November 2023

HEALTHY ILLINOIS 2028

State Health Assessment

Illinois Department of Public Health
IDPH
Protecting Health, Improving Lives

UIC Policy, Practice and Prevention Research Center

Illinois Public Health Institute

Contents

Acknowledgments

We would like to thank the State Health Assessment (SHA) and State Health Improvement Plan (SHIP) Partnership appointed by Dr. Sameer Vohra, director, Illinois Department of Public Health, in consultation with Gov. JB Pritzker. The partnership developed the vision for the SHIP, the fundamental principles and practices for successful development and implementation of the SHA and SHIP, and provided essential oversight and guidance in developing the SHA and the SHIP.

SHA and SHIP Partnership

Hillary Aggertt
Woodford County Health Department

Naila Al Hasni
Illinois Primary Health Care Association

Jeff Aranowski
Illinois State Board of Education

Damon Arnold
Blue Cross Blue Shield of Illinois (separated before project completed)

Karen Ayala
Northern Illinois Public Health Consortium/DuPage County Health Department (separated before project completed)

Angela Bailey
Southern Illinois Healthcare

Patricia Canessa
Illinois Public Health Association

James Caporusso
Aunt Martha's Health and Wellness

Garrett Carter
Illinois Department of Commerce and Economic Opportunity

Nina Dixon
Illinois Department of Children and Family Services

Laura Garcia
Illinois Department of Human Services

Joseph Harrington
CAPriCORN

Hana Hinkle
University of Illinois College of Medicine

David T. Jones
Illinois Department of Human Services (separated before project completed)

Sandy Leith
Illinois Department of Aging

Hong Liu
Midwest Asian Health Association

Laura Martinez
National Alliance on Mental Illness (separated before project completed)

James Miles
Lodestone R3 Institute

Ziyad Nazem
AbbVie

Elizabeth Patton-Whiteside
East Side Health District

Karen Phelan
State Board of Health

Robert Planthold
Illinois Department of Insurance

Anita Stewart
Blue Cross and Blue Shield of Illinois

Sameer Vohra
Southern Illinois University School of Medicine (separated and joined IDPH before projected completed)

Heather Whetsell
Southern Illinois University School of Medicine (separated and joined IDPH before project completed)

Teschlyn Woods
Illinois Environmental Protection Agency

Jeffrey Workman
Clay and Effingham County Health Department

Lauren Wright
Illinois Partners for Human Service

The overall SHA and SHIP process was designed, managed, and implemented by the core team from the Illinois Department of Public Health (IDPH); the University of Illinois at Chicago (UIC) School of Public Health faculty and staff, including staff from the UIC Policy, Practice, and Prevention Research Center (P3RC); and the Illinois Public Health Institute (IPHI). The IDPH regional health officers took part in the partnership meetings with the core team to make connections with regional resources and needs.

IDPH Core SHA and SHIP Staff

Nelson Agbodo
acting chief, Division of Health Data and Policy, Office of Policy, Planning, and Statistics (separated before project completed)

Chaundra Bishop
regional health officer

Kelsey Cutler
research scientist II

Julie Davis
assistant deputy director, Office of Women's Health and Family Services

Jenny Epstein
deputy director, Office of Policy, Planning and Statistics

Omayra Giachello
regional health officer

Marilyn Green
regional health officer

Patrick Harper
CDC epidemiology assignee, Division of Chronic Disease, Office of Health Promotion

Mark Hunter
regional health officer

Mohammed Shahidullah
state demographer

Tiefu Shen
MD, PhD, deputy director, Office of Policy Planning and Statistics (separated before project completed)

Mark Stevens
regional health officer

Amaal Tokars
assistant director (separated before project completed)

Tanya Zaks
regional health officer

UIC P3RC Faculty and Staff

Yadira Herrera
project coordinator, Policy, Practice and Prevention Research Center

Swati Jain
research assistant, Policy, Practice and Prevention Research Center

Guddi Kapadia
assistant director, Policy, Practice and Prevention Research Center

Steven Seweryn
associate director, DrPH in Leadership Program, Clinical Assistant Professor, Epidemiology and Biostatistics Division

Amber Uskali
deputy director, Policy, Practice and Prevention Research Center

Christina Welter
director, DrPH in Leadership Progra, Associate Director Policy, Practice and Prevention Research Center (P3RC), Clinical Associate Professor, Health Policy and Administration

IPHI Staff and Consultants

Tiosha Bailey
SHA/SHIP project consultant (separated before project completed)

Elissa Bassler
chief executive officer

Adrian Blasi
program associate

Laurie Call
director, Center for Community Capacity Development

Janece Gough
senior program manager

Samantha Lasky
program manager

Elise Ramos
program associate

Alison Goldstein
report writing consultant

For more information, please visit: https://dph.illinois.gov/healthy-illinois-report

OFFICE OF THE GOVERNOR
207 STATE HOUSE
SPRINGFIELD, ILLINOIS 62706

JB PRITZKER
GOVERNOR

November 6, 2023

Illinois Department of Public Health
524 S. 2nd Street
Springfield, IL 62701

Greetings,

I am pleased to present the 2023 State Health Assessment and State Health Improvement Plan for Illinois. These documents form the basis of "Healthy Illinois 2028," a five-year plan to address the most significant health challenges facing our state.

As your governor, protecting the health and safety of all Illinoisans is my highest priority. This was true during the COVID-19 public health emergency when we took extraordinary measures to address a once-in-a-lifetime global pandemic and is just as true today. My commitment to preserving and improving the health and quality of life for everyone remains as strong as ever.

These reports look at the state of public health in Illinois and our path forward in dealing with the issues that have the greatest impact on people's well-being. The topline issues include not only the lingering effects of COVID-19 but also the wide range of chronic health issues that affect thousands of Illinoisans every day, maternal and infant health, and the struggles people face from mental illness and substance use disorders.

Along with the Illinois Department of Public Health (IDPH), I have committed substantial resources to address all aspects of public health. We have prioritized and invested in learning the lessons from the COVID-19 public health emergency while preparing for future emerging diseases. We have built new systems and allocated funding to improve collaboration and coordination to support mental and behavioral health in adults and children. We have done the same to assist people who experience homelessness. My administration also continues to invest in the health workforce during a challenging time for our workers throughout the entire state.

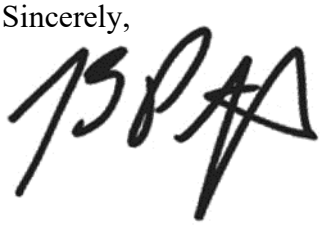
Additionally, I have been proud to sign legislation that will keep our state safer by restricting access to dangerous assault weapons, taking steps to hold gun manufacturers accountable for unsafe marketing practices, and banning use of e-cigarettes in indoor public spaces.

We are well prepared and have already built a strong foundation for a Healthy Illinois 2028.

One critical component of this report deals with racism as a public health issue. Access to care and good health should not be determined by where one lives, where one works, or the color of one's skin. We are making progress to correct historic and systemic disparities in care but we have more work to do. This initiative represents an important step toward achieving the goal of equitable access to health and equitable access to care.

I wish to extend my heartfelt thanks to Director Sameer Vohra and the team at the Illinois Department of Public Health, as well as our partners at the State Board of Health, the Illinois Public Health Institute, and the University of Illinois Chicago Policy, Practice, and Research Center. Their tireless efforts will help us fulfill IDPH's goal of building brighter futures for every community across the State of Illinois.

Sincerely,



Governor JB Pritzker

Letter from Illinois Department of Public Health Director

Dear Illinoisans:

Thank you for your partnership in building a healthier Illinois. On behalf of the Illinois Department of Public Health (IDPH), I am thrilled to present the Healthy Illinois 2028 State Health Assessment. This report is devoted to improving the health of Illinoisans. We invite everyone interested in improving health throughout our state—from individuals and community organizations to businesses, policy makers, and local health departments—to read on and partner with us in this work. This document describes the statewide assessment process, the methods that IDPH—along with our partners inside and outside of government—uses to understand how healthy Illinois is and determine the best solutions to make us healthier.

Healthy Illinois 2028 consists of two statewide initiatives, each working together to achieve the shared goal of improving the health of Illinois residents. Assessing the health status of Illinoisans is essential to measure progress we have made—or need to improve upon—since the last State Health Assessment: Healthy Illinois 2021. Understanding where we are and how far we have come as a state allows us to update and improve the effectiveness of our strategies and implementation plans.

Through this State Health Assessment, we have identified the key priorities necessary to strengthen Illinois's public health system to effectively improve health and advance health equity statewide. Based on the findings, we will develop specific approaches and strategies to address the state's health needs, especially those that surfaced during the COVID-19 public health emergency and in its aftereffects. These recommendations will be documented in the State Health Improvement Plan (SHIP), a companion document to this one that will be released at the end of 2023.

The Healthy Illinois 2028 State Health Assessment was made possible through the collaborative and coordinated efforts of many individuals and organizations across the state. The project was led by IDPH; the SHA/SHIP Partnership; the University of Illinois at Chicago (UIC) School of Public Health and Policy, Practice, and Prevention Research Center (P3RC); and the Illinois Public Health Institute (IPHI).

This Healthy Illinois 2028 Partnership guided the assessment process and met monthly during 2021 and 2022. I am grateful for their tireless work and commitment to building the brightest futures for every resident in Illinois. The partnership also prioritized engagement of organizational and community partners at every step in the process. Their feedback greatly enriched this State Health Assessment, and I thank them for their valuable contributions.

Addressing the health issues that Illinois faces today and into the future will require the collaboration of all of us, at every level and in every corner of the state along with continuous, meaningful engagement with partners in the communities we serve. I look forward to engaging with all of you as we pursue an improved and more equitable Healthy Illinois 2028.

Sameer Vohra, MD, JD, MA
Director

1 Executive Summary

The mission of the public health system is to promote health equity, prevent and protect against disease and injury, and prepare for health emergencies. Toward the fulfillment of this mission, the Illinois Department of Public Health (IDPH) is tasked with leading the State Health Assessment (SHA) process every five years. In 2021, an interim update[1] of the 2016 SHA was published with some updates on the previous SHA and preliminary data analysis for this SHA.

A state health assessment is a systematic approach to fulfilling Illinois's public health mission by collecting, analyzing, and using data to educate and to help mobilize communities, to develop priorities, to garner resources, and to develop an action plan to improve the public's health. This document represents the 2023 State Health Assessment, a process led by IDPH, SHA/SHIP Partnership, Illinois Public Health Institute, and the University of Illinois at Chicago (UIC) School of Public Health Policy, Practice, and Prevention Research Center (P3RC).

For this SHA, the SHA/SHIP Partnership, formed by IDPH and the Office of the Governor, implemented a model assessment process using four different methods to hear from the community, identify forces of change, review secondary data on the health status of Illinoisans, and assess the health equity capacity of the public health system. This work built upon the last Healthy Illinois update, published in 2021, which included community and public health provider input, gathered through focus groups and surveys, and an analysis of local health department (LHD) assessments. The partnership synthesized the data and developed findings to inform the prior process. Through dozens of meetings in 2022 and 2023, the partnership honed in on five priority health areas with crosscutting issues that must be addressed for each issue.

The findings in this report demonstrate how statewide health priorities were selected by presenting summary data that highlight our key challenges and areas for improvement. These data also inform the development of recommended strategies for improving the health of Illinoisans and advancing health equity, which will be described in the State Health Improvement Plan (SHIP), a companion document to this (SHA) Together, the SHA and the SHIP make up Healthy Illinois 2028.

Approach

The approach taken to develop the SHA includes components designed to: (a) apply a sound framework for conducting the assessment; (b) build on existing work; (c) identify a preliminary; flexible set of priorities; and (d) engage stakeholders throughout the assessment and final prioritization process. This approach was carried out through four core assessments developed as part of the Mobilizing for Action through Planning and Partnerships (MAPP) process by the National Association of County and City Health Officials (NACCHO) and modified for these purposes:

- Community Themes and Strengths Assessment
- Forces of Change Assessment
- Public Health System Health Equity Capacity Assessment
- Community Health Status Assessment

This report features select data and health status indicatorss from the MAPP assessments that highlight the current state of health in Illinois. The indicators presented in this document are provided by race and ethnicity, geography, and trend wherever possible.

Findings

The health priorities selected for Healthy Illinois 2028 are:

- chronic disease,
- COVID-19 and emerging diseases,
- maternal and infant health,
- mental health and substance use disorder, and
- racism as a public health crisis.

Each of these priorities for health improvement will be approached utilizing implementation strategies that address the crosscutting issues necessary for each priority to succeed. These crosscutting issues include:

- access to health care and wrap-around services,
- physical and built environment,
- public health system infrastructure,
- racial equity, and
- social and structural determinants.

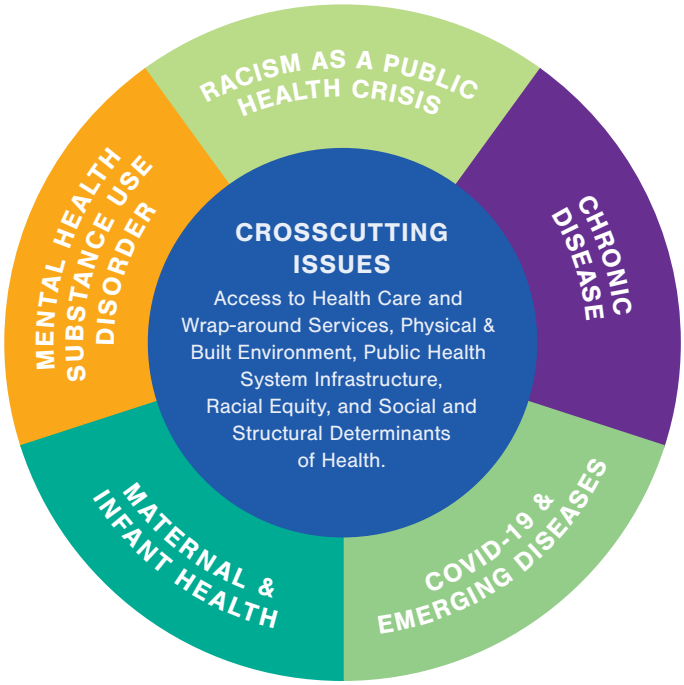


Figure 1. Healthy Illinois 2028 Priorities

These priorities were collaboratively developed and supported throughout the community and stakeholder engagement processes that contributed to the four core assessments that comprise the SHA process.

2 Introduction

The mission of the Illinois Department of Public Health (IDPH) is to serve as an advocate for and partner with the people of Illinois to re-envision health policy and to promote health equity, to prevent and protect against disease and injury, and to prepare for health emergencies. This mission builds upon the core functions of public health in the United States: to assess the needs, assets, and opportunities of the public's health to facilitate and assure programming and policy strategies that drive health improvement.

In partial fulfillment of its mission and under Illinois state statute 20 ILCS 5/5-565,[2] IDPH is designated to lead an effort to create a unified strategy for improving the state's public health system. To this end, the IDPH—in partnership with the Illinois Public Health Institute (IPHI); the University of Illinois at Chicago (UIC) School of Public Health and Policy, Practice, and Prevention Research Center (P3RC); and the appointed SHA/SHIP Partnership—led this State Health Assessment (SHA) process to guide the development of the 2023 State Health Improvement Plan (SHIP).

IDPH and its partners engaged subject-matter experts and community stakeholders in this comprehensive assessment and action planning process to develop and to address statewide health priorities, while recognizing and building upon other statewide and local health improvement efforts across the state. This process is an important strategic component of the Healthy Illinois 2028 initiative, which emerges from the following two major statewide projects.

Healthy Illinois 2028 Components

Healthy Illinois 2028 comprises two statewide initiatives that together work to coordinate and to align plans, processes, and resources to facilitate health improvement and advance health equity throughout the state (Figure 2).

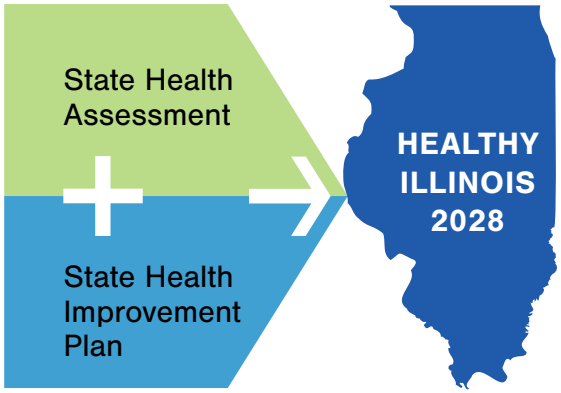


Figure 2. Healthy Illinois 2028 Components

Illinois State Health Assessment

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

Illinois State Health Improvement Plan

A SHIP is a five-year systematic plan to address issues identified in the SHA. Based on the SHA, the SHIP describes how the state public health system and the communities it serves will work together to improve the health of the population and advance health equity.

Purpose of the 2023 State Health Assessment

This report presents the process and the findings of the 2023 Illinois SHA. The SHA serves as a basis for understanding the current state of health in Illinois and provides valuable information regarding the needs and opportunities for health improvement and advancing health equity. This process included the work of committed organizations, associations, research institutions, agencies, and many others.

Healthy Illinois 2028

Healthy Illinois 2028 represents a coordinated, aligned approach to lead health improvement and improve health equity. With a five-year timeline, the Healthy Illinois 2028 Partnership agrees that the success of the overall initiative would lead to improvements in the root causes of health inequities, strengthening of the public health system infrastructure, and advancements in specific health priority areas that would benefit all Illinoisans.

Healthy Illinois 2028 Vision

The process of elaborating the assessments, objectives, and action steps that make up Healthy Illinois 2028 was driven by the partnership's desire to realize its vision:

Achievement of health equity across Illinois by addressing structural and social determinants of health through a unified public health system, community engagement and collaboration, a strong workforce, and sustainable and flexible local funding.

Principles and Practices for Success

The partnership established the following fundamental principles and practices to support the advancement of Healthy Illinois 2028:

- **Break down silos across the Illinois public health and health care delivery system through increased communication, coordinated prevention strategies, and resource sharing.**
- **Implement community-engaged, asset-based decision-making through partnerships with an array of organizations engaged in public health improvement and prevention.**
- **Prioritize strategies that address the underlying root causes, including structural and social determinants of health.**
- **Create sustainable impact through policy, systems, and environmental change strategies.**
- **Define objectives that are achievable, measurable, and aligned across programs, sectors, and systems.**
- **Foster innovation that occurs through the use of evidence-based strategies and best practices.**
- **Implement data-driven decision-making, measurement, and monitoring of success toward outcomes.**
- **Practice transparency and accountability to ensure aligned implementation of action plans and ongoing progress toward outcome attainment.**
- **Invest in current workers and cultivate new workers within the public health system to effectively implement the SHIP.**

The partnership recognizes that advancing these needed improvements, particularly as they relate to each of the Healthy Illinois 2028 priorities, is critical to realizing the shared unified vision for a healthy future, advancing health equity, and combatting structural and institutional racism.

The findings of this SHA provide a clear direction for the SHA/SHIP Partnership as it develops the plan for Healthy Illinois 2028. In order to drive toward action, attention must focus on both the health status priorities—chronic disease, COVID-19 and emerging diseases, maternal and infant health, mental health and substance use disorder, and racism as a public health crisis—and the root causes of health inequities. The charge is to improve the health of Illinoisans by advancing health equity and building brighter futures for all residents.

Participants

The Healthy Illinois 2028 initiative is supported by a SHA/SHIP Partnership appointed by the IDPH director in consultation with Gov. JB Pritzker. The partnership was charged with the following:

1. Collaborate with IDPH and the consultant team to develop a comprehensive, equity-driven SHA/SHIP that includes data-driven strategic priorities to advance health equity in Illinois.
2. Develop and implement an actionable plan with measurable objectives, owners, and timelines.
3. Collaborate on implementation of the plan and help facilitate the implementation of the plan through December 2028.

The SHA/SHIP Planning Team, which consisted of IDPH IPHI, and UIC P3RC staff, provided facilitation and guidance to the partnership. Partnership members represent organizations from numerous sectors and agencies, including state agencies, health care, local public health departments, insurance agencies, education, health care associations, and other entities as representatives of a holistic public health system in Illinois. Partnership members supported the assessment phase, identification of priorities, and development of the improvement plan.

The partnership met monthly between June and December 2022 (moved to quarterly in 2023) to assess the current state of health in Illinois. Each meeting, in 2022, represented a review and discussion of assessment data to obtain further validation of key themes emerging on public health systems infrastructure and health priority issues. In 2023, the partnership continued to meet quarterly to finalize the priorities and support the work of developing the action plans.

