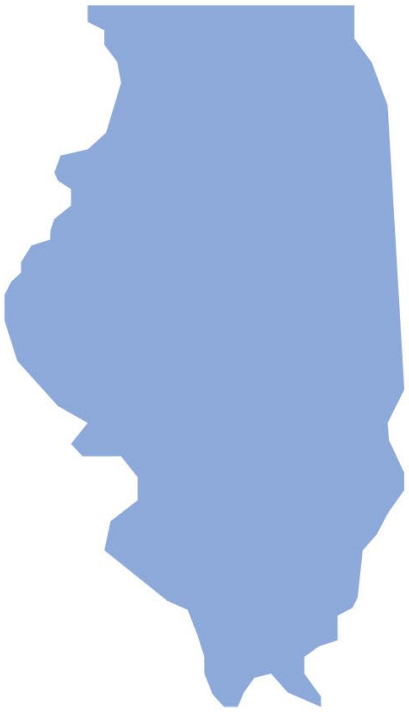
ANNUAL REPORT 2022

HEALTH IN ALL POLICIES

A REPORT TO THE
ILLINOIS GENERAL ASSEMBLY

Health in All Policies
Annual Report 2022



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UIC IDPH Illinois Department of Public Health

December 8, 2022

To the Honorable Members of the Illinois General Assembly:

It is our pleasure to share with you the first report of the Health in All Policies Workgroup, a cross-sector partnership of 22 state and non-state agencies co-led by the Illinois Department of Public Health (IDPH) and the University of Illinois Chicago School of Public Health (UIC SPH), in compliance with the requirements set forth in Health in All Policies Act ("The Act" (410 ILCS 155/10(a) thru 155/10(i)).

Effective January 1, 2020, the act centers our work on the development, adoption, and implementation of a Health in All Policies (HiAP) Framework to serve as a process through which policymakers and stakeholders in the public and private sectors use a cross-sector collaborative approach to improve health outcomes and reduce health inequities for the residents of the state of Illinois by incorporating health considerations into decision-making and policy.

A legislative change was pursued to extend the submission deadline of the first workgroup report (initial due date: December 31, 2020) in light of competing commitments related to the response to the COVID-19 pandemic and other emerging public health threats. Public Act 102-1071 was approved by Gov. JB Pritzker on June 10, 2022, to extend the report deadline to December 31, 2022, and our workgroup officially convened with meetings in September and November.

The focus selected for this year's report is social justice and health. In our work over the last few years to mitigate health threats both related to and compounded by COVID-19 and other emerging diseases, we've had to face the manifestations of historic systemic and structural injustice and disproportionate impacts to the health, well-being, and mortality of communities across the state. This act presents a timely opportunity to explore innovative ways to use our collective voices, power, and action to foster a system-wide culture of health and address the forces that underlie health inequities.

We want to take this opportunity to thank the members of the workgroup for their cooperation and commitment, and hereby respectfully submit the Health in all Policies December 31, 2022, report.

Sincerely,

Sameer Vohra, MD, JD, MA
Director
Illinois Department of Public Health

Wayne H. Giles, MD, MS
Dean and Professor
UIC School of Public Health

cc: Illinois Department of Public Health
cc: Illinois Board of Health

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Statement of Purpose

The Health in All Policies Workgroup was convened in accordance with the mandate set forth in the Health In All Policies Act (410 ILCS 155/10(a) thru 155/10(i)). Full agency membership of the workgroup is located in the appendix. This workgroup is required to:

1. Review legislation and make new policy recommendations relating to the health of residents of the state.

2. Examine the following:
   - The health of the residents of the state.
   - Ways for units of local government and state agencies to collaborate in implementing policies that will positively impact residents' health.
   - The impact of the following on the health of the state's residents (herein referred to as "areas of impact"):
     (A) Access to safe and affordable housing.
     (B) Educational attainment.
     (C) Opportunities for employment.
     (D) Economic stability.
     (E) Inclusion, diversity, and equity in the workplace.
     (F) Barriers to career success and promotion in the workplace.
     (G) Access to transportation and mobility.
     (H) Social justice.
     (I) Environmental factors.
     (J) Public safety, including the impact of crime, citizen unrest, the criminal justice system, and governmental policies that affect individuals who are in prison or released from prison.

3. Use a public health framework as defined in the act to:
   - Review and make recommendations regarding how health considerations may be incorporated into the decision-making processes of government agencies and private stakeholders who interact with government agencies.
   - Foster collaboration among units of local government and state agencies.
   - Develop laws and policies to improve health and to reduce health inequities.
   - Make recommendations regarding how to implement laws and policies to improve health and to reduce health inequities.

4. Meet at least twice a year and at other times as deemed appropriate.

5. Prepare a report that summarizes its work and makes recommendations resulting from its study.

6. Determine an annual focus area for the report.

7. Submit an annual report of findings and recommendations to the General Assembly by December 31, as well as to the Illinois Department of Public Health and the Board of Health.

Executive Summary
410 ILCS 155/10(a) thru 155/10(i))
Health in All Policies Workgroup
December 31, 2022, Report

410 ILCS 155/5 Legislation
The University of Illinois Chicago School of Public Health, in consultation with the Illinois Department of Public Health, shall convene a workgroup to review legislation and make new policy recommendations relating to the health of residents of the state. (The 410 ILCS 155/10)

Recommendations
The 410 ILCS 155/ Health in All Policies (HiAP) Workgroup respectfully submits the following recommendations for the General Assembly's consideration:

1. Develop and implement a process for providing technical assistance on the evaluation and incorporation of health in future legislation and policies.
2. Develop appropriate tools to measure health impact.
3. Appropriate funding annually for the implementation of HiAP activities.

Additional recommendations are also included to advance health justice and identify opportunities for collaboration and policy intervention specific to behavioral health, maternal and child health, and chronic disease.

Health in All Policies Framework
A "health in all policies framework" means a public health framework through which policymakers and stakeholders in the public and private sectors use a collaborative approach to improve health outcomes and reduce health inequities in the state by incorporating health considerations into decision-making across sectors and policy areas. (410 ILCS 155/5).

Health in All Policies Principles
1. Promote health, equity, and sustainability
2. Enhance cross-sector collaboration
3. Benefit multiple partners
4. Engage stakeholders
5. Create structural and procedural change

Workgroup Process
The workgroup met twice (September – November 2022) to learn from subject matter experts (SMEs) and to develop its workplan. Through individual team discussion, phone interviews, and an examination of potential policy opportunities tied to the State Health Assessment (SHA) and the State Health Improvement Plan (SHIP), the workgroup generated its recommendations.

Health in All Policies in Other States
Illinois is among the few states (including California, Maryland, Massachusetts, and Vermont), that are implementing HiAP as a result of a formal mandate with requirements for collaboration between state governmental agencies.

Background

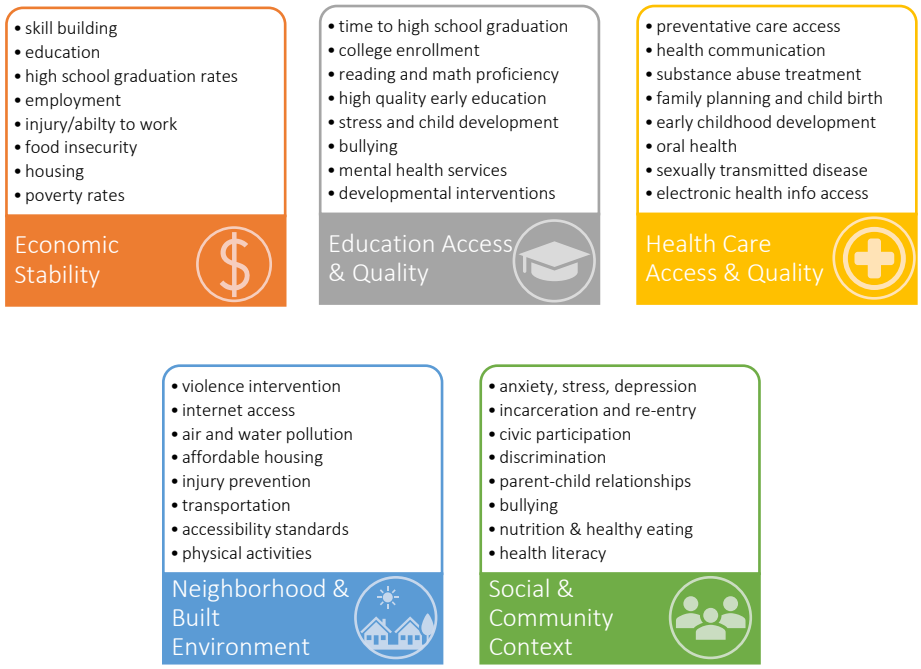
In 1948, the World Health Organization expanded its definition of health beyond the mere absence of disease or infirmity to a state of complete physical, mental, and social well-being.[18] Although health is deemed a fundamental human right, increasing evidence shows that while our nation has made strides over the last century in improving the health and longevity of the population, not everyone has a fair chance of attaining the highest level of health.[13]

Health equity means that everyone has an equal opportunity to obtain optimal health. To achieve health equity, our policies, systems, and social structures must work together to ensure people have access to the basic needs and conditions that enable health, such as healthy food, a living wage, affordable housing, quality education, access to health care, and safety.[15] These and other factors, often referred to as **structural and social determinants of health (SSDOH),** impact a person's health well before they need to see a health care professional, and are among the root causes of health inequities and disparities.

Healthy People 2030, the nation's public health priorities as identified by the U.S. Department of Health and Human Services, groups social and structural determinants into 5 domains[8]

Adapted from Healthy People 2030, Social Determinants of Health

The themes called out in Healthy People 2030 priorities and objectives are summarized in the graphic below to illustrate the ways social and structural determinants of health show up in our daily lives.



What is Health in All Policies?

Good health outcomes are not driven solely by policies and practices within the health sector. They are most enabled by policies that shape the environments where people are born, live, learn, work, play, worship, and age everyday.[8] Health in All Policies (HiAP) is grounded in the fundamental understanding that different sectors, such as agriculture, economy, education, environment, housing, justice, and transportation, must work together to actively support the development, advocacy, and implementation of policies that help ensure all people have the opportunity to achieve the highest level of health. The Association for State and Territorial Health Officials (ASTHO) states:

> *"The HiAP approach addresses the complexity of health inequities and improves population health, systematically incorporating health considerations into decision-making processes across sectors and at all government levels, and shared planning and assessment between government, community-based organizations, and often businesses. In sum, 'all policy is health policy.'"*[1]

HEALTH IN ALL POLICIES DEFINED

"Health in All Policies (HiAP) is a collaborative approach that integrates and articulates health considerations into policymaking across sectors to improve the health of all communities and people. HiAP recognizes that health is created by a multitude of factors beyond health care and, in many cases, beyond the scope of traditional public health activities."
~Centers for Disease Control and Prevention[6]

The concept of Health in All Policies was first introduced in 1978 in the World Health Organization Declaration of Alma-Ata with a formal acknowledgment of the importance of intersectoral action for health. HiAP efforts in the U.S. began with the Health in All Policies Taskforce in 2010 in California and have been implemented since then in varying forms across the country at federal, state, county, and city levels.[16] A 2018 ASTHO report on the state of HiAP in the U.S. included California, Connecticut, Massachusetts, Minnesota, North Carolina, Oklahoma, Oregon, Tennessee, and Vermont among states that have implemented state-level HiAP efforts. Illinois is now among the few states (including California, Maryland, Massachusetts, and Vermont), that are implementing HiAP as a result of a formal mandate with requirements for collaboration between state government agencies.[3]

There is no one way to implement health in all policies. Several frameworks and resources exist upon which agencies across sectors might build their approaches, including:

- American Public Health Association | Health in All Policies: A Guide for State and Local Governments[16]
- Association for State and Territorial Health Officials | Health in All Policies: A Framework for State Health Leadership[1]
- Centers for Disease Control and Prevention | Health in All Policies[6]
- ChangeLab Solutions | From Start to Finish: Health in All Policies[7]
- National Association of County and City Health Officials | HiAP Resource Page[12]
- World Health Organization | Health in All Policies Training Manual[19]

Each framework generally references the 5 Key Principles of Health in All Policies[16]:

The Illinois Health in All Policies Workgroup consists of leaders from 22 state and non-state cross-sector agencies. While traditional representation from public health practice, health care, policy, and public health science and education exists on the workgroup, here we illustrate where other member organization sectors and their respective missions intersect to address the structural and social determinants of health.

