest rates at 2.5 times the state rate. Asian (at 6.4%) and White (5.8%) had the highest prevalence of use.

Tobacco Use Prevalence – Illinois, Age, Race/Ethnicity, and Sex (2017–2019)



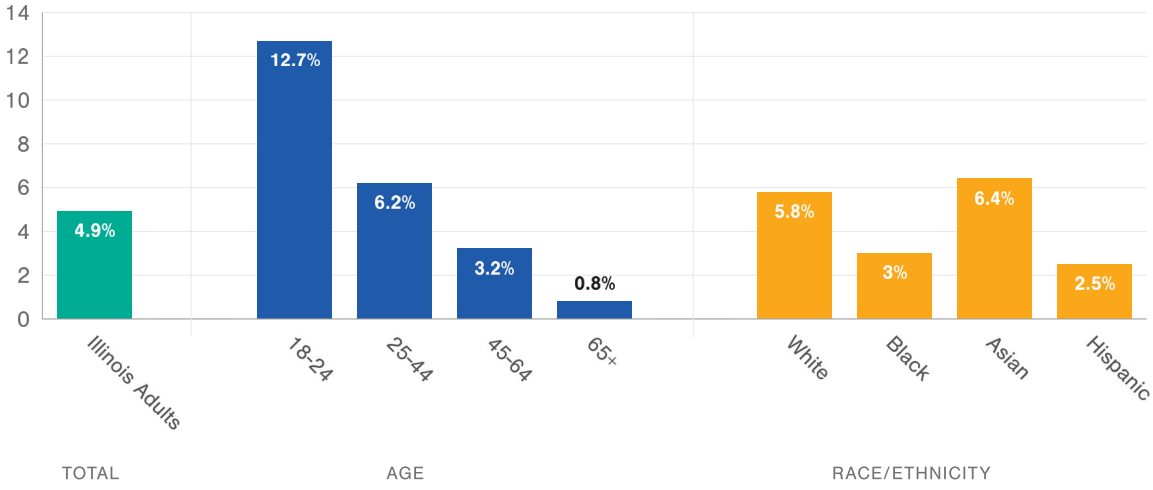
Source: Illinois BRFSS, 2017, 2018, 2019. IDPH

Tobacco Use Prevalence – Illinois, Income and Region (2017–2019)



Source: Illinois BRFSS, 2017, 2018, 2019. IDPH

E-Cigarette Use Prevalence – Illinois, Age and Race/Ethnicity (2016–2018)



Source: Illinois BRFSS, 2017, 2018, 2019. IDPH

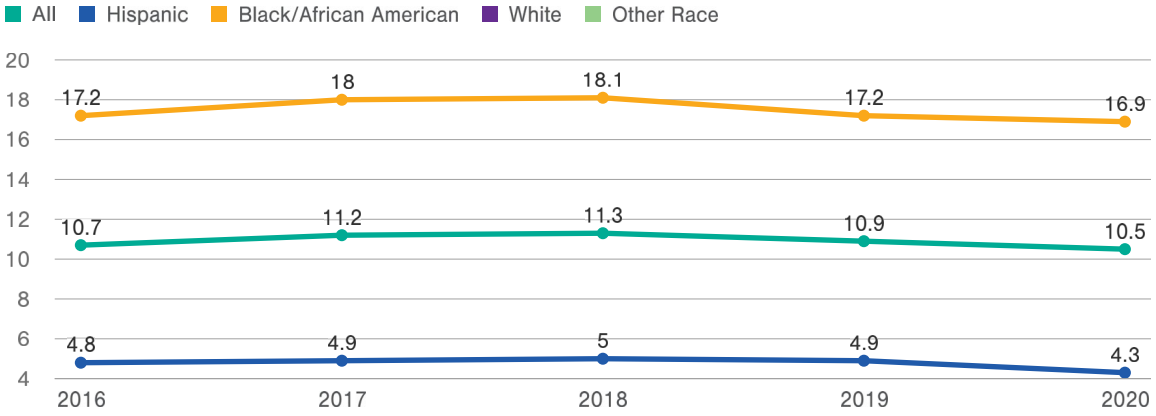
12 Mental Health: Mood and Anxiety Disorders

Suicide (Self-Harm) Mortality

For the period 2016 to 2020, suicide (self-harm) mortality remained stable overall and by sex. Illinois had a five-year median rate of 10.9 deaths per 100,000 population. This was lower than the U.S. rate of 13.9 per 100,000 population and the HP2030 benchmark of 12.8 per 100,000 population. Despite this, a consistent disparity was seen with male rates between three and four times higher than female rates. Male rates peaked in 2018 at 18.1 per 100,000 and female rates were at a peak in that same year at 5.0 per 100,000.

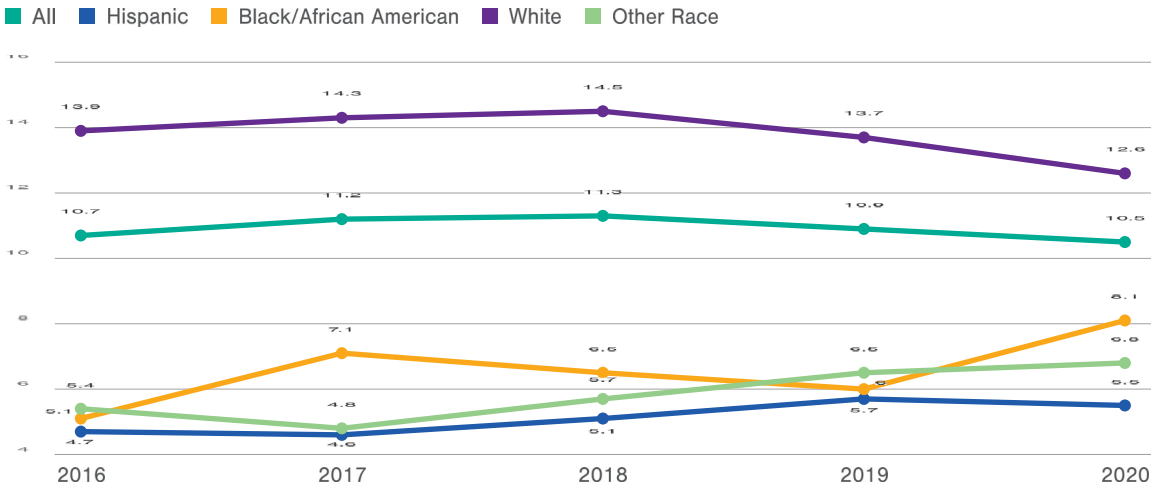
Race/ethnicity-specific suicide mortality rates showed disparity among White residents with rates, on average, 20% above the state rate and higher than the HP2030 rate for four of the last five years. White suicide rates declined between 2018 and 2020 from a high of 14.5 per 100,000 to 12.7 per 100,000. In contrast, rates for Black/African Americans rose sharply in 2020 to 8.1 per 100,000 from 6.0 per 100,000 in 2019. Other Race residents' suicide mortality also increased from 4.8 per 100,000 in 2017 to 6.8 per 100,000 in 2020—a 40% increase.

Suicide (Self-Harm) Mortality – Age-Adjusted Rate per 100,000 Population Illinois and by Sex (2016–2020)



Source: Illinois Death Registry, IDPH 2022

Suicide (Self-Harm) Mortality – Age-Adjusted Rate per 100,000 Population Illinois and by Race/Ethinicty (2016–2020)



Source: Illinois Death Registry, IDPH 2022

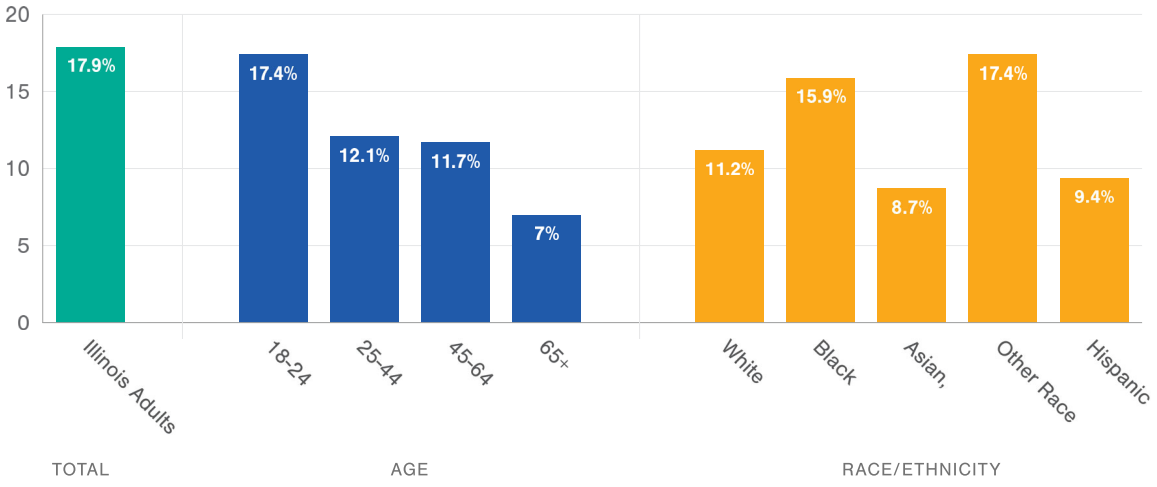
Poor Mental Health Prevalence

BRFSS results for 2017 to 2019 had 11.5%, or more than 1 in 10 Illinoisans, reporting they experienced poor mental health for 14 or more days in the past month. This was above the U.S. prevalence of 8.2% and nearly three times higher than the HP2030 benchmark of 3.4%.

This measure decreased with increasing age with 17.4% reporting poor mental health in those 18 to 24 years old compared to only 7.0% of those 65 years of age and older. Poor mental health prevalence was highest among those of Other Race (17.4%) followed by Black/African Americans (15.9%).

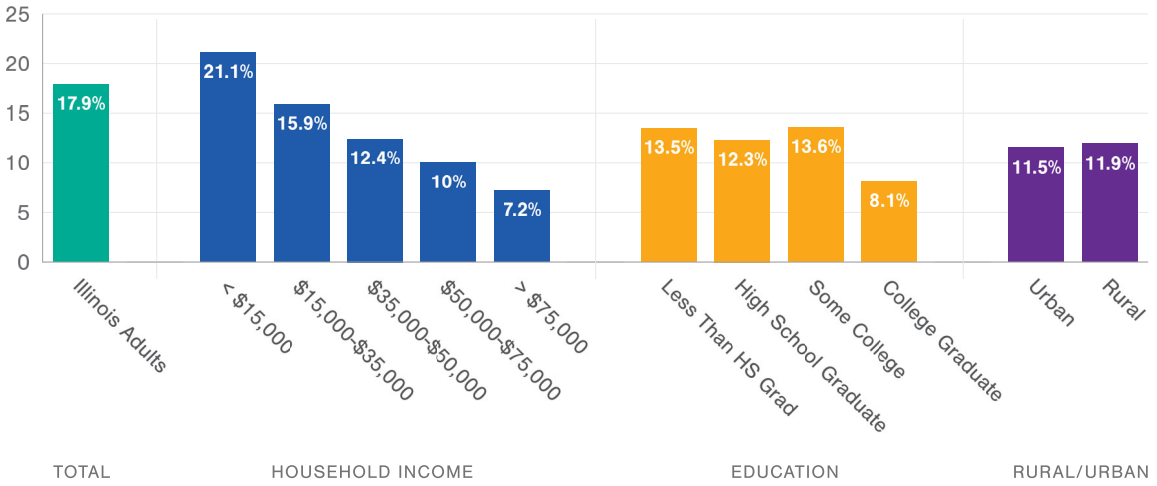
This measure decreased with increasing household income with residents with income under $15,000 most likely to report poor mental health (21.1%). The measure varied only slightly by education level but remained above the state level (range of 12.3% to 13.6%) for all but those with college degrees (8.1%). Similar prevalence was seen in both urban and rural areas, which was similar to the state rate.