While the partnership guided the plan's development, numerous other entities contributed through a series of focus groups, interviews, surveys, presentation meetings, and participatory webinars. Nearly 250 individuals and agencies were engaged and contributed throughout the planning process.

3 Approach & Methodology

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

The Healthy Illinois 2028 SHA was conducted with a holistic approach, intentionally applying a sound framework for conducting the assessment while collating and building upon existing work. The SHA process included an early elaboration of preliminary, flexible priorities that were tested through stakeholder engagement in the assessment and final prioritization process.

In 2021–2023, IDPH completed a comprehensive SHA using the MAPP process (Figure 3)[3]. MAPP utilizes four assessments to gain a comprehensive picture of community health. They are the Community Themes and Strengths Assessment, the Forces of Change Assessment, the Public Health System Assessment, and the Community Health Status Assessment.

The **Community Themes and Strengths Assessment (CTSA)** identifies assets in the community and issues that are important to community members.

The **Forces of Change Assessment (FOCA)** identifies forces that may affect a community and the opportunities and threats associated with those forces.

The **Public Health System Assessment (PHSA)** measures how well different state public health system partners work together to deliver the Essential Public Health Services. The PHSA was under revision from NACCHO during the Illinois process.

The **Community Health Status Assessment (CHSA)** provides quantitative information on community health conditions.

Figure 3. The MAPP Process

MAPP Process and Framework

The MAPP process comprises four distinct assessment approaches to inform a community-driven strategic planning process, which has been used by hundreds of state and local health departments (LHDs) to improve community health across the country. The MAPP framework helps participants apply strategic thinking to prioritize public health issues and to identify resources to address them using an interactive process to improve the efficiency, effectiveness, and performance of public health systems. The findings of the four assessments build upon each other to raise key issues that must be addressed to strengthen the public health system.

Since the MAPP process was designed with local-level health departments in mind, some adaptations were made to conduct this analysis at the state level. The MAPP framework was modified for this SHA and improvement process by focusing on organizational or system-level issues and using a health equity lens. A brief description of each of the MAPP assessments and their corresponding tools follows. Both primary and secondary data were used in the core MAPP

assessment framework, adapted for a state process. Figure 3 illustrates how the data sources came together to inform the core assessments. Data collection processes are also described in the following section. Data collected, analyzed, produced, and/or reviewed are presented throughout the rest of this document.

A brief description of each of the MAPP assessments and their corresponding tools follows. Both primary and secondary data were used in the core MAPP assessment framework, adapted for a state process. Figure 4 illustrates how the data sources came together to inform the core assessments. Data collection processes are also described in the following section. Data collected, analyzed, produced, and/or reviewed are presented throughout the rest of this document.

SUMMARY OF CORE ASSESSMENT METHODS			
HEALTH STATUS ASSESSMENT	**COMMUNITY THEMES AND STRENGTHS**	**PUBLIC HEALTH SYSTEM HEALTH EQUITY CAPACITY ASSESSMENT**	**FORCES OF CHANGE ASSESSMENT**
• Health status indicators. • Illinois Project for Local Assessment of Need (IPLAN) review for the update in 2021.	• Focus groups with social service providers and Local Health Department staff across the seven regions in Illinois. • Community focus groups with people with lived experience.	• Public health essential service performance review with key stakeholders across the Illinois public health system.	• Presentations on trending issues and key factors by experts in the field. • Focus groups with regional social service providers and LHD staff. • 1:1 interview with partnership members.

Figure 4. Sources of Data for the Core MAPP Assessment

Community Themes and Strengths Assessment

This qualitative assessment captures perspectives from public health practitioners and community members throughout the state to aid in understanding community assets, health challenges, health equity priorities, and infrastructure issues facing the state's public health system. The majority of the data for the 2021–2022 SHA CTSA assessment were collected through community focus groups.

On behalf of IDPH, the SHA/SHIP Planning Team and the partnership, IPHI conducted eight focus groups (71 total participants) with regional social service providers and LHDs. In addition, a total of eight focus groups (92 total participants) were held with people with lived experience (PWLE) across the state. For the purposes of this report, PWLE are defined as "individuals directly impacted by a social issue or combination of issues who share similar experiences or backgrounds and can bring the insights of their experience to inform and enhance systems, research, policies, practices, and programs that aim to address the issue(s)."[4]

In particular, there was a strategic focus to hear from communities that experience most health inequities, including communities of color; immigrants and refugees; individuals living with disabilities; lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA+) communities; and older adults. IPHI also conducted a focus group with community members whose primary language is Spanish and one with rural community members exclusively from southern Illinois.

The focus groups explored a range of key topics that included the identification of health priorities, availability of community resources as well as barriers encountered when seeking to access said resources and the impact of the COVID-19 pandemic.

Upon completion of the focus groups, staff conducted a preliminary round of manual, structural coding to identify "big bucket" themes and develop researcher reflections. The coded data were grouped into themes using an inductive thematic analysis approach. After the data analysis was completed, final results were presented to the SHA/SHIP Partnership, and the planning team led the group in a discussion to gather feedback and determine next steps regarding future community engagement efforts. The process of the community engagement piece of the CTSA is depicted in Figure 5 below.

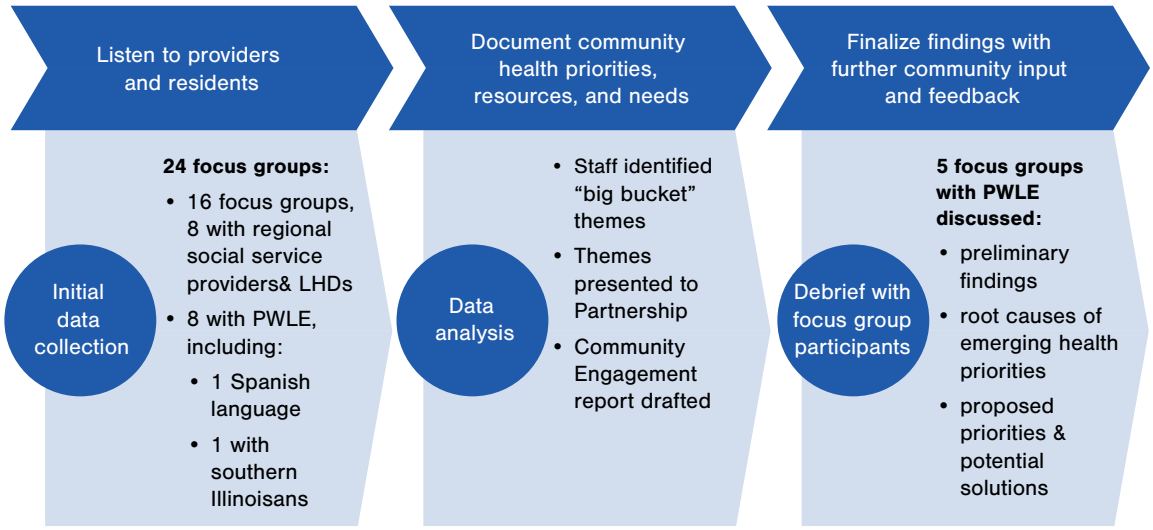


Figure 5. Community Themes and Strengths Assessment Process

Following the initial drafting of the SHA Community Engagement Report, the SHA/SHIP Planning Team, on behalf of IDPH and the partnership, followed up with previous focus group participants to share the draft Community Engagement report and invited individuals to participate in a debriefing focus group. The intent of the debriefing was to receive feedback on the data collected from previous focus group participants, to share data findings from the other assessments, and to solicit input on the proposed SHIP priorities and potential solutions.

Five follow up focus groups (50 total participants) were conducted with PWLE from a subset of original focus group participants. A total of 40 (80%) of the participants identified as people of color and participants were geographically dispersed. In an effort to prioritize voices from the rural communities, recruitment was staggered to provide a longer recruitment period for community members from central and southern Illinois.

The planning team drafted a high-level summary of the key findings from the SHA to share with participants and developed a focus group guide to ensure a systematic approach to conducting the sessions. Questions were designed to gather feedback on the presented data summary, determine the underlying root causes of the emerging health priorities, and provide possible solutions to include in the SHIP. Following the debrief focus groups, the findings were again reviewed by the partnership, and the CTSA report was finalized.

Forces of Change Assessment

The Forces of Change Assessment (FOCA) identifies external forces across a diverse set of categories, such as legislation, technology, demographic shifts, and other recent or impending changes that affect the context in which communities and the public health system operate. The

information for the FOCA for the 2021–2023 SHA was gathered through consultation with planning team members, focus groups, and organizational presentations. Forces are considered in terms of trends, factors, and events, as depicted in Figure 6.

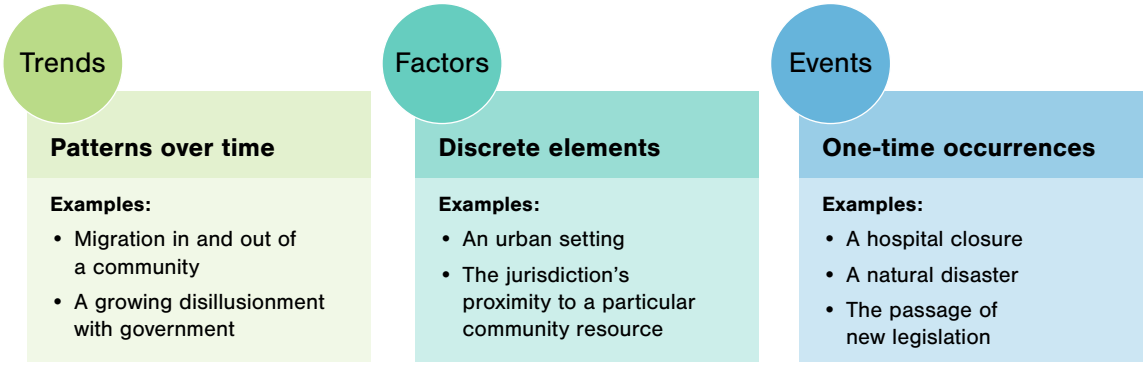


Figure 6. Forces of Change

During the FOCA, participants answered the following questions:

- What is occurring or might occur that affects the health of our community or the local public health system?
- What specific threats or opportunities are generated by these occurrences?

To ensure a comprehensive assessment in a virtual environment, the SHA/SHIP Planning Team solicited volunteers from the partnership to plan the FOCA and created a FOCA planning work group. The work group, with facilitation by the SHA/SHIP Planning Team, proposed and discussed strategies to conduct the assessment and decided on three approaches: focus groups, interviews with partnership members, and guest speaker presentations to the partnership on potential forces of change. The FOCA planning work group suggested questions to include in the provider and LHD focus groups as well as the interviews to inform the FOCA.

Collaborators focusing on issues identified by the FOCA planning work group shared presentations on current or probable forces of change. Each of the presentations included a high-level state of the state, information on how the topic/issue is or will be impacting individuals living in Illinois, and/or the public health system, and any potential forces of change and opportunities and threats associated with those forces of change. The presentation subjects are depicted in Figure 7.

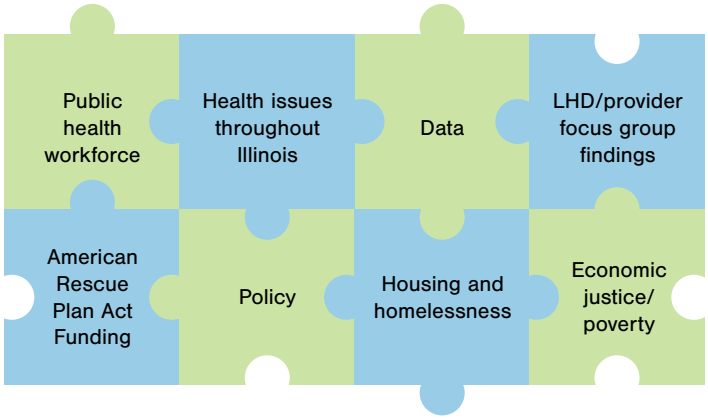


Figure 7. Topics Covered in Organizational Presentations

During these presentations, the partnership was encouraged to note in shared online documents any current or likely forces of change they heard in the presentations and the opportunities and threats associated with those forces of change. The partnership divided into small groups to review these notes, add any additional forces as well as their opportunities and threats, and discuss responses to questions on themes, impacts on current SHIP priorities, and potential shifting of

priorities, if at all. The partnership drew out and discussed key infrastructure themes, health-related themes, and crosscutting themes to finalize the FOCA process.

Public Health System Health Equity Capacity Assessment

The PHSA measures the overall strengths and weaknesses of the public health system based on the 10 essential public health services (Figure 8).[5] The PHSA tool was under revision by the NACCHO during the Illinois SHA process. Therefore, the SHA/SHIP Partnership developed an adaptation of the PHSA for the state level that focused on health equity—the Health Equity Capacity Assessment (HECA)—to complete this component of the MAPP process for the 2021–2022 SHA.

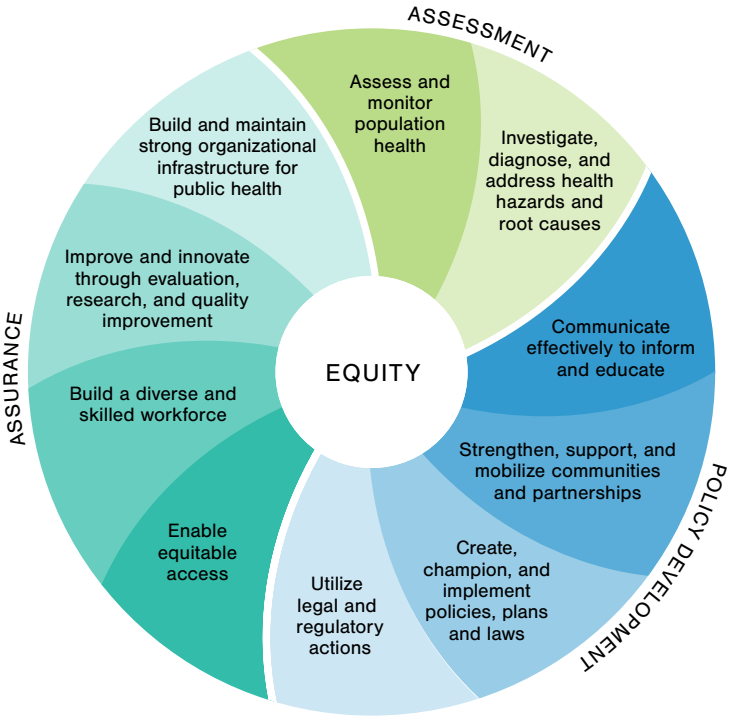


Figure 8. The 10 Essential Public Health Services, Updated 2020

Source: PHNCI (2020)

In 2020, the Public Health National Center for Innovations (PHNCI) and the de Beaumont Foundation convened a task force to revise the 10 Essential Public Health Services to achieve health equity. The SHA/SHIP Planning Team used the updated 10 Essential Services to guide the revision of the PHSA.

IDPH, along with the SHA/SHIP Partnership and Planning Team, noted the need to incorporate health equity throughout the assessment. In 2019, the Chicago Department of Public Health (CDPH) developed the HECA—an assessment similar to the PHSA that measures the performance of their public health system from a health equity perspective. With each of these tools, the planning team pulled together an advisory committee of partnership members and external public health system partners and experts to revise the PHSA using the updated 10 essential services and the HECA as a framework. Since external partners are not often familiar with the inner workings of health departments, the 10th essential public health service—which deals with internal organizational infrastructure—was excluded from this HECA process.

The advisory committee met to discuss the framework for the updated assessment and revise the descriptions and questions from the PHSA and HECA to meet two criteria: 1) a focus on health equity and 2) describe a state public health system. Building on the work of the advisory committee, the planning team finalized the tool for the updated HECA to carry out the statewide public health system assessment.

The MAPP PHSA scoring model was used to score the assessment questions (see details under the HECA section below). The HECA was conducted virtually on May 26, 2022, and comprised more than 85 public health practitioners across the state.

Community Health Status Assessment

This assessment collects and analyzes data to determine the health status of Illinoisans overall and by population groups. As a first step for this assessment, LHD plans were analyzed to understand health priorities already identified by other organizations in the public health system. In addition,

summarization of secondary data was carried out to produce a snapshot of the current state of health, highlighting specific health priorities in Illinois. The information was culled from reports and documents that provided health status indicators and was intended to provide an initial picture of the current state of health. This was built upon through the indicator selection process described later in this document and data were presented through the indicator set. The UIC P3RC team then focused on the data and generated descriptive analysis. A compendium of the data is included in a separate companion document.

A key foundational principle of the MAPP process, and the motivating factor for NACCHO's ongoing MAPP evolution process,[6] is equity. Specifically, the process seeks to "encourage shared exploration of the social injustice including structural racism, class oppression, and gender oppression that create and perpetuate inequities." This principle is reflected in this assessment's emphasis on the concepts of health equity, the social and structural determinants of health (SSDOH), racism and discrimination, and demographic differences by race and ethnicity.

This assessment presents health outcomes and highlights SSDOH where possible. However, data related to SSDOH are often not collected in surveillance of behaviors, risk factors, and outcomes. Critical to the understanding of health inequities presented in this report is acknowledgment that these are most often not related to group differences but to undocumented, often unrecognized, systemic factors and conditions—the underlying SSDOH that serve as root causes of these inequities. Additionally, it is important to acknowledge that race and ethnicity are social constructs with limited utility in understanding medical research, practice, and policy. However, the terms may be useful as a lens through which to study and view racism as it manifests through inequities in health, health care, medical practice, education, and research.

IDPH Regions

IDPH divides the state geographically into seven administrative regions. These correspond to areas for IDPH regional offices led by regional health officers. For this assessment, regional data are presented according to these designations. The regions are as follows:

REGION	NAME
Region 1	Cook
Region 2	West Chicago
Region 3	Champaign
Region 4	Marion
Region 5	Edwardsville
Region 6	Peoria
Region 7	Rockford

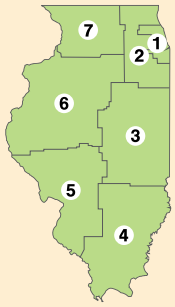


Figure 9. IDPH 7 Administrative Regions.

Selection of Indicators

The current state of health in Illinois is described using health data collected by IDPH. In order to monitor, to assess, and to report on the state of the state's health to the public, a discrete set of indicators was selected. This indicator selection process also required agreement on how the data would be accessed, organized, and analyzed. This process serves as the foundation for periodic examination of a set of indicators in order to monitor the extent of progress being made on improving the health of Illinois citizens.

Census, health indicator, survey, and service utilization data related to population characteristics were reviewed to identify preventive and risk factors and health outcomes to assess the health status of Illinoisans. Indicators were selected from the Healthy People 2030[7] objectives, established indicators from the 2016 health assessment, and other sources. UIC and IDPH staff worked

together to review and arrive at a broad set of indicators for which data were readily available and that could provide a picture of the state of the health of Illinoisans.

A data template was developed by the UIC P3RC data team to provide a consistent framework for data reporting by IDPH. The template specified a standard set of categories for racial/ethnic groups and for geographic regions, several alternative sets of categories for age, and called for as many years of trend data as feasible by the racial/ethnic categories when possible. Also, when possible, the template linked each indicator to relevant benchmark data either from Healthy People 2030 or other sources. The IDPH data team provided data for the indicators to the UIC P3RC data team that then completed indicator calculations, generated tables, graphs, and maps for presentation, and provided narrative description and interpretation of the findings.

The focus is on the health status of Illinoisans. Select subgroup data are presented, as appropriate, by age, sex, race and ethnicity, and geographic region to aid in identification of disparities and trends.

These data present a time-bound snapshot of the health and related conditions of Illinois residents. Every effort was made to utilize timely data, however, lags in data availability exist. As population level measures generally change incrementally over time, these lags should not adversely affect this assessment. Where possible, consistent years for data were selected for comparison purposes. In some instances, only differing time frames were available for this report.

While the assessment sought to provide a comprehensive picture of the health status of Illinois residents and to inform the statewide planning process, the data are limited to those that are routinely collected and analyzed by national and state agencies. Existing systems and approaches of public health data reporting and collection are often limited to outcome events, such as those surrounding birth and death or reportable diseases. Collection of detailed data on chronic, precipitating causes and other social and structural community conditions that may have contributed to specific health outcomes tend to be limited. Due to this limitation in availability and practices in routinely collected data variables on health-related factors and outcomes, it is important to consider underlying structural and social factors, not directly evident in the data, which the disparities in outcomes reflect.