The food people consume as part of their diets contributes to chronic conditions, such as obesity, diabetes, and hypertension. Agriculture also ensures access to materials for shelter and creates jobs in low-income communities.[2]

Members: Illinois Department of Agriculture, Illinois Department of Human Services

Wage stagnation and the declining value of the minimum wage have been linked to increased health inequities. Health disparities contribute to hundreds of billions of dollars in direct and indirect costs. Health care is projected to represent over 20% of the economy by 2025.[2]

Members: Illinois Department of Commerce and Economic Opportunity, Illinois Department of Labor

Each year of education completed beyond high school is associated with higher earnings, access to jobs with health care benefits and paid leave, reduced stress, better social skills and networks, increased life expectancy, and health behaviors.[2]

Members: Illinois State Board of Education

Air pollution, poor drinking and recreational water, toxic and hazardous chemicals, and inadequate heating and sanitation pose clear risks to human health, while positive changes in the physical environment, such as sidewalks and parks, can improve health.[2]

Members: Illinois Environmental Protection Agency

Access to safe, stable, affordable housing decreases risk for disease, offers shelter from weather extremes, and improves emotional and behavioral health and access to key social services.[2]

Members: Illinois Department of Human Services

A record of incarceration can limit access to government services which impact socioeconomic status and health. Unmet health needs of children and adolescents in foster care are compounded by poor access to mental and health care services.[2] Youth in foster care with five or more moves are more likely to become involved in the juvenile justice system.[14]

Members: Illinois Criminal Justice Information Authority, Illinois Department of Corrections, Illinois Department of Healthcare and Family Services

Public transportation enables access to health care and other services, improves people's ability to commute to work, and lowers air pollution that can cause health problems. Affordable public transit reduces social isolation for the elderly and disabled.[2]

Members: Illinois Department of Transportation

Adapted from ASTHO's Introduction to Multi-Sector Intersections and Collaborations to Advance Health Equity.[2]

Through the Lens of Social Justice

> *Social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death.*
>
> *~World Health Organization, 2008*[17]

Of the 10 areas of impact cited in the Health in All Policies legislation, social justice was selected by the workgroup as this year's report focus via a prioritization poll based on interest level and perceived impact to health.

The New Oxford American Dictionary defines social justice as "*justice in terms of the distribution of wealth, opportunities, and privileges within a society."* However, there are no widely accepted standard definitions for social justice within the context of health. Workgroup members generally agree that concepts of social justice and health equity are very closely connected, citing a range of relationships from "symbiotic" to "synonymous." Recognizing that one's definition of "social justice" is subject to their experience, the following context statement summarizes key terms and concepts shared by the HiAP Workgroup on the advancement of social justice through its ongoing work:

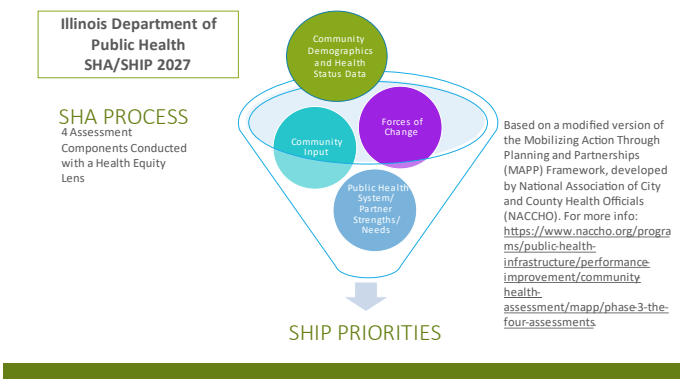
> *Social justice enables personal agency, restores human dignity, and creates equal and equitable access to optimal holistic health and well-being regardless of race, ethnicity, socioeconomic status, geographic origin/location, sex, gender identity, sexual orientation, religion, language, ability, age, or other socially defined group. It means being free to call out unfair treatment and disproportional impacts to one's health and demand reform without fear of being socially or economically disenfranchised, marginalized, or excluded. Without acknowledging historic injustices and removing resultant systemic barriers to addressing structural and social determinants of health, health equity cannot be achieved.*

This report summarizes the progress and findings of the Health in All Policies Workgroup to date with a focus on social justice.

Workgroup Approach

Alignment with Statewide Health Efforts

As described in our statement of purpose, the HiAP Workgroup is required to examine the health of the residents of the state, the impact of areas outlined in the mandate, and ways to collaborate to implement health policy. The University of Illinois School of Public Health (UIC SPH), Illinois Department of Public Health (IDPH), and Illinois Public Health Institute (IPHI) are long-time leading partners in the development of the State Health Assessment (SHA) and State Health Improvement Plan (SHIP).



The SHA is a systematic approach to collecting, analyzing, and using data to educate and mobilize communities, develop priorities, garner resources, and plan actions to improve the public's health.[9]

The SHIP/Healthy Illinois 2021 is a long-term systematic plan to address issues identified in the SHA. It describes how the state health department and the communities it serves will work together to improve the health of the population.[10]

A summarized update to the 2016-2021 SHA/SHIP reports is located here: https://dph.illinois.gov/content/dam/soi/en/web/idph/files/publications/updated-shaship-summary-report.pdf

A comprehensive, equity driven SHA/SHIP that includes data-driven strategic priorities to advance health equity in Illinois is in progress for 2022-2027, focusing on the drivers of disparities, rather than disparities alone. Revised priorities of the SHA/SHIP retain behavioral health, chronic disease, and maternal and child health as priorities and add emerging diseases and racism as public health issues.

Our mandate also requires that our recommendations inform the SHIP every five years. With more than 400 engaged stakeholders, the SHA and SHIP are the most comprehensive health assessment and improvement efforts conducted on health in the state. To minimize duplication of effort, to leverage overlap in leadership across the HiAP Workgroup and SHA/SHIP, and to ensure bidirectional feedback and response between efforts, the HiAP examination and intervention requirements will be satisfied through alignment with SHA/SHIP findings and priorities to the greatest extent possible.

Meetings and Communications

The Health in All Polices Workgroup held two meetings in 2022 as minimally required by the act. Meetings were facilitated to encourage member engagement, included presentations from subject matter experts and guests from organizations that have executed health in all policies work (Chicago Department of Public Health and University of Maryland), and offered opportunities for open discussion and reflection. Meeting minutes and agendas are located in the appendix. Meeting objectives are summarized below:

Meeting 1 Objectives September 1, 2022	Meeting 2 Objectives November 18, 2022
•Member introductions. •Orientation to the HiAP legislation.. •Review SHA/SHIP data. •Initiate work approach development. •Discuss and vote on areas of focus.	•Discuss workgroup mission and structure. •Annual report outline review. •Identify opportunities for collaboration related to social justice. •Discuss indicators for success and potential opportunities for policy intervention.

Phone Interviews

Seventeen 30-minute phone interviews were conducted across 15 workgroup agencies from October 27-November 15, 2022, to collect member perspectives between meetings to inform the workgroup's framework development. The full questionnaire is located in the appendix.

PHONE INTERVIEW QUESTIONS

- How do you define social justice?
- How is your agency addressing matters of social justice and/or health equity?
- What has worked well/not worked well in your experiences with cross-sector collaboration and communication?
- What approaches have you used that worked well/didn't work well in getting policy makers and stakeholders to consider and incorporate your org's priorities in their decision making?

Interview outcomes will help to:

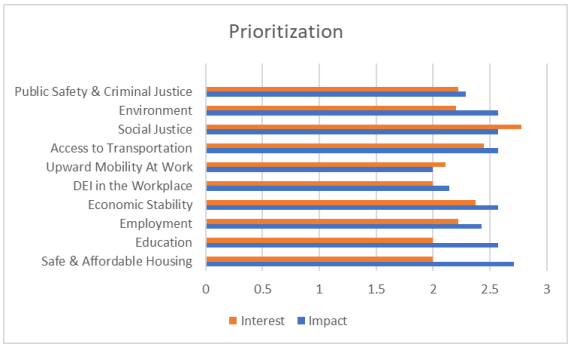
- Synthesize standard workgroup definitions, guiding statements, and frameworks.
- Map current, planned, and potential cross-sector efforts to advance health equity.
- Define indicators of HiAP success.
- Identify preferred characteristics of an HiAP framework.
- Identify barriers and approaches to collaboration and communication.
- Assess opportunities and resources for leadership and agency development and support.

Selecting an Area of Focus

To determine the area of focus for this year's report and prioritize areas for future work, workgroup members were polled during the September 1st meeting to rate each of the 10 areas of impact on a scale of 1-3 based on their level interest and perceived degree of impact to health. The following questions were asked:

1. What is our interest (based on your or org's institutional knowledge and mission alignment)? (1=I need more information; 2=I can work with this if selected; 3=I'm interested in this)

2. What is the level of impact to the health of the residents of Illinois? (known or perceived) (1=low; 2=medium; high=3)



Among nine members polled, social justice received the highest composite score on interest and perceived impact to health compared to other areas of impact. The selection of this topic is consistent with the focus of the SHA/SHIP and health improvement plans across the nation to address health inequities tied to historical injustice, racism, and discrimination. General agreement with the election of social justice as the area of focus among members of the group who did not participate in the poll was generated in phone interviews and in the November meeting. Areas that scored lower in either interest or perceived impact to health have been marked for further examination and as potential opportunities for leadership development.

Literature Review

The impacts of social justice to health were explored in a literature review to set the foundation for future HiAP work. The approach was to:

1. Identify definitions for key terms, such as social justice, determinants of health, health equity, health disparities, and health inequities.

2. Explore health disparities related to socioeconomic well-being, race/ethnicity, gender, immigrant status, disability, and structural and social determinants of health.

3. Ground the examination in the priorities outlined in the SHA/SHIP – behavioral health, maternal and child health, chronic disease, racism as a public health issue, and emerging diseases.

The complete literature review is located in the appendix and highlights are discussed in our examination findings.