Poor Mental Health Prevalence – (14+ Days Mental Health Not Good)
Illinois, Age and Race/Ethnicity (2017–2019)



Source: Illinois BRFSS 2017, 2018, 2019. IDPH

Suicide (Self-Harm) Mortality – Age-Adjusted Rate per 100,000 Population
Illinois, Income, Education and Region (2016–2020)



Source: Illinois BRFSS 2017, 2018, 2019. IDPH

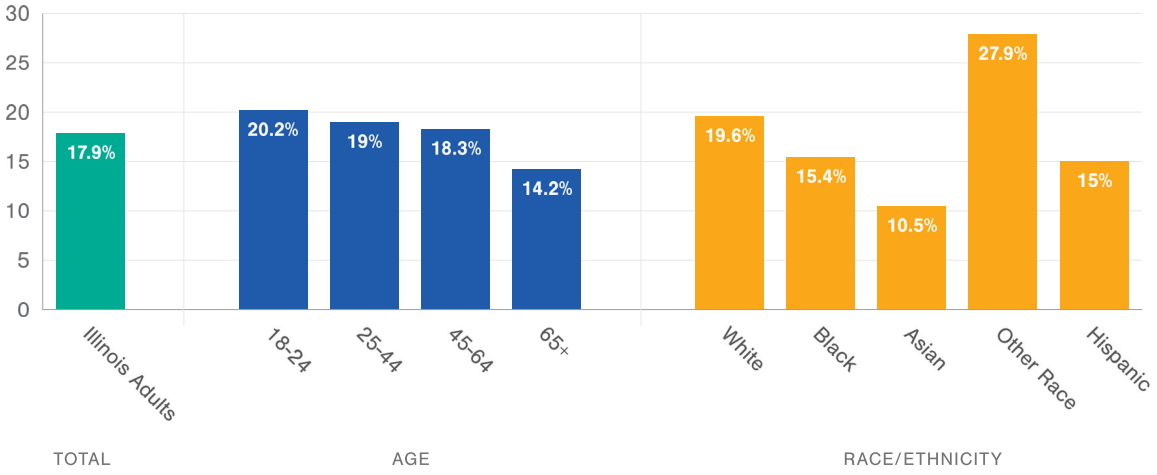
Depression Prevalence

Prevalence of depression or a depressive disorder from 2017 to 2019 stood at 17.9% or more than 1 in 6 residents. This compares to 18.5% for the U.S. (2019). Depression decreased somewhat across age groups with those younger than 65 years of age having values above the state rates; those 65 years of age and older had the lowest prevalence at 14.2%. By race/ethnicity, those identifying as Other Race had the highest prevalence of depression at 27.9% or 56% higher than the state average; Asians had the lowest rate at 10.5%. Females reported a 60% higher prevalence of depression than males at 22.0% compared to 13.6%.

The proportion of adults reporting depression decreased steadily as income increased with those in the lowest household income group (<$15,000) showing 29.0% prevalence while those in the highest group (>$75,000) were at 14.2% for this measure.

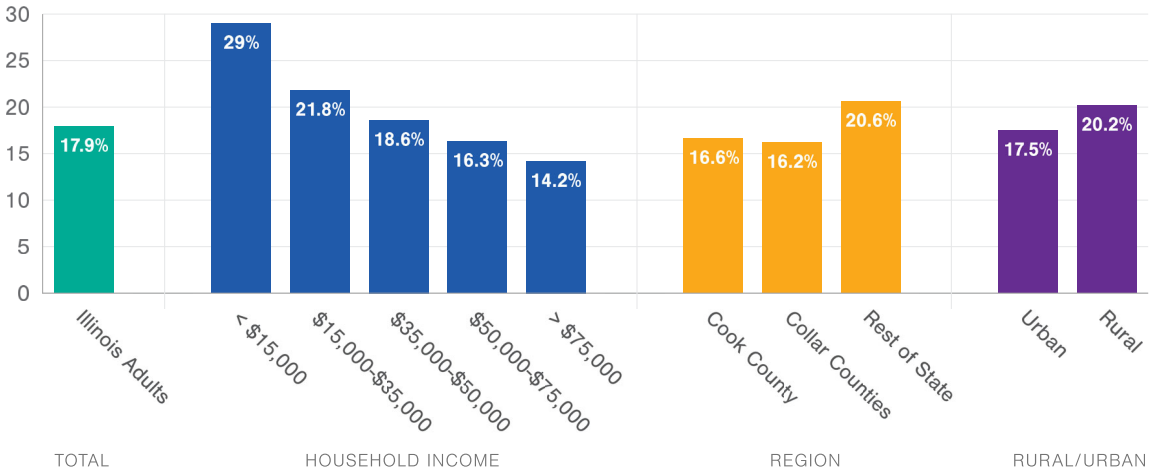
By region, higher prevalence was seen outside of the Chicago metropolitan region with 20.6% reporting having depression; rural areas also showed a higher value for this measure at 20.2%.

Depression Prevalence – Illinois, Age, Race/Ethnicity and Sex (2017–2019)



Source: Illinois BRFSS 2017, 2018, 2019. IDPH

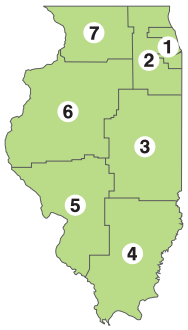
Depression Prevalence – Illinois, Income, and Region (2017–2019)



Source: Illinois BRFSS 2017, 2018, 2019. IDPH

Emergency Department Visits – Rate Per 10,000 Population – Illinois, Race/Ethnicity, And IDPH Region (2018–2020)

MOOD	RATE PER 10,000 POPULATION
Illinois	30.4
Black	56.3
Hispanic	16.0
White	27.8



ANXIETY	RATE PER 10,000 POPULATION
Illinois	36.7
Black	50.9
Hispanic	31.6
White	34.5

MOOD	REGION	COUNTY	
IDPH REGION	MEDIAN	MIN	MAX
Region 1	28.7	NA	NA
Region 2	36.1	22.1	50.1
Region 3	26.0	17.1	65.6
Region 4	30.5	16.4	59.0
Region 5	30.3	3.8	72.5
Region 6	26.4	20.1	42.6
Region 7	29.7	20.8	42.9

ANXIETY	REGION	COUNTY	
IDPH REGION	MEDIAN	MIN	MAX
Region 1	32.3	NA	NA
Region 2	32.1	26.0	45.6
Region 3	41.1	20.9	75.4
Region 4	45.1	22.0	56.8
Region 5	44.3	5.9	68.7
Region 6	38.9	26.7	60.1
Region 7	46.1	20.2	73.7

Source: IDPH, 2021

Mood Disorder Visits

Emergency department (ED) visit rates for mood disorders for 2018 to 2020 stood at 30.4 per 10,000 population. Visit rates by race/ethnicity showed disparities in that Black/African Americans, at 56.3 per 10,000, were nearly twice as likely to visit the ED for mood disorders than Whites at 27.8 per 10,000 and over three times more likely than Hispanics (16.0 per 10,000).

Across regions, similar regional median rates were seen with the highest rate in Region 2 (West Chicago). Region 5 (Edwardsville) had the widest range of county-specific visit rates, varying from a low of 3.8 per 10,000 to a high of 72.5 per 10,000.

Anxiety Disorder Visits

Emergency department (ED) visit rates for anxiety disorders for 2018 to 2020 stood at 36.7 per 10,000 population. Visit rates by race/ethnicity showed disparities in that Black/African Americans; at 50.9 per 10,000 they were more than 30% higher than Whites at 34.5 per 10,000 and Hispanics at 31.6 per 10,000.

Across regions, higher median regional visit rates were seen in regions 3 through 7. Region 1 (Cook) and Region 2 (West Chicago) showed similar lower visit rates at 32.3 per 10,000 and 32.1 per 10,000, respectively. Region 5 showed the widest range of county rates from 5.9 per 10,000 to 68.7 per 10,000.

13 Injury and Violence

Motor Vehicle Crash Mortality

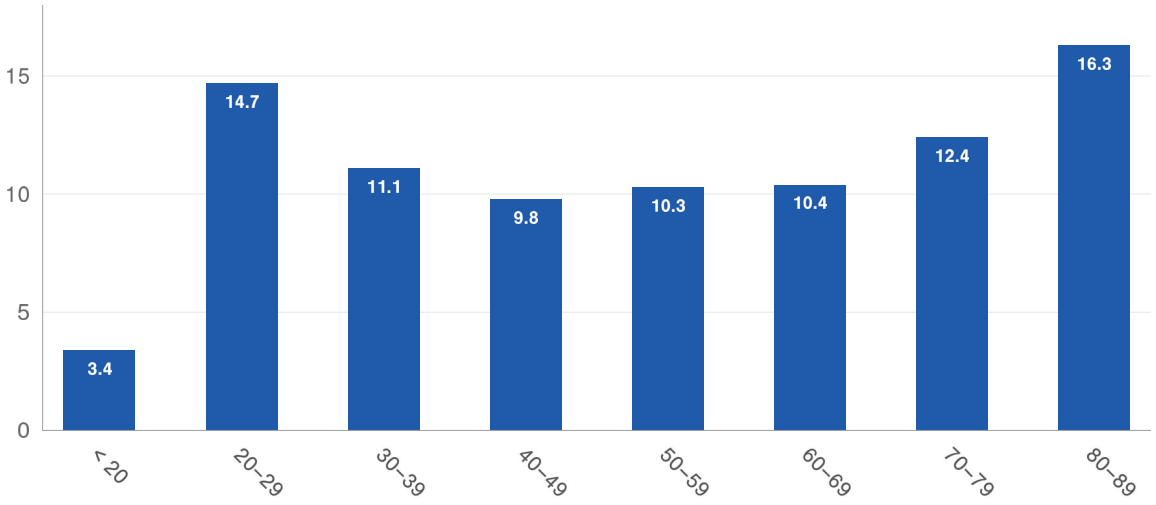
Death rates due to motor vehicle crashes remained relatively level between 2016 and 2019. In 2020 the number and rates of death increased to 10.2 per 100,000 population. This was lower than the rate of 11.1 per 100,000 for the U.S.