Illinois Health Status Indicators

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

- **social and structural determinants of health**
  - educational attainment
  - income and poverty
  - unemployment
  - housing and homelessness
  - health insurance
  - language
  - immigration status
  - racism and discrimination
  - safety and violence
  - adverse childhood experiences
- **population**
- **mortality indicators**
- **maternal and infant health**
- **chronic diseases and conditions**
- **behavioral and mental health**
- **access to health care**
- **injury and violence**
- **communicable diseases**

Building on the Healthy Illinois 2021 Update

In accordance with the requirements of Illinois law, P.A. 93-0975, IDPH was to complete a new five-year SHA/SHIP by 2021, since the previous SHA/SHIP was completed in 2016. Due to the urgent and all-encompassing need for IDPH to respond to the COVID-19 pandemic that required unprecedented levels of time and effort by the state and local public and private resources, IDPH was unable to engage in a comprehensive SHA and SHIP process at the time.

In addition, widespread public demonstration to combat racial injustice raised the importance of examining structural racism as an issue to consider in relation to health priorities in the landscape of the public health system in Illinois. Therefore, to update the SHA, data were collected on emerging health issues, including COVID-19 and structural racism, the capabilities and capacities of the public health system, and health status related to major public health issues to inform a more accurate understanding of the landscape of the public health system in relation to the Healthy Illinois 2021 priorities.

The planning team, including IDPH, the UIC P3RC, and IPHI, worked collaboratively to conduct an interim update to the SHA/SHIP from August 2020 to December 2020 to adhere to Illinois law and guide priorities for the next two and a half years while IDPH and its public health system partners completed a more comprehensive, equity-driven SHA/SHIP between January 1, 2021 and December 30, 2022. Figure 10 displays this process from 2020 until 2023.

Figure 10. SHA/SHIP 2020-2023 Process.

Public Health 3.0 and Emphasis on Structural Determinants of Health Inequities

The approach of this SHA also represents a shift in thinking within the field of public health, born out of the evolution of field and the field's response to growing social awareness of historically unjust systems and structures that often serve as the root causes of health inequities. Two of the main components of this new framework include Public Health 3.0 and the focus on structural determinants of health inequities.

Public Health 3.0

According to the U.S. Department of Health and Human Services Office of the Assistant Secretary for Health:

> Public Health 3.0 is a major upgrade in public health practice to emphasize cross-sectoral environmental, policy, and systems-level actions that directly affect the social determinants of health and advance health equity. It represents a challenge to business leaders, community leaders, state lawmakers, and federal policy makers to incorporate health into all areas of governance.[8]

Public Health 3.0 involves a shift toward a more systems-level, holistic approach focused on regional issues and de-emphasizing individual service provision and programs in local areas, which was identified as a threat in the forces of change analysis. Partnership members noted the need to incorporate a Public Health 3.0 approach at both the state and local levels of the public health system. Through Public Health 3.0, the system would dismantle silos to encourage comprehensive sharing of data that would facilitate increased access and use of data to inform policy and practice. Such integration would serve as protection against system failure due to overreliance on one group—another threat identified in the forces of change analysis.

Furthermore, Public Health 3.0 reflects lessons learned during the COVID-19 pandemic[9] about the necessity of deeper and more meaningful community partnerships, as it "emphasizes collaborative engagement and actions that directly affect the social determinants of health inequity."[10] This consistent focus on the social and structural determinants of health inequities is another key element of the framework of Healthy Illinois 2028.

Social and Structural Determinants of Health Inequities

The World Health Organization (WHO) defines social determinants of health as follows:

> Social determinants of health are the conditions in which people are born, grow, live, work, and age, and also include the health system. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels, which are themselves influenced by policy choices. Social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries.[11]

This assessment adds "structural" to the now ubiquitous "social determinants of health (SDOH)" throughout to ensure that the root causes of health inequities,[12],[13] are being considered and addressed in this assessment process as well as the subsequent health improvement and implementation plans. WHO[14] draws a distinction between intermediary determinants, or the social determinants of health, and structural determinants, or the social determinants of health inequities. By using the term social and structural determinants of health (SSDOH) instead of SDOH, this assessment aims to focus the analysis and recommendations of this SHA/SHIP process as much as possible on structural determinants or the root causes of health inequities. Poverty, systemic racism, and discrimination—both continuing and historic—are some of the key root causes of health inequities that emerged during this assessment process.

State Health Assessment Update

To inform the update to Healthy Illinois 2021, a high-level health needs assessment was conducted beginning in August 2020. For that assessment, state-level data and reports were obtained from IDPH related to the existing SHIP 2021 priorities: chronic diseases; behavioral health, including substance use disorder and mental health; and maternal and child health.

High-level summary status data and reports of other urgent, emerging, or relevant health outcomes and risk factors were also gathered from relevant IDPH divisions and programs, including population data; leading causes of death and premature mortality; communicable diseases, such as sexually transmitted infections and foodborne outbreaks; environmental health indicators, specifically childhood lead poisoning; disease and risk factor prevalence data from the Behavioral Risk Factor Surveillance System (BRFSS); measures related to equity and social determinants, including income, health care access, and educational attainment; and injury data, including homicide, suicide, and firearm-related injury.

Since the COVID-19 pandemic was a central focus of much of public health activity in Illinois for 2020, IDPH provided data on the status of the pandemic. Publicly available data from the U.S. Census Bureau, American Community Survey, and other federal and Illinois departments (i.e., U.S. Bureau of Labor Statistics) were also queried for the assessment. This effort was led by staff and faculty from UIC P3RC.

Due to the aim of updating relevant data, including looking at new forces of change and the short timeline for the Healthy Illinois 2021 Update, the analysis consisted of a limited high-level overview of the Illinois health status. Data were not available or could not be prepared in specific detail for county or regional levels in the state. Since the 2021 update was published, these data have been updated, including a full update of the Illinois Data Book in 2021–2023 during the comprehensive SHA process.

For the analysis, data were compiled into a presentation format that documented the current status of each of the SHIP 2021 priorities: chronic disease, behavioral and mental health, and maternal and child health. To reflect changes since the 2016 SHA/SHIP and the public health climate at the time of the SHA update, other selected health status measures and indicators were presented in several domains. These include context, which covers demographics and SSDOH; health status, or mortality and morbidity; health behaviors, or behavioral factors; health care factors, including access, utilization, and clinical indicators; and emerging issues like equity, climate change, and COVID-19.

Overall, the data revealed a clear need to enhance and further build the state's public health system infrastructure. For this reason, the SHIP team focused on priorities related to infrastructure for the 2021 update, which served as the basis for this comprehensive SHA.

Revisiting Healthy Illinois 2021 Objectives

The IDPH team reviewed subsequent primary and secondary data collected on the Healthy Illinois 2021 objective measures to evaluate progress made in achieving the objectives and advance understanding on how prevalent health issues affect different sociodemographic groups. For reference, the overarching goals of Healthy Illinois 2021 are presented in the figure below.

The IDPH team reviewed subsequent primary and secondary data collected on the Healthy Illinois 2021 objective measures to evaluate progress made in achieving the objectives and to advance understanding on how prevalent health issues affect different sociodemographic groups. For reference, the overarching goals of Healthy Illinois 2021 are presented in the figure below.

BEHAVIORAL HEALTH	CHRONIC DISEASE	MATERNAL AND CHILD HEALTH
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 tobacco-free living. 2. Increase opportunities for healthy eating. 3. Increase opportunities for active living. 4. Increase community-clinical linkages to reduce chronic disease.	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, linkage, and continuity of services through patient-centered medical homes. 2. Support healthy pregnancies and improve birth and infant outcomes. 3. Assure that equity is the foundation of all maternal and child health (MCH) decision making; eliminate disparities in MCH outcomes. 4. Strengthen public health data systems, infrastructure, and capacity through unified statewide planning and leadership.

Figure 11. Overarching goals of Healthy Illinois 2021

The data used for this analysis were collected through the BRFSS, Pregnancy Risk Assessment Monitoring System (PRAMS), vital records (birth and death) data, and a survey sent to health program managers within and outside of IDPH working on the same goals and objectives.

The analysis computed changes in current and baseline values of the objective measures and compared the results to the target values to identify objectives and goals that are or are not being met. A qualitative analysis of programs' activities and interventions implemented to address each objective helped identify programs' strengths and areas of opportunity. The analysis highlighted the **emerging issues associated with opioid overdose, cigarette smoking, and COVID-19, such as increasing exposure of pregnant women to opioid drugs, e-cigarettes, vaping, and excess deaths due to COVID-19 among people who have comorbidities**. The results were shared with the State Board of Health (SBOH) for awareness, comments, and inputs.

In addition to the analysis and presentation of health status data, where applicable, relevant response data from the two surveys described in more detail below—the LHD stakeholder survey and the IDPH staff and SBOH survey—were examined and presented. Questions about the perceptions of current and emerging health priorities and the status of the COVID-19 pandemic response were presented to the SHIP Update Team by the SHA/SHIP Planning Team to assist in determining health and strategic priorities for the updated SHIP.

Local Health Department Assessments

Every five years, IDPH requires LHDs to complete a community health assessment and improvement plan, or IPLAN, as part of a re-certification process to ensure that LHDs are adequately addressing the core public health functions. IPLAN is a community health assessment and planning process that is conducted every five years by local health jurisdictions in Illinois. Based on the Assessment Protocol for Excellence in Public Health (APEX-PH) model, IPLAN is grounded in the core functions of public health and addresses public health practice standards. The completion of IPLAN fulfills most of the requirements for LHD certification under Illinois Administrative Code Section 600.400:

Certified Local Health Department Code Public Health Practice Standards. As part of the IPLAN process, LHDs must convene a community health committee composed of diverse stakeholders to identify at least three health priorities within their county or region and a community health plan focusing on three priority health problems.[15,16]

As part of the SHA process, UIC P3RC students, faculty, and staff at the UIC School of Public Health systematically reviewed 92 IPLANs to identify areas of alignment, inform the update to the SHA/SHIP, and inform capacity building initiatives for LHDs. Results of this scan helped to understand the selected priorities and types of strategies used by LHDs, including **alignment of statewide priorities; unique geographic differences in priorities; use of policy, systems, environmental change approaches; and alignment in approaches and interventions across LHDs**.

Selected priorities and types of strategies used by LHDs

- alignment of statewide priorities
- unique geographic differences in priorities
- use of policy, systems, environmental change (PSE) approaches; and
- alignment in approaches and interventions across LHDs.

IPLAN Data

The priority scan included a review of 92 IPLANs representing all 102 Illinois counties. The structure of IPLANs is guided by section 600.400 of the Certified Local Health Department Code. Notably, all the IPLANs were created before the emergence of the COVID-19 pandemic.

Most IPLANS (84%) included chronic disease as a health priority. Mental health was listed as a priority in half of the IPLANs (52%), and access to care and substance use disorder were each listed as priorities in more than one-third (37%) of IPLANs. Priorities to address the SDOH appeared in only 13% of IPLANs. All other SHIP priorities appeared in 10% or less of the IPLANs.

Overall, few IPLANs proposed the multilevel, robust interventions necessary for addressing and improving health issues at a community level. Only 10% of (n=9) IPLANs proposed multilevel health education initiatives. In addition, **97% (n=87) of IPLANs contained strategies at the intrapersonal level on the socioecological model and 100% (n=92) of IPLANs had strategies pertaining to health education and counseling. Only 13% (n=12) IPLANs included priorities related to SDOH**. In alignment with recommendations from Public Health 3.0,[17] these findings point to a **need and opportunity to provide LHDs with capacity building or skill building supports to create more robust, wide-reaching, and sustainable interventions to improve community health**. This systematic scan provides a framework for categorizing LHD strategies. Additionally, findings may inform public health practitioners of key gaps, challenges, and opportunities for LHDs.

Surveys

The planning team conducted two surveys to gather insights from IDPH staff and the SBOH as well as LHD staff throughout Illinois to inform the SHA/SHIP update and the IDPH Strategic Plan. For the SHA/SHIP update, the purpose of the stakeholder survey was to inform priorities for the next two and a half years, inform the approach to address the priorities, and to understand the public health system's leadership and capacity needs. Perceptions of the Healthy Illinois 2021 SHIP priorities and the tension with new/emerging priorities, including COVID-19 and racism, were explored as well as perceptions about the capacity and capability of the Illinois public health system.

Focus Groups

The UIC P3RC and IPHI co-developed a facilitation guide designed to seek input from **public health system and community stakeholders and partners throughout the state** who are working on **Healthy Illinois 2021 priorities and emerging priorities**, including **COVID-19, anti-racism, and social justice and equity**. Five focus groups with various stakeholders from the public health system were held from September to October 2020 to **inform priorities for the next 18 months**, to **inform the approach to address the priorities**, and to **inform leadership capacity building in Illinois** to help address needs and gaps. Focus group participants were asked to discuss the **current and future state of the public health system, the role of the system in addressing structural racism, and the COVID-19 response thus far and needs for future COVID-19 response**.

4 Assessment Results

The four core assessments of the MAPP process that contributed to this SHA process provided detailed insights into community assets and priorities for health improvement, the forces of change contributing to and shaping the health of Illinoisans, the capacity of the statewide public health system to advance health equity, and the health status of residents throughout the state.

Summary of Findings from Each Assessment

Key findings from each of the four core assessments are highlighted below. For further details on any of the assessments, see the full reports in the Appendix.

Community Themes and Strengths

The CTSA gathered input from stakeholders throughout communities across the entire state, from social service providers to PWLE from groups that have historically been marginalized and/or experienced some of the poorest health outcomes.

Focus Group Findings

Through the focus groups, IDPH and the SHA/SHIP Planning Team were able to explore the concerns, perceptions, experiences, and priorities facing communities in their own words. The process elicited information about health priorities, systemic and structural barriers to health and well-being, community strengths and assets, the impacts of COVID-19, and challenges in accessing resources and services. After the preliminary data analysis, a second round of focus groups—a subset of previous PWLE—was conducted to solicit their feedback from the initial findings.

HEALTH CONDITIONS	SOCIAL AND STRUCTURAL DETERMINATIONS OF HEALTH (SSDOH)	COVID-19-RELATED ISSUES	PEOPLE WITH LIVED EXPERIENCE (PWLE)-SPECIFIC ISSUES
Key systemic issues for behavioral and mental health conditions (including substance use disorder) are access to services, stigma and bias of providers, and provider shortages. Chronic disease management difficulties—workforce, health education, and access. Access and education for reproductive health and early childhood years.	Transportation identified as an issue most frequently—access should be expanded through additional routes, medical transit, and expanding operations. Need training and education on health equity and SSDOH for public health system.	Heightened trauma from social isolation, grief, and increased substance use. Unemployment caused loss of income during the pandemic. Trust, awareness, and misinformation. Technology is both a strength and a barrier: + technology enables better access to health care and other services. – access to technology (affordability, internet, learning tech) is inequitable.	Community violence was elevated as a health priority in communities of color (CoC) and LGBTQIA+ sessions. Lack of transgender health and LGBTQ+ health care (especially in rural areas). Racism and discrimination are critical challenges for individuals with lived experience.

Figure 12. Focus Group Findings.

The key findings from the follow-up focus groups were consistent with the findings from previous focus groups. Community members agreed that **the COVID-19 pandemic has worsened outcomes for the emerging health priorities, especially mental health**. All focus groups identified that **access to care is a persistent barrier in addressing needs around the emerging health priorities**. Limited availability of health care providers, lack of awareness of available resources, and limited transportation options were cited as specific obstacles community members face when trying to access health care services. Community members offered ideas to **improve transportation** and emphasized that **communication between communities and LHDs is critical in improving access** to health care services.

The follow-up focus groups contributed to another level of stakeholder engagement and participation that helped produce a more refined SHA report that continues to uplift the voices in the community. Collaboration with PWLE allows for deep insight into the needs of communities across the state of Illinois. The input provided by PWLE served as a substantial resource during the development of the recommended strategies for the 2028 SHIP.

Forces of Change

The forces of change described in the partnership meetings—in response to the presentations and the findings from focus group and partner interviews—yielded the crosscutting themes described below, which are divided between broader infrastructure themes and specific health-related issues.

Infrastructure Themes

The Infrastructure Themes (Figure 13) were determined by the SHA/SHIP Partnership based on the data from presentations on key issues and summary findings of the partner discussions during the FOCA assessment and the priorities from the Healthy Illinois 2021: State Health Improvement Plan update. The infrastructure themes include Public Health 3.0,[18] Social (and Structural) Determinants of Health, Systems Level Changes through Policy, System Communication and Coordination, Workforce, Funding, and Data.

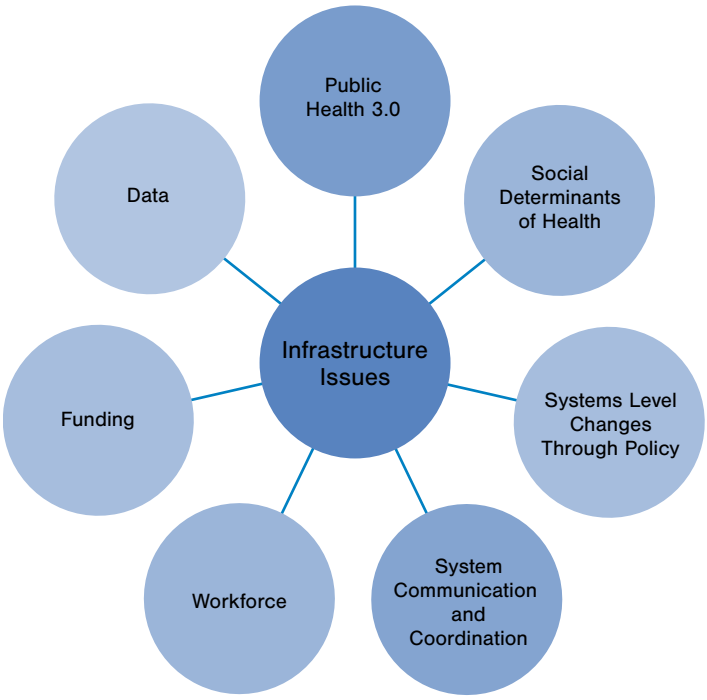


Figure 13. FOCA Infrastructure Themes

Health-Related Themes

The partnership discussed health-related themes (Figure 14) in discussion following the presentation on health priorities from the 2021 SHIP update and initiatives IDPH hopes to focus on in the future. Health-related themes were determined from data collected for the FOCA and discussions within the partnership. The main themes were Chronic Disease, Oral Health, and Behavioral and Mental Health.

The forces of change identified by the SHA/SHIP Partnership FOCA participants and primary data collected from regional social service providers and LHD staff represent key issues that will have important implications for the state public health system.

The partnership articulated the following recommendations based on the themes that emerged from the FOCA analysis, depicted in Table 1.

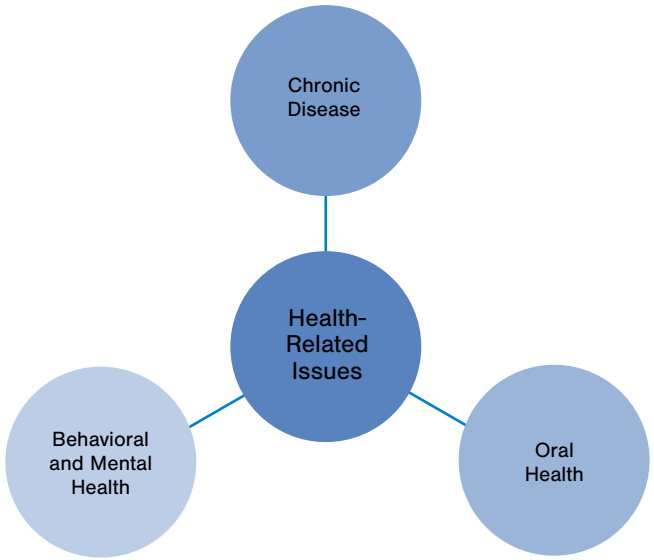


Figure 14. FOCA Health-Related Themes

	THEMES	RECOMMENDATIONS
INFRASTRUCTURE	Public Health 3.0	There is a need to incorporate a **Public Health 3.0 approach** at both the state and local levels of the public health system.
	Social and Structural Determinants of Health	**SSDOH** were frequently noted as something to focus on due to their impacts on the health and well-being of community members, as **starkly revealed by the COVID-19 pandemic.**
	Systems Level Changes Through Policy	Existing policies play an important role in maintaining inequities to **target health equity through systems level changes.**
	System Communication and Coordination	There is a need to **increase communication and coordination across sectors and state agencies** to encourage collaboration and improvement of existing work.
	Workforce	The current state of the public health system workforce is a major theme that serves as an opportunity (**recognizing existing expertise, increasing community representation,** and **providing professional development**) to address barriers due to COVID-19 and general burnout, workforce shortages, and hiring difficulties.
	Funding	There are both threats and opportunities related to funding, in particular these include the needs to **de-silo funding** and **eliminate inequitable funding**.
	Data	There is an opportunity and a need for **data modernization**, as the system is behind in data technology, lacks data standards, and needs user-friendly governance.
HEALTH	Chronic Disease	Increased need for **chronic disease management and prevention** were cited across presented data as well as through discussions with FOCA participants as an emerging trend throughout the state, specifically with **increases in need for renal dialysis caused by diabetes**.
	Oral Health	**Oral health** was noted as a statewide issue that is **particularly persistent in rural areas**, with access to treatment and resources remaining as barriers to care.
	Behavioral and Mental Health	**Youth mental health support**, an **improved behavioral and mental health workforce**, and more **culturally inclusive practices** in these programs and initiatives are emerging trends in behavioral and mental health.

