ANNUAL REPORT 2025

HEALTH IN ALL POLICIES

A REPORT TO THE
ILLINOIS GENERAL ASSEMBLY

Health in All Policies
Annual Report 2025

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UIC

Illinois Department of Public Health
IDPH
Protecting Health, Improving Lives

To the Honorable Members of the Illinois General Assembly:

It is our pleasure to share with you the 2025 report of the Health in All Policies (HiAP) Workgroup, a cross-sector partnership of 22 state and non-state agencies co-led by the University of Illinois Chicago School of Public Health (UIC SPH) and the Illinois Department of Public Health (IDPH), in compliance with the requirements set forth in Health in All Policies Act ("The Act" (410 ILCS 155/10(a) thru 155/10(i)).

Our work focuses on integrating health considerations into decision-making and policy through cross-sectoral collaborative approaches to enhance health outcomes and reduce health disparities for Illinois residents.

Public health is Illinois' first line of defense in an essential system that improves lives, preserves economic stability, and safeguards our shared future. Inspired by the symbolism of the Purple Heart, this report spotlights public health as Illinois' quiet hero, proven in its service and impact, now bearing wounds of political crossfire. Like every decorated soldier, it remains committed to its mission, but it's our responsibility to support it in its fight for the health and well-being of all Illinoisans. Our message is urgent and clear: **public health needs to be protected**.

For Illinois to continue making strides toward being the healthiest state in the nation, we must stabilize, modernize, and elevate public health. The health of our residents should not be subject to the whims of federal volatility or political headwinds. To that end, the recommendations herein seek to build a resilient public health enterprise through investment in the following areas:

- Disease Monitoring & Response
- Workforce Capacity & Development
- Disease Prevention & Management
- Evaluation & Continuous Improvement
- Resources and Cross-sector Partnerships for HiAP

We encourage state leaders to see this moment not as a challenge to endure but as an opportunity to lead. It is our responsibility to protect public health, as public health has protected Illinois for generations.

Thank you for your leadership, partnership, and commitment to the people of Illinois. We hereby respectfully submit the Health in All Policies report.

Sincerely,

Sameer Vohra, MD, JD, MA
Director
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Wayne H. Giles, MD, MS
Dean and Professor
UIC School of Public Health

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

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Statement of Purpose

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

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

2. Examine the following:
   - The health of the residents of the state.
   - Ways for units of local government and state agencies to collaborate in implementing policies that will positively impact residents' health.
   - The impact of the following on the health of the residents of the state (herein referred to as "areas of impact"):
     1. Access to safe and affordable housing.
     2. Educational attainment.
     3. Opportunities for employment.
     4. Economic stability.
     5. Inclusion, diversity, and equity in the workplace.
     6. Barriers to career success and promotion in the workplace.
     7. Access to transportation and mobility.
     8. Social justice.
     9. Environmental factors.
     10. Public safety, including the impact of crime, citizen unrest, the criminal justice system, and governmental policies that affect individuals in prison or released from prison.

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

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

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

6. Determine an annual focus area for the report.

7. Submit the report of its findings and recommendations to the General Assembly by December 31 of each year.

8. Share the annual report and recommendations with the Illinois Department of Public Health and the State Board of Health.

Executive Summary

Annual Report Executive Summary
410 ILCS 155/10(a) thru 155/10(i))
Health in All Policies Workgroup
December 31, 2025

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

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

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

Workgroup Process
The workgroup met twice (July and September 2025) to learn from subject matter experts (SMEs) and to develop its work plan. The workgroup generated its recommendations through team discussion, a review of peer-reviewed and grey literature, and an examination of state and national evidence-based interventions relevant to Healthy Illinois 2028.

The Value of Public Health
Public health works to protect and improve the health of populations by addressing the social, environmental, behavioral, and biological factors that impact a person's health well before they need to see a health care professional. Recent proposals to reduce federal support for public health and human services threaten Illinois' ability to prevent, treat, and manage illness and disease. This challenge will create undue burden on our already strained healthcare systems, significantly increasing costs for the state and its residents. Every public health dollar spent reduces healthcare costs and improves the health and well-being of our residents. Now is the time to invest in public health.

Recommendations
The Health in All Policies (HiAP) Workgroup endorses continued support of initiatives that reduce health disparities and ensure equitable access to services that address social and structural determinants of health in Illinois. Specific recommendations to invest in public health are hereby submitted for the General Assembly's consideration in the following areas:

- Surveillance & Response
- Workforce Capacity & Development
- Disease Prevention & Management
- Evaluation & Continuous Improvement
- Resources and Cross-sector Partnerships for HiAP

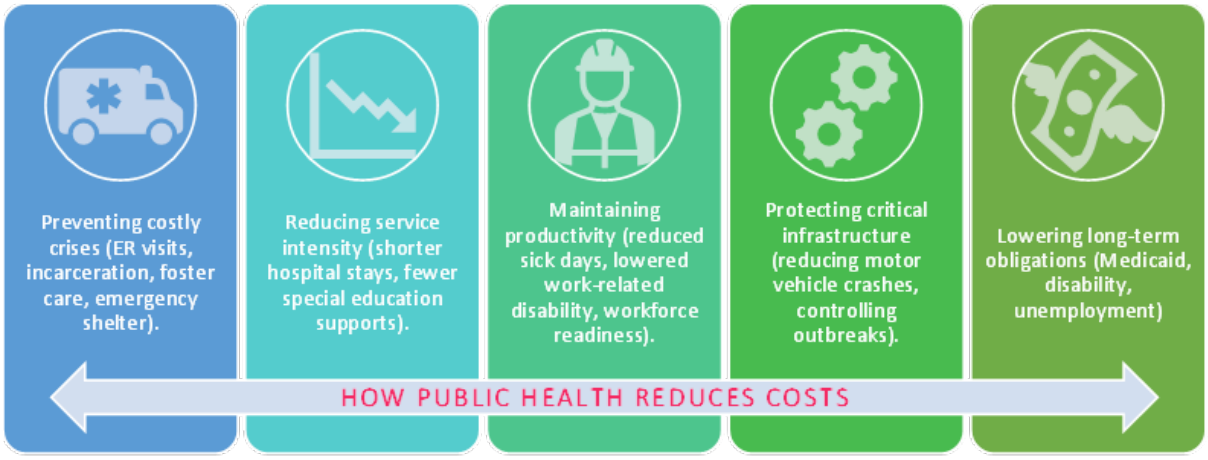
Introduction

Illinois is at a critical inflection point. Across the state, local health departments, community organizations, hospitals, schools, and public-sector partners are working every day to protect the health and safety of all Illinoisans. Yet **challenges posed by the current fiscal, political, and social environment threaten our ability to improve the conditions that allow residents to thrive.**

Almost half of Illinois' total operating budget is dedicated to healthcare and human services[1], and many of the federal funding streams that support their programs are now slated for significant cuts or elimination, threatening to reverse improvements in resident health status and shift costs back onto the state, employers, and families. **The consequences of agency restructuring, elimination, and budget cuts at the federal level are already visible:** higher healthcare costs for families, reduced wrap-around support for vulnerable communities, and weakened capacity to meet the needs of our residents.