Workgroup Examination Findings

Social and Structural Drivers of Health Inequities

At the September 1, 2022 workgroup meeting, UIC SPH presented on the Community Health Status Assessment (CHSA). The CHSA is one of the four components of the SHA and identifies key health needs and issues through systematic, comprehensive data collection and analysis of 67 measures. The assessment will provide health outcome data on the Healthy 2027 health priorities which include Chronic Disease, Maternal and Child Health, Behavioral Health, and Emerging Diseases. The CHSA assessment presents these health outcomes and highlights SSDOH where possible identifying causes for the disparities and inequities beyond the behavioral risk factors. These non-medical and non-biological factors shape daily life and include forces and systems such as economic policies, social policies, and political systems. Addressing the SSDOH is fundamental for improving health and reducing longstanding health inequities.[17]

Preliminary findings of the CHSA shows that the common theme across many indicators is persistent disparity and inequity in health status by race/ethnicity with social determinants associated with lower income and opportunity – household income, educational attainment status and access to health services, and 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 in the CHSA. These include socioeconomic status, education, training, as well as racism.[20]

It is important to differentiate racism from individual prejudice or perspectives. Structural racism refers to the overt or implicit application of programs, practices, policies, rules, and laws that unfairly disadvantage a group solely based on their perceived racial characteristics. As race is a social and not a biological construct, it is important to consider differences between group outcomes and risk factors not as functions of some biological shortcoming or deficit, but as the result of some long-term consequence of decisions, policies, and practices that have impacted the conditions and, in many cases, the choices individuals have available to them.

Continued alignment of outcomes with the underlying root causes such as racial and socioeconomic factors is needed to effectively monitor and inform efforts to address the disparities and inequities in health status among Illinois residents.

Literature Review Highlights

Definitions

Social justice in health presents itself through reducing and ultimately eliminating unjust and avoidable health inequities that result from policies and practices that create an unequal distribution of power, money, and resources among communities.[4]

Health equity is the principle that motivates us to increase opportunities to achieving good health, especially for those who lack access to health resources or have poorer health outcomes. Progress towards health equity is determined by measuring change in health disparities over time with the goal of eliminating disparities in health and its determinants.[5]

Health inequities are shaped by social structures and practices that promote the unfair distribution of wealth, power, and resources. These unfair distributions are often associated with racism and discrimination, resulting in health disparities by racial and ethnic minorities.

Acknowledging Historic Injustice

U.S. history of slavery, oppression, racism, and discrimination has left a legacy of racially biased and discriminatory laws, policies, and practices that contribute to health inequities and **structural racism**. Promoting health equity requires acknowledging historic injustices and removing resultant systemic barriers that produce health inequities and disparities.

SHA/SHIP Priority Areas

The 2021 SHA and SHIP identified three health priority areas: behavioral health, chronic disease, and maternal and child health. Social determinants of health affect health status across all three priority areas. Health disparities are also present across all three priority areas.

Behavioral Health

Nearly 15% of adults in Illinois experience more than one week of poor mental health in a month.[9]

The suicide rate among non-Hispanic Whites is more than twice as high as that of other groups.[10]

In 2014, men had a suicide rate four times greater than that of women.[10]

The rate of all drug poisoning deaths increased among women of reproductive age, reaching a 101% increase.[11]

The rate of infants born with neonatal abstinence syndrome (NAS) has also grown.[11]

Chronic Disease

1 in 3 Illinois adults are obese, with obesity defined according to the consensus cut point on the Body Mass Index (BMI). Approximately 2 of 5 non-Hispanic Black adults fell in this category.[9]

1 in 5 children in Illinois were obese, with approximately 1 in 3 non-Hispanic Black children falling in this category.[9]

1 in 6 adults in Illinois reported being current smokers. Approximately, 1 in 4 non-Hispanic Black adults reported smoking.[9]

Among pregnant women, approximately 10% report smoking while pregnant.[9]

Maternal and Child Health

Approximately 4 in 5 pregnant women in Illinois started prenatal care in the first trimester of pregnancy, but only two-thirds of non-Hispanic Black women have access to early prenatal care.[9]

Maternal mortality was six times higher among non-Hispanic Black women from 2015 to 2016.[11]

In 2018, Black infants were more than twice as likely to be born at a low birthweight than White infants. Black infant death rates were nearly three times higher compared to White infant death rates.[11]

Meeting Outcomes

Meeting 1 (9/1/22)

THE WORKGROUP DISCUSSED ITS APPROACH FOR THE 2022 ANNUAL REPORT

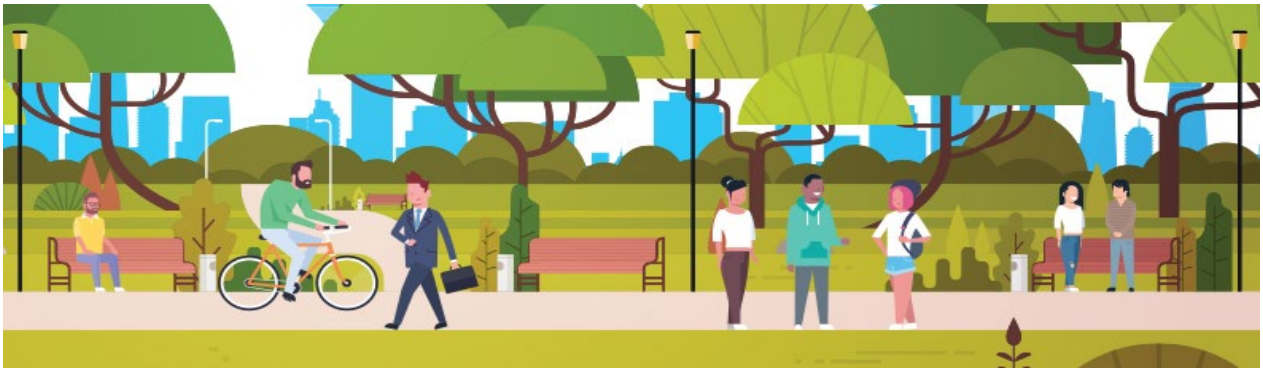
- Align HiAP work very closely with the SHA and SHIP/Healthy Illinois 2021.
- Elect social justice as the focus of the 2022 report to the General Assembly and conduct a literature review on the impact of social justice on health.
- Present the findings and work of the SHA/SHIP to satisfy the requirement to examine the health of the residents of Illinois and the impact of the areas defined in HiAP legislation (i.e., social determinants of health) on health as part of the 2022 report to the General Assembly.
- Provide September and November meeting proceedings as evidence of fulfilling meeting requirements and progress to date in the 2022 report to the General Assembly.
- Develop a plan to identify barriers to collaboration and communication across policymakers and cross-sector stakeholders in decision-making to improve health outcomes and reduce health inequities.

Meeting 2 (11/18/22)

THE WORKGROUP DISCUSSED THE CHARACTERISTICS OF A HEALTHY COMMUNITY

A healthy community is one that:

- Creates inclusive spaces where people from various backgrounds can come together on equal terms.
- Welcomes, affirms, and destigmatizes its members.
- Equitably distributes its resources and opportunities to ensure its members have fundamental access.
- Employs respectful and fair processes and produces outcomes that ensure justice.
- Provides support needed to ensure that community voices can be shared and are heard.
- Is designed around the people it serves.
- Comes together and helps its members regularly and in times of crisis.
- Ensures life sustaining wages and access to healthy food.
- Provides access to the outdoors and nature (e.g., parks, walkable communities).
- Freely engages in self and community care.
- Is safe and affordable.
- Moves from “my health” to “our health” regardless of community size.
- Enables trust.



The workgroup also discussed existing efforts to advance health justice, and opportunities for collaboration and policy intervention (see recommendations).

Phone Interview Outcomes Summary

The workgroup provided rich input on efforts to advance social justice/health equity, ways to optimize cross-sector collaboration, approaches to advocating for HiAP priorities to decision makers and community stakeholders, and indicators for HiAP success.

Current or Planned Efforts to Advance Social Justice/Health Equity

Each workgroup agency, its partners, and community stakeholders have a wide range of activities planned or in progress to advance social justice and health equity that fall into several domains: diversity, equity and inclusion (DEI) efforts (targeting audiences internal and external to the organization), special interest groups, funding opportunities, policies, partnerships, workforce development, and outreach and communication. Examples cited for each of these domains are provided below.

Internal DEI Efforts
- Development in cultural competence
- Implicit bias training
- Equity officer

External DEI Efforts
- Resources in different languages
- Disability accommodations

Special Interest Workgroups
- IDHS advisory councils, task forces, boards and commissions
- Health Equity and Access Response Team (HEART)
- Activating Relationships in *Illinois* for Systemic Equity (ARISE)

Funding Opportunities
- Decolonizing Data
- Gun Violence Prevention and Safe Communities Act

Policies
- Reimagine Public Safety Act
- Medicare/Medi-caid expansion
- Health benefits for immigrant adults
- Environmental laws (lead, air toxins)
- Telehealth expansion
- Restore, Reinvest, and Renew (R3) Program

Advocacy Partnerships
- Every Child Matters
- Missing and Murdered Indigenous Women

Workforce Development
- ISMS training for clinical researchers and health care providers

Outreach and Communication
- Health Equity Action Day
- Farm and Family Resource Initiative

Cross-sector Collaboration and Communication

Based on their experiences with cross-sector collaboration and communication, workgroup members shared their advice on what to do and not to do to help ensure success.

Do
- Establish standard definitions/shared language.
- Have SMART goals and specific actions.
- Have points of accountability.
- Synthesize and report outcomes to keep people informed.
- Establish an approach to completing the work.
- Include people who do the work to identify best practices.
- Build trust among agencies.
- Facilitate data sharing.

Don't
- Try to boil the ocean.
- Reinvent the wheel/duplicate work.
- Discount the varied constraints of representative organizations.
- Ignore the work/workloads of team members/agencies.