Table 1. FOCA Themes and Recommendations

Public Health System Health Equity Capacity

The HECA, conducted with more than 85 public health practitioners across the state, unveiled the system's overall strengths, areas of opportunity, and priority actions to support the improvement of well-being and health equity for Illinois residents. This process not only elevated the importance of these key factors, but it will also inform the development of future state capacity assessment tools.

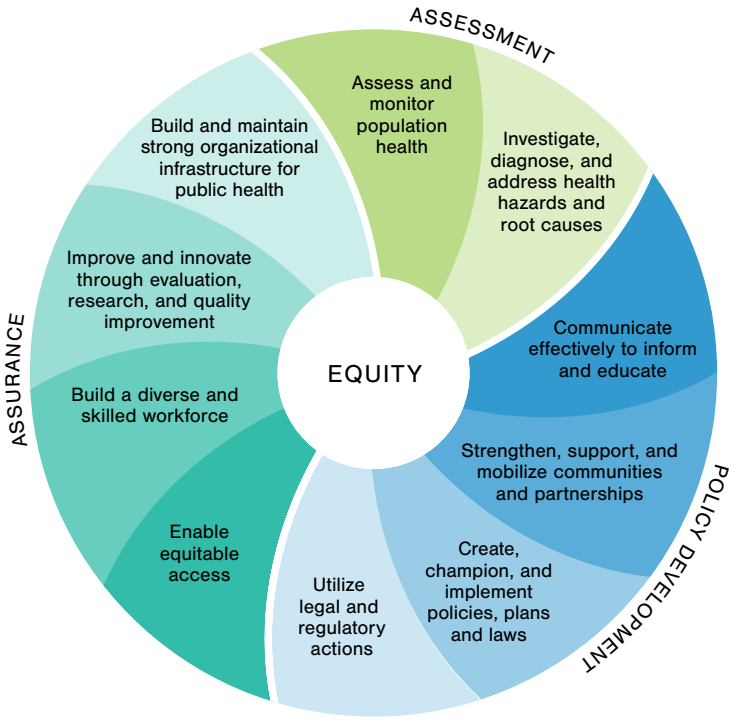


Figure 15. The 10 Essential Public Health Services, Updated 2020

Source: PHNCI (2020)

The findings related to system strengths and opportunities evolve around the need for increased and sustained funding to support critical public health functions in areas of workforce recruitment and development, enhanced data development and data-sharing capabilities to inform decision-making, and dynamic partnerships across the system inclusive of communities most impacted by health inequities. There is a need to expand system capacity in order to effectively learn from and work in partnership with communities to better understand needs, codevelop plans, and measure progress using a health and racial equity lens to guide/anchor all activities.

The identified priority actions call for an assessment of existing policies and procedures that cause harm to marginalized communities and stifle opportunities to tailor interventions that are in alignment with the diverse needs across the state. Practitioners are seeking greater autonomy, increased internal capacity, and mechanisms that support the needed systematic professional development to meet the adaptive range of both the system and community needs.

Data	Access to and use of data have improved. Acknowledgment of the role that data play in informing evidence-based practice and supporting evaluation, research, and quality improvement.
Partnership and Collaboration	There is a commitment to maximize impact through partnerships and collaboration that are inclusive of communities and range across various entities. The public health system displays expertise in effective convening of people and groups.
Workforce	Across the system, there is a desire to increase the size of and diversity represented in the public health workforce. The workforce is comprised of dedicated and competent staff to drive the work.
Health and Racial Equity	Recognition and progress toward advancing health and racial equity and addressing systems of oppression. Evidence of strong examples using a health equity lens to root and center public health efforts.

Emergency Preparedness	There is a heightened focus on strengthening systems and readiness to address hazardous events and improve rapid response efforts.
Funding	There is a need for greater and more equitable distribution of sustainable funding to support systemwide needs that include recruitment, retention, training of a diverse workforce, and data modernization efforts. Flexible funding is required to address the differing needs and priorities across the state.
Collaboration and Communication	Messaging across the system can be improved to be more timely, consistent, and bidirectional. Greater collaboration is also needed between the state health department, LHDs, and other coalitions/groups.
Community Engagement and Decision-Making	Outreach efforts and internal capacity to engage communities that have been marginalized and disproportionately affected by inequities in support of co-executing planning, implementation, and evaluation activities. Community member involvement is needed at every level including leadership and policy development.
System Infrastructure and Framework Improvements	Communication efforts should be built into the IPLAN and implemented in alignment with integration of existing plans across the state. A state-coordinated process should be used to conduct a racial equity impact assessment to better understand needs and to inform future action. A framework should be generated, and capacity aligned to improve perceived value of performance management and evaluation.

Table 2. Health Equity Capacity Assessment Themes.

Community Health Status

The CHSA reviews census, health indicator, survey, and service utilization data related to population characteristics, preventive and risk factors, and health outcomes to assess the health status of Illinois residents. The main focus is on the health status of Illinoisans. Select subgroup data are presented by age, sex, race and ethnicity, and geographic region, as appropriate, to aid in identification of disparities and trends.

It is important to note that data related to SSDOH are often not collected in surveillance of behaviors, risk factors, and outcomes. Critical to the understanding of health disparities presented in this report is acknowledgment that these are most often not related to group differences but to undocumented, systemic factors and conditions—the underlying SSDOH—that serve as root causes of these inequities.

State Demographics

Since the Healthy Illinois 2021, the state's population remained at nearly 13 million residents. Between 2010 and 2020, the total population decreased by 0.1 percent to 12,812,508 from 12,830,632 (Table 8). Its rank moved from 5th to 6th among the most populous states. As of 2020, nearly 70% of the state's population resided in the Chicago metropolitan area (Region 1 [Cook] and 2 [West Chicago]). These regions (Figure 15) each saw growth of slightly less than 2%. Over the last decade, other regions of the state experienced decreases in population of between 2.6% and 4.5%.

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

Table 3. Population Change in Illinois by Region, 2010–2020

Source: U.S. Census Bureau, 2020

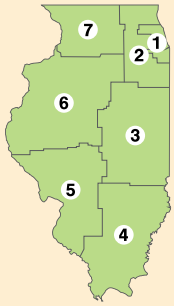


Figure 15. IDPH Regions

Illinois' population is aging, with the median age increasing from 36.3 years in 2010 to 38.3 years in 2020 (tables 4 and 5). The largest increase in population by age was among those 65 years and older, with a 25.3% rise from 12.5% to 15.7% of the population. Proportions of both working-age adults and children under 18 years decreased during this period. By sex, the proportion of males 65 years of age and older rose the most, from 10.8% to 13.9%, a 28.7% increase.

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

Table 4. Illinoisans' Age and Dependency Status, 2010–2020

*2020 Decennial Census (U.S. Census Bureau, 2022)

AGE BY SEX**	FEMALE		MALE	
	2010	**2020**	**2010**	**2020**
<18	23.4%	21.6%	25.4%	23.3%
18-64	62.3%	61.1%	63.8%	62.8%
65+	14.3%	17.3%	10.8%	13.9%

Table 5. Illinoisans' Age by Sex, 2010–2020

**ACS 5-Year Estimates (U.S. Census Bureau, 2022)

While the size of the overall population has not changed much in the past decade, the population has become more diverse in terms of residents' self-identified race and ethnicity (Table 6). There was a 125.5% increase in the share of residents identifying as more than one race, along with increases in the shares of Asians and Hispanics.

	2010		2020		
Race/Ethnicity	**Count**	**Percent**	**Count**	**Percent**	**% Change**
American Indian/Alaska Native	18,849	0.1%	16,561	0.1%	-12.1%
Asian/Pacific Islander	583,563	4.5%	747,280	5.8%	28.1%
Black or African American	1,832,924	14.3%	1,775,612,	13.9%	-3.1%
Hispanic	2,027,578	15.8%	2,337,410	18.2%	15.3%
White	8,167,753	63.7%	7,472,751	58.3%	-8.5%
Other Race	16,008	0.1%	45,080,	0.4%	181.6%
More than 1 Race	183,957	1.4%	414,855	3.2%	125.5%
Total Population	**12,830,632**		**12,812,508**		**-0.1%**

Table 6. Racial/Ethnic Demographics of Illinois Residents, 2010–2020
Source: U.S. Census Bureau, 2020

Illinois' population is more diverse in 2020 than it was in 2010. This is reflected most in the large increase in those identifying as More than 1 Race (125.5%), Hispanic (15.3%), and Asian/Pacific Islander (28.1%). In contrast, there were decreases in the shares of the population identifying as White (8.5%), Black or African American (3.1%), and American Indian/Alaskan Native (12.1%).

These patterns are similar across most of the state's regions (Figure 16). Decreases were seen in the proportion of the White population in all regions except for Region 4 (Marion), which showed an increase from 81% to 87%. The Hispanic population increased in all regions except Region 5 (Edwardsville), where it decreased from 6% to 3%. The largest increase in the Hispanic population was seen in Region 7 (Rockford), which grew from 10% to 13%. The share of Illinoisans who identify as Black or African American increased in Region 3 (Champaign) and especially in Region 5 (Edwardsville), where it grew from 3% to 13%; the population of Black or African American Illinoisans decreased most in Region 4 (Marion), from 14% to 5%. Asian population shares increased slightly or remained stable in most regions.

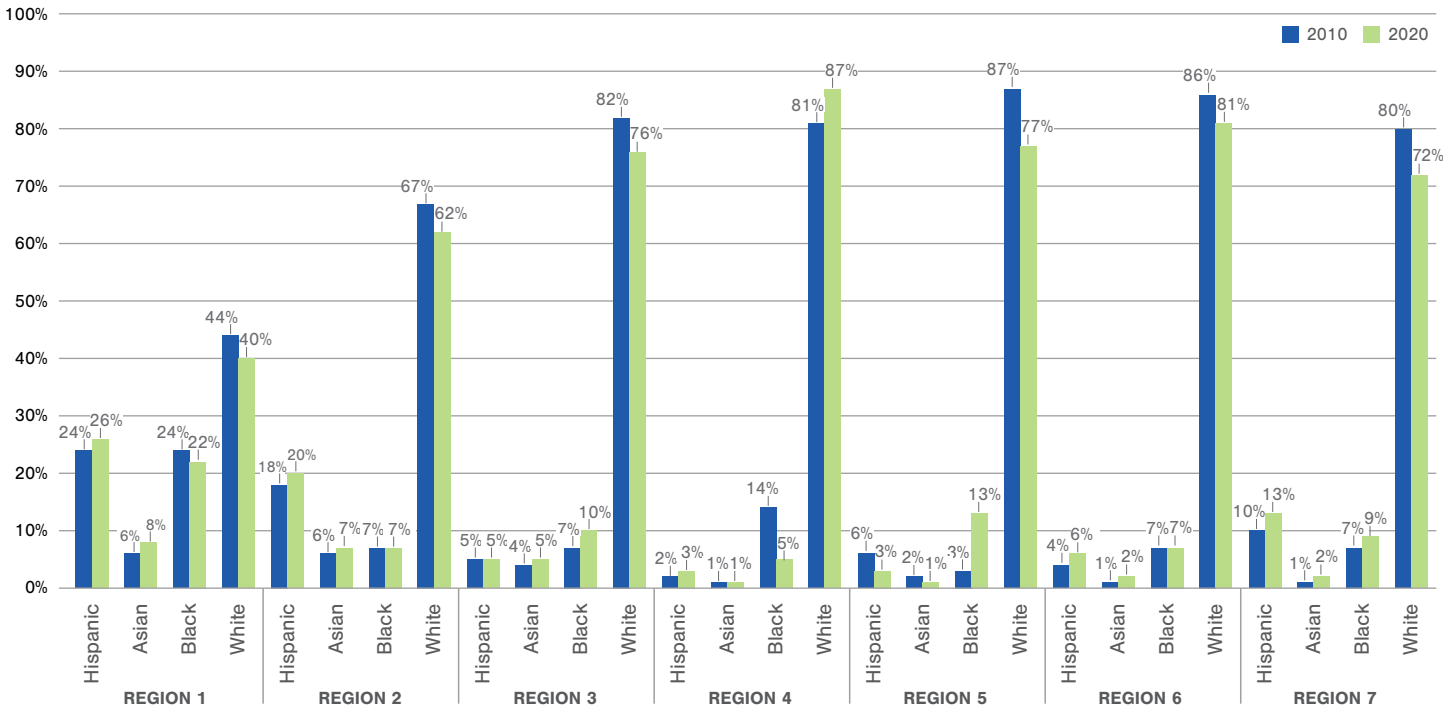


Figure 16. Changes in Race/Ethnicity Population Shares by IDPH Region, 2010–2020

Nearly two-thirds of Illinois households speak a language **other than English** (Table 7), and more than one-third of these speak English at a level below "very well."

		PERCENT WHO SPEAK ENGLISH ONLY OR SPEAK ENGLISH "VERY WELL"	PERCENT WHO SPEAK ENGLISH LESS THAN "VERY WELL"
Illinois			
Total population 5 years of age and older		91.4%	8.6%
Share of population that speaks only English	76.8%		
Share of population that speaks a language other than English	**23.2%**	**62.7%**	**37.3%**
Chicago			
Population 5 years of age and older		85.3%	14.7%
Share of population that speaks only English	64.0%		
Share of population that speaks a language other than English	**36.0%**	**59.3%**	**40.7%**

Table 7. Language Diversity and Capacity in Illinois and Chicago, 2015–2019

Source: U.Ss Census Bureau, 2015-2019
American Community Survey 5-Year Estimates

Additional findings from the CHSA are integrated into the descriptions of relevant priorities of the Healthy Illinois 2028 described below.

Convergence and Divergence Between Healthy Illinois 2021 and 2028

Partnership members reviewed the findings of each of the core assessments to identify cross cutting themes. They identified a number of health, structural, and infrastructure themes that appeared throughout the assessment. These are detailed in Figures 17, 18, and 19 below.

Health Themes

COVID-19 PANDEMIC	MENTAL AND BEHAVIORAL HEALTH	CHRONIC DISEASE
Leading cause of death in 2020—disparate rates across ethnic groups. Heightened trauma from social isolation, increased substance use. Communication efforts contributed to misinformation, public mistrust, and awareness gaps. Highlighted the need to focus on SSDOH (transportation, housing, food, racism). Opportunity to leverage lessons learned into future rapid response efforts.	High rates of mortality due to drug overdose, spikes in emergency department (ED) visits and substance use—disparate rates across ethnic groups. Need to implement culturally inclusive practices for these programs and initiatives and strengthen youth mental health support and increase behavioral/ mental health workforce as a whole. Challenges: access to services for youth and adults, stigma, and bias of providers.	Heart disease and diabetes are the leading cause of death, high rates of ED visits due to diabetes, hypertension, and asthma. Existence of chronic management difficulties—workforce, health education, and access.

Figure 17. Crosscutting Health Themes of 2023 SHA Findings

Structural Themes

SOCIAL AND STRUCTURAL DETERMINANTS OF HEALTH	STRUCTURAL RACISM AND HEALTH EQUITY	ACCESS TO HEALTH CARE AND WRAP-AROUND SERVICES
• Transportation • Unemployment • Community violence • Housing • Poverty • Food insecurity • Climate change • Physical and built environment	Persistent occurrence of hate crimes largely due to race and ethnicity. Racism and discrimination—evidence challenge shared by individuals with lived experience. Existence of increased recognition and progress toward advancing health, racial equity, and addressing systems across the state public health system. Opportunities—examine existing policies that sustain inequities and improve outreach and capacity to engage communities that have marginalized/ disproportionately affected.	Nearly 75% of adults completed annual checkups. Lack of trans health and LGBTQ+ health care (especially in rural areas). Barriers: health insurance coverage (or lack of), stigma, and workforce shortages.

Figure 18. Crosscutting Sructural Themes of 2023 SHA Findings

Infrastructure Themes

WORKFORCE DEVELOPMENT + OVERALL CAPACITY	DATA USE IMPROVEMENTS	SYSTEM COORDINATION AND COLLABORATION IMPROVEMENTS	OTHER—FUNDING
• Systemwide staffing shortages, burnout, training to address expertise gaps, hiring difficulties, diversity, and compensation. • Funding.	• Evaluation, data modernization, increased access and use of data for decision-making. • Shifts in existing data collection practices, development of shared definitions and practices. • Funding.	• Increase timeliness, bi-directional, and consistent communication, and coordination across the system. • Strengthen the commitment to maximize through partnerships and collaboration.	• Need to de-silo funding and eliminate inequitable funding practices. • Sustainable resources and flexible funding structures—where the need and spend-down plan is determined at the local level.

Figure 19. Crosscutting Infrastructure Themes of 2023 SHA Findings

The health, structural, and infrastructure themes identified above helped the partnership to narrow down the SHA findings to identify key priorities for Healthy Illinois 2028, as well as overarching SSDOH that should be addressed for each priority through implementation strategies.

Comparing the implementation requirements and key priorities of Healthy Illinois 2021 to Healthy Illinois 2028 (Figure 20), nothing was discarded from the previous SHA. The past several years has only added to the implementation requirements and key priorities for IDPH and its partners to address in the SHIP.

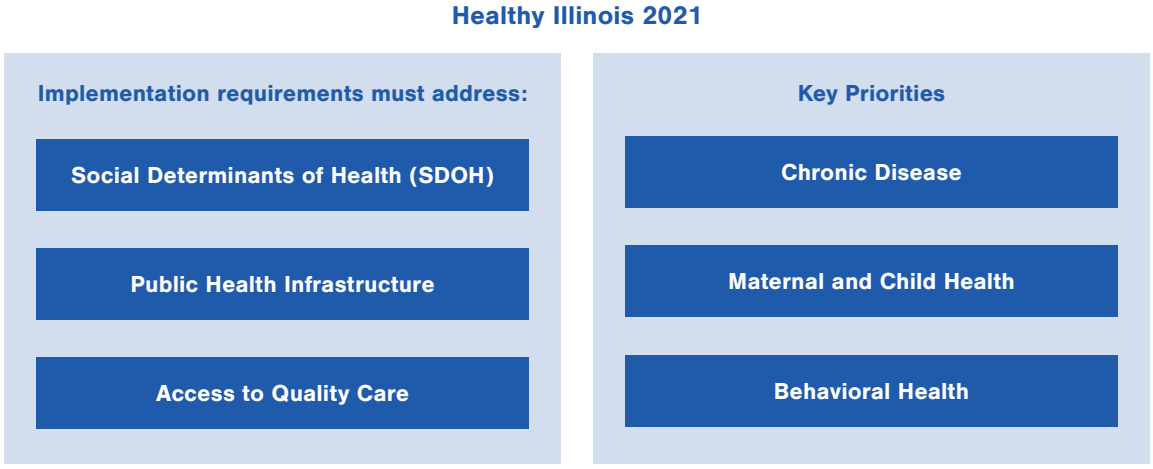


Figure 20. Evolution of Overarching Implementation Strategies and Key Priorities from Healthy Illinois 2021 to Healthy Illinois 2028

The overarching implementation strategies to address the key priorities grew from SDOH and Access to Quality Care to a broader umbrella of crosscutting issues, which includes Access to Health Care and Wrap-Around Services, Physical and Built Environment, Public Health System Infrastructure, Racial Equity, and Social and Structural Determinants of Health.

The key priorities from Healthy Illinois 2021—chronic disease, maternal and child health, and behavioral health—remained for Healthy Illinois 2028. Behavioral health was modified to mental health and substance use disorder was also added to this key priority. The major public health issues that emerged during the pandemic—COVID-19 and emerging diseases and racism as a public health crisis—were added to the key priorities.

5 Priorities

Several steps in the planning process were necessary in order to identify a set of health priorities for the state. Building on existing work was the first component in this process.