As state leadership strategizes for resilience amidst fiscal and political uncertainties, this year's Health in All Policies Annual Report presents public health as the key to advancing the priorities shared across Illinois: fiscal responsibility, economic competitiveness, improved access to care, modernization of state systems, and reduction of disparities that hinder community and economic development.

Public health can achieve significant savings in downstream spending – not just in healthcare, but across human services, education, transportation, labor, and corrections systems[2]. The graphic below illustrates ways disease and injury prevention and health promotion reduce overall costs across sectors.



Core public health activities, such as chronic disease prevention, immunization, emergency disease control, health education, environmental safety and work injury prevention, and statewide disease tracking systems ensure that investments made across sectors can achieve and sustain their intended impact. In collaboration with other health and human service partners, public health reduces preventable hospitalizations, lowers Medicaid expenditures, decreases emergency department use, prevents overdose deaths, improves maternal and infant outcomes, increases workforce participation, keeps children healthy and in school, and protects aging adults from costly complications[3-7].

Illinois' Six Largest Health and Human Services Agencies

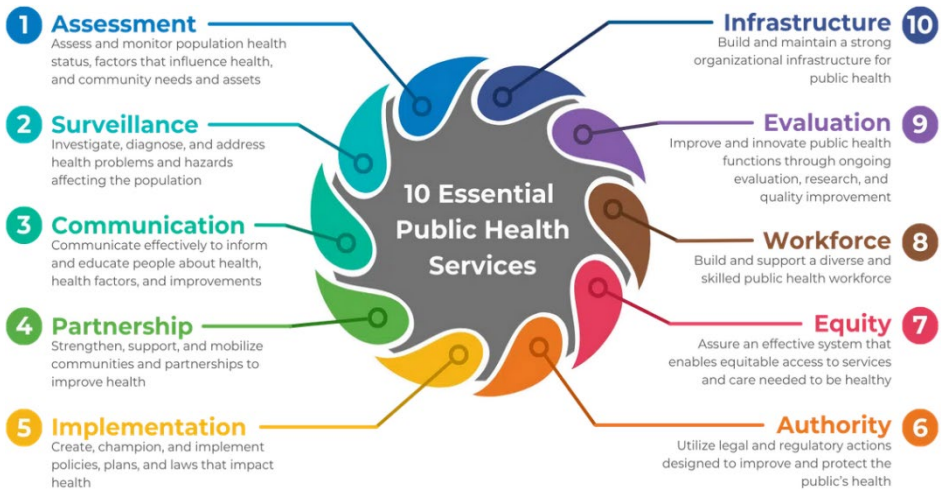
Department of Public Health (IDPH) Est. 1877 as Board of Health	Department of Children and Family Services (IDCFS) Est. 1964	Department of Aging (IDoA) Est. 1973
Department of Veterans Affairs (IDVA) Est. 1976	Department of Healthcare and Family Services (IDHFS) Est. 1983 as Department of Public Aid	Department of Human Services (IDHS) Est. 1997

The health of our residents and the future of our state depend on decisive action now. Dollar for dollar, **public health is one of the highest-return investments Illinois can make to improve both health and economic outcomes**[8]. This report provides the evidence, the context, and a path forward.

The Work of Public Health

What is Public Health?

Public health works to prevent illness and injury for all people in all communities. This science-backed, evidence-based field strives to give everyone safe places to live, learn, work and play. **When you drink clean water, eat safe food, breathe clean air, or make it home unharmed, that's public health.** The graphic on the right summarizes the ten public health services that are essential to **supporting the health of everyone, everywhere.**

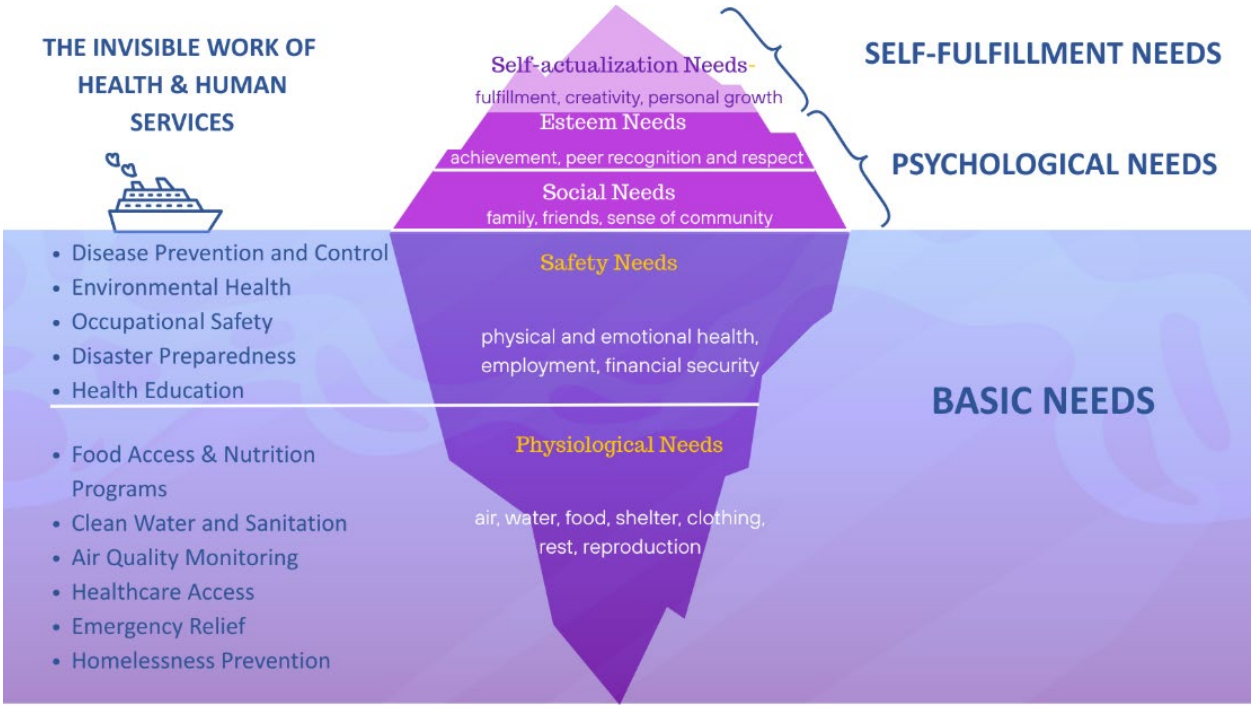


Source: "10 Essential Public Health Services", Public Health & Equity Resource Navigator