Advocating for Priorities in Decision Making

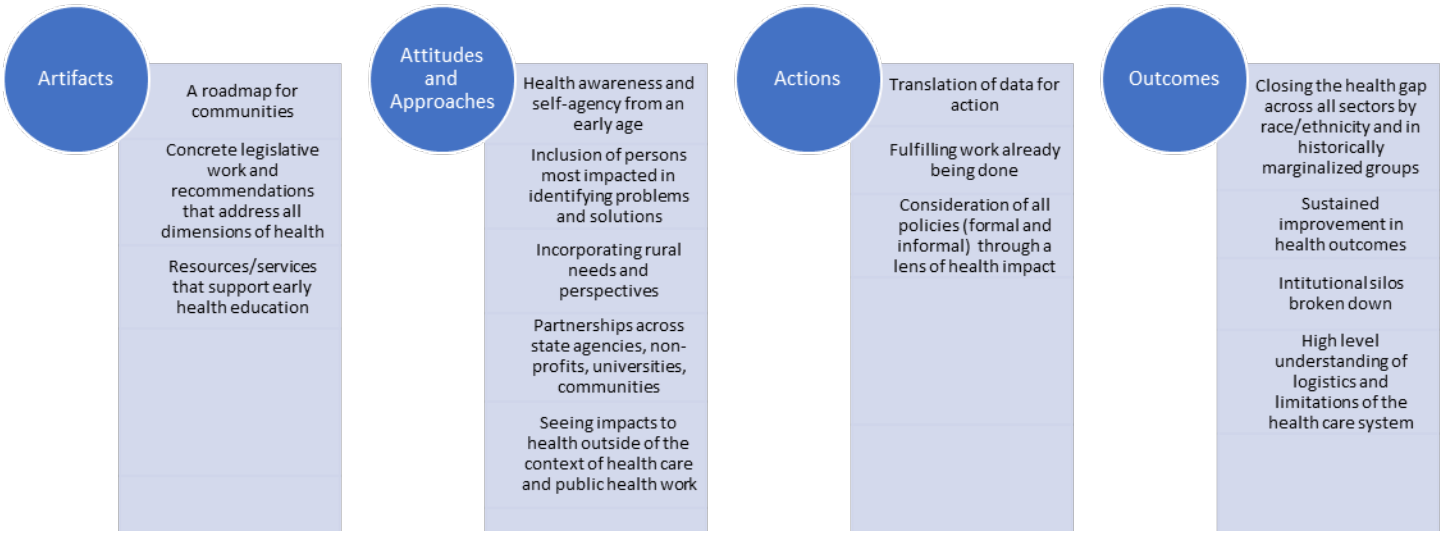
Based on their experiences with advocating for their respective priorities in decision making among policy makers and community stakeholders, workgroup members shared their advice on what to do and not to do to help ensure success.

Do
- Include voices of those with lived experience.
- Conduct a scan of existing efforts.
- Invest in relationship building.
- Provide resources and forums for communities to advocate for themselves.
- Be transparent in information and decision-making.
- Serve as a bidirectional resource.
- Make it easy for elected officials and stakeholders to access your org and SMEs.

Don't
- Overwhelm with complexity.
- Use overly academic or discipline-specific jargon.
- Communicate only during election time.

Indicators of HiAP Success

Although metrics are not yet established for this effort, workgroup members shared what they thought it would look like if the HiAP efforts were successful. While not exhaustive, these characteristics are categorized below as artifacts (tangible products), attitudes and approaches (underpinning principles, processes, and behaviors), actions (specific activities), and outcomes (downstream results).



Recommendations

Consistent with the expressed intent to ensure bidirectional feedback and response between HiAP and SHA/SHIP efforts, the following recommendations carry forward and address some of the high-priority policy-related needs and opportunities identified through the SHA/SHIP process.

1. Develop and implement a process for providing technical assistance on the evaluation and incorporation of health in future legislation and policies.

Technical assistance will help state agencies and community-based organizations (CBOs) build capacity and strengthen organizational capacity to foster a culture of health and well-being and address the forces that underlie health inequities. This includes answering questions, assessing needs, providing training and guidance, and sharing key resources. Several workgroup organizations are providing technical assistance to state agencies and CBOs.

For example, UIC School of Public Health's Collaboratory for Health Justice supports academic-community partnerships by facilitating the meaningful participation of broad stakeholders; fostering representation and presence in academic and community settings; and providing training and technical assistance for integrating community engagement across research, teaching, and practice. More information on their work may be found here: https://publichealth.uic.edu/community-engagement/collaboratory-for-health-justice/

2. Develop appropriate tools to measure health impact.

Given that social disparities are rooted in the underlying infrastructure and resources that support community health, tools to measure health impact may aspire to:

- Apply a structured inquiry to identify unmet social determinants of health that result in person-based/population-based health disparities.
- Articulate how a proposed intervention strategy will improve overall health and advance health equity by reducing disparities and/or health inequities in disparately impacted persons/communities.
- Proactively identify any barriers or undue burdens the proposed intervention strategy may impose upon disparately impacted persons/communities that would limit the effectiveness of the intervention strategy.
- Ensure that members of disparately impacted communities are engaged/consulted in the planning and implementation of the intervention strategy.
- Assess the intervention strategy's impact on disparately impacted persons/community over time.

3. Appropriate funding annually for the implementation of HIAP activities.

The ability to implement policy is limited due to the lack of funding. When building a foundation for HiAP initiatives, it is crucial to have several key resources in place, such as relationships, information, funding, staff, and legal resources. Maintaining relationships are

crucial to getting started, while funding and personnel can help sustain an initiative.[1] Our work will require that we:

- Build capacity for cross-sector leadership and policy interventions.
- Ensure administrative support and high-level direction-setting and coordination.
- Engage with and develop plans to inform, and be informed by, individuals with lived experience.
- Identify best practices for delivering and evaluating interventions.
- Establish and maintain governmental and community partnerships that support advocacy and drive the development of policy.

Estimated funding needs for the HiAP Workgroup and its efforts is $250,000 per year, which includes:

- Salary and Fringe Benefits for 1.5 FTEs (FT coordinator and graduate student) - $100,000
- Meeting Expenses - $10,000
- Travel - $7,000
- Report Preparation Costs - $15,000
- Community Outreach and Engagement Costs – $20,000
- Training Development and Delivery - $70,000
- Technical Assistance Expenses - $30,000

Other Considerations

The following recommendations were generated from a series of workgroup breakout discussions used to brainstorm ideas to advance health justice and identify opportunities for collaboration and policy intervention in SHIP priority areas of behavioral health (BH), maternal and child health (MCH), and chronic disease (CD).

Initiatives that align with/could support the three SHIP priorities in a way that advances social justice	Improving collaboration and communication	Opportunities for policy
COVID-19 Public Health Emergency Declaration (MCH) *Medicaid enrolled with continuous coverage and 12-month postpartum extension provides full Medicaid benefits with continuous eligibility regardless of immigration status or how pregnancy ends.*	Use the Children's BH Initiative portal to remove administrative burden and the time needed for families to call different agencies to figure out eligibility. (BH)	Explore whether there are any initiatives to expand access to MCH services. MCH
Illinois Department of Healthcare and Family Services: Pathways to Success (BH)	Highlight/promote programs that are the first choice of the community. (BH) *Assess the gap between what services adults have access to and what services they prefer to have access to.* *Conduct research on treatment settings: where do people of different socioeconomic backgrounds or different demographics go to receive care?* *Offer services that everyone wants and can access (e.g., provide inpatient or residential placement for mental health).*	Consider the addition of other provider types to Medicaid in order to enhance access to care. (MCH)

Initiatives that align with/could support the three SHIP priorities in a way that advances social justice	Improving collaboration and communication	Opportunities for policy
IDPH - Coalition Work on Suicide Prevention (BH)	Create community communication at the beginning of the program/initiative. (BH)	Work with the Medicaid Technical Assistance Center to create additional training and supports for new Medicaid provider types. (MCH)
Health Care Transformation Collaboratives (CD)	Encourage collaboration between public and private for-profit organizations to work together as a part of the same community.	Champion higher education as a pathway economic stability and access to health care. (CD)
Reconnecting Communities Pilot Program – Planning Grants and Capital Construction Grants (CD)	Add community members to committees/taskforces and also give community voices more power to make decisions.	Focus on access and opportunities to access healthy foods and exercise rather than indicators for obesity (i.e., BMI). (CD)
ICJIA: Community-Law Enforcement Partnership for Deflection and Substance Abuse Treatment (CLEP) (BH)	Make local health department plans publicly available.	Employ approaches that ensure that actions are taken through a lens of health equity.
Complete Streets (CD)	Post health improvement efforts on social media to increase communication.	Expand transportation enhancement programs, including rail-to-rail conversions, pedestrian bike lanes, stormwater management.
Illinois Department of Children and Family Services: YouthCare Health Plan		Consider environmental impacts and burden of disease and trying to avoid operations that will cause harm to the environment. (CD)
McLean County Bridge Academy		Increase capacity to deliver wrap around services for support of persons in or exiting the criminal justice system.
Teen Parent Connection		Make evaluation criteria for health and health equity publicly accessible.
West Side United		Create more access to yield less chronic disease. (CD)

Conclusion

As we conclude this first report of the Health In all Policies workgroup, we want to thank the workgroup partners for all their hard work and dedication. It is through this and other collective efforts that we will improve the health and well-being of the residents of Illinois and strive toward making Illinois the healthiest state in the nation. In the new year we will continue to work across sectors to improve residents' health and well-being, this includes addressing health inequities, implementing a health in all policies framework, and addressing the social determinants of health with a social justice lens. To this end we will cooperatively examine some of the manifestations of historic, systemic, and structural injustices as they relate to the disproportionate impacts on health, well-being, and mortality. Participation in this timely work presents an opportunity to explore innovative ways to use our collective voices to a foster system-wide culture of health.

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Appendices

UIC UNIVERSITY OF ILLINOIS CHICAGO
School of Public Health

IDPH ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Health in All Policies Workgroup
Confirmed Members

Sec.	Agency	Designee
10.a.	University of Illinois Chicago School of Public Health	Wayne H. Giles, Professor & Dean
10.d.1.	Illinois Department of Human Services	Hina Mahmood, Deputy Chief of Staff
10.d.2.	Illinois Department of Transportation	Elizabeth Irvin, Deputy Director of the Office of Planning and Programming
10.d.3.	Illinois Environmental Protection Agency	Teschlyn Woods, Environmental Toxicologist/Environmental Health Specialist II
10.d.4.	Illinois Department of Agriculture	Jeremy Flynn, Chief of Staff
10.d.5.	Illinois Department of Labor	Jane Flanagan, Acting Director
10.d.6.	Illinois Department of Public Health	Sameer Vohra, Director
10.d.6.	Illinois Department of Public Health	Amaal Tokars, Deputy Director
10.d.7.	Illinois Public Health Association (Statewide Public Health Association)	Thomas Hughes, Executive Director
10.d.8.	(Federally Qualified Health Center - *redesignation in progress*)	*Redesignation in progress*
10.d.9.	Chicago Department of Public Health (Health Department local to UIC)	Kate McMahon, Director, Health Equity in All Policies
10.d.10.	Illinois Health and Hospital Association (Hospital and Health Systems Association)	Lisa Harries, Assistant Vice President, Health Equity and Policy
10.d.11	Illinois Department of Healthcare and Family Services	Theresa Eagleson, Director
10.d.12.	Illinois State Board of Education	Rebecca Doran, Principal Consultant Nurse
10.d.13.	Illinois Department of Corrections	Steven H. Bowman, Agency Medical Director
10.d.14	Illinois Criminal Justice Information Authority	Delrice Adams, Director
10.d.15.	Illinois Department of Commerce and Economic Opportunity	*Awaiting Confirmation*
10.d.16.	Illinois Department on Aging	Amy Lulich, Senior Policy Analyst
10.d.17.	Office of the Governor	*Awaiting Confirmation*
10.d.18.	Jackson County Health Department (Local Health Department (serving pop of <3M)	Bart Hagston, Director
10.d.19.	Illinois Public Health Institute (Statewide Public Health Institute representing multisector public health system stakeholders)	Meher Singh, Senior Program Manager, Health Equity in All Policies Alliance for Health Equity
10.d.20.	Companeros en Salud (Organizations representing minority populations in public health – 1 of 2)	Laura Martinez, Executive Board Vice Chair
10.d.20.	Springfield Urban League, Inc. (Organizations representing minority populations in public health – 2 of 2)	Marcus E. Johnson, President & CEO
10.d.21.	Illinois State Medical Society (Statewide agency representing physicians licensed to practice medicine in all its branches)	Rashmi Chugh, Medical Officer, DuPage County Health Department