Healthy Illinois 2028 Prioritization Process

IDPH, in collaboration with the SHA/SHIP Partnership and the planning team, developed the priorities through extensive data analysis and assessment and feedback from stakeholders and community members throughout the state. The planning team began by identifying crosscutting themes shown across the four assessments. They presented these themes to the partnership, which provided feedback and further refined them. From there, the SHA/SHIP Planning Team compiled a list of priorities based on data from the four assessments and feedback from the partnership. The priority needs that surfaced largely reflect the same needs from the Healthy Illinois 2021 SHIP as well as the interim Healthy Illinois 2021 Update conducted in 2021. This priority list was split into two categories: health priorities and infrastructure priorities.

The compiled list was then sent back to the partnership for further prioritization. They ranked the health and infrastructure priorities separately, based on the agreed-upon prioritization criteria listed below.

Prioritization criteria:

- Potential severity of consequences for not addressing the issue.
- Potential impact: disparities, large number of people impacted and large geographic reach.
- Importance to the community.
- Complexity of issue—requires a strategic, collaborative approach, including policy, systems, and environmental change strategies.
- Alignment with other state plans and local IPLANs.
- Community strengths and assets to leverage.

The planning team also engaged community members with lived experience from the previous focus groups (from the Community Engagement report) to support the prioritization process. The planning team conducted follow-up focus groups with some of the previous participants. The intent of the focus groups was to receive feedback on the data collected from previous focus group participants, to share data findings from the other assessments, and to solicit input on the proposed SHIP priorities and potential solutions.

Following the community follow up focus groups and survey to the partnership members, the partnership further refined and finalized the priorities for Healthy Illinois 2028.

Framework to Inform Prioritization

To support the partnership's selection of priorities, the team was presented with three frameworks: the ASTHO Triple AIM for Health Equity, the CDC Health Impact Pyramid, and the three "Buckets" of Prevention. From those frameworks, the partnership utilized the ASTHO Triple AIM for Health Equity framework (Figure 31) due to the focus on health equity and systems change. This model was used to support the prioritization process as well as the recommendation of strategies to address the priorities for improving the public health system infrastructure.

ASTHO Triple AIM for Health Equity

Developed in partnership with the Association of State and Territorial Health Officials (ASTHO) and the Minnesota Department of Health (MDH),[19] the Triple AIM for Health Equity[20] is a multipronged approach to mobilize people, narrative, and resources to advance health equity.[21] These practices are based on a theory of change that recognizes the need to build collective capacity to advance health equity. As shown in Figure 21, the Triple AIM consists of 1) implementing a health in all policies approach with health equity as the goal, 2) expanding our understanding of what creates health, and 3) strengthening the capacity of communities to create their own healthy future.

Figure 21. ASTHO Triple AIM for Health Equity

Implement a Health in All Policies (HiAP) Approach with Health Equity as the Goal

This piece of the model takes a broader view of what creates health to better understand how policies related to transportation, housing, education, public safety or environmental protection can affect health outcomes. It begins to address these factors by taking a HiAP approach that encourages working across sectors to implement policies that broadly affect health in a variety of ways.

Expand Our Understanding of What Creates Health

The next component of the model is grounded in the belief that state health agencies serve a critical role in promoting public health and protecting the health of the people by providing access to health care services and applying the core public health functions to public health programs and systems (assessment, assurance, and policy development). Further, state health agencies are leaders in implementing programs and policies that address health disparities, populations with the greatest inequities, and rural populations. The model is intended to empower state public health systems to think about the impact social determinants have in health outcomes and, more importantly, the role state, local, and national policies play in shaping and addressing those determinants. By expanding the understanding of what creates health, we can begin to develop and to implement innovative policies that address key determinants of health inequities.

Strengthen the Capacity of Communities to Create Their Own Healthy Future

This piece focuses on strong public health leadership at the state level that can empower and support communities to get involved in creating policies and systems that improve conditions for their residents. State health agencies have a unique opportunity to chart a new course as public health transitions from focusing solely on preventing disease to understanding the whole person and the impact culture, society, and the environment have on a person's health journey. The component is intended to inspire state health agencies to build strong bridges with local and community organizations who support communities in strengthening their capacity to create their own health future.

Update of Healthy Illinois 2021 Plan Priorities: Improving Public Health Infrastructure to Address Health Equity

Overall, chronic disease; mental and behavioral health, including substance use disorder; maternal and infant health disparities; SDOH; and access to health care and wrap-around services continue to be significant Illinois public health priorities. Based on the data presented for the SHA update, the SHIP team – a separate team consisting of similar participants as the partnership but appointed prior to 2022 – identified the need to continue to focus on these priorities while also focusing on increased disparities related to mental and behavioral health and chronic disease as well as a need to prioritize health equity, including addressing racism and COVID-19.

Since the updated SHA data revealed a clear need to enhance and further build the infrastructure for a high-functioning and resilient public health system, the SHIP team determined a focus on improving the public health system infrastructure was necessary to adequately address the Healthy Illinois 2021 priorities.

Specifically, COVID-19 illuminated the need to greater bolster the public health infrastructure to address racial and ethnic inequities in health. As such, the SHIP seam recommended that the public health system should collectively execute specific areas of focus to support communities of color and low-income communities to provide resource needs and build capacity for better health outcomes.

The data identified current public health system strengths in Illinois that should be leveraged and amplified and several challenges that must be improved. When finalizing the Healthy Illinois 2028 priorities and crosscutting issues, the partnership recognized the importance of improving public health infrastructure to address health equity. As a result, public health infrastructure strengths and challenges were integrated into the crosscutting issues when developing the goals, objectives, and recommended strategies for the Healthy Illinois 2028 priorities.

Healthy Illinois 2028 Priorities

The final priorities identified for Healthy Illinois 2028 are presented below in Figure 22, with the crosscutting issues integrated throughout the priorities. Each priority is described thereafter, with supporting data from the core assessments that make up the SHA.

Nearly every one of the crosscutting issues appears within the

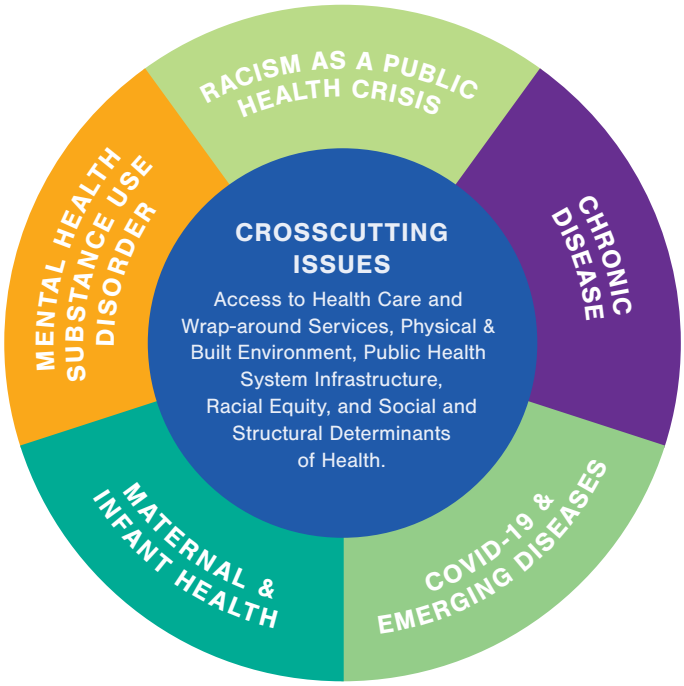


Figure 22. Healthy Illinois 2028 Priorities

descriptions of the health priority areas. For example, public health system infrastructure shapes the system's ability to identify and to improve issues in each priority area. Access to health care and wrap-around services, or lack thereof, is a root cause of the inequities seen across the health priorities. The physical and built environment– which to some extent encapsulates transportation, food insecurity, and housing—is fundamental to many of the issues related to chronic disease. Climate change also impacts the physical environment as well as contributing to emerging diseases. And community violence shapes public health throughout the life course in terms of weathering, which plays a key role in the health outcomes that make racism a public health crisis. Community violence throughout the life course also has devastating effects on maternal and infant health, mental health and substance use disorder, and even chronic disease through issues such as mobility.

Following the descriptions of the relevant data from the assessment processes for each health priority area are similar summaries for each of the crosscutting issues that impact health inequities.

Chronic Disease

Chronic diseases are defined broadly as conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both. Chronic diseases, such as heart disease, cancer, and diabetes, are the leading causes of death and disability in the United States. They are also leading drivers of the nation's $4.1 trillion in annual health care costs. Many chronic diseases are caused by a short list of risk behaviors: tobacco use and exposure to secondhand smoke; poor nutrition, including diets low in fruits and vegetables and high in sodium and saturated fats; physical inactivity; and excessive alcohol use.

The CHSA shows that **slightly more than half of Illinois residents are living with a chronic condition. This rate is similar across most racial/ethnic groups**. The prevalence of conditions like **arthritis and functional disability** increases with increasing age. Higher proportions of these conditions are seen **outside of the Chicago metropolitan area** and rural areas. **Diabetes** prevalence is higher in Hispanic and African American residents, in nonurban areas, and among those with less than a high school diploma. **Adult asthma** is more prevalent among Black or African American Illinoisans and those who identify as "other race" as well as for females and lower-income households.

Nearly 1 in 3 Illinoisans are obese; the highest prevalence is seen in Black or African American residents and in nonurban areas of the state. Similar, though higher, rates of obesity are seen among those without a college degree. **Nearly 1 in 3 Illinoisans have high blood pressure and high cholesterol**. The frequency of hypertension and high cholesterol increases with age, and higher prevalence is seen among African American, White, and non-urban residents. Prevalence of hypertension and high cholesterol align with obesity prevalence for many demographic characteristics.

Chronic disease management and prevention were some of the most frequently cited challenges in the FOCA. FOCA participants specifically mentioned several chronic diseases, such as hypertension and diabetes. A few participants in the northeast and southwest areas of the state identified issues with high use of renal dialysis in their communities caused by diabetes and high blood pressure often related to physical conditions and SSDOH.

In the FOCA, oral health was highlighted by partnership members as a statewide issue that has shown significant disparities among populations considered low-income, rural communities, communities of color, people who are pregnant, and people living with disabilities.[22] They most frequently identified lack of access to care for treatment and resources related to oral health as

barriers for those communities. Oral health becomes a chronic disease the longer it goes untreated or undertreated and contributes to the worsening of other conditions.

The partnership identified some of the most important chronic diseases and factors impacting Illinoisans to include asthma, diabetes, cardiovascular disease, hypertension, nutrition, and oral health. Focus group participants, including service providers and PWLE, both shared concerns about how the COVID-19 pandemic and preexisting conditions compounded to make chronic conditions worse.

Selected quotes from focus groups:

> *Existing public health issues need to be resolved—like diabetes, obesity, cardiovascular disease. These things [were] put on the back burner from COVID, and there is a significant need to revisit those public health issues. Not being able to go to actual doctors made chronic conditions worsen."*
>
> – SOCIAL SERVICE PROVIDER FROM MARION

> *I have been diagnosed with diabetes and I have some treatment plans for it, and I couldn't carry it out effectively as a result of being low income."*
>
> – FOCUS GROUP PARTICIPANT FROM CHAMPAIGN

COVID-19 and Other Emerging Diseases

The COVID-19 pandemic has had devastating direct impacts on the health status of Illinoisans. At the same time the public health emergency revealed substantial weaknesses within the public health system as well as its inextricable interconnectedness with key SSDOH issues. But the partnership highlighted COVID-19 and emerging diseases as a priority area for Healthy Illinois 2028 not only because of the failures and flaws in the system that COVID-19 revealed but also because of the innovations it precipitated. Namely, partnership members acknowledged that the public health system thrived in the COVID-19 response when it leveraged partnerships to address capacity and infrastructure shortcomings. Ideally, this more integrated approach to preparedness for addressing new and emerging diseases will align with a systemwide transition to focus on preventative measures, deemphasizing reactive responses to negative health outcomes.

CHSA data show that the **COVID-19 pandemic** saw at least three peaks thus far in infections and deaths since its official declaration in March 2020. Case rates by race/ethnicity were highest in the most recent period for which data are available—January through June 2022. Case rates by race/ethnicity varied by time period (Figure 23), with **those who identify as Hispanic or "other race" having higher rates early in the pandemic**. Black or African American and White case rates have increased in periods since January 2021. **COVID-19 mortality remains highest among Black or African American Illinoisans**. Hispanic mortality from COVID-19 has decreased gradually across periods, while White mortality rates rebounded in the most recent period.

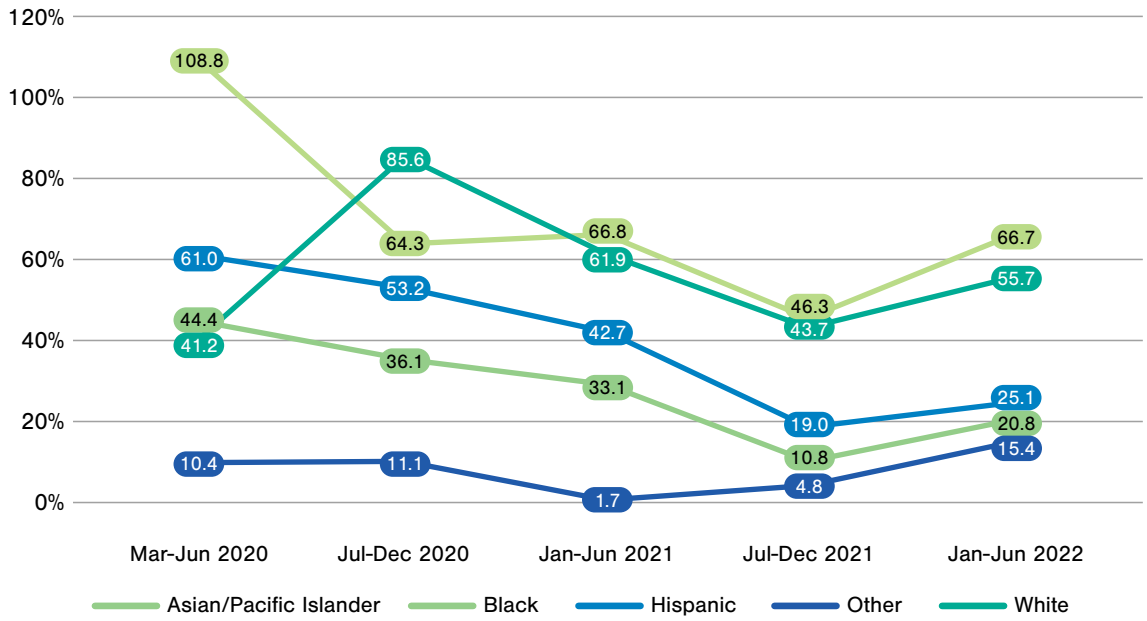


Figure 23. Illinois COVID-19 Mortality Rates per 100K Population, by Race/Ethnicity, Selected Periods March 2020–June 2022

Source: IDPH, 2022

The FOCA found that COVID-19 highlighted and exacerbated threats existing within the public health workforce, such as burnout, workforce shortages, and hiring difficulties (recruitment and retention), and limited available time due to staff being pulled in many different directions. The partnership also described the need to strengthen policies related to protecting local public health authority and clarify the vagueness of other policies, such as those related to quarantine. More attention to policies that protect the public's health through SSDOH was also identified as an opportunity. These include policies like increasing the minimum wage to a living wage, ensuring paid sick leave and access to affordable child care, and making tax policy more equitable.

Some of the most concerning issues to arise out of the COVID-19 pandemic were the breakdown of trust and communications between public health/government and communities. This has and will continue to cause real harm until it is repaired.

Selected quotes from focus groups:

> *Trust in the health care system—this is a real issue we will be facing. Doctors are saying [COVID-19] doesn't exist. We are learning as we are living in this pandemic, and guidance has changed, so people don't trust us. Social media has also contributed. Entitled behavior—if it doesn't affect me, I don't have to deal with it. Communities, schools, parents who don't think COVID is serious are showing the youth that if you argue with a rule, you get your way."*
>
> – SOCIAL SERVICE PROVIDER FROM CHAMPAIGN

> *Decreased trust in public health—we deal with on daily basis. Not only with the community but also with elected officials. The pandemic was a perfect storm. It will take a while for the community and constituents to trust us again. How can we continue to work towards improving public health when in some communities there is no trust?"*
>
> – SOCIAL SERVICE PROVIDER FROM PEORIA

> *Another thing we will see and are seeing is increased vaccine hesitancy for ALL vaccines because of the COVID vaccine and politicization of it. That can have negative implications for many communicable diseases in addition to COVID."*
>
> – SOCIAL SERVICE PROVIDER FROM CHAMPAIGN

The FOCA also identified a need to improve external communications to build trust with the populations public health serves in order to combat misinformation and increase health literacy and trust in public health. One way to do this is to bring in partners that represent diverse communities to understand and address community needs, specifically identifying the best and most-trusted voice for each community. The HECA also recommended that public health should ensure staff are representative of the communities served, especially in health communication roles, to help facilitate increased trust and collaboration.

Through the HECA, the partnership also recommended public health should take a harm reduction approach when it comes to vaccination, boosters, and treatment, recognizing the history of mistrust with communities in developing and implementing approaches to outreach.

Vaccine access and distribution were also recognized as priority issues related to COVID-19 and emerging diseases across the assessments. In the FOCA, the partnership recognized the emerging threat of overreliance on web-based systems to reach the public, as many community members are unable to access events and information, which was revealed through barriers to COVID-19 vaccination and testing. Transportation also plays a key role in facilitating vaccine access and distribution, as noted by a focus group participant.

> *"Access to transportation. That is a major concern even to get the vaccine. Had to make huge effort to get folks the vaccine [especially] older adults and people with disabilities."*
>
> – SOCIAL SERVICE PROVIDER FROM CHICAGO/CHICAGOLAND SUBURBS

Maternal and Infant Health

Maternal and infant health (MIH) seeks to improve access to health care and deliver quality public health services for reproductive and infant health. The partnership decided to modify the priority area from Healthy Illinois 2021 to MIH, rather than maternal and child health, to align with existing efforts and to make the goals more feasible within a five-year time frame.

MIH is of particular concern, since statewide MIH data show that Illinois falls short of national benchmarks and has higher rates of negative outcomes than the national average for many indicators. Since 2010, infant mortality rates in Illinois have remained relatively unchanged—consistently higher than the national Healthy People 2030 benchmark of 5.0 deaths per 1,000 live births—with a statewide average of 6.3 over the decade. What is even more concerning is the stark disparity observed

between population groups by race/ethnicity. For example, the infant mortality rate among Black/African American Illinoisans remains more than two times higher than the overall Illinois rate.

Preterm births and low birthweight births have also remained consistently higher statewide than the national average over the last decade, with Black/African American rates appearing as extreme outliers for each, consistently 40% and more than 70%, respectively, higher than the national averages.

As with many other health indicators, MIH is impossible to extricate from SSDOH. Racism and discrimination against immigrants, for example, show up in inequities in access to care and outcomes in MIH in Illinois.

> *"[We're] seeing maternal health disparities with race, due to less access for our families of color [who are] not able to get prenatal care, and transportation is an issue. Seeing wider discrepancies with families of color and immigrant families. One of many challenges to connecting immigrant families with health care."*
>
> – SOCIAL SERVICE PROVIDER FROM ROCKFORD

Another concern related to maternal health that emerged during the FOCA process is that oral health is a risk factor for maternal mortality throughout the state. The partnership recognized that it is necessary to strengthen monitoring and access to care to reduce maternal mortality due to oral health problems.

Mental Health and Substance Use Disorder

The WHO definition of mental health is as follows:

> *Mental health is a state of mental well-being that enables people to cope with the stresses of life, to realize their abilities, to learn well and work well, and to contribute to their communities. Mental health is an integral component of health and well-being and is more than the absence of mental disorder.*[23]

The positive dimension of mental health is stressed in the WHO definition of health as contained in its constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[24]

Behavioral and mental health was described as a crosscutting theme across communities in the state that was greatly exacerbated by the COVID-19 pandemic. Overall, the partnership identified youth mental health support, an improved behavioral and mental health workforce, and more culturally inclusive practices in these programs and initiatives as emerging trends in behavioral and mental health.

CHSA data confirm the increases in mental health problems and substance use disorder throughout the state. **Mortality due to drug overdose and opioid overdose** increased over the period from 2016 to 2020 (Figures 24 and 25), with the **highest rates seen in 2020 across all groups**. The highest death rates were among Black or African American Illinoisans, while the lowest rates were among Hispanic residents and those who identify as "other race."