Motor vehicle related mortality shows a bimodal distribution with highest rates at both younger age — 20 to 29 years at 14.7 per 100,000 and at older age —80 to 89 years at 16.3 per 100,000.

Illinois – Motor Vehicle Crash Mortality Age-Adjusted Rate per 100,000 Population (2016–2020)

Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2021

Illinois – Motor Vehicle Crash Mortality Rate per 100,000 Population By Age Group (2016–2020)



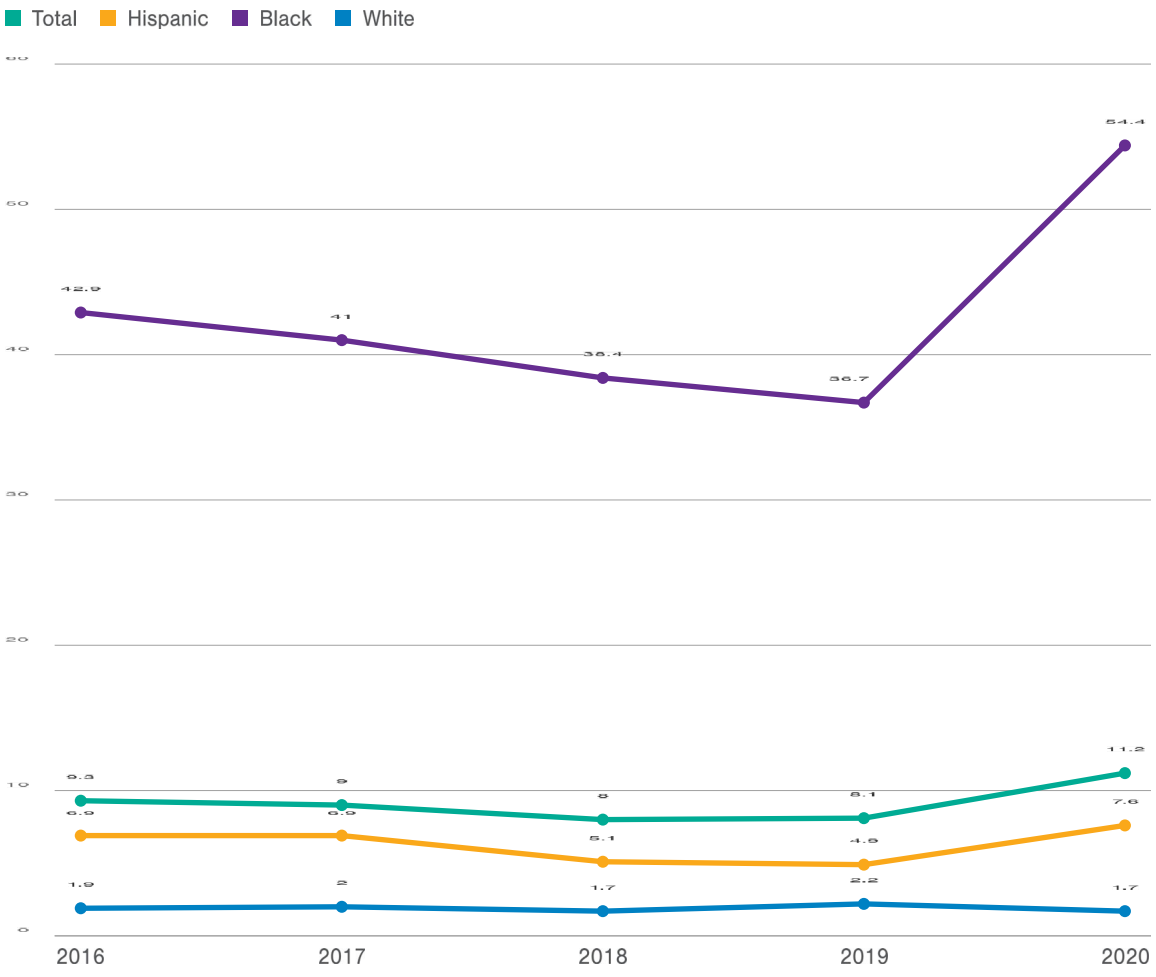
Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2021

Homicide (Assault) Mortality

Homicide mortality was fairly level for the period 2016 through 2019. In 2020, the homicide mortality rate rose to 11.2 per 100,000 population—an increase of 38% from the previous year and slightly more than double the HP2030 rate of 5.5 per 100,000. The U.S. homicide rate stood at 6.0 per 100,000.

By race/ethnicity, dramatic disparities were evident. Black/African American homicide mortality rates were 4.5 times the Illinois rate for 2016 to 2019 and increased in 2020 to 54.4 per 100,000. This was nearly five times the overall Illinois rate and nearly 10 times the HP2030 goal.

Homicide (ASSUALT) Mortality by Race/Ethnicity – Age-Adjusted Rate per 100K Population Illinois (2016–2020)



Source: Illinois Death Registry, IDPH 2022

14 Access To Health Care

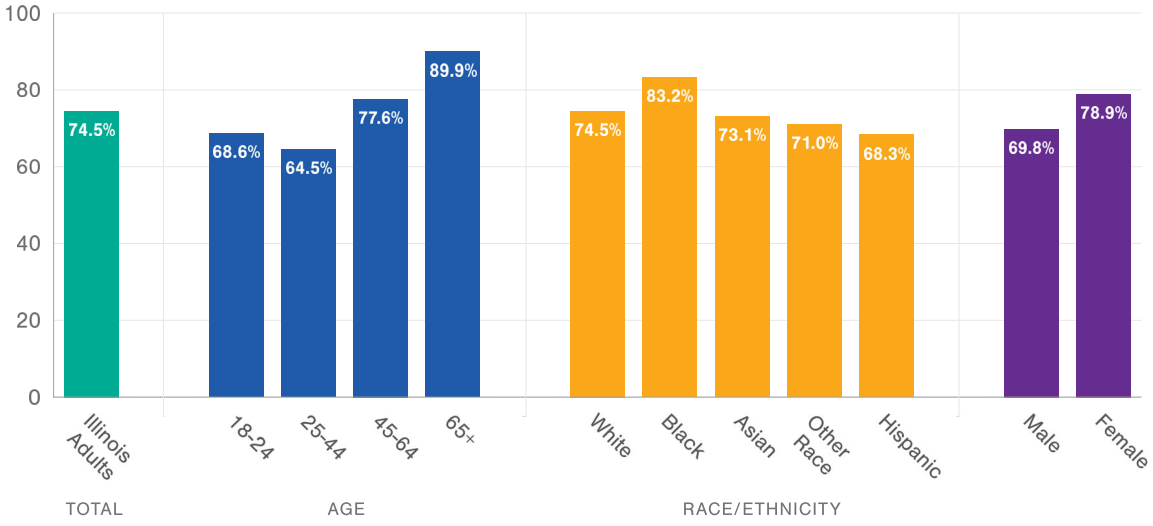
Primary Care Annual "Checkup"

Access to health care can be reflected in having a primary care home or primary care provider. Having an annual "checkup" can be a measure of routine access to care and utilization. For 2017 to 2019, nearly three-quarters of Illinois residents reported having had an annual "checkup." In general, this prevalence rose with increasing age with nearly 90% of those 65 years of age and older having a routine annual visit.

By race/ethnicity, data shows that Black/African Americans had the highest value for this measure at 83.2%. Hispanic residents had the lowest prevalence at 68.3% or 8% lower than the state average. Females were more likely than males to report an annual visit (78.9% vs. 69.8%, respectively).

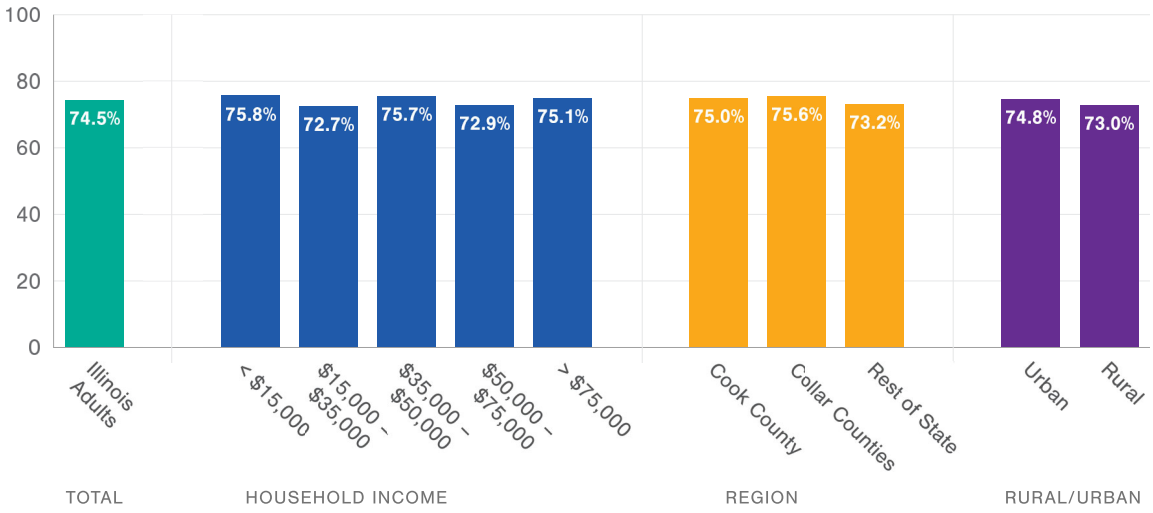
Little difference was seen in this measure by household income or region with all categories at or near the state prevalence of 74.5%.