Meeting Basic Needs with Complex Solutions

When we think of improvements to health, we often think about investments in our healthcare system. However, to support complete physical, mental and social well-being, our **policies, systems, and social structures must work together to make sure basic needs that enable our health are met** well before we need to see a healthcare professional. This includes ensuring residents have access to healthy food, living wages, affordable housing, quality education, healthcare, and safety. These and other factors, often referred to as **structural and social determinants of health (SSDOH), make the difference between sickness and health.**

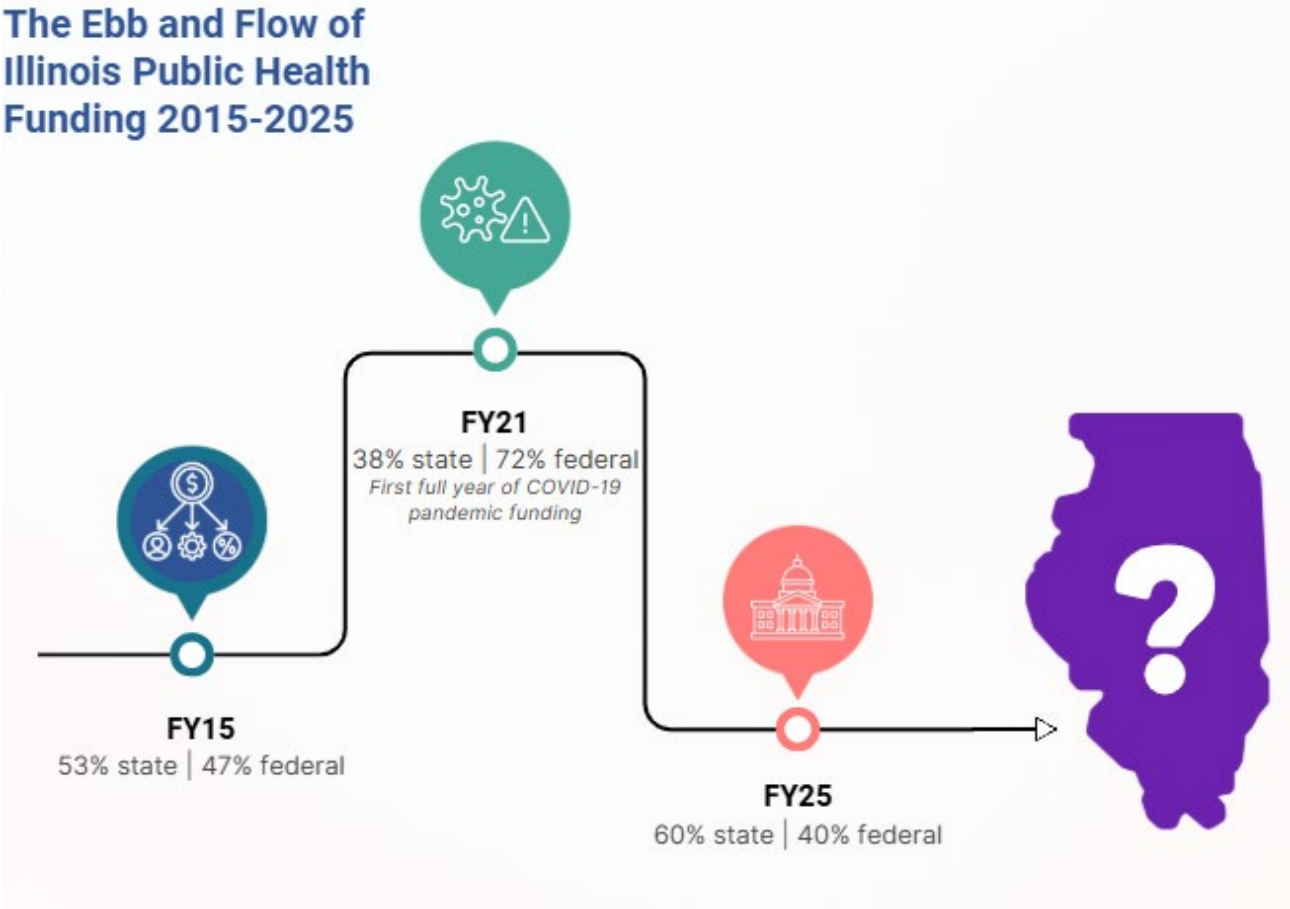
Health and human services agencies and systems perform the invisible work to ensure that people have the basic needs for survival and protection, allowing them to progress toward higher-level needs and actively contribute at home, at work, and in their communities. The graphic below illustrates how public health and its partners address the basic needs of Maslow's hierarchy.



Funding Public Health

The ebb and flow of public health funding in the United States is nuanced. While large investments tend to occur after crises (e.g., 9/11 bioterrorism funding, H1N1, Ebola, and COVID-19), baseline programs such as immunization, maternal health, chronic disease prevention, and environmental health have, until recently, had more stable funding. Occasionally, funds may be leveraged into proactive investments in infrastructure and workforce development. For example, IDPH is leveraging over $125 million in Public Health Infrastructure Grant (PHIG) funds received from the Centers for Disease Control and Prevention (CDC) since 2022 to support and train our public health workforce, strengthen our ability to monitor and respond to public health threats, and modernize technology to translate public health data into insights for decision-making and action[9].

Routine prevention work requires stable, long-term funding to fully protect communities, but public health capacity building is overlooked in "peacetime" budgets for investments in acute care and insurance. While emergencies generate urgency and bipartisan support, prevention work goes unseen outside of a crisis, making it challenging for public health to compete for political visibility and funding. This long-standing "boom-and-bust" cycle leaves the state's residents vulnerable and its public health enterprise crippled in its ability to respond quickly and strategically to ongoing and emerging threats.



The Bottom Line

Experts often cite that **public health receives less than 3% of total health spending**, even though prevention could save billions in treatment costs[10]. **Public health prevents crises *before* they occur** and helps residents achieve better quality health at a lower cost. It detects outbreaks, keeps water and food safe, reduces traffic deaths, supports healthy pregnancies, strengthens behavioral health services, protects aging adults, improves school environments, and responds to emergencies ranging from pandemics to natural disasters. It is the unseen infrastructure that allows the healthcare system to function, the workforce to remain strong, and the state's most significant fiscal liabilities to remain manageable. The table below generally summarizes the avoidable cross-sector costs that are addressed through the objectives of the state's health improvement plan.