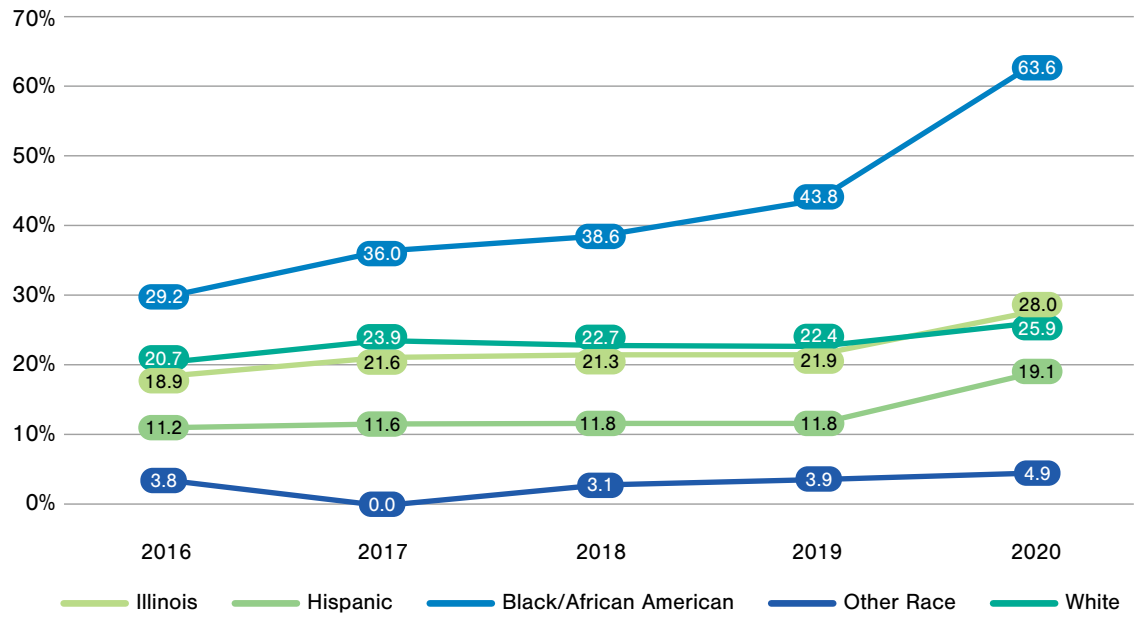


Figure 24. Drug Overdose Mortality Age-Adjusted Rate per 100K Population, Illinois and by Race/Ethnicity, 2016–2020

Source: Illinois Deth Registry, IDPH

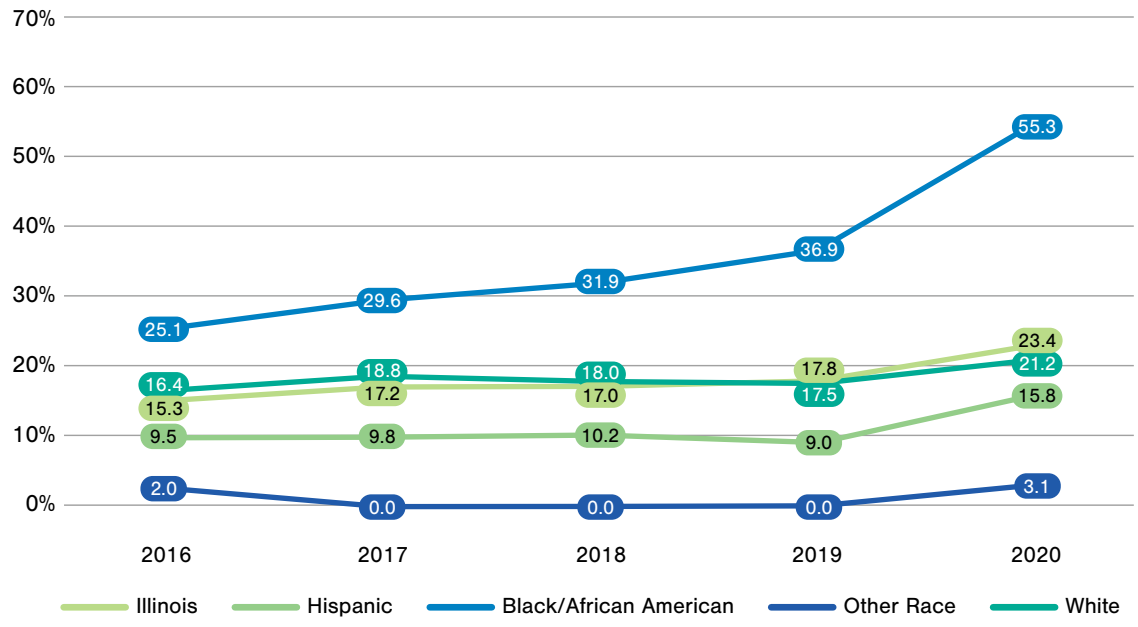


Figure 25. Opioid Overdose Mortality Age-Adjusted Rate per 100K Population, Illinois and by Race/Ethnicity, 2016–2020

Source: Illinois Deth Registry, IDPH

Racial/ethnic disparities in access to mental health care and substance use disorder treatment are evident in CHSA data that show the rate of emergency department visits for nonfatal opioid overdoses are highest among Black or African American residents, while the rate of hospitalization is highest among White residents. Similarly, overall **emergency department visit rates for substance or alcohol misuse** were highest for Black or African American residents.

Slightly more than 1 in 10 residents reported having **14 or more days of poor mental health**, with similar rates across regions of Illinois. The highest prevalence was seen in those 18-24 years of age, African Americans and those who identified as "other race," and lower-income groups.

Increasing need for accessible mental health and substance use disorder supports

Participants in the social service provider focus groups identified a significant increase in the prevalence and severity of behavioral and mental health as well as substance use disorder issues.

Selected quotes from focus groups:

> *Behavioral health and mental health issues come up in every conversation we have had. Longstanding underfunding of those issues and issues emerging with COVID. Substance use disorder issues are also increased. COVID aggravated an already bad issue."*
>
> – SOCIAL SERVICE PROVIDER FROM MARION

> *Schools and providers in [our] county are reporting that individuals are presenting with significantly increased levels of need for behavioral health and substance use disorder services. The numbers of people are not increased as much as the level of care needed."*
>
> – SOCIAL SERVICE PROVIDER FROM WEST CHICAGO

Participants in the focus groups with community residents and PWLE also commented on challenges related to mental health.

Selected quotes from focus groups:

> *There is a lot of stigma. People don't want to talk about or choose to ignore mental health issues."*
>
> – FOCUS GROUP PARTICIPANT FROM CHICAGO/CHICAGOLAND SUBURBS

> *We need affordable mental health resources to help with anxiety/depression that may have come from the pandemic experience."*
>
> – FOCUS GROUP PARTICIPANT FROM CHICAGO/CHICAGOLAND SUBURBS

> *I have tried getting an appointment with a therapist and it took maybe like four or five months to set up an initial appointment with a therapist and then finally when I did set it up, they no-showed; and so I couldn't really get the help that I needed."*
>
> – FOCUS GROUP PARTICIPANT FROM CHICAGO

Access to mental health services is further limited by intersecting issues such as language barriers:

> *"[It's] very difficult to find counselors and therapists that speak Spanish."*
>
> – FOCUS GROUP PARTICIPANT FROM CHICAGO/CHICAGOLAND SUBURBS

In the FOCA, partnership members identified a continuous and growing need to provide culturally and linguistically inclusive mental health resources, programs, and initiatives across the state and in rural areas.

Youth and adult mental health and substance use

Focus group participants particularly highlighted how youth mental health and substance use disorder issues have increased.

Selected quotes from focus groups:

> *Working with the high school, we've seen a jump in substance use infractions (usually 100 all year, now 30 in the first month). [Also, we're] hearing throughout the country that adults are reporting 25% more alcohol use to cope. Seeing a trend."*
>
> – SOCIAL SERVICE PROVIDER FROM BELLWOOD

> *Schools are behind on learning and social-emotional because of COVID."*
>
> – SOCIAL SERVICE PROVIDER FROM ROCKFORD

> *[There's been an] uptick in demand for behavioral health services, for students especially. It's not over. And will be a foreseeable problem. School issues—around quarantining, isolation, behavioral issues in school, transition issues for incoming freshman/socializing."*
>
> – SOCIAL SERVICE PROVIDER FROM BELLWOOD

> *Youth may have lost a family member or caregiver [or been affected by] unemployment. Other kids have anxiety and fear thinking they are going to die, etc. The number of kids who have lost a parent or caregiver may be 146,000. Some families and kids may not be able to pick up education and catch up. . . . We are going to take decades to recover from this."*
>
> – SOCIAL SERVICE PROVIDER FROM EDWARDSVILLE

Adults are also facing mental health and substance use disorder challenges.

> *"Definitely isolation [is a problem]. It's hard to get back into the real world and talking to other people because you're not used to the face-to-face communication."*
>
> – FOCUS GROUP PARTICIPANT FROM CHICAGO/CHICAGOLAND SUBURBS

Racism as a Public Health Crisis

Racism is defined by Dr. Camara Jones, a physician, epidemiologist, and anti-racism activist, who specializes in the effects of racism and social inequities on health, as a

> "...system of structuring opportunity and assigning value based on the social interpretation of how one looks (. . .what we call 'race'), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strengths of the whole society through the waste of human resources."[25]

The American Public Health Association (APHA) website on racism and health describes the relationship between racism and health as follows:

> Racism structures opportunity and assigns value based on how a person looks. The result: conditions that unfairly advantage some and unfairly disadvantage others. Racism hurts the health of our nation by preventing some people the opportunity to attain their highest level of health.

At the time of writing, seven entities within the northeastern and central regions of Illinois have declared racism is a public health crisis. These include the Champaign School Board, the city of Chicago, and Chicago Department of Public Health, the Cook County Board of Commissioners, Decatur Public School District, Lake County Health Department, Peoria City/County Health Department, and the Rook Equity Rapid Response Team.

The number of items highlighted in this report for which American Indian/Alaska Native, Hispanic, and Black or African American Illinoisans have the most negative outcomes is staggering. **It cannot be overstated that findings disaggregated by race/ethnicity do not indicate a biological, genetic, or pathological causal link between race/ethnicity and health outcomes.**[26] **This is because race and ethnicity are social constructs, with no biological basis**, and thus they have limited utility in understanding medical research, practice, and policy. However, the terms may be useful as a lens through which to study and to view racism and the resulting disparities and inequities in health and health care. With this caveat, it is essential to reiterate that **disparities in health outcomes according to race/ethnicity have nothing to do with biology and everything to do with inequitable distributions of money, power, and resources due to geography, culture, and sociopolitical forces**.

For quantitative data on these inequities by race/ethnicity, see the full CHSA report in the Appendix. Suffice to say that communities of color experience the poorest health outcomes in Illinois for the vast majority of indicators. **The mere fact that these inequities by race/ethnicity persist across diverse morbidity and mortality statistics, across geographies and income levels, demonstrates that addressing these health outcomes at an individual or clinical level will be wholly insufficient at reversing, mitigating, or preventing the continuation or worsening of these inequities**.

Racialized health disparities and discrimination

Throughout this SHA process, partnership members noted that health disparities are racialized. This is evident through the substantial disparities by race/ethnicity in key priorities, including chronic disease (e.g., heart disease, cancer, diabetes, and kidney disease), as well as accidents and maternal/infant mortality. Focus group participants pointed out that discrimination and prejudice or implicit bias are serious contributors to these inequitable outcomes.

Selected quotes from focus groups:

> *[The biggest barrier is] the racism in providing health care and diagnoses that are racist—it's implicit in all of this."*
>
> – REPRESENTATIVE FROM NAMI

> *We get a lot of people judging us because there are some parts of my family that don't speak really good English. People get really impatient or start saying things. Even within the Hispanic community, there is racism because there are some Hispanics that are darker than others (colorism)."*
>
> – FOCUS GROUP PARTICIPANT FROM CHICAGO/CHICAGOLAND SUBURBS

> *[We] have a lot of White doctors. Need to have more Black doctors to communicate more freely with each other. The barrier is racism."*
>
> – FOCUS GROUP PARTICIPANT FROM CARBONDALE

To begin to address these inequities, the FOCA determined that data collection standards are needed for greater specificity, particularly with respect to race/ethnicity. This lack of specificity precludes disaggregation of race/ethnicity data required to understand and to address the needs of specific marginalized populations.

Moreover, the HECA identified a need to expand system capacity in order to effectively learn from and work in partnership with communities to better understand needs, codevelop plans, and measure progress using a health and racial equity lens to guide/anchor all activities. At a minimum, the identified priority actions call for an assessment of existing policies and procedures that cause harm to marginalized communities and stifle opportunities to tailor interventions that are in alignment with the diverse needs across the state.

Illinoisans who identify as "other race"

In considering inequitable health outcomes according to race/ethnicity, it is worth highlighting the lack of specificity when it comes to individuals whose racial/ethnic identity does not correspond with one of the given categories. While the demographics data indicate that Illinois residents who choose "other race" as their racial/ethnic identity represent only 0.4% of the state's overall population, many of the health indicators described in this report show that this group has some of the worst outcomes.

For example, Illinoisans who identify as "other race:"

- are among the most likely to lack a high school diploma,
- are nearly 1.5 times as likely to be unemployed compared to their White counterparts,
- have the highest rates of smoking and a higher prevalence of adult asthma, and
- have among the highest rates of poor mental health days and depression.

One finding that may be suggestive of a protective factor is that those who identify as "other race" have consistently had the lowest drug-related mortality rates in the state over the past five years.

Because the sample size is relatively small, it can be difficult to draw broader conclusions from these data. But while analyzing small samples may be challenging, it is not impossible. Small population methodologies exist that facilitate such analysis and should be considered in this case.

Furthermore, this population group has grown significantly in size over the past five years, from 16,008 Illinois residents in 2016 to 45,080 in 2020. This represents nearly a fourfold increase from this group's share of 0.1% of the state's population in 2016, which both facilitates analysis and underscores the need for a better understanding of this population group's assets and needs as it relates to SSDOH equity.

Lack of diversity in the workforce

Another issue identified throughout this SHA is lack of diversity in the workforce. The assessments highlighted that decision-makers are not representative of the communities they serve. In the HECA, the health system's ability to fulfill one of the assurance functions of public health, "Build and support a diverse and skilled public health workforce," was rated as minimal. Comments from focus groups confirmed this finding and shed light on how this shortcoming precludes equitable access to quality care and perpetuates inequitable outcomes.

Selected quotes from social service providers focus groups:

> *What we're hearing from the Spanish-speaking community, [the problem is] not only speaking the language but a need for cultural competency, especially for new immigrants. If the provider does not look like them, there is a gap."*
>
> – REPRESENTATIVE FROM NAMI

> *One thing that I think is impacting my community's health is the language barrier. Many Chinese immigrants do not speak English, and this makes it hard to even schedule appointments, to understand health care professionals, and communicate their own needs."*
>
> – FOCUS GROUP PARTICIPANT FROM CHICAGO/CHICAGOLAND SUBURBS

> *[We need to] hire to reflect the community. . . . The long history of housing segregation is so deeply ingrained in this area."*
>
> – SOCIAL SERVICE PROVIDER FROM BELLWOOD

In the HECA report, the partnership recommended strengthening the assurance functions of public health with respect to increasing diversity in the workforce by working toward equitable engagement of community health workers, community-based organizations, and community members; identifying funding for workforce tuition reimbursement sourced from outside of health departments and community-based organizations; and supporting and offering micro credentials—not just degrees. Additionally, the FOCA identified improving external communications as an opportunity to support workforce development by building health literacy and trust in public health to inspire recruitment from the diverse communities served by public health.

Institutional and systemic racism

The assessments that make up the SHA found that the health system's capacity to work with a racial equity approach is limited by institutional and systemic racism. Focus group participants suggested the present moment is the perfect opportunity to tackle these challenges head-on.

Selected quotes from focus groups:

> *IDPH needs to look at what policies they are implementing, enforcing, or not enforcing that have an impact. Nonprofits can't take it all on when faced with the restrictions. Take a look [with a] racial equity lens at their own policies."*
>
> – SOCIAL SERVICE PROVIDER FROM BELLWOOD

> *With the politics, [this may be] one of our few chances to lean in to address systemic racism and inequities of our health systems and ensure resources are going the right way. Use this generational influx of resources to make a lasting difference. . . . Address racism as a public health crisis to make the most impact with the funds we are using. [We need a] funding formula to identify where we send out more funding to Black and Brown communities."*
>
> – SOCIAL SERVICE PROVIDER FROM BELLWOOD

To improve the health system's capacity to better understand needs and inform future action, particularly with respect to racism as a public health crisis, the HECA recommended improving the state's capacity to fulfill its assurance functions for public health through the development of a state-coordinated process to coordinate, to fund, and to conduct racial equity impact assessments. In the FOCA, the partnership also recognized that some policies (specifically tax) are inequitable and have historically contributed to worsening income, wealth, and health disparities.

Crosscutting Issues

The key crosscutting issues incorporated across the health priority areas of Healthy Illinois 2028 are: access to health care and wrap-around services, public health system infrastructure, physical and built environment, racial equity, and social and structural determinants of health. As described earlier, by using the term social and structural determinants of health (SSDOH) instead of social determinants of health (SDOH), this assessment aims to focus the analysis and recommendations of this SHA/SHIP process as much as possible on structural determinants, or the root causes, of health inequities. Social and structural determinants of health include transportation, food insecurity, housing, community violence, and climate change. These crosscutting issues were drawn from the outcomes of the core assessments that contributed to the development of Healthy Illinois 2028, as summarized in the following section.

Core Assessments

The CTSA findings included a significant focus on SSDOH, with housing, transportation, healthy food access, violence, lack of trust in health systems, social isolation, and the impact of COVID-19 cited as significant issues impacting communities' ability to achieve optimal health and well-being.

The crosscutting issues approach aligns with the recommendation from the FOCA for the field to incorporate more of a Public Health 3.0 approach in its work. Specifically, the partnership described the need to shift toward a more systems-level, holistic approach focused on regional issues and de-emphasize individual service provision and programs in local areas, which was identified as a threat in the forces of change analysis.

HECA provided recommendations for improving the assessment functions of public health. These included conducting a review of processes to reimagine the focus through the lens of the crosscutting issues rather than just health. Other HECA recommendations include allocating funding to address SSDOH and eliminating silos related to funding to facilitate and increase systemic and systematic approach.

Implementation Requirements

For the purposes of Illinois' SHA and Improvement Plan, SSDOH are considered implementation requirements for addressing health improvement. These factors are described here to better

understand what contributes to the health of Illinois residents. The information provides a more complete picture of the health of Illinoisans but will also be used in the action planning process to identify recommendations that can improve health and advance health equity in the Healthy Illinois 2028 priority areas.

Building off of the overall strengths and targeting the specific challenges identified in this SHA, the partnership settled on the following crosscutting issues that relate to all of the priorities for Healthy Illinois 2028: access to health care and wrap-around services, physical and built environment, public health system infrastructure, racial equity, and SSDOH. Each of these crosscutting themes are described below, along with supporting data from the SHA assessment processes.

Public Health System Infrastructure

Public health system infrastructure includes systems and capacity related to data, workforce, resources and funding, and coordination and collaboration. Some of the elements of public health system infrastructure that were highlighted throughout this SHA process included workforce capacity, workforce support, and greater coordination and collaboration, including with respect to data analysis.

The FOCA's emphases on Public Health 3.0 and systems-level changes through policy help to define the crosscutting issues of public health system infrastructure, particularly in terms of Health Equity in All Policies and necessary changes to public health system funding.

The FOCA's emphases on Public Health 3.0 and systems-level changes through policy help to define the crosscutting issues of public health system infrastructure, particularly in terms of Health Equity in All Policies (HEiAP) and necessary changes to public health system funding.

The partnership identified a need to address inequities in existing policies, emphasizing the importance of a Health in All Policies (HiAP)[27] approach and the opportunity for a Health Equity in All Policies (HEiAP)[28] approach. There is an opportunity to better align policy and practice and recognize that policy is related to funding. The Partnership noted a lack of public health expertise with county boards and boards of health as a threat to system-level changes through policy. Education and civil literacy are needed for both community collaborators and the public.

Funding is a major theme across the public health system in Illinois—particularly limitations in funding to support an adequate public health workforce, acknowledged in the CTSA focus groups, FOCA, and HECA. There is a need to de-silo funding and eliminate inequitable funding. The partnership recognized specific threats with funding, including inequitable funding by locality and a lack of county boards funding public health in the way that collaborators think is needed. The partnership noted the need to develop an equitable funding model. The partnership recognizes that American Rescue Plan Act (commonly known as "ARPA") funding is a major opportunity to the public health system to make transformative, systems-level change. Greater emphasis on tax equity, as a part of systems-level change through policy, would also improve funding resources at the state level.