"Checkup" in the Past Year Prevalence – Illinois, Age, Race/Ethnicity, and Sex (2017–2019)



Source: Illinois BRFSS 2017, 2018, 2019. IDPH

"Checkup" in the Past Year Prevalence – Illinois, Income, and Region (2017–2019)

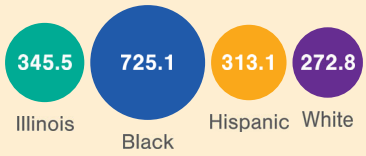


Source: Illinois BRFSS 2017, 2018, 2019. IDPH

Primary Care Related Emergency Department Visits

Adult Diabetes, Hypertension, and Asthma – Emergency Department Visits – Rate per 10,000 Population – Illinois, Race/Ethnicity, and IDPH region (2018–2020)

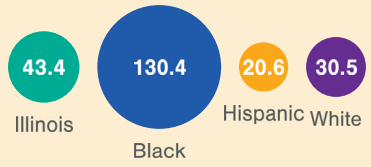
DIABETES



All Races	345.5
Black	725.1
Hispanic	313.1
White	272.8

	Median	MinImum	Maximum
Illinois	345.5		
Region 1	334.86	NA	NA
Region 2	293.7	221.4	400.1
Region 3	437.9	118.1	780.7
Region 4	278.1	136.1	616.2
Region 5	378.9	95.7	569.4
Region 6	264.5	166.0	512.5
Region 7	354.2	77.3	494.5

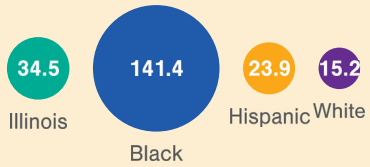
HYPERTENSION



All Races	43.4
Black	130.4
Hispanic	20.6
White	30.5

	Median	Minimum	Maximum
Illinois	43.4		
Region 1	51.4	NA	NA
Region 2	30.0	24.0	54.3
Region 3	46.0	24.4	81.1
Region 4	46.8	26.2	82.4
Region 5	51.0	8.0	66.8
Region 6	42.7	23.8	62.2
Region 7	36.5	13.7	50.0

ASTHMA



All Races	34.5
Black	141.4
Hispanic	23.9
White	15.2

	Median	Minimum	Maximum
Illinois	34.5		
Region 1	45	NA	NA
Region 2	22.3	13.8	47.0
Region 3	25.1	11.8	54.6
Region 4	17.9	10.5	115.6
Region 5	23.0	4.2	55.9
Region 6	22.9	8.7	36.1
Region 7	26.5	8.4	49.3

Source: IDPH, 2021

Emergency department (ED) visits for diabetes, hypertension, and asthma can be indicative of access to adequate primary care and chronic disease management. While some visits may be for a life-threatening event requiring immediate attention, substantial portions of these visits may reflect a lack of access to regular primary care and/or disease management with a medical home. This may be due to a lack of available providers issues with cost and lack of insurance, or other accessibility issues.

Diabetes-related Visits

In 2018 to 2020, an average rate of 345.5 per 10,000 population was seen for diabetes-related ED visits. The Black/African American visit rate was double that rate at 725.1 per 10,000. White and Hispanic rates were below the state rate for this condition. By region, the highest rates were seen in Region 3 (Champaign) at 437.9 per 10,000. Other regions varied somewhat around the state rate. Region 3 had the highest variation across county rates with a low of 118.1 per 10,000 and a high of 780.7 per 10,000.

Hypertension-related Visits

For 2018 to 2020, the ED visit rate for hypertension was lower than for diabetes at 43.4 per 10,000 population. Disparities by race/ethnicity persisted for this condition with the Black/African American visit rate three times higher than the state rate at 130.4 per 10,000. Regional data showed the highest rates were seen in Region 1 (Cook) at 51.4 per 10,000 and in Region 5 (Edwardsville) at 51.0 per 10,000. County rates within regions varied the most in Region 5 with a low of 8.0 per 10,000 and a high of 66.8 per 10,000.

Asthma-related Visits

The adult asthma ED visit rate for 2018 to 2020 stood at 34.5 per 10,000 population. Race/ethnicity disparities were evident for this condition with an ED visit rate for Black/African Americans at 141.4 per 10,000 — four times higher than the state rate. By region, Region 1 (Cook) saw the highest median rate at 45.0 per 10,000; Region 4 (Marion) was lowest at 17.9 per 10,000 population. Region 4 (Marion) also had the greatest variation between county rates with a low of 10.5 per 10,000 and a high of 115.6 per 10,000.

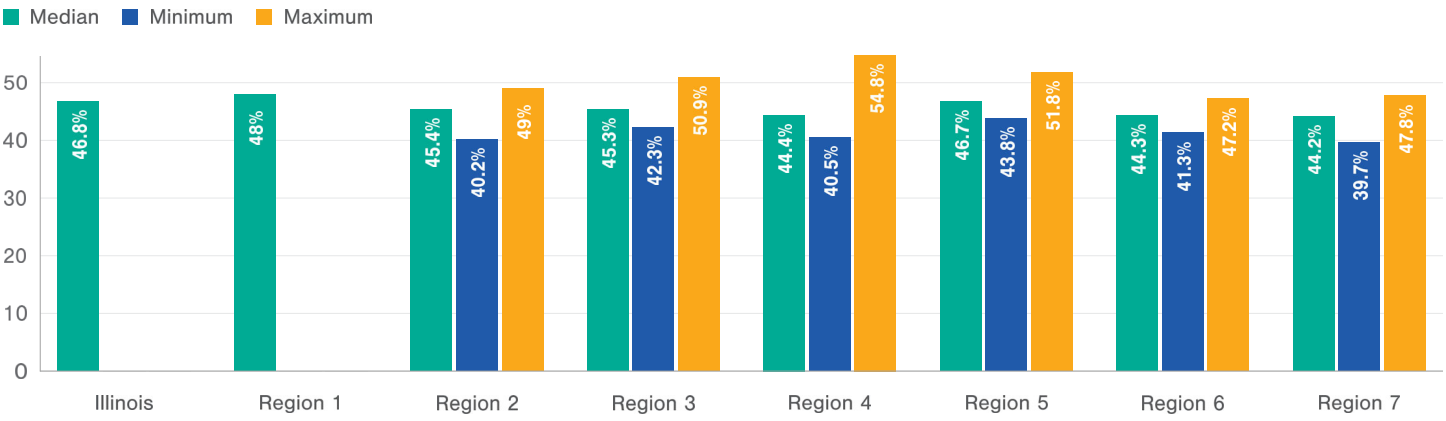
Ambulatory Care Sensitive (ACS)* Conditions

Ambulatory care sensitive (ACS)* conditions are considered emergency department (ED) visits that, in most instances, could have been managed by a primary care provider instead of an emergency care visit. It suggests a misuse of emergency services and reflects a potential lack of access to primary care or a medical home. These proportions and rates are also affected by the number of hospital EDs and provider availability in a locale.

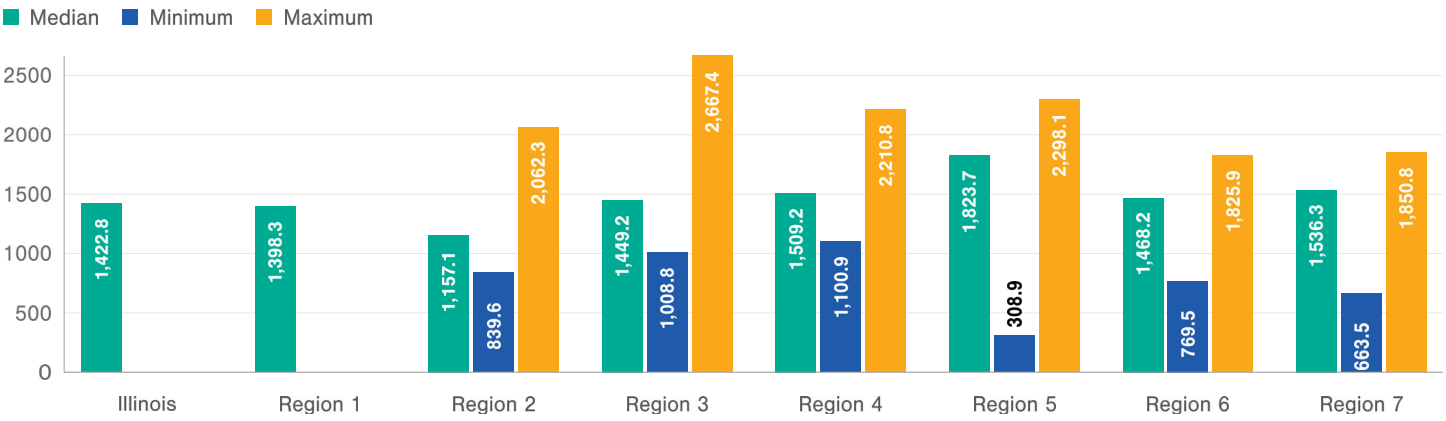
For 2018 to 2020, nearly half of all ED visits (48.0%) can be classified as ACS visits. This proportion was stable across Illinois' regions with median regional proportions between 44.2% (Region 7, Rockford) and 46.8% (Region 1, Cook).

Population-based visit rates showed an ACS visit rate of 1,422.8 visits per 10,000 population for 2018 to 2020. This rate varied from a low of 1,157.1 visits per 10,000 population in Region 2 (West Chicago) to a high of 1,823.7 visits per 10,000 population in Region 5 (Edwardsville).

Ambulatory Care Sensitive (ACS) Conditions – Emergency Department Visits – Percent of All Visits (Cases) (2018–2020)



Ambulatory Care Sensitive Conditions – Emergency Department Visits Rate per 10,000 Population (2018–2020)



* Includes visits for which 1) immediate medical care was not required within 12 hours; 2) treatment was required within 12 hours, but care could have been provided effectively and safely in a primary care setting; or 3) care was required but the emergent nature of the condition was potentially preventable/avoidable if timely and effective ambulatory care had been received during the episode of illness. (NYU Acuity Classification)

Health Professional Shortage Areas: 2022

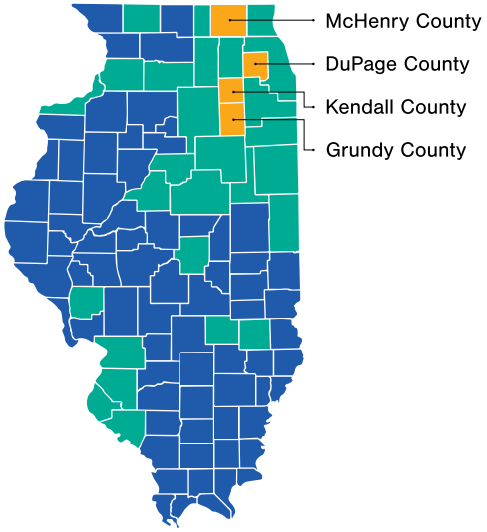
Health professional shortage areas (HPSA) are areas designated by the federal Health Resources and Service Administration (HRSA) as a geographic area, population, or facility that has a shortage of primary, dental, or mental health care providers.

In 2022, among Illinois' 102 counties, 71 (70%) are entirely designated as a HPSA for primary care, another 27 have a portion of the county designated as a primary care HPSA, and only four have no designated HPSA for primary care shortage.