UIC UNIVERSITY OF ILLINOIS CHICAGO
School of Public Health

IDPH ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Health in All Policies (HiAP) Workgroup Agenda
September 1, 2022
1-4pm CST
Zoom
Meeting ID: 868 9779 4194
Passcode: Xw1zT3Sq
(To join by phone: Find your local number: https://uic.zoom.us/u/kekigN9Eys; Passcode: 41632357)

Meeting Objectives

- Workgroup introductions
- Orientation to the Health in All Policies Act
- Introduction to health data on the residents of the State of Illinois
- Initiate framework development

1:00-1:15pm	Welcome & Introductions *Name, Title, Organization, Superpower (i.e. personal and/or professional strengths you add to our team)*	Wayne H. Giles, Professor & Dean University of Illinois Chicago School of Public Health (UIC SPH) Sameer Vohra, Director Illinois Department of Public Health (IDPH)
1:15-1:30pm	Overview: Workgroup Charge & HiAP Legislation with Q&A *(see mandates on pg 3)*	Antoniah Lewis-Reese, Senior Director of Strategic Initiatives, UIC SPH *(Optional: Thomas Hughes, Executive Director, Illinois Public Health Association – historical context of HiAP in IL)*
1:30-1:45pm	HiAP Example: State of Maryland/University of Maryland	Stephen Thomas, Professor, Health Policy and Management & Director, Center for Health Equity University of Maryland School of Public Health
1:45-2:15pm	Grounding Exercise: Setting the Foundation *What is health/culture of health?* *What is health equity?* *In what ways is your organization impacting health/health equity?* *In what ways can your organization contribute to this work?* *How do we know if we're successful?*	Wayne H. Giles, Professor & Dean University of Illinois Chicago School of Public Health (UIC SPH) *(Optional: Bart Hagston, Director, Jackson County Health Department – county efforts to advance health equity)*
2:15-2:35pm	Background: Why This, Why Now, Why Us? *Background on Social Determinants of Health* *Why is this important?*	Christina Welter, Clinical Associate Professor, UIC SPH

	Illinois Resident Health (Statewide Health Assessment & State Health Improvement Plan Overview)	
2:35-2:40pm	**Break**	
2:40-3:00pm	HiAP in Illinois and Nationwide with Q&A *Brief history of HiAP in U.S.* *What has been done in IL?* *What has been done nationwide?* *Successes/Challenges* *Potential next steps*	Kate McMahon, Director, Health Equity in All Policies, Chicago Department of Public Health
3:00-3:45pm	Setting the Frame: Defining an Approach – Who, What, When *Priorities, Inputs, Processes Output, Stakeholders, Accountable Persons, Current Initiatives, Resources (if funding were not a concern, how could we do this?)*	Antoniah Lewis-Reese, Senior Director of Strategic Initiatives, UIC SPH
3:45-4:00pm	November Agenda Planning	Wayne H. Giles, Professor & Dean University of Illinois Chicago School of Public Health (UIC SPH) Sameer Vohra, Director Illinois Department of Public Health (IDPH)

UIC UNIVERSITY OF ILLINOIS CHICAGO
School of Public Health

Health in All Policies (HiAP) Workgroup Meeting
September 1, 2022
1pm-4pm CST
Zoom
MINUTES

Attendance: Leah Barth, Steven Bowman, Rashmi Chugh, Rebecca Doran, Jane Flanagan, Jeremy Flynn, Bart Hagston, Lisa Harries, Elizabeth Irvin, Wayne Giles, RoxAnne LaVallie-Unabia, Shannon Lightner, Hina Mahmood, Kate McMahon, Amaal Tokars, Sameer Vohra, Teschlyn Woods

Guests: Wesley Queen, Stephen B. Thomas, Christina Welter, Steven Seweryn

Facilitator: Antoniah Lewis-Reese

I. Attendees Introduction

II. HiAP Legislation Overview - Slide 4

A. Timeline, our charge, membership in Slides 6-8
B. Specified responsibilities - Slide 9
    1. Examine health
    2. Review legislation
    3. Define a public health framework
    4. Make new recommendations
    5. Submit a report of findings and recommendations
C. Areas of impact/inquiry - Slide 10
    1. Discussions and/or prioritization of areas to target to happen at a later time

III. State of Maryland/University of Maryland HiAP Example

A. Stephen Thomas showed Mr. Green video example portraying the difficulty of receiving health care - Slide 12
    1. S. Thomas emphasized the importance of a human centered stories to policy development
B. Key difficulties discussed from Mr. Green video example
    1. Issues regarding health care providers treatment of patients: dismissive behaviors, lack of dignity for patients, lack of listening from health care providers
        a) Recommendations for health care providers: taking the time with patients, establishing connections, listening skills, establishing health care in earlier care rather than in an emergency room, training to consider patient's background and how it impacts one's health

2. Issues regarding health care system: the lack of safety net to prevent patients from worse health outcomes, addressing/training health care providers to consider individual backgrounds does not address root causes of inequity
3. Equity is the center of HiAP; this means that for certain populations we have to do more to meet them where they are
    a) Post-COVID brought the end of large community outreach - "back to normal" contributes to inaccessibility and inequality

C. UMD Guidebook - Box01: Recommendations for Institutionalizing HiAP in Maryland
1. Creation of a HiAP Council and development of HiAP Framework
2. Development of a HiAP Toolkit to be used by the state agencies, and other organizations
3. Funding announcements that encourage applicants to include HiAP in their funding proposals
4. A process to guide state and county agencies to facilitate data sharing between and within agencies

IV. Grounding Exercise: Setting the Foundation

A. Discussed limitations to current health care culture: individuals are responsible for seeking out help and often when health is worse, current treatments for symptoms and outcomes without addressing root causes, stigma to accessing health services (i.e. mental health access in rural areas), and health education or literacy
B. Discussed a goal of having 'access with ease' in terms of receiving health care

V. IDPH State Health Assessment (SHA) 2022 - Selected Results and Indicators Overview Slide 19

A. Discussed including racism and discrimination in framework assessments
1. Racial and ethnic disparities are a social construct and they can represent larger health care system or social inequalities; rather than a biological difference

B. Data presented on racial and ethnic disparities for Illinois leading causes of death in 2016-2020, life expectancy, and social determinants of health
C. Forces of Change Assessment (FOCA) Summary Findings 2022
1. Health-related issues included chronic disease management and prevention, oral health, youth mental and culturally inclusive practice
2. Infrastructure issues included the need to focus on determinants of health (transportation, housing, food, racism, etc.), targeting health equity at a systems level change, data modernization and increased communication/coordination between different agencies

VI. Chicago Department of Public Health (CDPH) HiAP Overview - Slide 44

A. Discussed the differences between social and structural determinants of health
1. Social determinants are the circumstances in which are shaped by a set forces that are beyond the person's control (i.e. where you are born, grow, work, or learn)

2. Structural determinants are the root causes of health inequalities; this includes how unfairly resources are distributed based on demographic or social factors

B. Defined equity as a process and an outcome - Slide 49
C. Critical success factors - Slide 53
D. Further discussion - what would CDPH do differently in the beginning waves?
    1. Allowing those most affected by the changes to be decision makers and evaluators of health policy changes
    2. Language and framing matters (less specific public health language)
    3. Creating smaller focus/issues areas as well as the bigger picture
    4. How to create priorities - taking direction from other organizations/communities (as a starting point)
    5. Working with communities - sometimes relationship building is needed before action
    6. How to deal with low resources - being transparent in the decision making and identifying what operational or political complexities may not be apparent for those in the community

VII. Setting the Frame: Defining an Approach

A. Areas of inquiry poll was taken
    1. Question 1 - What is our interest (based on you or your organization's institutional knowledge and mission alignment)?
    2. Question 2 - What is the level of impact on the health of the residents of Illinois (known or perceived)?
B. Initial topics of interest: social justice, access to transportation, diversity/inclusion at work

VIII. Next Steps

A. Report to the General Assembly due by December 31st, 2022
    1. Discussion to align with SHA and SHIP priorities
B. November Meeting Agenda
    1. Need to create poll for virtual/hybrid November meeting data
    2. Need to share resources in chat
    3. Explore potential of conducting phone interviews to understand barriers to cross-sector collaboration
    4. Requested items: CVs, contact information, and resources or suggestions
    5. Potential agenda for November meeting
        a) Solidify framework topics
        b) Review outputs/data tied to priority areas

UIC UNIVERSITY OF ILLINOIS CHICAGO
School of Public Health

IDPH ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Health in All Policies (HiAP) Workgroup Agenda
November 18, 2022
9am-12pm CST
Zoom
Meeting ID: 847 1729 0667
Passcode: V6EmCVwm
(To join by phone: Find your local number: https://uic.zoom.us/u/k9bFSDff; Passcode: 41281054)

Meeting Objectives

- Define Workgroup Mission, Vision, and Structure
- Approve Annual Report Outline
- Identify Opportunities for Improved Collaboration and Communication
- Make Recommendations to Advance SHIP Through A Social Justice Lens

9:00-9:20am	Opening Remarks & Introductions* *Name, Title, Organization, Provide one characteristic of a healthy community*	Wayne H. Giles, Professor & Dean University of Illinois Chicago School of Public Health (UIC SPH) Sameer Vohra, Director Illinois Department of Public Health (IDPH)
9:20-9:35am	Healthy Illinois 2021 Priorities: Behavioral Health, Maternal & Child Health, & Chronic Disease *Think of ways social justice impacts these priorities.*	Illinois Department of Public Health (IDPH)
9:35-9:50am	Phone Interview Highlights, Potential Operation Framework, Potential Foci, and Report Outline	Antoniah Lewis-Reese, Senior Director of Strategic Initiatives, UIC SPH
9:50-10:10am	Feedback & Discussion *What's missing?* *What should change?* *Who can contribute?*	HiAP Membership
10:10-10:15am	Break	
10:15-11:15am	Breakout Sessions (Rounds 1 & 2) *What current initiatives align/could support the 3 SHIP priorities in a way that advance social justice? Think of how our areas of impact play a role. What specific actions can we take to ensure communication and collaboration across these initiatives? Are there opportunities for policy intervention at the agency or state level?*	HiAP Membership
11:15-11:20am	Break	
11:20-11:50am	Breakout Debrief & Discussion	Wayne H. Giles, Professor & Dean

		University of Illinois Chicago School of Public Health (UIC SPH)
11:50am-12:00pm	2023 1st Quarter Action Planning & Wrap-up	HiAP Membership

UIC UNIVERSITY OF ILLINOIS CHICAGO
School of Public Health

Health in All Policies (HiAP) Workgroup Meeting
November 18, 2022
9am-12pm CST
Zoom
MINUTES

Attendance: Rashmi Chugh, Rebecca Doran, Jennifer Epstein, Jeremy Flynn, Wayne Giles, Bart Hagston, Roxanne LaVallie-Unabia, Amy Lulich, Laura Phelan, Meher Singh, Elizabeth Irvin, Jane Flanagan, Lisa Harries, Kristin Hartsaw, Hina Mahmood, Javon Gregoire, Amaal Tokars, Sameer Vohra, Teschlyn Woods