The HECA findings related to system strengths and opportunities evolve around the need for increased and sustained funding to support critical public health functions in areas of workforce recruitment and development, enhanced data development, and data-sharing capabilities to inform decision-making, and dynamic partnerships across the system inclusive of communities most impacted by health inequities.

Workforce supports

The public health workforce has been through a lot since 2016, particularly during the COVID-19 pandemic. Acknowledging that the pandemic has contributed to workforce shortages within and outside of the health care system, social service providers highlighted the rebuilding that will be needed in order for the state to move forward effectively.

Selected quotes from focus groups:

> *Workforce was already an issue pre-pandemic. The trauma from the experience, including the amount of people who have been lost—we're going to see an even greater drop."*
>
> – SOCIAL SERVICE PROVIDER FROM CHAMPAIGN

> *Many public health workers are burned out (due to COVID) and institutional knowledge has been lost. Rebuilding will be needed."*
>
> – SOCIAL SERVICE PROVIDER FROM WEST CHICAGO

> *Capitalize on the public health workforce. As we move from pandemic to endemic, time to focus on that. Paying more attention to recruitment and education in public health."*
>
> – SOCIAL SERVICE PROVIDER FROM WEST CHICAGO

Through the FOCA, the partnership identified the current state of the public health system workforce as a major theme that serves as an opportunity and barrier to the forces of change. There is a need to better prepare and train the workforce, specifically to build skills in community engagement and coalition building and to leverage trusted voices in each community. The partnership also noted that finding ways to retain the COVID-19 workforce and help them transition to new roles will be important. Overall, the partnership identified that workforce stability is needed to tackle major system transformation.

The HECA found that practitioners are seeking greater autonomy, increased internal capacity, and mechanisms that support the needed systematic professional development to meet the adaptive range of both the system and community needs.

HECA also identified ways to support the workforce through the policy development functions of public health. The HECA recommends that standards are established for equitable pay for public health communications roles, especially, including health educators. Additionally, through the HECA, the partnership recommended a pipeline be developed for the public health workforce that includes securing federal funding to support hiring and staff retention.

The pandemic highlighted to many employers the stresses that employees are facing at home and in the workplace. Some focus group participants suggested ways employers can support workers.

Selected quotes from focus groups:

> *In rural Illinois you have people quitting social health work to work at ALDI."*
>
> – REPRESENTATIVE FROM NAMI

> *[We need] tuition loan reimbursement for clinicians/practitioners to increase the workforce."*
>
> – SOCIAL SERVICE PROVIDER FROM WEST CHICAGO

> *The mental health piece is the biggest one. Providing supports for our staff. It's a lot for everyone. Parents don't have great mental health because there is a lot in the air. Help employers address when a parent has to be out."*
>
> – SOCIAL SERVICE PROVIDER FROM ROCKFORD

Coordination and collaboration

Additionally, greater coordination and collaboration is needed across the state to improve public health capacity.

Selected quotes from focus groups:

> *Coordination and collaboration [are] key to building capacity. Keeping everyone in the loop and communication is big—knowing what's going on."*
>
> – SOCIAL SERVICE PROVIDER FROM PEORIA

> *How do we, as a state or communities, get together to look at resources we have to make sure they are all working together towards the same end? I would like to see more IDPH working with these different entities."*
>
> – SOCIAL SERVICE PROVIDER FROM BELLWOOD

Coordination and collaboration were also highlighted in the FOCA. The partnership frequently noted the need to increase communication and coordination across sectors and state agencies to encourage collaboration. They identified governmental public health as a possible coordinating entity, including a fiscal entity for communities. This increased coordination would include redefining and/or clarifying the relationship between state and local public health roles in emergency and day-to-day work. The FOCA also identified opportunities to address SSDOH through a coordinated state system that builds and engages coalitions and constituencies to work together. Some opportunities the partnership identified to facilitate this work include leveraging smaller partners for assessment, planning, and implementation.

Data and technology

The FOCA identified data and technology as forces of change within the health system. Specifically, the partnership noted that health data systems lack a statewide approach to data collection and overall data strategy as do public health informatics data for population health—all of which contribute to challenges in understanding and addressing the needs of marginalized populations.

The CTSA found that providers and LHDs are concerned about barriers related to technology and social media. Focus group participants shared that technology served as a barrier to feeling socially connected to family, friends, and health care professionals. Data and technology training and education for public health practitioners were noted as potential solutions to improve the health and well-being of the community.

Some focus group participants suggested IDPH could provide greater support for coordination and collaboration by creating state- or regional-level epidemiologists to fill gaps in data skills in LHDs. In the FOCA, the partnership also identified opportunities such as increasing workforce capacity for informatics data for population health.

Selected quotes from focus groups:

> *We have access to various data sets, but we don't have an epidemiologist on staff or an expert to interpret them. Trying to identify trends and share that data with the local community, we are only able to go so far. [We need] someone at the state to help interpret all of that to help us understand."*
>
> – SOCIAL SERVICE PROVIDER FROM WEST CHICAGO

> *Regional epidemiologists, more than we have now, would be helpful. Having a regional approach to understanding anything public health-related is helpful."*
>
> – SOCIAL SERVICE PROVIDER FROM WEST CHICAGO

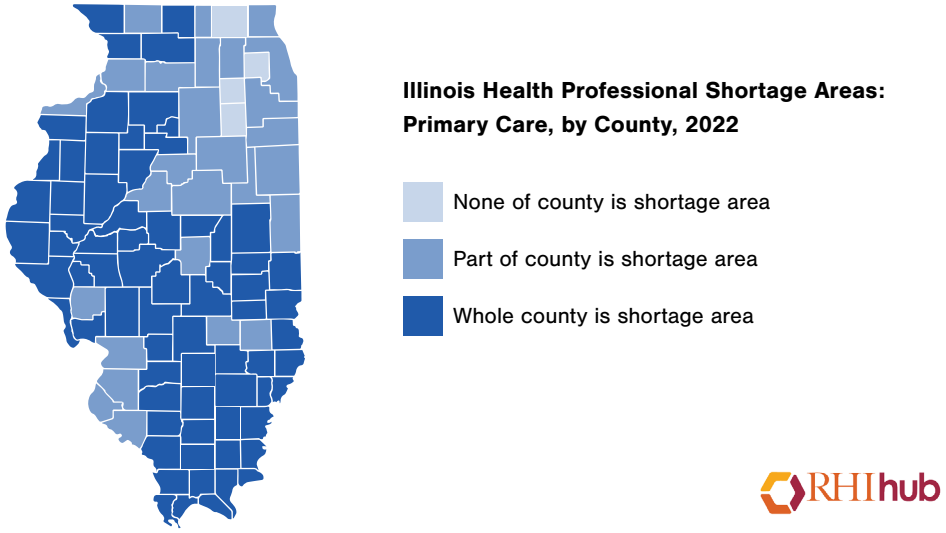
Through the FOCA, the partnership recognized the opportunity and need for data modernization, greater accessibility of data, centralized resource hubs and databases, and improved data sharing. They noted the system is behind in data technology, lacks data standards, and needs user-friendly governance. Current data systems lack access to health data, specifically from health insurers, Medicaid, managed care, and other system partners. Health data systems lack a statewide approach to data collection and overall data strategy as do public health informatics data for population health. Public health also needs more intentional partnerships for data collection, sharing, and analysis around nonmedical issues including social determinants of health.

Data and technology were also highlighted in the FOCA in terms of its recommendation to a shift toward Public Health 3.0. Through a Public Health 3.0 approach, the system would dismantle silos to encourage comprehensive sharing of data that would facilitate increased access and use of data to inform policy and practice. Such integration would serve as protection against system failure due to overreliance on one group—another threat identified in the forces of change analysis.

Access to Health Care and Wrap-around Services

According to the Institute of Medicine, access to health care means "the timely use of personal health services to achieve the best health outcomes."[29] Attaining good access to care requires: 1) gaining entry into the health care system, 2) getting access to sites of care where patients can receive needed services, and 3) finding providers who meet the needs of individual patients and with whom patients can develop a relationship based on mutual communication and trust. Access and quality are both critical components of the health care system. Equitable access to care is viewed as foundational for improving health and advancing health equity in Illinois. And because public health is more than just health care, Healthy Illinois 2028 acknowledges the importance of wrap-around services—formal and informal supports that meet the needs of individuals and communities to ensure health improvement—for advancing health equity. Increasing equitable access to wrap-around services can support progress in each of the health priority areas by moving toward a more holistic and community-engaged approach to health improvement.

The CHSA data reveal that, In 2022, **71 (70%) of Illinois' 102 counties are entirely designated as a health professional shortage area (HPSA) for primary care**, another 27 have part of the county designated as a primary care HPSA, and only four (DuPage, Grundy, Kendall, and McHenry) counties have no designated HPSA for primary care shortage.



Source: data.HRSA.gov, January 2022

Figure 26. Health Professional Shortage Areas for Primary Care, by County, 2022

Community members and social service providers across Illinois pointed out what they saw as the main barriers to equitable access to quality health care in the state.

Selected quotes from focus groups:

> *It's difficult to take advantage of medical, dental, oral, mental health care when the only place that will take your insurance is 45 minutes away at minimum."*
>
> – PARTICIPANT FROM JERSEYVILLE

> *Language barriers for Spanish and AAPI communities—if they can get in to see someone but aren't able to understand, it will do no good."*
>
> – REPRESENTATIVE FROM NAMI

> *Home support workers—a big issue that's come up is the services they receive through the department of rehab services. They can receive a certain amount of support up to age 59 from the Department of Aging, then it goes to home care services, and the amount of hours they receive is significantly less. They can't choose who they work with. Most concerning is the significant decrease in the level of support. Adults who need help with daily living, that is not an option for them."*
>
> – SOCIAL SERVICE PROVIDER FROM BELLWOOD

> *I think if there are community health workers there'll be outreach and things like that to the community. . . . Having accessibility to people you know, they are going to have a lot more accessibility to services as well."*
>
> – PARTICIPANT FROM CHICAGO

Access to quality care was highlighted as a particular struggle for the LGBTQ+ community due to stigma and shortages of compassionate, evidence-based treatment.

Selected quotes from focus groups:

> *The LGBTQ community feels like they're being judged—people don't understand their problems."*
>
> – REPRESENTATIVE FROM NAMI

> *A lot of people and I have sought services from Howard Brown. The one barrier we keep hitting is a super long waiting list for services. They are provided and that is wonderful, but there are so many more requests than available hands, minds, and hearts to support. People end up not getting the support they need."*
>
> – FOCUS GROUP PARTICIPANT FROM CHICAGO/CHICAGOLAND SUBURBS

Differently abled Illinoisans also face systemic barriers in access to quality care when it comes to health literacy, communications, and availability of compassionate care.

Selected quotes from focus groups:

> *With respect to the Deaf community, health literacy and outcomes are impacted by health care providers' lack of awareness of delivering culturally sensitive services to Deaf and hard-of-hearing individuals, as well as health care providers' failure to provide effective communication."*
>
> – FOCUS GROUP PARTICIPANT FROM CHICAGO/CHICAGOLAND SUBURBS

> *There is a woman that is blind and lives on her own and can't make it to or schedule her own appointments. She was recently in the hospital and the hospital was completely neglecting her because she doesn't speak the language and couldn't see what was going on."*
>
> – FOCUS GROUP PARTICIPANT FROM CHICAGO/CHICAGOLAND SUBURBS

> *I have a child with autism and it's always been challenging to find specialists and therapists, now with the pandemic and after the pandemic, everything is so filled up, there is so much anxiety and very long wait lists to see a professional therapist or specialist."*
>
> – FOCUS GROUP PARTICIPANT FROM CHICAGO/CHICAGOLAND SUBURBS

One of the most obvious indicators for access to care is language capacity, particularly mismatches between a population and the health care providers located nearby. The data from the CHSA reveals a number of important findings in this area between 2015 and 2019. For example, the fact that nearly two-thirds of Illinois households speak a language other than English, and of those more than one-third speak English at a level below "very well" indicates a great need for providers, or at least translators, who can communicate with these Illinoisans in their own languages.

The FOCA also identified language and communications as key factors contributing to health access and outcomes. In keeping with the key principles of Public Health 3.0, the partnership noted the need for the public health lens to be expanded to encapsulate SSDOH, which would include culturally inclusive interventions and communication as key to reduce disparate health outcomes.

The COVID-19 pandemic revealed technology as a key component of access to care, as utilization of telehealth increased exponentially. While in-person care is returning as the pandemic subsides, telehealth is likely to continue to be an important tool. Telehealth can play an important role in reducing barriers in access to care throughout Illinois—such as lack of transportation or local providers—but only if each community and each individual has access to reliable, high-speed internet paired with the technological literacy needed to use it.

Selected quotes from focus groups:

> *Access to affordable and quality internet [is important] to be able to access telehealth services."*
>
> – SOCIAL SERVICE PROVIDER FROM WEST CHICAGO

> *Too many resources/announcements give only website address rather than a phone number. It locks out folks who are not connected electronically."*
>
> – SOCIAL SERVICE PROVIDER FROM EDWARDSVILLE

> *Reliance on telehealth has been great, but people in rural areas don't have broadband connections. That makes telehealth impossible."*
>
> – FOCUS GROUP PARTICIPANT FROM CENTRAL ILLINOIS

> *A number of our adult day program participants who are still not coming in because of fear are managing things at home without support. They have switched some things to virtual, but people are too overwhelmed, afraid of technology, and refuse to use it. We had the ability to provide tablets to participants and many were refused."*
>
> – SOCIAL SERVICE PROVIDER FROM EDWARDSVILLE

Social and Structural Determinants of Health

Transportation

Transportation serves as a key structural determinant of health for Illinoisans in rural areas, where services are far apart if they are available at all, and in suburban areas, where public transportation is insufficient or nonexistent. Furthermore, regardless of where they live, Illinoisans with mobility issues face even more obstacles.

Selected quotes from focus groups:

> *Limited to no services available in rural counties for services, providers. Transportation is a barrier because people have to travel far."*
>
> – SOCIAL SERVICE PROVIDER FROM EDWARDSVILLE

> *We don't have a public transportation system in Kendall. Serving [Illinoisans with] low income, WIC, substance use disorder—there's not affordable transportation or availability."*

– SOCIAL SERVICE PROVIDER FROM WEST CHICAGO

It's harder for people with disabilities because they need to have specific vehicle accommodations."

– SOCIAL SERVICE PROVIDER FROM WEST CHICAGO

It is a big issue getting transportation for the disabled, and if you are able to get it there are a lot of strings. You have to fill out forms, get approved, and in the meantime, you can't get to the doctor's office."

– FOCUS GROUP PARTICIPANT FROM CHAMPAIGN

Focus group participants also discussed how transportation plays a key role in community connectedness, a crucial component for strong social capital that can be an asset to public health.

Selected quotes from focus groups:

I think connectedness goes back to transportation."

– SOCIAL SERVICE PROVIDER FROM WEST CHICAGO

[We need] more English as a second language (ESL) classes, because a lot of the ESL classes that are available to our community aren't even in our community and are quite a drive away. Especially when transportation is an issue, you can't really get to those services."

– FOCUS GROUP PARTICIPANT FROM CHICAGO/CHICAGOLAND SUBURBS

Food Insecurity

The American Public Health Association defines food insecurity as:

> Lack of consistent access to enough food to fuel a healthy lifestyle, typically due to lack of financial resources, and it has lasting impacts on public health.[30] Inconsistent access to healthy food limits the potential of a population to achieve and maintain a dignified status of public health and well-being. Participants in the CTSA focus groups shared their experiences with how food insecurity precludes public health across Illinois.

Selected quotes from focus groups:

If someone is housing- or food-insecure, it greatly impacts everything. It impacts youths' ability to succeed in school."

– SOCIAL SERVICE PROVIDER FROM ROCKFORD

Without having transportation there's a lot of people that are living in what we call food deserts. They are not able to get into supermarkets for healthy types of food. There are a lot of little corner markets with snacks and junk food but being able to get to a full-service grocery store is a challenge."

– FOCUS GROUP PARTICIPANT FROM PEORIA

> *Access to healthy foods [is a problem]—[we have] mostly mom and pop corner stores without healthy choices, and limited services offered in Spanish."*
>
> – SOCIAL SERVICE PROVIDER FROM EDWARDSVILLE

Housing

As the American Public Health Association explains in its 2018 policy statement on Housing and Homelessness as a Public Health Issue:

> Ending homelessness is a public health issue, as those experiencing homelessness have high rates of chronic mental and physical health conditions, co-occurring disorders, and barriers to care, such as inability to access care when needed or comply with prescribed medications.[31]

Due to the pandemic and numerous other factors, more Illinoisans are at risk of or experiencing homelessness.

Selected quotes from focus groups:

> *Homelessness has gone up, for many it is older adult homelessness (up 24% from last fiscal year for suburban Cook County). Accessible, affordable housing is the biggest barrier to transitioning out of facilities."*
>
> – SOCIAL SERVICE PROVIDER FROM BELLWOOD

> *[Our biggest problems are] lack of behavioral health workforce and lack of one-bedroom affordable housing options."*
>
> – SOCIAL SERVICE PROVIDER FROM WEST CHICAGO

> *We're seeing a lot of people struggling with homelessness and mental health issues. We are not trained in a lot of the health care and mental health sector issues. For us to be helping with just homelessness, it doesn't fix the issue for the long term."*
>
> – SOCIAL SERVICE PROVIDER FROM PEORIA

Partnering with other government agencies and community organizations to address SDOH related to housing—such as availability and affordability of housing and mental health care—would be a powerful way for public health to prevent all the challenges that go along with unstable housing and homelessness. When asked what they would do if they had unlimited resources, one focus group participant responded:

> *"Focus on different areas at a time to help community rebuild housing stock. Low-interest forgivable loans or no interest."*
>
> – SOCIAL SERVICE PROVIDER FROM ROCKFORD

The FOCA also identified housing and homelessness as an opportunity area that could be addressed by developing a more coordinated state system that engages coalitions and constituencies to work together. The partnership specifically noted that collaboratives should drive the work to address housing and homelessness as more than just a health care issue.

Community Violence

Community violence impacts health in countless ways, and it is often tied up with many other structural determinants of health. As the quotes from provider focus groups below illustrate, community violence cannot be separated from other issues like coordination and collaboration, transportation, education, and racism.

Selected quotes from focus groups:

> *Domestic violence got an actual location with a shelter. Open less than a month and it's already full. [We need help with] coordinating intake systems, working with IRIS for resource referral."*
>
> – SOCIAL SERVICE PROVIDER FROM ROCKFORD

> *In our communities, queer people of color are still facing tons of violence. There's little to no type of support or institutions to support queer people. Or even basic counseling for all people. There is a lack of access if you don't live near a train station or have a car. No access to any type of services unless you commit to doing research and going out and finding them."*
>
> – FOCUS GROUP PARTICIPANT FROM CHICAGO/CHICAGOLAND SUBURBS

> *I would start looking at juvenile justice programs, working with folks in DCFS cases with violence. We need to take care of it early. We need to be putting money towards early intervention."*
>
> – SOCIAL SERVICE PROVIDER FROM ROCKFORD

> *Racism has affected a lot, from being Black to a lot of discrimination from police. It has affected people mentally by not being able to go to the police station anytime there is a problem."*
>
> – FOCUS GROUP PARTICIPANT FROM CARBONDALE

The CHSA reveals that, while documented hate crimes are few, the vast majority of these are race/ethnicity related. Violence-related mortality data show disparities by race, especially for Black or African American Illinoisans. Despite a trend from 2016 to 2019 of slightly declining rates for Blacks or African Americans, there was a sharp increase of nearly 50% for this group's homicide mortality rates from 2019 to 2020 (Figure 27).