Illinois Health Professional Shortage Areas: Primary Care, by County (2022)

COUNTY HSPA	NUMBER	COUNTY WITH NO HPSA
None	4	DuPage Grundy County Kendall County McHenry County
Part	27	
Whole	71	

Source: data.HRSA.gov. January 2022



15 Communicable Diseases

Sexually Transmitted Infections:

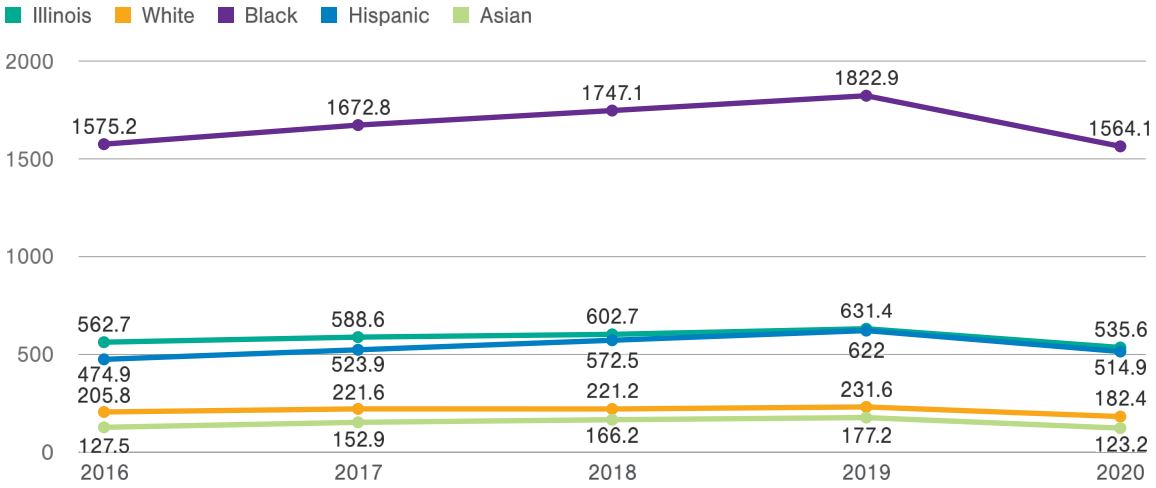
Chlamydia

The chlamydia incidence rate for Illinois for 2016 to 2020 stood at 588.6 per 100,000 population. This was above the U.S. incidence rate of 481.3 per 100,000 (2020). Annual incidence rates rose for 2016 through 2019 but fell to 535.6 per 100,000 in 2020. This decline may be related to mitigation of the COVID-19 pandemic, which may have decreased screening and testing for this condition, resulting in lower incidence.

Examining differences by race/ ethnicity showed that Black/African American incidence of chlamydia was three times higher than the state rates. All other race/ethnicity groups had rates at or below that.

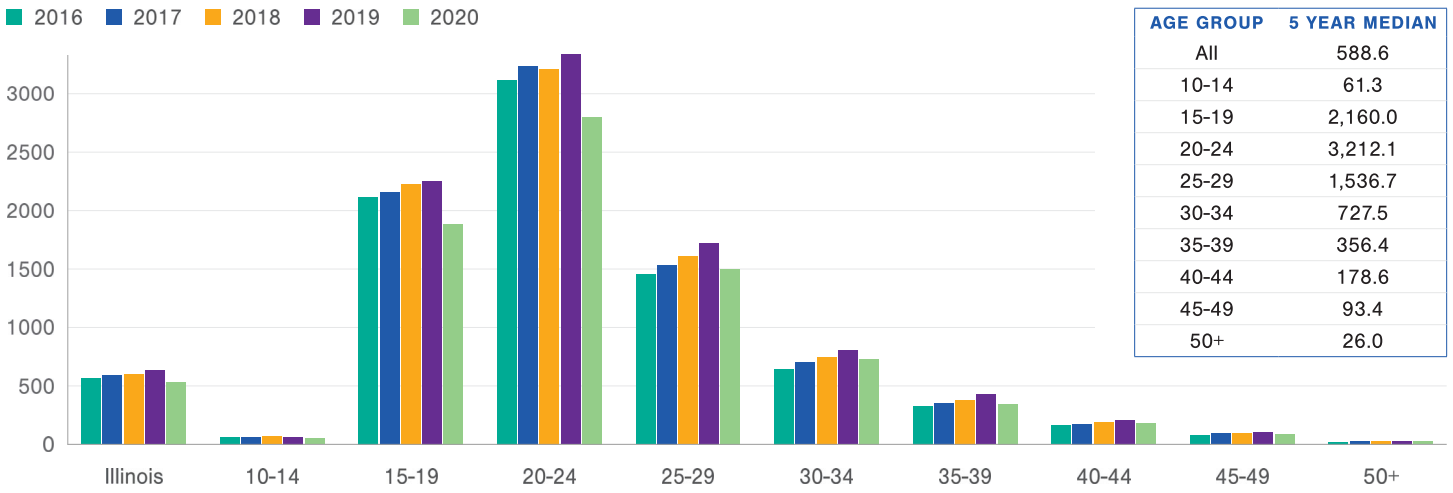
Surveillance data for chlamydia by age group showed that for 2016 to 2018 the highest rates were seen in persons 20 to 24 years of age with a five-year median rate of 3,212.1 per 100,000, followed by 15 to19 year olds at 2,160.0 per 100,000.

Chlamydia – Rate per 100,000 Population – Illinois and by Race/Ethnicity (2016–2020)



Source: IDPH 2022

Chlamydia – Rate per 100,000 Population – Illinois and by Age Group (2016–2020)



AGE GROUP	5 YEAR MEDIAN
All	588.6
10-14	61.3
15-19	2,160.0
20-24	3,212.1
25-29	1,536.7
30-34	727.5
35-39	356.4
40-44	178.6
45-49	93.4
50+	26.0

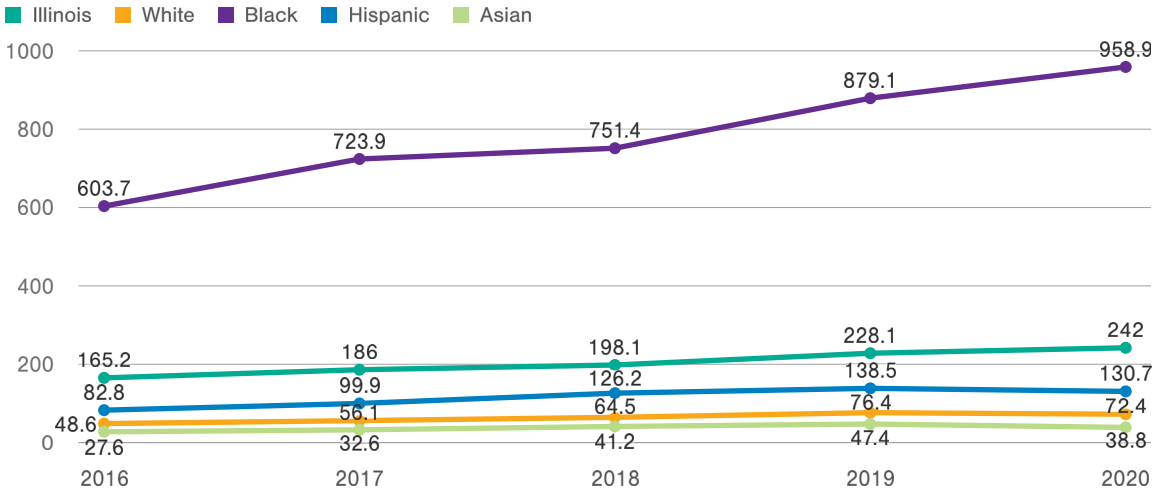
Source: IDPH 2022

Sexually Transmitted Infections: Gonorrhea

The gonorrhea incidence rate for 2016 to 2020 was 198.1 per 100,000 population. This was higher than the U.S. rate of 178.5 per 100,000 population (2019). During the period, rates increased steadily overall and among Black/African Americans. Rates for other race/ethnicity groups increased through 2019, but then decreased slightly during 2020. Black/African American gonorrhea incidence had a five-year median rate of 751.4 per 100,000. Rates in this group have increased by 56% from 603.7 per 100,000 in 2016 to 958.9 per 100,000 in 2020.

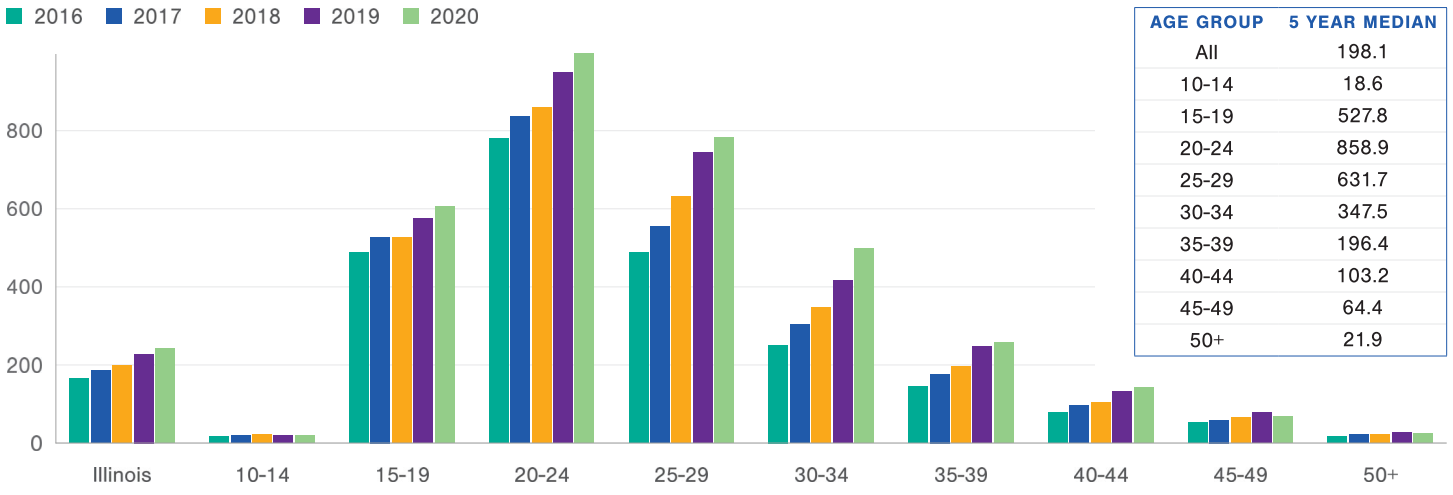
By age group, the highest gonorrhea incidence rate is seen in the 20- to 24-year-old age group with a five-year median of 527.8 per 100,000. Other age groups — 25 to 29 years of age (631.7 per 100,000) and 15 to 19 years of age (527.8 per 100,000) had the next highest rates.