		Avoidable-Cost Systems Addressed					
Healthy Illinois 2028 Priority	**Expected Intervention Outcomes**	Corrections	Education	Healthcare	Human Services	Labor	Transpo rt-ation
Chronic Disease 	○ fewer hospitalizations, chronic-disease treatment ○ less worker productivity loss ○ reduced long-term dependency on public aid programs ○ healthier children → lower remedial education costs ○ active living reduces demand on some transport/health services		✓	✓	✓	✓	✓
Maternal and Infant Health 	○ fewer NICU admissions, complications ○ less need for foster care, social supports ○ better early-childhood development → reduced special-education needs ○ better maternal health → workforce stability ○ long-term population health/social equity		✓	✓	✓	✓	
Mental Health & Substance Use Disorder (SUD) 	○ less emergency care, overdose treatment ○ reduced incarceration ○ less crisis stabilization, foster care, or social-service burden improved workforce participation, reduced disability ○ less youth behavioral issues → fewer school disruptions	✓	✓	✓	✓	✓	✓
Racism as a Public Health Crisis (cross-cutting priority) 	○ reduced disparities ○ improved access ○ enhanced environmental/living conditions ○ lower downstream costs tied to health inequities.	✓	✓	✓	✓	✓	
Public Health System Infrastructure / Cross-cutting Strategies (underlying SHIP implementation) 	strengthening public-health infrastructure and cross-sector coordination enables upstream prevention and reduces downstream burdens across systems.	✓	✓	✓	✓	✓	✓

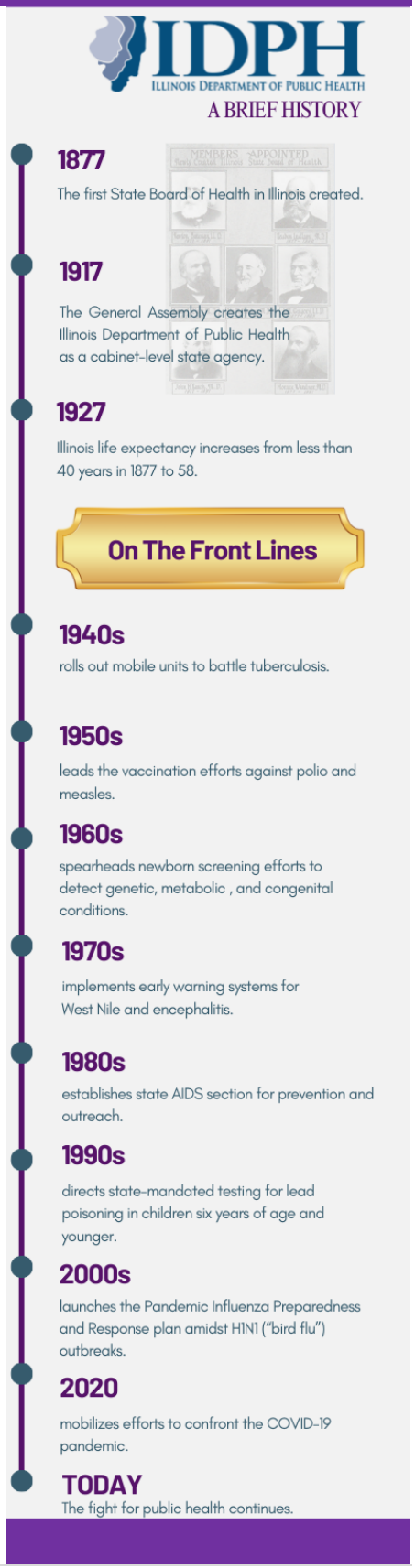
A Brief History of the Illinois Department of Public Health

IDPH is the oldest of the six health and human services agencies in the state. IDPH traces its roots back to 1877, with the creation of the first State Board of Health in Illinois. The new board was given oversight of everything from the licensing of physicians and midwives to establishing sanitary regulations and enforcing quarantines. It was a big task for a small operation. The State Board of Health initially had just three employees and a two-year budget of $5,000 (the equivalent of around $154,000 today).

In 1917, the General Assembly decided the State Board of Health needed a more formal structure and created IDPH as a cabinet-level state agency. The new agency was designed to have greater power for action and oversight than its predecessor and was organized for greater efficiency. Its expanded powers soon included hospital inspections, free vaccinations, and health regulation enforcement for hotels and boarding houses. This renewed focus began paying immediate dividends. **Within 10 years of IDPH's agency status, Illinois' average life expectancy increased** from 40 years of age to 58.