Guest: Jennifer Epstein, Lauren Pangelinan, Jacqueline Silva

Facilitator: Antoniah Lewis-Reese

I. **Attendees Introduction**
   A. Members shared one characteristic of a healthy community
II. **Healthy Illinois 2021 Priorities -Slide 4**
   A. According to the revised 2022-2027 State Health Improvement Plan (SHIP), priorities include behavioral health, chronic diseases, maternal and child health. Priorities of emerging diseases, and racism as a public health crisis added since 2021 SHIP.
   B. Reference to Public Health 3.0, which centers social determinants of health
III. **Report Outline Review**
   A. General agreement on draft report outline

IV. **Membership Phone Interview Highlights - Slide 9**
   A. Phone interviews were conducted in order to collect member perspectives that will help set the foundation of HiAP's work to advance health equity
      1. 17 30-minute interviews were conducted from October 27-November 15
      2. 15 organizations were represented
   B. Highlights
      1. Key concepts for defining social justice: equitable access across the board, having self-agency, removing barriers, structural and social determinants of health and having basic needs met, and acknowledging historical injustice
      2. List current or planned efforts to address matters of social justice
      3. Lists the do's and do not's of cross-sector collaboration and communication and advocating for your priorities in decision making
   C. Work Structure "Provotype" - Slide 22

1. Executive Committee to prioritize, inform, and facilitate HiAP work
2. Community Outreach and Communication to engage and develop plans to inform individuals with lived experience
3. Planning and Implementation to plan and prioritize work and help identify best practices
4. Policy Steering and Advocacy to carry legislative work forward

D. Indicators of HiAP Success - Slide 24
   1. Discussed short-term, intermediate, and long-term outcomes/indicators for HiAP success

E. Opportunities for HiAP Intervention - Slide 30
   1. For each SHIP priority, lists and indicates the goals met and not met
   2. HiAP strategies from SHIP
   3. Policy needs/opportunities identified in 2022-2027 SHIP revision

V. Breakout Sessions -Slide 37

A. Session topics include SHIP Priorities: chronic disease, behavioral health and substance abuse, and maternal and child health

B. Questions
   1. What current initiatives align/could support this SHIP priority in a way that advances social justice?
   2. What specific actions can we take to ensure communication and collaboration across these initiatives?
   3. Are there opportunities for policy intervention at the agency or state level?

C. Refer Jamboard Summary in Box

VI. Next Steps

A. UIC to submit report to IDPH by December 16th. Due to GA December 31st.

B. First Quarter Meeting
   1. Determine and assign interim work
   2. Identify potential date (March/April 2023)
   3. Identify meeting location

UNIVERSITY OF ILLINOIS CHICAGO
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Health in All Policies Workgroup Member Interview Questions
October-November 2022
Topics: Social Justice and Collaboration

Thank you for taking time to complete this interview questionnaire of the Illinois Health in All Policies Workgroup membership. The purpose of this interview is to collect perspectives from Health in All Policies workgroup members that will help set the foundation of our work to advance health equity. This includes establishing standard definitions, as well as understanding the current landscape of cross-sector communication and collaboration in decision making.

There are four primary questions (***bold italics***) that are required, and several related probing questions (indented, plain text) that are optional. The probing questions will help further develop your responses to the primary questions and will help us get a better understanding of your perspectives and work. All responses are confidential and summarized thematically and anonymously when shared with the broader group.

1. ***How do you define social justice?***
    - What does health equity look like to you?
    - What is the connection between social justice and health equity?
    - What would it look like if our health in all policies work is successful?
2. ***How is your agency addressing matters of social justice and/or health equity?***
    - In what ways do you see your organization mediating social justice impacts to health and/or health equity?
    - What efforts are currently active or planned?
    - Are there state policies that support this work?
    - Who is on the planning or implementation team?
    - Is there an opportunity for cross-sector collaboration?
3. ***What has worked well/not worked well in your experiences with cross-sector collaboration and communication?***
4. ***What approaches have you used that worked well/didn't work well in getting policy makers and stakeholders to consider and incorporate your org's priorities in their decision making?***
    - Who are the key stakeholders and policymakers of your organization?

If you are unavailable to schedule a phone interview, please send your responses to Antoniah Lewis-Reese, Senior Director of Strategic Initiatives, University of Illinois Chicago School of Public Health at alreese@uic.edu. Thank you!

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Literature Review
The Relationship Between Social Justice and Health/Health Equity

Prepared by: Jacqueline Silva, MPH Candidate, Division of Health Policy & Administration
University of Illinois Chicago School of Public Health
For Illinois Health in All Policies Workgroup

The purpose of this literature review is to explore the impacts of social justice and related contributing factors to health to set the foundation for future work conducted by the Health in All Policies workgroup. The approach was to review peer-reviewed and grey literature to:

1. Identify definitions for key terms, such as social justice, determinants of health, health equity, health disparities, and health inequities.

2. Explore health disparities related to socioeconomic well-being, race/ethnicity, gender, immigrant status, disability, and structural and social determinants of health.

3. Ground the examination in the priorities outlined in the 2021 Illinois State Health Assessment and State Health Improvement Plan: behavioral health, maternal and child health, and chronic disease.

Executive Summary

Social justice in health presents itself through reducing and ultimately eliminating unjust and avoidable health inequities that result from policies and practices that create an unequal distribution of power, money, and resources among communities.[1]

Health equity is the principle that motivates us to increase opportunities to achieving good health, especially for those who lack access to health resources or have poorer health outcomes. Progress towards health equity is determined by measuring change in health disparities over time with the goal of eliminating disparities in health and its determinants.[3]

Health inequities are shaped by social structures and practices that promote the unfair distribution of wealth, power, and resources. These unfair distributions are often associated with racism and discrimination, resulting in health disparities by racial and ethnic minorities.

U.S. history of slavery, oppression, racism, and discrimination has left a legacy of racially biased and discriminatory laws, policies, and practices that contribute to health inequities and **structural racism**. Promoting health equity requires acknowledging historic injustices and removing resultant systemic barriers that produce health inequities and disparities.

The 2021 Illinois State Health Assessment and State Health Improvement Plan identified three health priority areas: behavioral health, chronic disease, and maternal and child health. Social determinants of health affect health status across all three priority areas. Health disparities are also present across all three priority areas.

Behavioral Health

- Nearly 15% of adults in Illinois experience more than one week of poor mental health in month.[6]
- The suicide rate among non-Hispanic whites is more than twice as high as that of other groups.[7]
- In 2014, men had a suicide rate four times greater than that of women.[7]
- The rate of all drug poisoning deaths increased among women of reproductive age, reaching a 101% increase.[8]

Chronic Disease

- 1 in 3 Illinois adults are obese, with obesity defined according to the consensus cut point on the Body Mass Index (BMI). Approximately 2 of 5 non-Hispanic Black adults fell in this category.[6]
- 1 in 5 children in Illinois were obese, with approximately 1 in 3 non-Hispanic Black children falling in this category.[6]
- 1 in 6 adults in Illinois reported being current smokers. Approximately, 1 in 4 non-Hispanic Black adults reported smoking.[6]
- Among pregnant women, approximately 10% report smoking while pregnant.[6]

Maternal and Child Health

- Approximately 4 in 5 pregnant women in Illinois started prenatal care in the first trimester of pregnancy, but only two-thirds of non-Hispanic Black women has access to early prenatal care.[6]
- Maternal mortality was 6 times higher among non-Hispanic Black women from 2015 to 2016.[8]
- In 2018, Black infants more than twice as likely to be born at a low birthweight than White infants. Black infant death rates were nearly 3 times higher compared to White infant death rates.[8]

Literature Review

Important Definitions

Health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[13]

Social justice is the view that everyone deserves equal rights, resources, and opportunities. This includes the right to achieving good health.[1]

Structural racism is "produced and reproduced by laws, rules, and practices, sanctioned and even implemented by various levels of government and embedded in the economic system as well as in cultural and societal norms."[2]

Social determinants of health are social and structural non-medical factors that influence health outcomes, such as the conditions in which people are born, grow, work, live, and age; as well as the economic, political, and social policies and systems that shape conditions of daily life.[10]

Health inequities are differences in the distribution or allocation of resources to achieve good health between groups, leading to unfair and avoidable differences in health outcomes.[5]

Health disparities are differences in health status or health outcomes between groups closely linked with social, economic, and/or environmental disadvantage.[5]

Health care disparities are differences in quality of health care provided because of bias, discrimination, and stereotyping at the individual, institutional, and health system levels.[12]

Health equity is the view that everyone deserves a fair and just opportunity to be as healthy as possible.[3]

Social Justice and Health

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."[5] Social justice in health presents itself through reducing and ultimately eliminating unjust and avoidable health inequities that result from policies and practices that create an unequal distribution of power, money, and resources among communities.[1] Health equity is the "human rights principle" that motivates us to increase opportunities to achieving good health, especially for those who lack access to health resources or have poorer health outcomes. Progress towards health equity is determined by measuring change in health disparities over time with the goal of eliminating disparities in health and its determinants.[3]

Health Disparities and Structural Underpinnings

Healthy People 2030 defines health disparities as differences in health status or health outcomes between groups. These differences in health between groups are shaped by social and structural factors that influence the distribution of health. This implies health is not simply a function of an individual's biology, it is shaped and defined by a social context. Moving towards health equity requires making special efforts to improve the health of historically marginalized and medically vulnerable populations, such as low socioeconomic status individuals, racial and ethnic minorities, immigrants, women, LGBTQ individuals, people with disabilities, and rural populations.[12]

Socioeconomic Wellbeing

When thinking of socioeconomic status, the focus is most often on differences in income. However, socioeconomic status encompasses education, occupation, and income as it relates to social status or position. When stratifying individuals by social position, each person has better health than the person below them and, conversely, worse health than the person above them. This social gradient in health was first uncovered in the 1960's Whitehall I and II longitudinal studies lead by British physician and epidemiologist Michael Marmot. Dr. Marmot uncovered that despite universal access to health care through the National Health Service in the United Kingdom, health outcomes varied by socioeconomic status – more specifically employment grade, finding that "the lower a participant's status in his or her work hierarchy the worse his or her health."[12] For example, a rapid scoping review of the literature on COVID-19 transmission risk to workers in essential sectors, such as retail, health care, manufacturing, and agriculture, found that "racial and ethnic minority workers, including migrant workers, are concentrated in high-risk occupations and this concentration is correlated to lower socioeconomic conditions."[4] Whitehall Studies researchers explain this social gradient in health phenomenon as "the status syndrome."[12] Dr. Marmot explains, "the higher the social position, the better the health."[12]

Understanding the pathways of socioeconomic status and health is important to establishing socioeconomic wellbeing. However, understanding the relationship between socioeconomic status and health goes beyond understanding an individual's education level, occupation, or income. Dr. Marmot's research suggests that social status has a greater impact on health beyond material well-being. Dr. Marmot explains for people above the threshold of material well-being, another kind of well-being is central. Autonomy – how much control you have over your life – and the opportunities you have for full social engagement and participation are crucial for health, well-being, and longevity. It is inequality in these that plays a big part in producing social gradients in health."[12] The social production of disease can be understood using Diderichsen's model of "the mechanisms of health inequality."[10] In Diderichsen's model the mechanisms that play a role in stratifying health outcomes operate in the following manner:

- **Social contexts** create social stratification and assign individuals to different social positions.