Gonorrhea – Rate per 100,000 Population – Illinois and by Race/Ethnicity (2016–2020)



Source: IDPH 2022

Gonorrhea – Rate per 100,000 Population – Illinois and by Age Group (2016–2020)



AGE GROUP	5 YEAR MEDIAN
All	198.1
10-14	18.6
15-19	527.8
20-24	858.9
25-29	631.7
30-34	347.5
35-39	196.4
40-44	103.2
45-49	64.4
50+	21.9

Source: IDPH 2022

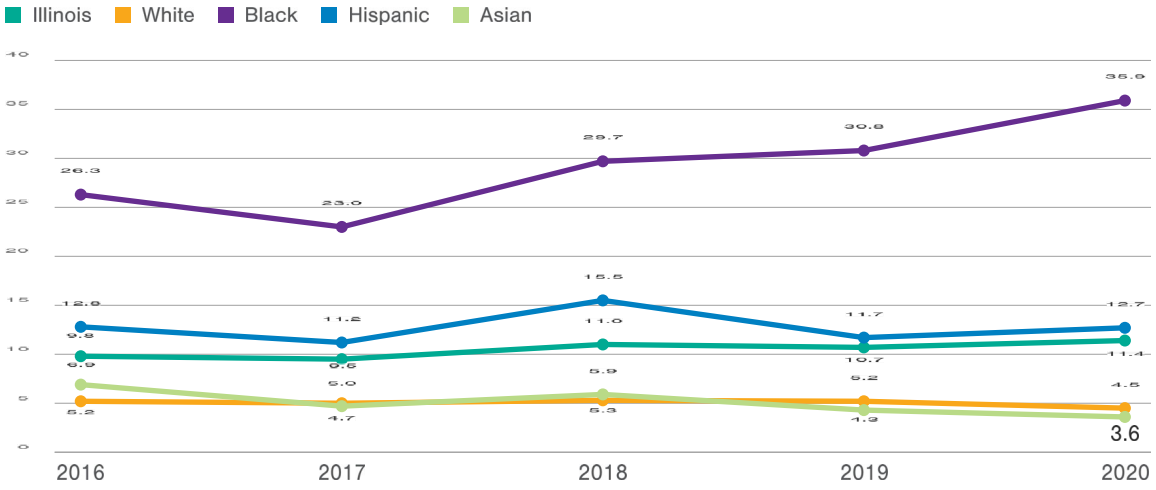
Sexually Transmitted Infections: Primary and Secondary Syphilis

The five-year median primary and secondary (P&S) syphilis incidence rate for 2016 to 2020 stood at 10.7 per 100,000 population, the same as the U.S. rate. Incidence rates increased over the period in Illinois from 9.8 per 100,000 in 2016 to 11.4 per 100,000 in 2020.

By race/ethnicity, disparities in rates became evident. Black/African American incidence rose significantly from a low of 23.0 per 100,000 in 2017 to a high in 2020 of 35.9 per 100,000, a 56% increase. Hispanic P&S, while higher than the state rate, remained stable, ending the period at similar levels. Other groups saw declines in P&S rates.

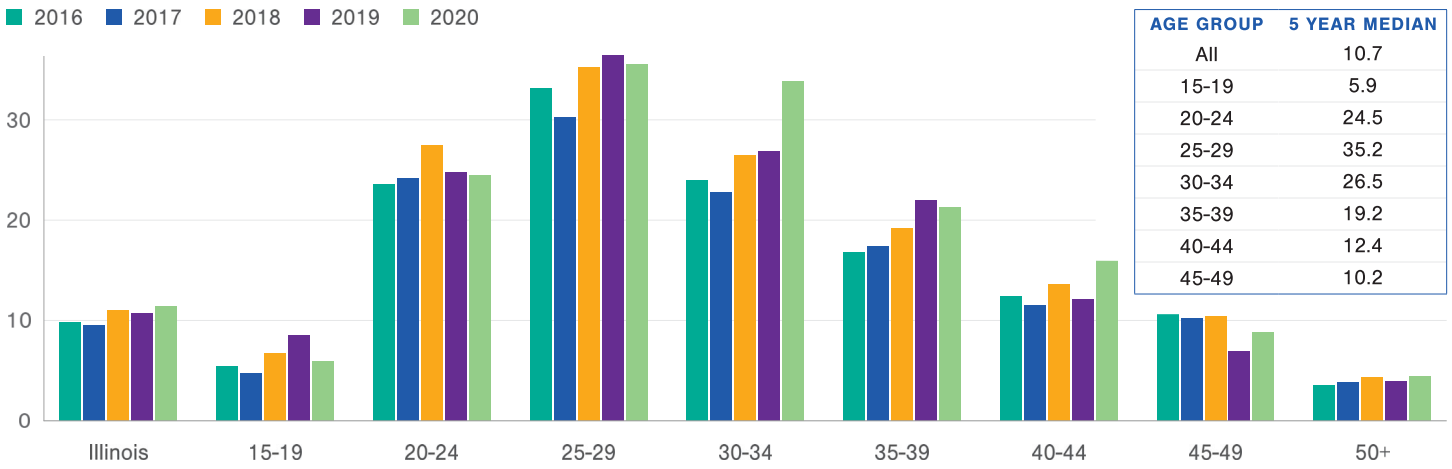
Rates by age group for the period had the 25- to 29-year-old age group with the highest rate of 35.2 per 100,000, followed by the 30- to 34-year-old age group (26.5 per 100,000). The older group saw an increase in P&S syphilis in 2020, rising to 33.8 per 100,000.

Primary and Secondary Syphilis – Rate per 100,000 Population – Illinois and by Race/ Ethnicity (2016–2020)



Source: IDPH 2022

Primary and Secondary Syphilis – Rate per 100,000 Population – Illinois and by Age Group (2016–2020)



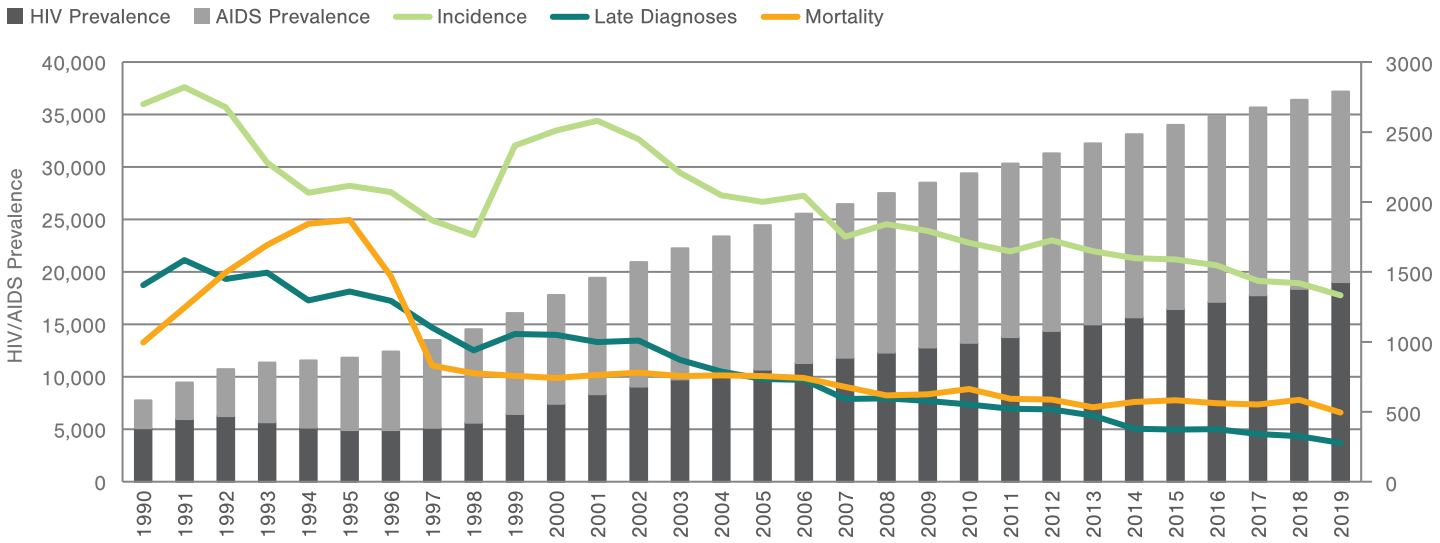
AGE GROUP	5 YEAR MEDIAN
All	10.7
15-19	5.9
20-24	24.5
25-29	35.2
30-34	26.5
35-39	19.2
40-44	12.4
45-49	10.2

Source: IDPH 2022

HIV and AIDS: HIV Diagnosis Over Time

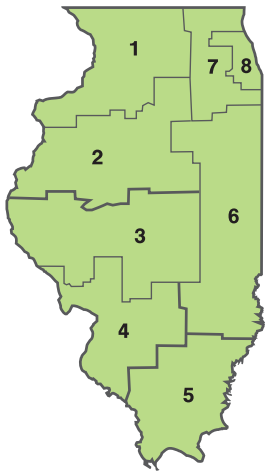
HIV incidence and mortality continue to decline while HIV and AIDS prevalence continues to rise as more people live with HIV and AIDS diagnosis.

HIV Diagnosis Over Time – Illinois (1990–2019)



HIV surveillance data for Illinois for 2010 to 2019 identified the following trends:

- HIV Diagnoses by Geographic Region
- Statewide HIV diagnoses are down 16% with an estimated annual percent change (APC) of -4.3.
- Chicago HIV diagnoses are down 26% (APC[2] = -9.1).
- Region 1 diagnoses are down 25% (APC[3] = -2.5).
- Region 4 diagnoses are down 24% (APC[3] = -6.1).
- Region 6 diagnoses are down 30% (APC[3] = -3.9).



HIV Diagnoses by Sex, Race/Ethnicity, and Age at Diagnosis

- Black Males 20-24 years of age – diagnoses are down 36% (APC = -8.82).
- Black Males 60+ years of age – diagnoses are up 35% (APC = 6.44).
- Black Females 30-39 years of age – diagnoses down 57% (APC – -4.45).
- Hispanic/Latino Females 40-49 years of age – diagnoses are down 41% (APC = -7.67).
- White Males 40-49 years of age – diagnoses down 67% (APC = -9.90).
- White Females 40-49 years of age ¯ diagnoses are down 77% (APC[1] = -15.7).

APC= estimated annual percent change

[1]2015-2019 APC, [2]2016-2019 APC, [3]2010-2019 APC

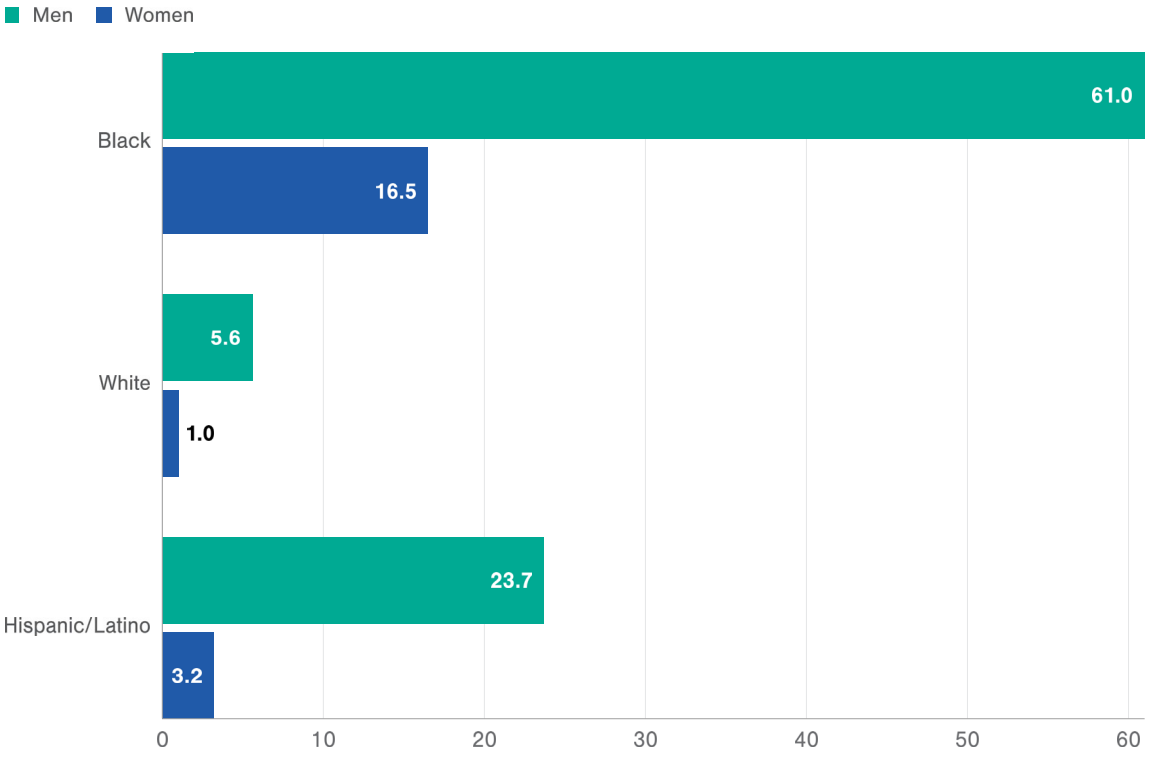
Sources: Illinois Department of Public Health, HIV Surveillance Unit, data as of December 2020.