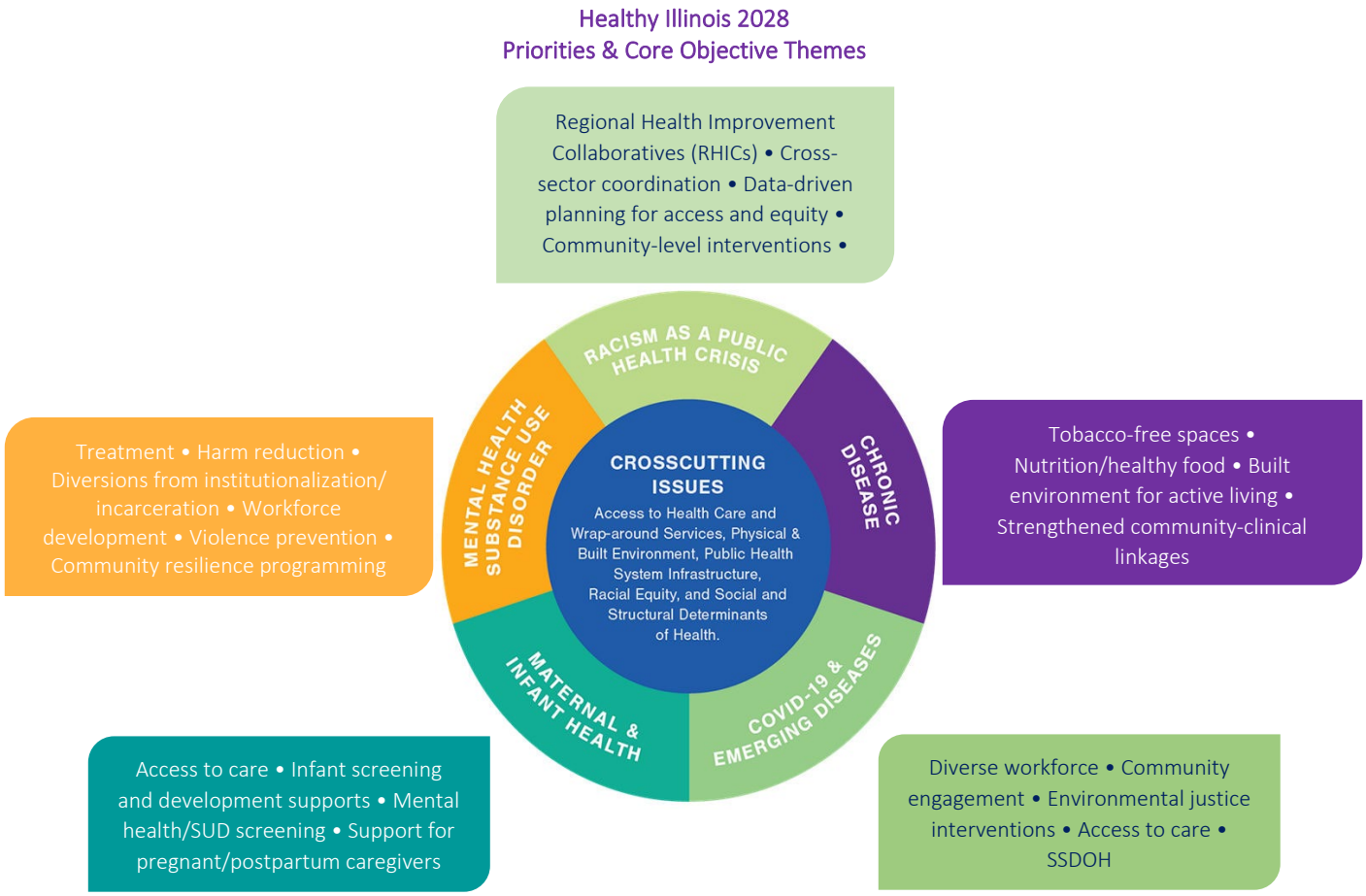
Over the years, IDPH has been at the forefront of major public health innovations, from rolling out mobile units to battle tuberculosis in the 1940s to leading the vaccination efforts against polio and measles in the 1950s and spearheading early detection efforts for young children and infants in the 1960s.

Today, IDPH continues to advocate for and partner with the people of Illinois to re-envision health policy, promote health equity, prevent and protect against disease and injury, and prepare for health emergencies. In FY25, IDPH shared a unified vision for health that was informed by lessons learned during the COVID-19 pandemic. Grounded in a health in all policies approach, its goals are to strengthen emergency preparedness, modernize the public health workforce and data systems, invest in community partnerships, and combat disinformation.



Healthy Illinois 2028

IDPH's efforts to keep Illinois residents healthy and safe advance the priorities of ***Healthy Illinois 2028***, a collaborative public/private cross-agency plan comprised of the Illinois State Health Improvement Plan (SHIP) and State Health Assessment (SHA), which are developed every five years in accordance with Public Act 102-0004. The SHA and SHIP are the most engaged and comprehensive health assessment and improvement efforts conducted in the state. The priorities of Healthy Illinois 2028 are chronic disease, maternal and infant health, mental health, substance use disorder (SUD), emerging diseases, and racism as a public health crisis. The illustration below briefly summarizes core themes of objectives undertaken by IDPH and its partners to advance these priorities.



Source: Illinois Department of Public Health

Chronic Disease

Chronic disease is **the most urgent driver of poor health and rising costs in Illinois**. State and national surveillance data show that **more than half of Illinois adults live with at least one chronic condition**, and over 25% are burdened with two or more simultaneously[11]. Heart disease, cancer, stroke, chronic lower respiratory disease, Alzheimer's disease, and diabetes remain **among the ten leading causes of death in the state**. Yet at least 80% of premature heart disease, stroke and type 2 diabetes and 40% of cancer diagnoses could be prevented through healthy diet, regular physical activity, avoidance of tobacco products, and curbing excessive alcohol intake.[12,13]

Strengthen prevention infrastructure to reduce avoidable health care spending and slow growth in Medicaid and state employee health plan costs.

Prioritize high-burden communities by aligning prevention investments with social determinants of health and Healthy Illinois 2028 priorities.

Integrate chronic disease strategies across sectors, including transportation, housing, education, and labor, consistent with the Health in All Policies (HiAP) approach.

Increase access to early detection and chronic disease management, especially in rural and underserved urban areas.

Support data modernization for timely tracking of chronic disease trends, including behavioral risk factors and social determinants.

STATE POLICY IN ACTION

The preventability of chronic disease represents one of Illinois' greatest opportunities to improve health and economic outcomes. Nationally, chronic and mental health **conditions account for an estimated 90% of annual health care expenditures**[14], and similar trends are reflected in Illinois' Medicaid program, employer-sponsored insurance markets, and local health system capacity. Although earlier estimates from IDPH placed the annual cost of chronic disease in Illinois in the tens of billions, these figures likely underestimate the current burden due to inflation, rising prevalence, and the aging of the Baby Boomer population.

Health Gap Alert

Chronic disease disproportionately affects older adults. Diseases such as heart disease, diabetes, and arthritis are more prevalent in individuals aged 65 and older.

Men have a higher mortality rate from cardiovascular disease, while women report higher rates of arthritis and mental health conditions.

Black Illinoisans have elevated rates of hypertension, diabetes, and cardiovascular disease. Hispanic/Latino populations report higher rates of diabetes and obesity.

Groups with higher risk of chronic disease often face the greater barriers to accessing care, contributing to worse outcomes.

Maternal and Infant Health

More than 100 women in Illinois died while pregnant or within a year of pregnancy in both 2021 and 2022 according to the 2025 Illinois Maternal Mortality Data report. Two statewide maternal mortality review committees (MMRCs) determined that **91% of pregnancy-related deaths were potentially preventable**. Each preventable maternal death represents the loss of a parent, often a primary caregiver and wage-earner, creating ripple effects for children, families, and communities. For these reasons, Illinois has prioritized the promotion of a comprehensive and equitable care system that supports mothers throughout pregnancy, birth, and the postpartum period[15].

STATE POLICY IN ACTION

- **Expand access to comprehensive prenatal, perinatal, and postpartum services**, with a focus on health gaps for Black women, rural communities, and low-income families.
- **Support extension or reform of Medicaid coverage** to provide postpartum care 1-yr beyond the immediate delivery period.
- **Invest in community-based birthing support (doula, midwife, community health workers)** to improve culturally responsive care, early risk detection, and maternal support services.
- **Strengthen statewide surveillance and data systems** for more granular tracking of maternal outcomes, causes of death, morbidity patterns, and interventions.
- **Address social determinants of health** that disproportionately affect disadvantaged communities.