- **Social stratification** in turn engenders **differential exposure** to health-damaging conditions and **differential vulnerability**, in terms of health conditions and material resource availability.
- Social stratification likewise determines **differential consequences** of ill health for more and less advantaged groups (including economic and social consequences, as well differential health outcomes per se).

As Diderichsen's model demonstrates health inequities are shaped by social structures and practices that promote the unfair distribution of wealth, power, and resources. These unfair distributions are often associated with racism and discrimination, resulting in health disparities by racial and ethnic minorities.

Racial and Ethnic Minority Health Disparities

Before describing health disparities by race and ethnicity, is it important to acknowledge how race has been used in public health research. In the early 1800s, Dr. Samuel Morton conducted research to demonstrate biological differences between races.[9] His findings have been used for hundreds of years to justify horrors like slavery and genocide.[9] Since then, we've come to view each race as a discrete group of people defined by specific genetic and biological differences and used race to explain observed differences in health.[9] For example, Sickle Cell Anemia is considered a disease that only impacts Black people; people of color are genetically predisposed to diabetes, obesity, and high blood pressure; the FDA has approved drugs for different races; and race-based medicine has established care standards that vary by race.[9] However, the basis of these conclusions is faulty because race is not a biological construct, but a social construct – "a human-invented classification system" to define physical differences between people.[9] As a result, many urge health research abandon the concept of race and instead use ethnicity.[11] However, if public health researchers no longer use "race" as a category by which to understand health disparities, there is a danger of "minimizing the health impact of racism, especially for populations subjected to social prejudice because of their dark skin and facial features."[11] Therefore, to address racial and ethnic disparities, data needs to include race as a variable even if it cannot be defined. Racial and ethnic minorities have poorer health outcomes compared to whites on several measures on morbidity and mortality in Illinois:

- In 2014, 1 in 6 adults in Illinois reported being current smokers, and 1 in 4 non-Hispanic Black adults reported smoking.[6]
- In 2014, almost 1 in 3 Illinois were obese, with obesity defined according to the consensus cut point on the Body Mass Index (30 or greater BMI), and approximately 2 of 5 non-Hispanic Black adults were in this category.[6]
- Maternal mortality was 6 times higher with non-Hispanic women from 2015 to 2016.[8]
- In 2018, Black infants were more than twice as likely to be born at low birthweight than White infants. Black infant death rates were nearly 3 times higher than White infant death rates.[8]
- In 2011, 2 in 5 Illinois children did not have a medical home; more than half of non-Hispanic Black children in Illinois did not have a medical home.[6]

In making sense of racial and ethnic health disparities, researchers have tied socioeconomic status to race and ethnicity. However, research studies show racial disparities persist at each level of socioeconomic status.[12] For example, infant mortality rates have shown to be higher among Black college-educated women compared to White college-education women.[12] By focusing on educational level, occupation, and income, but not on wealth, associations between socioeconomic status and race and ethnicity fail to capture economic disadvantage by race and ethnicity. There are large racial differences in inheritance and transfer of intergenerational wealth, especially among Blacks and Hispanics who have the lowest net worth.[12] In Illinois, household earnings for Black individual was 60% less than the highest group in 2019.[8] Additionally, from 2014 to 2018, Blacks were 3 times more likely than other groups to be unemployed.[8] Understanding how poverty is associated with poor health requires understanding that poverty is associated with multiple social determinants of health, often overlapping and influencing one another.

Racism and Other Structured Inequities

Another possible explanation for racial and ethnic health disparities is racism. Racism can impact health at three levels: (1) interpersonal racism, or experiences of discrimination and prejudice experienced in everyday life; (2) internalized racism, in which victims of racism internalize prejudicial attitudes resulting in stress or loss of self-esteem; and (3) structural or institutionalized racism.[12] The roots of interpersonal and structural racism in the United States began with the genocide, enslavement and legalized racial oppression of Native Americans and African Americans at the hands of white colonizers.[12] These events set in motion "an evolving and durable belief system the perpetuated the myth that people of color – Black people, in particular - were inferior to White people."[12] This had the long-term effects of legitimizing race-based discrimination and segregation – "relegating Blacks to a lower social, financial, and education status relative to Whites."[12]

This interpersonal and structural racism also seeped into the health care system. Just as there was separate schools, bathrooms, and transportation services for Blacks and Whites, there was separate hospital, medical schools, and professional medical societies.[12] While there is no one definition for structural racism, all definitions acknowledge that structural racism is "produced and reproduced by laws, rules, and practices, sanctioned and even implemented by various levels of government and embedded in the economic system as well as in cultural and societal norms."[2] While the health care system is no longer actively segregated, and there are laws and policies in place to protect individuals from discrimination, reduce health and health care disparities, and promote health, racial discrimination persists through implicit bias, radicalized residential segregation, mass incarceration, police violence, and unequal medical care.[2]

Residential segregation has profound impact on health equity – it impacts all aspects of individual and family life. Where someone lives impacts education, occupation, wellbeing, and access to resources (food, medical, transportation etc.). Marginalized groups subjugated to low-quality neighborhoods through years of redlining and radicalized residential segregation have

also been subjugated to low-quality schools and jobs, exposed to environmental toxins and psychological stress, with limited access to resources, if any.[2]

The U.S. has the highest rates of incarceration and murder of civilians at the hands of police compared to other wealthy countries.[2] U.S. criminal justice system is riddled with racial inequities and bias, with Black individuals "experiencing harsher outcomes in relation to police encounters, bail setting, sentence length, and capital punishment than white people."[2]

Although race is a social construct, racialized conceptions of susceptibility to disease are still practiced. A report by the Institute of Medicine in 2003 reviewed more than 100 studies and concluded that bias, prejudice, and stereotyping lead to differences in health care based on race and ethnicity.[2] However, individual bias and discrimination do not alone drive the substandard care of racial and ethnic minorities. Systemic disinvestment in historically segregated neighborhoods, where racial and ethnic minorities are concentrated, has resulted in under-resourced medical centers, affecting access and utilization of health care by these populations.[2] Promoting health equity requires acknowledging historic injustices and removing resultant systemic barriers that produce health inequities and disparities.

Social Determinants of Health and Inequity

The social determinants of health are the conditions in the environments where individuals are born, live, learn, work, play, worship, and age.[5] Social determinants of health have a major impact on people's health, well-being, and quality of life because they impact access to personal, physical, and social resources. For example, individuals who do not have access to grocery stores in their communities are less likely to have good nutrition and more likely to have poorer health status. In fact, research shows that the social determinants of health can influence health more than health care or individual choices. Numerous studies suggests that social determinants of health "account for 30-55% of health outcomes."[14] Therefore, addressing the social determinants of health is fundamental for promoting health equity and eliminating health disparities and inequities.

Adapted from Healthy People 2030, Social Determinants of Health

Addressing Social Determinants of Health in Illinois

There are approximately 13 million people in Illinois.[6] Two thirds of Illinois residents live in the northeastern region of the state.[6] While more than half of the population is white, Illinois is diverse – 15% of the population is non-Hispanic Black, approximately 17% are Hispanic, and about 5% are Asian/Pacific Islander.[6] Illinois has a sizable immigrant population: nearly 14% of the population is foreign-born.[6] Most Illinois residents have a high school education and close to two million were living in poverty in 2014.[6]

Select Sociodemographic Characteristics, Illinois, 2014

Source: IDPH, Center for Health Statistics*

	NUMBER	PERCENT
Illinois Overall	**12,880,580**	**100.0**
Race/Ethnicity		
Non-Hispanic Black	1,885,164	14.6
Non-Hispanic White	8.115,541	63.0
Hispanic	2,152,974	16.7
Asian/Pacific Islander	701,675	5.4
American Indian/Alaskan Native	25,226	0.2
Foreign-Born	1,786,926	13.9
Age		
< 18	2,988,474	23.2
18-44	4,712,911	36.6
45-64	3,390,662	26.3
65-84	1,532,481	11.9
85+	256,062	2.0
Geographic Region		
Central Illinois	426,349	3.3
Northeastern Illinois	8,687,508	67.5
Northwestern Illinois	1,251,758	9.7
Southern Illinois	972,440	7.6
Southwestern Illinois	756,311	5.9
Western Illinois	786,214	6.1
At Least High School Education, Among Ages 25 and Over	7,427,358	87.3
Below the Federal Poverty Line	1,772,333	14.1

*U.S. Census Bureau Population Estimates

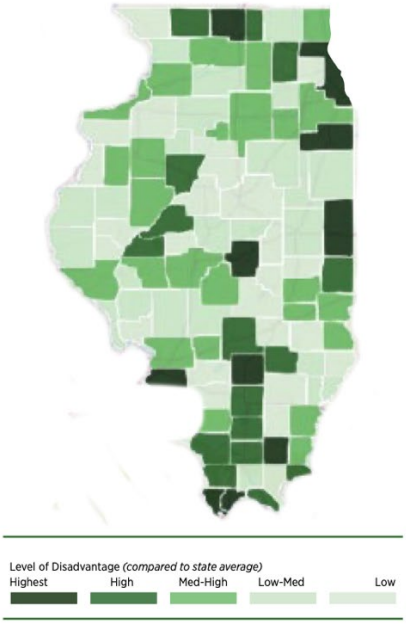
The 2021 Illinois State Health Assessment uncovered several indicators in relation to the social determinants of health. Issues with economic stability, education, the environment, health care access, and social and community context had an impact of health and well-being of Illinois residents.