HIV and AIDS: New HIV Diagnosis by Sex

Disparities by race and sex are dramatic in newly diagnosed HIV cases. In 2019, new HIV diagnosis data for males by race/ethnicity showed the HIV diagnosis rate among Black/African American males (61.0 per 100,000) was nearly 11 times that of White males (5.6 per 100,000) and 2.5 times higher than Hispanic males (23.7 per 100,000).

Among females in 2019, the HIV diagnosis rate for Black/African Americans (16.5 per 100,000) was more than 16 times the rate for Whites (1.0 per 100.000). Hispanic females had a diagnosis rate of 3.2 per 100,000, which was three times greater than the rate for white females, but five times lower than the rate for Black/African American females.

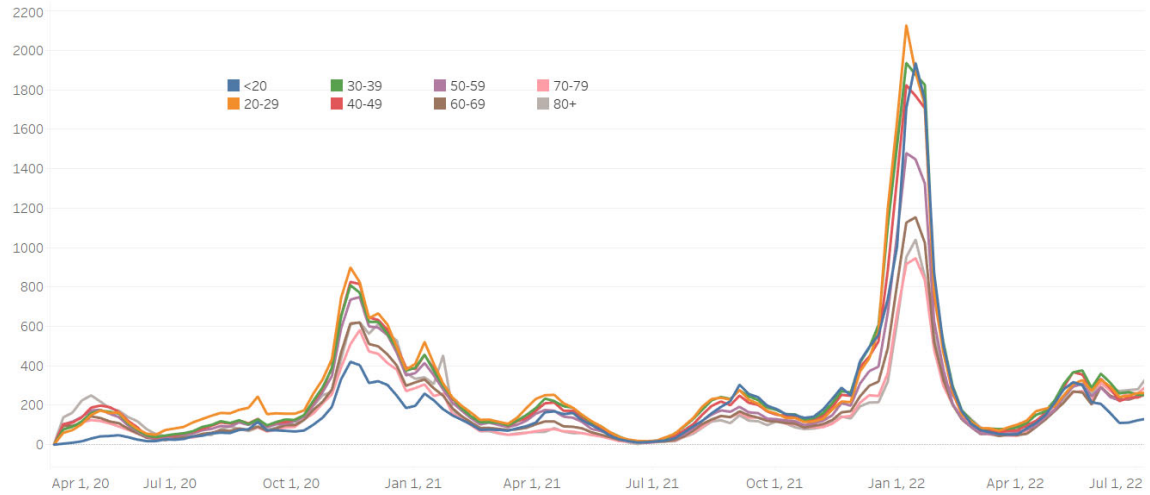
HIV Diagnosis – Rate by Sex, Race/Ethnicity (2019)



Sources: Illinois Department of Public Health, HIV Surveillance Unit, data as of December 2020.

COVID-19 Pandemic in Illinois

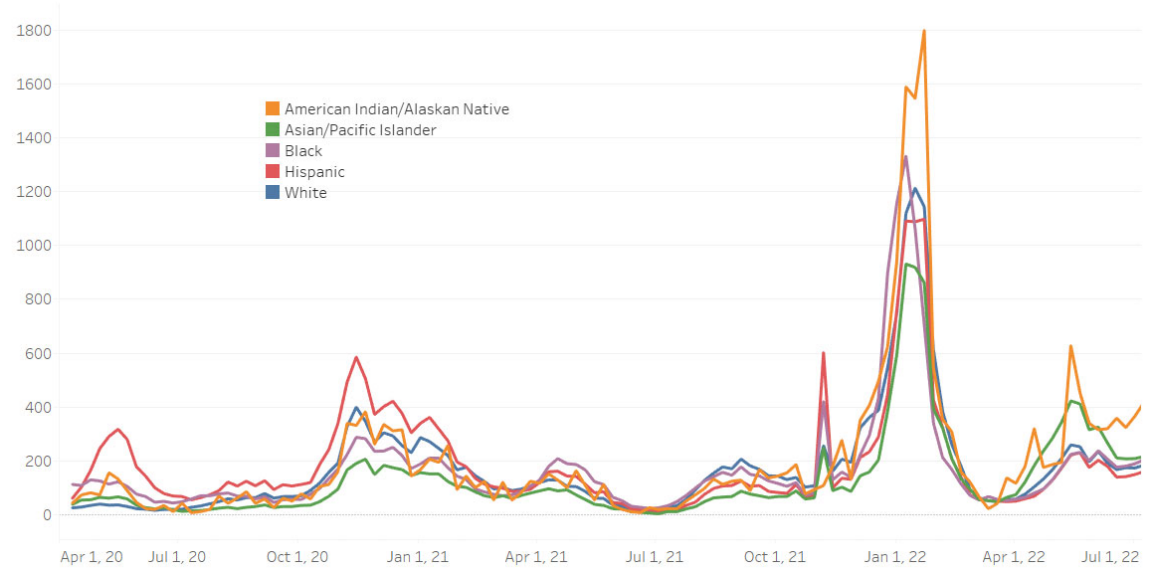
Illinois COVID-19 Case Rates per 100,000 Population, by Age Group (Mar 2020–Jun 2022)



Source: IDPH 2022

For most of the COVID-19 pandemic, the case rate was highest in younger adult age groups (20-29, 30-39, and 40-49). At the beginning of the pandemic, the oldest age group (80+) had the highest case rate. In the second half of 2021, those younger than 20 years of age experienced a higher case rate than previously reported.

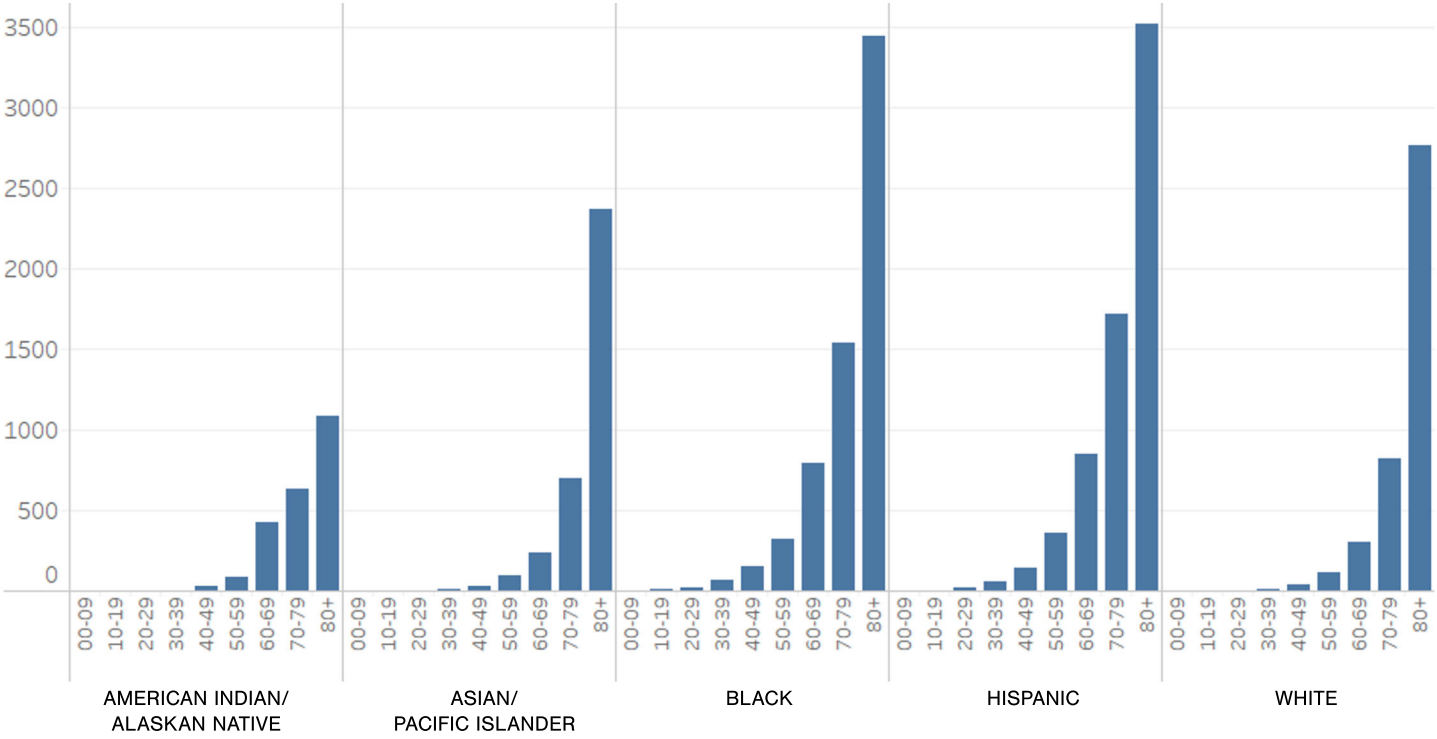
Illinois COVID-19 Case Rates per 100,000 Population, by Race/Ethnicity, (Mar 2020–Jun 2022)



Source: IDPH 2002

Trends in COVID-19 crude case rates by race/ethnicity depict the variations in population group incidence over the course of the pandemic period. Higher case rates were seen among Hispanic residents in the first year of the pandemic; while American Indian/Alaskan Natives (AIAN) had the highest case rates since late 2021.