The infant mortality rate in Illinois is higher than the national average at 5.6 deaths per 1,000 live births[16]. Receiving adequate, early prenatal care improves the chances of having a live birth. According to a 2022 survey, Illinois mothers who received prenatal care during the first trimester accounted for 91% of all live births[17].

One in five mothers experience depression or anxiety during pregnancy or postpartum. In Illinois, from 2018-2020, 8% of pregnancy-related deaths were due to mental health conditions resulting in suicide, and 32% were due to substance use disorder (SUD)[18]. Recognizing the need for continuous support of mothers and infants, Illinois has committed to strengthening the maternal workforce and infrastructure capacity and providing age and diagnosis-appropriate interventions for child growth and development [19,20]

Health Gap Alert

Rural populations are disproportionately impacted. 34.3% of Illinois counties are classified as maternity care deserts (no birth centers, obstetric providers, or hospitals with obstetric care)[16].

Infants born to Black women in Illinois are almost three times more likely to die than those born to White, Hispanic, and Asian women.

Older women are also more at risk. Infant deaths in Illinois are most common among pregnant women who are 40 years or older – almost 3 times as likely as other age categories.

Women in Illinois with a high school education or less are twice as likely to experience infant death during pregnancy.[17]

Mental Health and Substance Use Disorder

Behavioral health conditions are major drivers of disability, early mortality, emergency service utilization, homelessness, incarceration, and preventable health care costs. The state continues to experience rising rates of depression, anxiety, suicide risk, opioid-related morbidity, and polysubstance use. SUD is also a major public health issue in Illinois, with 22.7 fatal opioid-related overdoses per 100,000 in 2023, an increase of almost 50% since 2016[21].

STATE POLICY IN ACTION

- **Expand access to evidence-based treatment** for SUD, including MOUD, harm-reduction programs, and culturally responsive recovery supports.
- **Strengthen the behavioral-health workforce,** particularly in rural and underserved communities, through incentives, training, and pipeline programs.
- **Integrate behavioral health** into primary care and community settings, particularly FQHCs, schools, and crisis-response hubs.
- **Support 988 crisis response and mobile crisis infrastructure,** reducing strain on emergency departments and law enforcement.

Illinois has made hard-won progress in combating the opioid epidemic through naloxone distribution, medication-assisted treatment (MAT), data-driven interventions, and community-based programs[22]. Proposed federal budget cuts to funding streams from the CDC, the Substance Abuse and Mental Health Services Administration (SAMHSA), and Medicaid threaten to reverse these gains. For example, up to $28 million in federal funding to the Illinois Department of Human Services (IDHS) for mental health and substance use disorder treatment programs across 77 community-based organizations has been cut, according to a notice from SAMHSA[23]. Although legal counteractions have temporarily halted some of these cuts, proactive and sustained state investment is critical to prevent a resurgence in overdose deaths and associated costs.

It is also important to note that **the number of behavioral health workers is not adequate to meet the needs of the population**. Providers are unequally distributed throughout the state, with more than 6.5 million Illinoisans living in a community without sufficient mental health professionals. Low compensation, limited opportunities for professional development, high caseload demands, and unsupportive agency environments are among the reasons reported for turnover in mental health and substance positions.[24]

Health Gap Alert

Black individuals are about four times more affected by opioid-related overdoses than any other race or ethnicity[22].

Black and Brown communities have less access to mental health services and resources due to a lack of mental health and substance use facilities in their communities [25].

Rural areas experience disparities in accessing these services with fewer facilities located in rural areas and longer travel distances[24].

Systemic barriers such as poverty, financial instability, lack of health care insurance, and high treatment and service costs contribute to these disparities.

Emerging Diseases

Emerging diseases affect economic stability in several ways, including school disruptions, decreased workforce productivity, supply chain interruptions, and increased Medicaid and public health costs. **Outbreak response requires significant expenditures** in testing, vaccination, PPE, communication, staffing, and disease-control measures. Even after the outbreak is over, costs still accrue from long-term chronic complications (e.g., long-COVID), increased disability claims, and reduced workforce participation.

Sustain and expand infectious-disease surveillance systems, including wastewater, genomic sequencing, and real-time reporting.

Strengthen vaccination infrastructure (community partners, pharmacies, mobile clinics) to ensure rapid uptake during outbreaks.

Invest in workforce capacity, including epidemiologists, data analysts, public-health nurses, lab workers, and emergency responders.

Enhance statewide outbreak response coordination, including long-term care readiness, hospital surge systems, and community-based response networks.

Modernize communication systems to reach diverse communities quickly and effectively during emerging-threat events.

STATE POLICY IN ACTION

COVID-19 revealed infrastructure strengths and vulnerabilities for emerging disease surveillance and emergency response, fundamentally altering public health practice, clinical care, and emergency preparedness in Illinois. Hospitals struggled with high provider-patient ratios, burnout, turnover, and limited surge capacity, leaving both routine services and emergency response efforts weakened, particularly in under-resourced communities. Issues such as fragmented data systems, outdated technology, workforce shortages, and limited preparedness planning slowed coordinated action and resource allocation[26,27]. Laboratory and testing capacity also faced major strain, highlighting the need for sustained modernization and investment[27].

November 2025 data from IDPH's Seasonal Respiratory Illness Dashboard show that outbreak reports remain higher for COVID-19 than the flu or RSV[28]. Even as we respond to these aftershocks, West Nile Virus cases more than doubled from 69 to 147 in the last year, and measles re-emerged in Illinois during a year of the highest national case count in over three decades[29,30]. Illinois' recent landmark bill to counter federal rollbacks to vaccine access is one of many examples of leadership that empowers residents of all ages before, during and after a public health emergency[31]. Now more than ever, **Illinois needs public health to prevent, protect, respond to, and recover from major health threats** that can overwhelm our healthcare systems, our communities, and our resources.