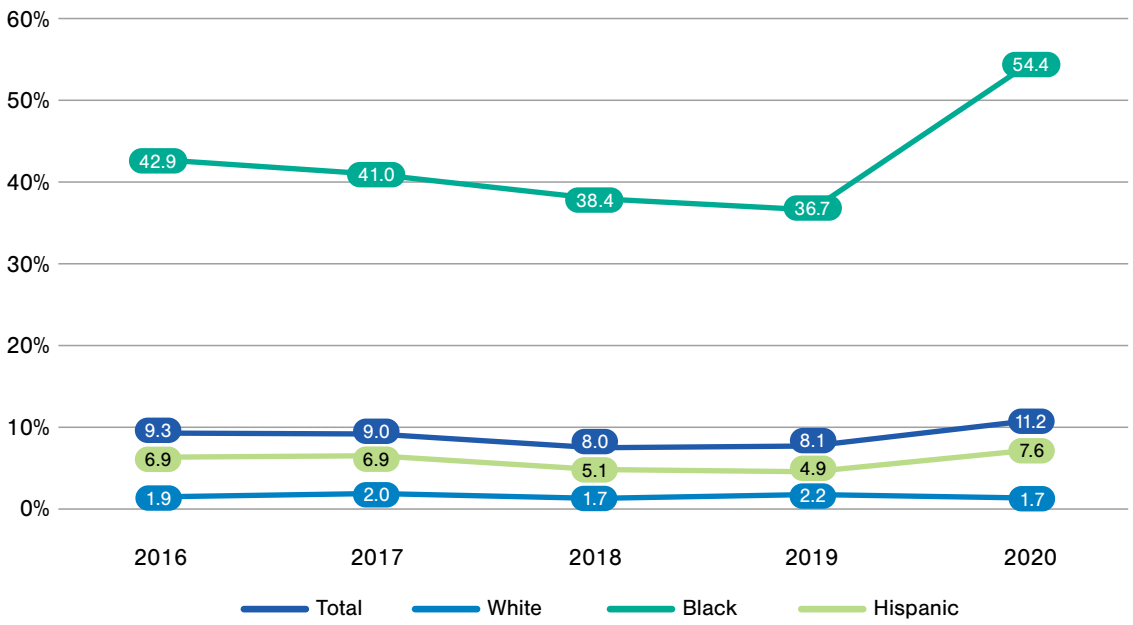
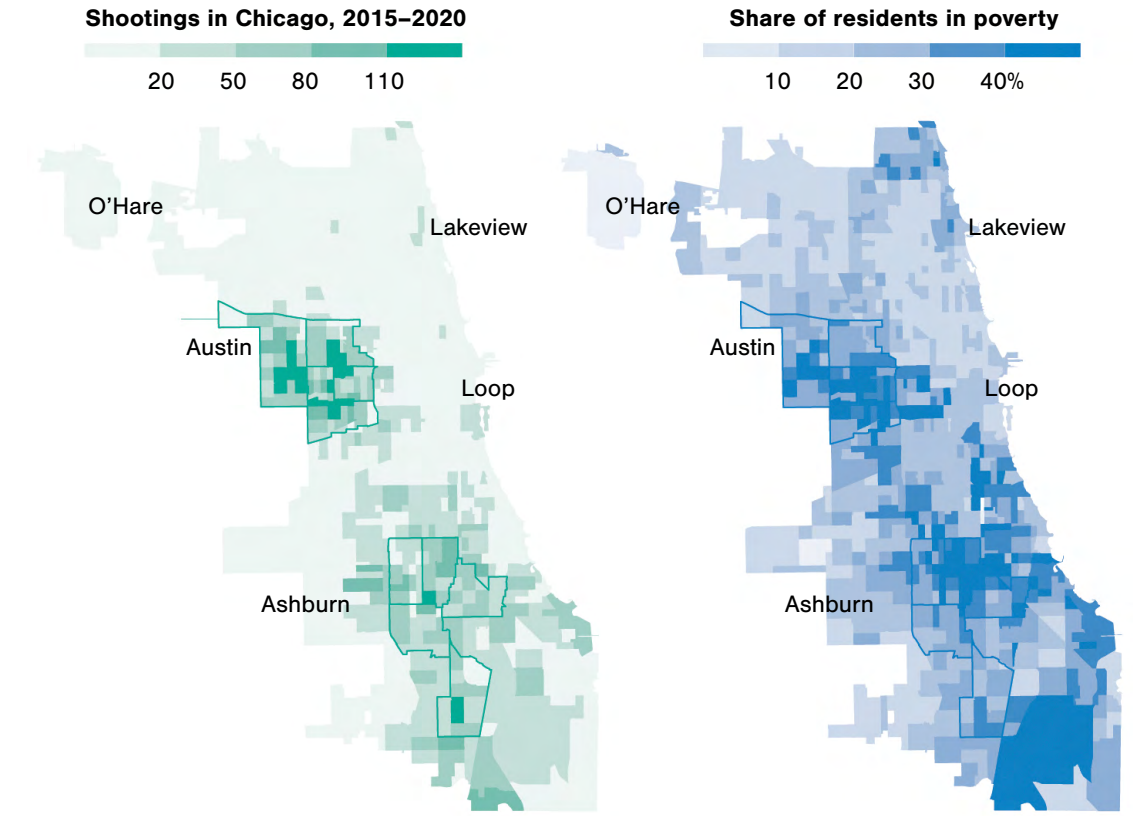


Figure 27. Homicide Mortality by Race/Ethnicity Age-Adjusted Rate per 100K Population Illinois, 2016–2020

Moreover, firearm events show alignments with poverty and segregated communities of color (Figure 28).



Neighborhoods with the most shootings

Poverty data from 2015 to 2019; grey regions are missing from data.
Sources: University of Chicago Crime Lab; Chicago Health Atlas

Figure 28. Geographic Alignment between Firearm Events and Poverty in Chicago

Climate Change

Climate change ties into every single SSDOH and SDOH and priority area identified in this SHA, especially health equity and racial justice, since climate change tends to affect marginalized populations most. Populations who have the least access to power and resources to protect their communities and mitigate or fight back against the worst impacts of climate change really need the allyship of public health as the climate crisis continues to intensify.

Climate change impacts chronic conditions as well as COVID-19 and other emerging diseases in a number of ways. Illness due to excess heat worsens existing chronic conditions. Air pollution causes higher rates of cardio-respiratory illnesses, and those living in areas with worse air quality are particularly susceptible to COVID-19 (and experience more severe symptoms). Moreover, global warming is expected to increase rates of vector-borne disease. With respect to maternal and child health, pregnant people and children are at high risk of severe effects due to extreme heat.

Physical and Built Environment

The physical and built environment also plays an enormous role in shaping the conditions in which people live, work, and play. Walkability and access to green space and fresh foods help stave off or minimize the worst effects of many chronic conditions, including obesity, diabetes, and mental health. Proximity to high-traffic roads or railways impacts air quality that contributes to respiratory diseases. And lead poisoning in water, paint, and air cause fetal abnormalities and other negative health effects to brain development and the reproductive system, with disparities by race, geography, and class. Addressing environmental racism, the root cause of many inequities in health impacts linked to physical and built environments, will be essential to uprooting causal factors that contribute to and exacerbate many health inequities.

Selected quotes from focus groups:

> *We need more resources for art, parks, access to places to play sports—low-cost programs for families and youth."*
>
> – FOCUS GROUP PARTICIPANT FROM CHICAGO/CHICAGOLAND SUBURBS

> *There is also a lack of access to affordable physical activity options—'gym deserts.' We need places to set up free or low-cost gyms for access in certain areas where there aren't safe places to work out. There is a growing number of boutique gyms, but those are often very expensive."*
>
> – SOCIAL SERVICE PROVIDER FROM WEST CHICAGO

> *[If we had unlimited resources], we would work with other organizations to put in infrastructure for safe, walkable communities to have a better built environment."*
>
> – SOCIAL SERVICE PROVIDER FROM ROCKFORD

6 Conclusion

Through this comprehensive State Health Assessment process, the state has identified the areas of the focus to inform the State Health Improvement Plan. The health priorities selected for Healthy Illinois 2028 are:

- chronic disease,
- COVID-19 and emerging diseases,
- maternal and infant health,
- mental health and substance use disorder, and
- racism as a public health crisis.

Each of these priorities for health improvement will be approached utilizing implementation strategies that address the crosscutting issues necessary for each priority to succeed. These crosscutting issues include:

- access to health care and wrap-around services,
- physical and built environment,
- public health system infrastructure,
- racial equity, and
- social and structural determinants.

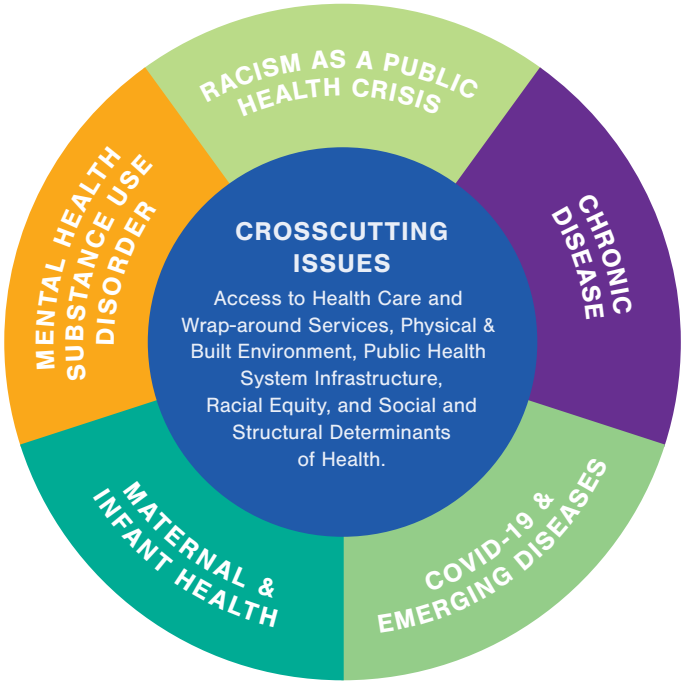


Figure 22. Healthy Illinois 2028 Priorities

These priorities were collaboratively developed and supported throughout the community and stakeholder engagement processes that contributed to the four core assessments that comprise the SHA process.

Additionally, the partnership identified the shared vision for Healthy Illinois 2028 as:

> Achievement of health equity across Illinois by addressing structural and social determinants of health through a unified public health system, community engagement and collaboration, a strong workforce, and sustainable and flexible local funding.

The partnership also developed a set of fundamental principles and practices to support the advancement of Healthy Illinois 2028 in order to make progress towards the shared vision. These principles and practices should inform the way public health partners and communities work together to develop, implement, and evaluate the SHIP.

- Break down silos across the Illinois public health system through increased communication, coordinated prevention strategies, and resource sharing.
- Implement community-engaged, asset-based decision-making through partnerships with an array of organizations engaged in public health improvement and prevention.
- Prioritize strategies that address the underlying root causes, including structural and social determinants of health.
- Create sustainable impact through policy, systems, and environmental change strategies.
- Define objectives that are achievable, measurable, and aligned across programs, sectors, and systems.

- Foster innovation that occurs through the use of evidence-based strategies and best practices.
- Implement data-driven decision-making, measurement, and monitoring of success toward outcomes.
- Practice transparency and accountability to ensure aligned implementation of action plans and ongoing progress toward outcome attainment.
- Invest in current workers and cultivate new workers within the public health system to effectively implement the SHIP.

Following the completion of the SHA, the partnership identified subject matter experts related to each of the priority areas and the crosscutting issues to focus on developing goals and objectives to improve health and advance health equity in the areas of chronic disease, COVID-19 and emerging diseases, maternal and infant health, mental health and substance use disorder, and racism as a public health crisis as well as identifying strategy recommendations to achieve these objectives. Efforts will also be made to complete a scan of resources and existing efforts to address the priorities, review health indicator data, assess best practices related to data collection and monitoring, and recommend policy, systems, and environmental strategies to help address the priorities by tackling the root causes, including SSDOH and public health system infrastructure challenges.

The content of this report will guide the next steps for Healthy Illinois 2028. IDPH and partners from across the Illinois public health system will work together to:

1. Develop a high-level plan of aligned goals, objectives, and recommended strategiess
2. Collect feedback through three public hearings.
3. Form action teams to prioritize recommended strategies and further plan action steps, timelines, and responsible parties for implementation of plans; and
4. Implement plans while monitoring and measuring progress for continuous improvement and impact.

These activities will be described in the State Health Improvement Plan, expected to be released at the end of 2023.

Endnotes

1 Illinois Department of Public Health. (2020). Healthy Illinois 2021 plan update: An addendum to the Illinois 2016-2021 State Health Assessment and State Health Improvement Plan. http://www.idph.state.il.us/ship/icc/documents/Updated%20SHASHIP%20Summary%20Report.pdf

2 Illinois General Assembly. The Civil Administrative Code of Illinois. 20 ILCS 5/5-565. http://www.ilga.gov/legislation/ilcs/ilcs5.asp?ActID=221&ChapterID=5

3 National Association of City and County Health Officials (NACCHO). (2022). Mobilizing for action through planning and partnerships (MAPP). https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp

4 U.S. Department of Health and Human Services. (2022). Engaging people with lived experience to improve federal research, policy, and practice. Office of the Assistant Secretary of Planning and Evaluation. https://aspe.hhs.gov/lived-experience

5 Public Health National Center for Innovations & de Beaumont Foundation. (2020). The 10 essential public health services. https://phnci.org/uploads/resource-files/EPHS-English.pdf

6 NACCHO. (2020). MAPP evolution blueprint executive summary. https://www.naccho.org/uploads/downloadable-resources/MAPP-Evolution-Blueprint-Executive-Summary-V3-FINAL.pdf

7 U.S. Department of Health and Human Services. (2022). Healthy People 2030. Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Health, Office of the Secretary. https://health.gov/healthypeople

8 CDC & NAM. (2017). Public health 3.0. Office of Disease Prevention and Health Promotion. https://www.naccho.org/uploads/downloadable-resources/Public-Health-3.0-White-Paper.pdf

9 DeSalvo, K., B., & Kushal T. Kadakia, K., T. (2021). Public health 3.0 after COVID-19—reboot or upgrade? American Journal of Public Health,111(S3), S179-S181. https://doi.org/10.2105/AJPH.2021.306501

10 NACCHO. Public Health 3.0. https://www.naccho.org/programs/public-health-infrastructure/public-health-3-0

11 WHO. Taking action on the social determinants of health. https://www.who.int/westernpacific/activities/taking-action-on-the-social-determinants-of-health

12 Crear-Perry, J., Correa-de-Araujo, R., Lewis Johnson, T., McLemore, M. R., Neilson, E., & Wallace, M. (2021). Social and structural determinants of health inequities in maternal health. Journal of Women's Health, 30(2), 230–235. https://www.liebertpub.com/doi/10.1089/jwh.2020.8882

13 Crear-Perry, J., Correa-de-Araujo, R., Lewis Johnson, T., McLemore, M. R., Neilson, E., & Wallace, M. (2021). Social and structural determinants of health inequities in maternal health. Journal of Women's Health, 30(2), 230–235. https://www.liebertpub.com/doi/10.1089/jwh.2020.8882

14 WHO. (2010). A conceptual framework for action on the social determinants of health. https://www.who.int/publications/i/item/9789241500852

15 Department of Public Health. (nd). A Workbook for Local Public Health Department Administrators, IPLAN Leaders and Community Participants. http://app.idph.state.il.us/pdfs/IPLAN_workbook_v2.0.pdf

16 Illinois Department of Public Health. (nd). Illinois Project of Local Assessment of Needs. http://app.idph.state.il.us/Resources/IPLANProcess.asp?menu=3

17 DeSalvo, K. B., Wang, Y. C., Harris, A., Auerbach, J., Koo, D., & O'Carroll, P. (2017). Public health 3.0: A call to action for public health to meet the challenges of the 21st century. Preventing Chronic Disease, 14, E78. https://doi.org/10.5888/pcd14.170017

18 CDC & NAM. (2017). Public health 3.0. Office of Disease Prevention and Health Promotion. https://www.naccho.org/uploads/downloadable-resources/Public-Health-3.0-White-Paper.pdf

19 Minnesota Department of Health. (2019). https://healthequityguide.org/case-studies/minnesota-changes-the-narrative-around-health-equity/

20 Elhinger. (2016). We need a Triple Aim for Health Equity. https://www.astho.org/Health-Equity/2016-Challenge/Ehlinger-Commentary-Article/

21 Health Equity and Social Determinants of Health. ASTHO. https://www.astho.org/Programs/Health-Equity/

22 Van Kanegan, M., & Price, J. (2021). Oral health surveillance plan 2021-2025. Springfield, Illinois: Division of Oral Health, Illinois Department of Public Health. https://dph.illinois.gov/content/dam/soi/en/web/idph/publications/idph/topics-and-services/prevention-wellness/oral-health/oral-health-plans/Illinois-Oral-Health-Surveillance-Plan_10.25.2021.pdf

23 WHO. (2022). World Mental Health Report: Transforming mental health for all. https://www.who.int/publications/i/item/9789240049338

24 WHO. (2022). Mental health. https://www.who.int/health-topics/mental-health

25 Jones C. P. (2021). Addressing Violence Against Children Through Anti-racism Action. Pediatric clinics of North America, 68(2), 449–453. https://doi.org/10.1016/j.pcl.2021.01.002

26 Flanagin, A., Frey, T., Christiansen, S. L., & AMA Manual of Style Committee. (2021). Updated guidance on the reporting of race and ethnicity in medical and science journals. JAMA, 326(7), 621–627. https://jamanetwork.com/journals/jama/fullarticle/2783090

27 American Public Health Association (APHA). (2013). Health in all policies. https://www.apha.org/topics-and-issues/health-in-all-policies

28 Boston Public Health Commission (BPHC). (2022). Health equity in all policies. https://www.boston.gov/government/cabinets/boston-public-health-commission/racial-justice-and-health-equity/health-equity-all-policies-initiative

29 Institute of Medicine. (1993). Access to health care in America. Millman, M., editor. Committee on Monitoring Access to Personal Health Care Services. Washington: National Academies Press.

30 Hunger and Health. What is food insecurity in America? Available at: https://hungerandhealth.feedingamerica.org/understand-food-insecurity/

31 https://apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2018/01/18/housing-and-homelessness-as-a-public-health-issue

7 Appendix

Acronyms

ACE	Adverse Childhood Experience
APEX-PH	Assessment Protocol for Excellence in Public Health
APHA	American Public Health Association
ARPA	American Rescue Plan Act
ASTHO	Association of State and Territorial Health Officials
BIPOC	Black, Indigenous, People of Color
BRFSS	Behavioral Risk Factor Surveillance System
CD	Chronic Disease
CDPH	Chicago Department of Public Health
CHNA	Community Health Needs Assessment
CHSA	Community Health Status Assessment
CHW	Community Health Worker
CISD	Critical Incident Stress Debriefing
CMS	Central Management Services
COVID-19	Coronavirus Disease 2019
CPM	Certified Professional Midwives
CSPAP	Comprehensive School Physical Activity Program
CTSA	Community Strengths and Themes Assessment
EJ	Environmental Justice
EHR	Electronic Health Record
ESL	English as a Second Language
FEMA	Federal Emergency Management Agency
FIMR	Fetal and Infant Mortality Review
FOCA	Forces of Change Assessment
HBCU	Historically Black College or University
HECA	Health Equity Capacity Assessment
IDOT	Illinois Department of Transportation
IDPH	Illinois Department of Public Health
IDHS SUPR	Illinois Department of Human Services Substance Use Prevention and Recovery
IEPA	Illinois Environmental Protection Agency
IMMT	Infant and Maternal Mortality Among African Americans
IPHI	Illinois Public Health Institute

IPLAN	Illinois Project for Local Assessment of Need
ISBE	Illinois State Board of Education
ITEP	Illinois Transportation Enhancement Program
LARC	Long-acting Reversible Contraception
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual
LHD	Local Health Department
MAPP	Mobilizing Action for Planning and Partnerships
MAR	Medicated Assisted Recovery
MAUD	Medications for Alcohol Use Disorder
MDH	Minnesota Department of Health
MIH	Maternal and Infant Health
MMRC	Maternal Mortality Review Committees
MOUD	Medications for Opioid Use Disorder
NAACP	National Association for the Advancement of Colored People
NACCHO	National Association of County and City Health Officials
NAS	Neonatal Abstinence Syndrome
P3RC	Policy, Practice, and Prevention Research Center
PHNCI	Public Health National Center for Innovations
PHSA	Public Health System Assessment
PRAMS	Pregnancy Risk Assessment Monitoring System
PSE	Policy, Systems, and Environmental Change
PWLE	Public with Lived Experience
SBIRT	Screening, Brief Intervention and Referral to Treatment
SBOH	State Board of Health
SDOH	Social Determinants of Health
SFIA	Smoke-Free Illinois Act
SHA	State Health Assessment
SHIP	State Health Improvement Plan
SME	Subject Matter Experts
SSDOH	Social and Structural Determinants of Health
SUD	Substance Use Disorder
UIC	University of Illinois at Chicago
WHO	World Health Organization
WIC	Womens, Infants, and Childrens