Economic Stability

- In 2014, approximately 14% of the Illinois population was living in poverty.[6]
- Non-Whites experienced higher rates of poverty throughout Illinois.[6]

- Southern Illinois had the highest rate of poverty, but most of the people in poverty live in the northeast region of Illinois.[6]
- In 2019, 1 in 6 children in Illinois live in poverty.[8]
- Unemployment increased from 4% in 2019 to 11% in mid 2020.[8]
- In 2019, Black households earned 60% less income than the highest group.[8]
- Between 2014 and 2018, Black individuals were 3 times more likely than other groups to be unemployed.[8]

Concentrated Disadvantage

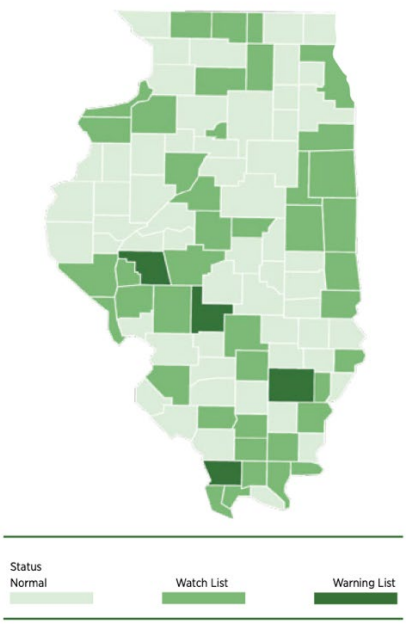


Source: IDPH, Office of Women's Health and Family Services

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

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

County Well-Being



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

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

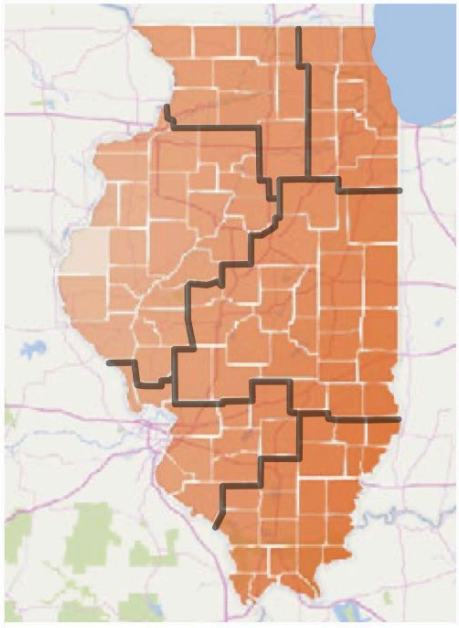
Education Access and Quality

- The lowest rates of high school graduation were in the northeast and south region of Illinois.[6]
- Between 2014 and 2018, high school graduation rates in Illinois were 88.9%.[8]
- Between 2014 and 2018, only two thirds of Hispanics graduated high school.[8]

Neighborhood and Built Environment

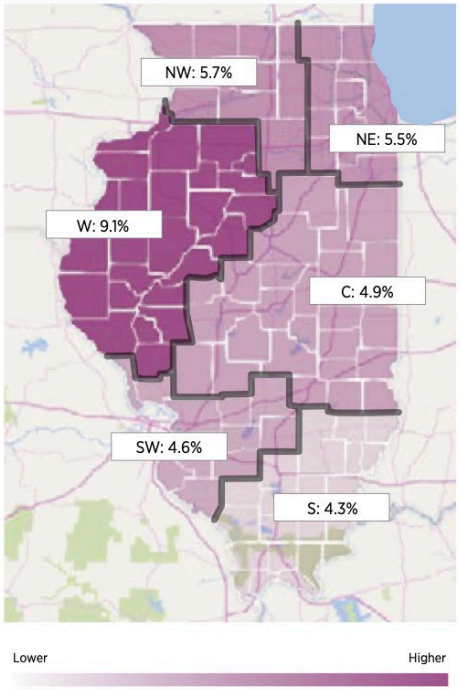
- The eastern part of Illinois, from north to south has the highest level of fine particulate matter pollution, causing decreased air quality.[6]
- The western region of Illinois has a higher percentage of older housing as well as a higher percentage of high lead level among children test in 2014.[6]

Daily Fine Particulate Matter, Avg Daily Measure, by County,
Micrograms per cubic meter, 2011
U.S. EPA PM 2.5 Standard: 12.0
Illinois Overall: 12.6



Source: U.S. Environmental Protection Agency

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



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

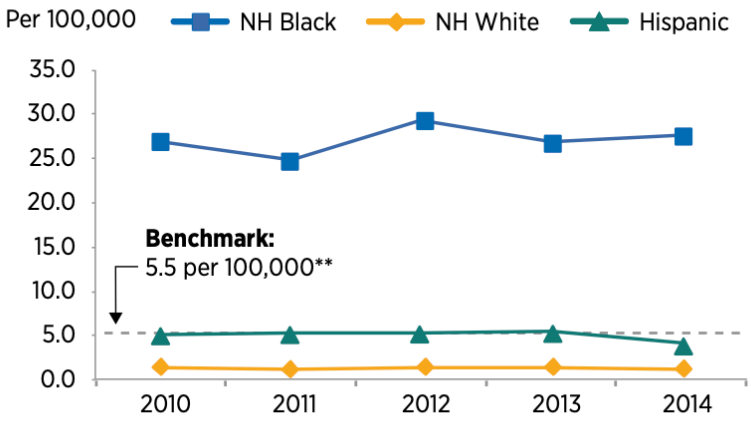
http://www.cdc.gov/nceh/lead/data/state/ildata.htm

Social and Community Context

- In Illinois, close to 1 in 6 children were reported by a parent or guardian as living in an unsafe community. For non-Hispanic Black and Hispanic children, approximately 1 in 4 were reported as living in an unsafe community.[6]
- Non-Hispanic Blacks were more often the victims of homicide compared to other racial and ethnic groups.[6]

Age-Adjusted Homicide Rate
per 100,000 Population
by Year and Race/Ethnicity, 2010-2014*

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



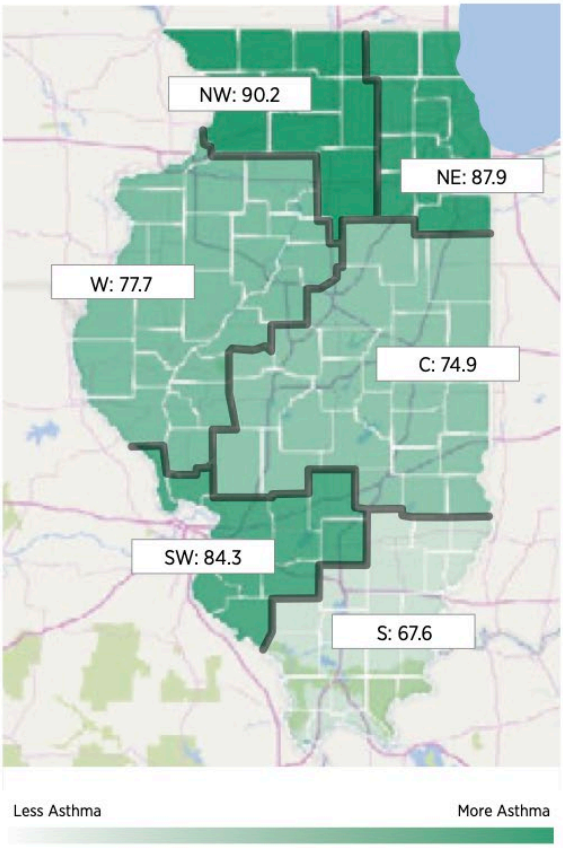
**2014 data are provisional.*
***Healthy People 2020 IVP-29, Reduce homicides; based on age-adjusted rates.*

Health Care Access and Quality

- In 2014, non-Hispanic Blacks had much higher rates of emergency department use for pediatric asthma, type 2 diabetes, and hypertension compared to other Illinois residents.[6]
- In 2014, northern Illinois and southwestern Illinois had the highest rates of emergency department use for pediatric asthma compared to other regions of the state.[6]
- In 2011, 2 in 5 Illinois children did not have a medical home. More than half of non-Hispanic Black children in Illinois did not have a medical home.[6]
- In 2014, approximately 4 in 5 pregnant women in Illinois started prenatal care in the first trimester of pregnancy, but only two thirds of non-Hispanic Black women received early care.[6]
- The southern, southwestern, and northeastern regions of Illinois had lower percentages of pregnant women who obtained adequate prenatal care.[6]

Rate of Emergency Department Discharges, Pediatric Asthma

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



Source: IDPH, Division of Patient Safety and Quality

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

Illinois Overall and by Race/Ethnicity, 2014*

Source: IDPH, Division of Patient Safety and Quality

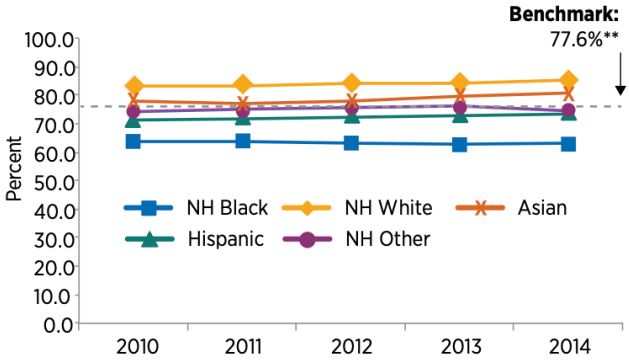
Illinois Overall	**288.0**	**(286.9-289.0)****
Non-Hispanic Black	601.5	(597.4-605.5)
Non-Hispanic White	224.0	(222.8-225.1)
Hispanic	283.6	(280.8-286.3)
Non-Hispanic Other	296.0	(291.8-300.3)

*Denominator is the mean 2012-2014 data, from Claritas.
**(95% confidence intervals)

Percent of Pregnant Women with Adequate Prenatal Care

by Year and Race/Ethnicity, 2010-2014*

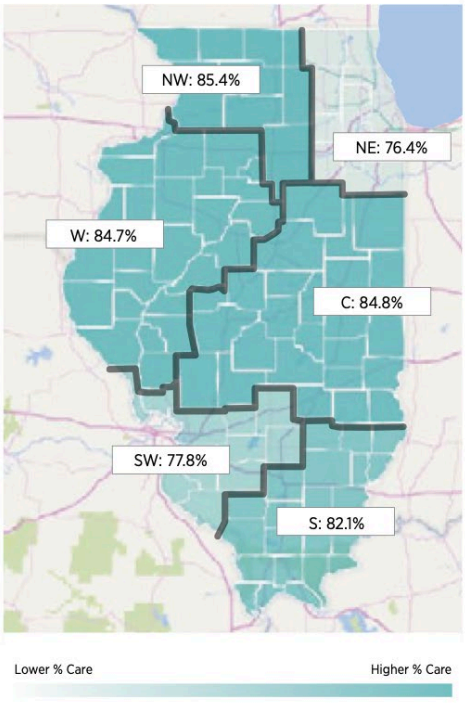
Source: IDPH, Center for Health Statistics and Division of Vital Records



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

Adequate Prenatal Care

Benchmark: 77.6%
Illinois Overall: 78.3%



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

Illinois Priority Health Areas and Improvement Plans

The 2021 Illinois State Health Assessment and State Health Improvement Plan identified three health priority areas: behavioral health, chronic disease, and maternal and child health. The Healthy Illinois 2021 Plan Update by the Illinois Department of Public Health identified these three priority areas continue to be in alignment with current data and are urgent priorities to promote the health and well-being of Illinois residents. These three health improvement areas will be addressed using approaches that incorporate the Social Determinants of Health.[6]

Illinois State Health Improvement Plan Priority Areas

Behavioral Health Goals	Chronic Disease Goals	Maternal & Child Health Goals
1. Improve the collection, utilization, and sharing of behavioral health-related data in Illinois 2. Build upon and improve local system integration 3. Reduce deaths due to behavioral health crises 4. Improve the opportunity for people to be treated in the community rather than in institutions 5. Increase behavioral health literacy and decrease stigma 6. Improve response to community violence	1. Increase opportunities for active living 2. Increase opportunities for health eating 3. Increase opportunities for tobacco-free living 4. Increase opportunities for community-clinical linkages	1. Assure accessibility, availability, and quality of preventive and primary care for all women, adolescents, and children, including children with special health care needs, with a focus on integration of services through patient-centered medical homes 2. Support healthy pregnancies and improve birth and infant outcomes 3. Ensure that equity is the foundation of all MCH decision making eliminate disparities in MCH outcomes 4. Strengthen data systems, infrastructure, and capacity relevant to MCH

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