Health Gap Alert

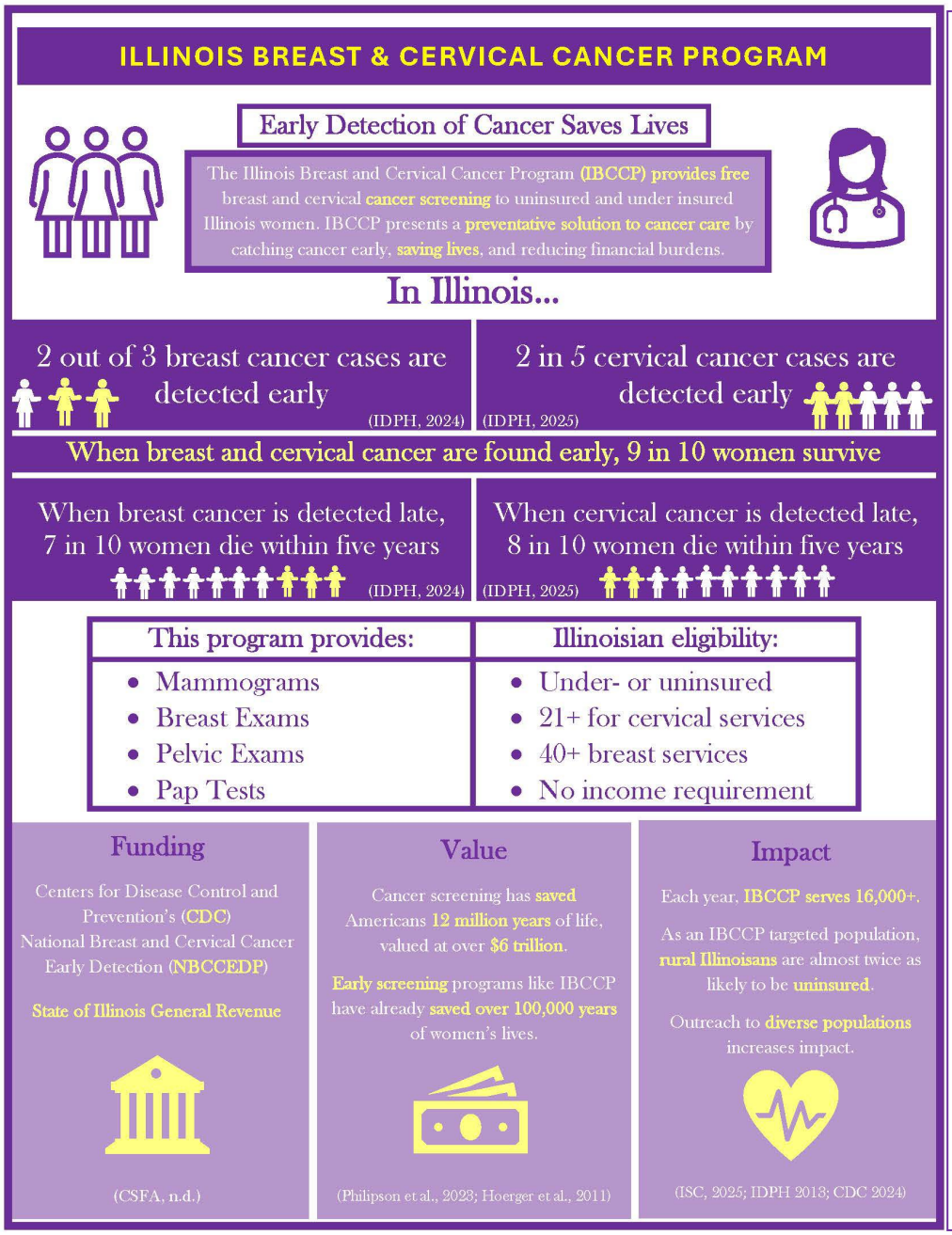
Vulnerable residents with chronic conditions, disabilities, unstable housing, or low income face intensified risks during emergencies[32].

Limited English proficiency or low health literacy can also increase vulnerability and worsen health outcomes during emerging disease outbreaks[32].

Rural communities have additional barriers and risk of emerging diseases due to limited infrastructure and funding[33].

The Impact of Public Health

Here, we highlight several programs that, despite making a measurable impact on health outcomes prioritized in Healthy Illinois 2028, are vulnerable to recently proposed federal budget cuts and agency restructuring. Infographics summarizing each program's context and progress are provided below.

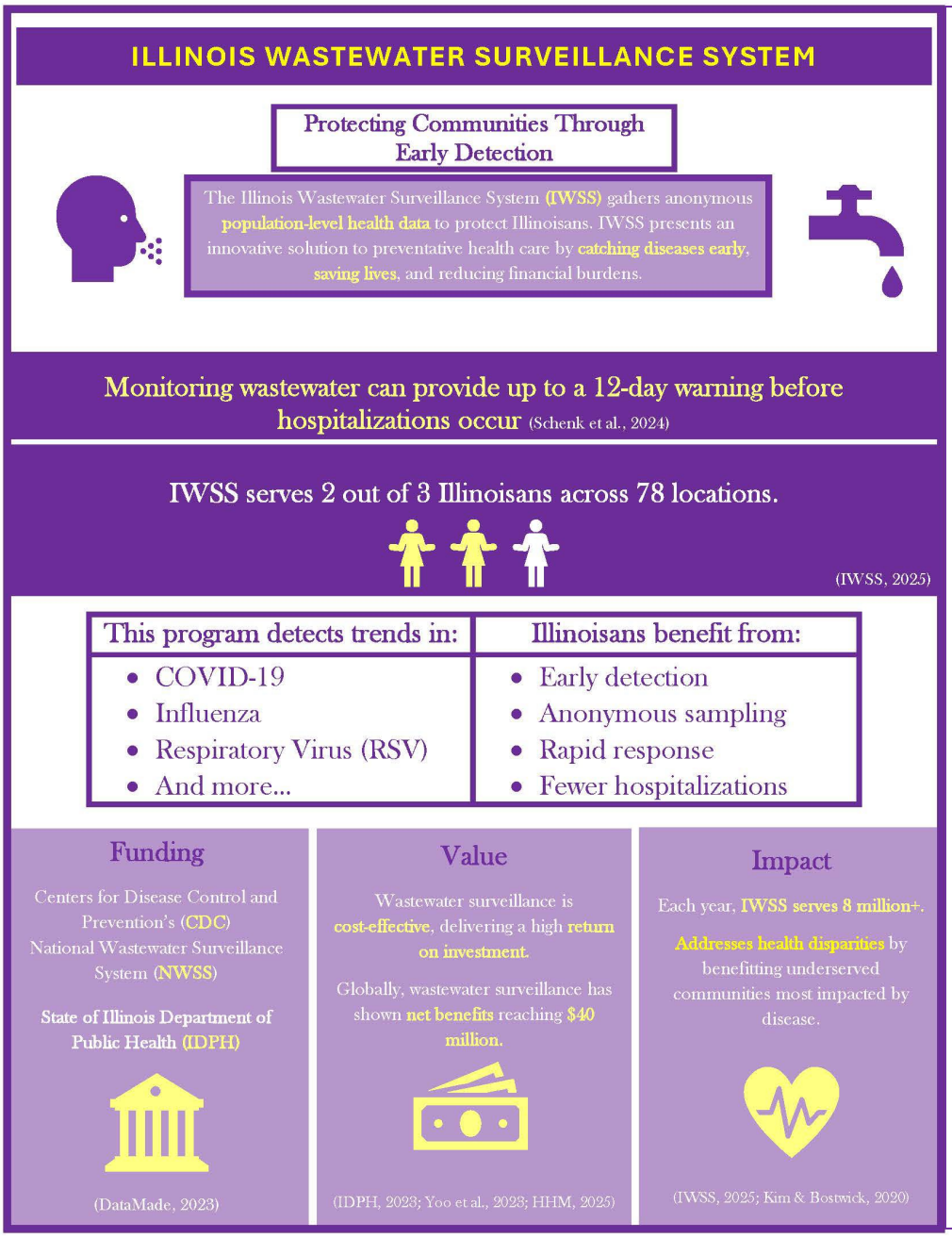


Illinois Breast and Cervical Cancer Screening Program[34-40]