Illinois COVID-19 Death Rates per 100,000 Population, by Age and Race/Ethnicity (Mar 2020–Jun 2022)



Source: IDPH 2022

Patterns in age-specific mortality rates for COVID-19 revealed disparities in death rates by age. The highest mortality throughout the pandemic period was seen among older residents. Persons 80 years of age and older had mortality rates multiple times higher than other groups. This was followed by elevated mortality rates among those 70 to 79 years of age. These patterns highlight the elevated risk of death due to COVID-19 among older residents. Younger groups showed much lower mortality rates. Hispanic and Black/African American residents experienced higher death rates in each age group than those of other races/ethnicities.

16 References

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Williams, D. R., Lawrence, J. A., & Davis, B. A. (2019). Racism and Health: Evidence and Needed Research. Annual Review of Public Health, 40(1), 105–125. https://doi.org/10.1146/annurev-publhealth-040218-043750

References: Core Indicator Summary – U.S. and HP2030 Comparative Measures

INDICATOR	MEASURE	US*	HP2030	REFERENCE
Social Determinants of Health				
High School Diploma	Percent	28.1% (2019)		https://www.census.gov/data/tables/2019/demo/educational-attainment/cps-detailed-tables.html
Bachelor's Degree	Percent	22.5% (2019)		https://www.census.gov/data/tables/2019/demo/educational-attainment/cps-detailed-tables.html
Median Income	Annual Household	$69,560 (2019)		https://www.census.gov/library/publications/2021/demo/p60-273.html
Population Living in Poverty	Percent	10.5%		https://www.census.gov/library/publications/2021/demo/p60-273.html
Unemployment	Percent	3.6% (2019)		https://www.bls.gov/cps/
Homeless Population	Count	580,466		https://www.hud.gov/sites/dfiles/CFO/documents/FY2021HUDAnnualPerformanceReport.pdf
Medicaid Adults	Percent	14.7% (2016-2020)		https://data.census.gov/cedsci/table?t=Health%20Insurance&tid=ACSST5Y2020.S2704
Medicaid Children	Percent	39.7% (2016-2020)		https://data.census.gov/cedsci/table?t=Health%20Insurance&tid=ACSST5Y2020.S2704
Non-English Primary Language	Percent	21.5%		https://www.census.gov/acs/www/about/why-we-ask-each-question/language/
Less than Well English Fluency	Percent	8.2%		https://www.census.gov/library/visualizations/interactive/people-that-speak-english-less-than-very-well.html
Homicide Mortality	Age-Adjusted Rate per 100,000	6.0	5.5	https://health.gov/healthypeople
Firearms Mortality	Age-Adjusted Rate per 100,000	13.6 (2020)		https://www.kff.org/other/state-indicator/firearms-death-rate-by-sex/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
Mortality Indicators				
Life Expectancy at Birth	Years	77.0	78.6	https://health.gov/healthypeople
Life Expectancy at Age 65 years	Years	19.6		https://www.cdc.gov/nchs/products/databriefs/db427.htm
Premature Death – Years of Potential Life Lost <75 years	Cumulative Years	6968.6 (2016)		https://www.cdc.gov/nchs/data/hus/2017/018.pdf
Mortality – Diseases of the Heart	Age-Adjusted Rate per 100,000	211.5		https://www.cdc.gov/nchs/fastats/heart-disease.htm
Mortality – Ischemic Heart Disease	Age-Adjusted Rate per 100,000	88.0	71.1	https://health.gov/healthypeople
Mortality – Malignant Neoplasms	Age-Adjusted Rate per 100,000	146.2	122.7	https://health.gov/healthypeople

INDICATOR	MEASURE	US*	HP2030	REFERENCE
Mortality – Female Breast Cancer	Age-Adjusted Rate per 100,000	19.4		https://www.cdc.gov/mmwr/volumes/70/wr/mm7039a6.htm#:~:text=In%202019%2C%20the%20age%2Dadjusted,was%2019.4%20per%20100%2C000%20population.
Mortality – Prostate Cancer	Age-Adjusted Rate per 100,000	18.0		https://www.cdc.gov/cancer/uscs/about/stat-bites/stat-bite-prostate.htm
Mortality – Lung Cancer	Age-Adjusted Rate per 100,000	34.8		https://www.cdc.gov/mmwr/volumes/69/wr/mm6936a8.htm
Mortality – COVID-19	Age-Adjusted Rate per 100,000	91.5		https://www.cdc.gov/mmwr/volumes/70/wr/mm7014e1.htm
Mortality – Accidents	Age-Adjusted Rate per 100,000	49.3 (2019)		https://www.cdc.gov/nchs/data/hus/2020-2021/SlctMort.pdf
Mortality – Cerebrovascular Disease (Stroke)	Age-Adjusted Rate per 100,000	37.0	33.4	https://health.gov/healthypeople
Mortality – Alzheimer's Disease	Age-Adjusted Rate per 100,000	32.4		https://www.cdc.gov/nchs/data/databriefs/db427.pdf
Mortality – Diabetes Mellitus	Age-Adjusted Rate per 100,000	24.8 (2020)		https://www.cdc.gov/nchs/data/databriefs/db427.pdf
Mortality – Kidney Diseases	Age-Adjusted Rate per 100,000	12.9		https://www.cdc.gov/nchs/products/databriefs/db427.htm
Mortality – Influenza and Pneumonia	Age-Adjusted Rate per 100,000	12.3		https://www.cdc.gov/nchs/products/databriefs/db427.htm
Motor Vehicle Crash Mortality	Age-Adjusted Rate per 100,000	11.1		https://www.cdc.gov/mmwr/volumes/70/wr/mm7011a4.htm
Maternal and Child Health				
Infant Mortality	1000 live births	5.8 (2017)	5.0	https://health.gov/healthypeople
Preterm Births (< 37 weeks)	Percent	10.1% (2020)		https://www.cdc.gov/reproductivehealth/features/premature-birth/index.html
Low Birthweight Births	Percent	8.2% (2020)		https://www.cdc.gov/nchs/fastats/birthweight.htm
Adequate Prenatal Care	Percent	76.7%	80.5%	https://health.gov/healthypeople
Maternal Mortality (Defines as HP2030)	100,000 live births	17.4	15.7	https://health.gov/healthypeople
Breastfeeding Prevalence	Percent	83.2%		https://www.cdc.gov/breastfeeding/data/facts.html
Teen Birth Rate	Birth Rate per 1000 Female Population	16.7		https://www.cdc.gov/teenpregnancy/about/index.htm
Immunization Coverage Age 24 months – 7 vaccine series	Percent	69.7%		https://www.cdc.gov/nchs/fastats/immunize.htm

INDICATOR	MEASURE	US*	HP2030	REFERENCE
Childhood Lead Poisoning Prevalence (>5 mg/dl)	Percent	2.6%		https://www.cdc.gov/nceh/lead/docs/cbls-national-data-table-508.pdf
Chronic Disease and Conditions				
Prevalence of Adults Living with a Chronic Condition	Percent	51.8% (2018)		https://www.cdc.gov/pcd/issues/2020/20_0130.htm
Arthritis Prevalence	Percent	25.6%		https://www.cdc.gov/brfss/brfssprevalence/index.html
Disability Prevalence	Percent	26.0%		https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html#:~:text=61%20million%20adults%20in%20the,have%20some%20type%20of%20disability.
Diabetes Prevalence	Percent	10.8%		https://www.cdc.gov/brfss/brfssprevalence/index.html
Asthma Prevalence	Percent	9.5%		https://www.cdc.gov/brfss/brfssprevalence/index.html
Obesity Prevalence	Percent	34.9%		https://www.cdc.gov/brfss/brfssprevalence/index.html
Hypertension Prevalence	Percent	31.8%		https://www.cdc.gov/brfss/brfssprevalence/index.html
High Cholesterol Prevalence	Percent	33.6%		https://www.cdc.gov/brfss/brfssprevalence/index.html
Behavioral and Mental Health				
Drug Overdose Mortality	Age-Adjusted Rate per 100,000	28.3 (2020)		https://www.cdc.gov/drugoverdose/deaths/index.html
Opioid Mortality	Age-Adjusted Rate per 100,000	16.6		https://www.kff.org/other/state-indicator/opioid-overdose-death-rates/?currentTimeframe=1&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
Substance Misuse Emergency Department Visit Rate	Rate per 10,000	14.7 (Opioids)		https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP22-07-03-001.pdf
Alcohol Misuse Emergency Department Visit Rate	Rate per 10,000	39.3 (2021)		NA
Marijuana Use	Percent	18.0% (2019)		https://www.cdc.gov/marijuana/data-statistics.htm#:~:text=Marijuana%20is%20the%20most%20commonly,at%20least%20once%20in%202019.
Binge Drinking	Percent	16.0%	15.7%	https://nccd.cdc.gov/BRFSSPrevalence
Tobacco Use Prevalence	Percent	12.5% (2020)		https://www.cdc.gov/media/releases/2022/p0318-US-tobacco-use.html#:~:text=This%20study%20shows%20that%20adult,reported%20smoking%20cigarettes%20in%202020.
Suicide Mortality	Age-Adjusted Rate per 100,000	13.9	12.8	https://health.gov/healthypeople
Poor Mental Health Prevalence	Percent	12.8% (2020)		https://www.kff.org/other/state-indicator/poor-mental-health-among-adults-days-per-month/?currentTimeframe=1&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

INDICATOR	MEASURE	US*	HP2030	REFERENCE
Depression Prevalence	Percent	18.5%		https://www.cdc.gov/nchs/products/databriefs/db379.htm#:~:text=During%202019%2C%20approximately%20one%20in,and%202.8%25%20experiencing%20severe%20symptoms.
Access to Healthcare				
No personal doctor or health care provider	Percent	20.1%		https://www.kff.org/other/state-indicator/percent-of-adults-reporting-not-having-a-personal-doctor-by-sex/?currentTimeframe=3&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D,%
Diabetes Emergency Department Visit Rate	Rate per 10,000	NA		NA
Hypertension Emergency Department Visit Rate	Rate per 10,000	29.5	27.7	https://health.gov/healthypeople
Asthma Emergency Department Visit Rate	Rate per 1,000	54.9 (2013-2015)	44.0	https://health.gov/healthypeople
Ambulatory Care Sensitive Emergency Department. Visit Rate	Per 10,000	NA		NA
Communicable Diseases				
Chlamydia Incidence Rate	Rate Per 100,000	481.3 (2020)		https://www.cdc.gov/std/statistics/2020/2020-SR-4-10-2023.pdf
Gonorrhea Incidence Rate	Rate Per 100,000	206.5 (2020)		https://www.cdc.gov/std/statistics/2020/2020-SR-4-10-2023.pdf
Primary and Secondary Syphilis Incidence Rate	Rate per 100,000	12.7 (2020)		https://www.cdc.gov/std/statistics/2020/2020-SR-4-10-2023.pdf
HIV Diagnosis Rate	Rate Per 100,000	12.6 (2019)		https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics
AIDS Prevalence	Rate Per 100,000	162.3		https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics
COVID-19 Mortality Rate	Rate per 100,000	91.5		https://www.cdc.gov/mmwr/volumes/70/wr/mm7014e1.htm