Combined medical and prescription drug costs for breast and cervical cancer total $32.1B annually in the U.S. Cancer screenings and early diagnoses significantly reduce breast and cervical cancer deaths. The Illinois Breast and Cervical Cancer Screening Program (IBCCSP) expands access to mammograms and cervical cytology and human papillomavirus (HPV) screening and education to women in economically disadvantaged and rural communities.

In the past four years, Illinois has invested $57 million in breast and cervical cancer screenings and education. In FY24, the IBCCSP administered nearly 15,000 breast cancer screenings and over 5,000 cervical cancer screenings.

Although there have been no reports of plans to eliminate funding, it remains unclear whether program oversight will remain at the CDC or move to the new, proposed Administration for a Healthy America (AHA) division within HHS. As of the release of this report, breast and cervical cancer prevention do not appear among the Make America Healthy Again (MAHA) Commission's priorities. In addition, recent actions by the current administration, such as the dismantling of the Women's Health Initiative (WHI) and gradual declines in NIH funding for women's health research, suggest that **women's health is being deprioritized at the highest level.**

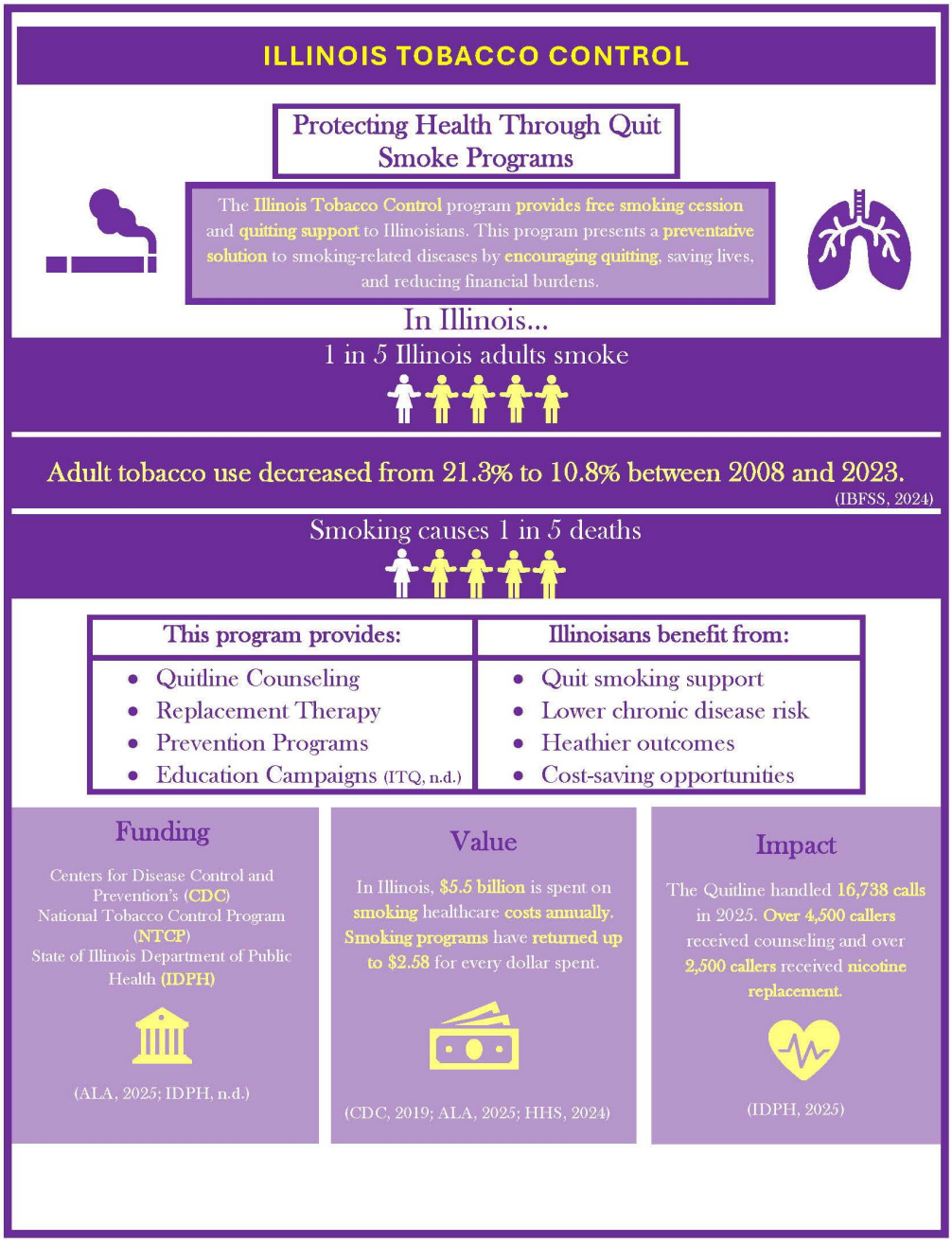


Early Disease Detection: Wastewater Analysis[41-48]

The Illinois Wastewater Surveillance System (IWSS) monitors viral concentrations in wastewater samples from nearly 80 treatment plants across Illinois, providing weekly data for viruses including COVID-19, flu, RSV, hepatitis A, measles, and mpox. By identifying changes in viral strains weeks before they are widely detected through clinical testing, the program offers a powerful and cost-effective tool for proactive public health intervention and preparedness across Illinois.

The IWSS was established as part of the National Wastewater Surveillance System (NWSS), which leveraged more than $500 million in federal COVID-era supplemental funding between 2021 and 2024. These emergency funds expired September 30, 2025, with no baseline budget or ongoing appropriation beyond FY2025.

IWSS' operations are funded largely through CDC's Epidemiology and Laboratory Capacity (ELC) cooperative agreement. If NWSS winds down or federal ELC allocations shrink, Illinois' operational capacity will decline sharply, increasing risk to residents and potentially leading to higher social and economic costs for the state.

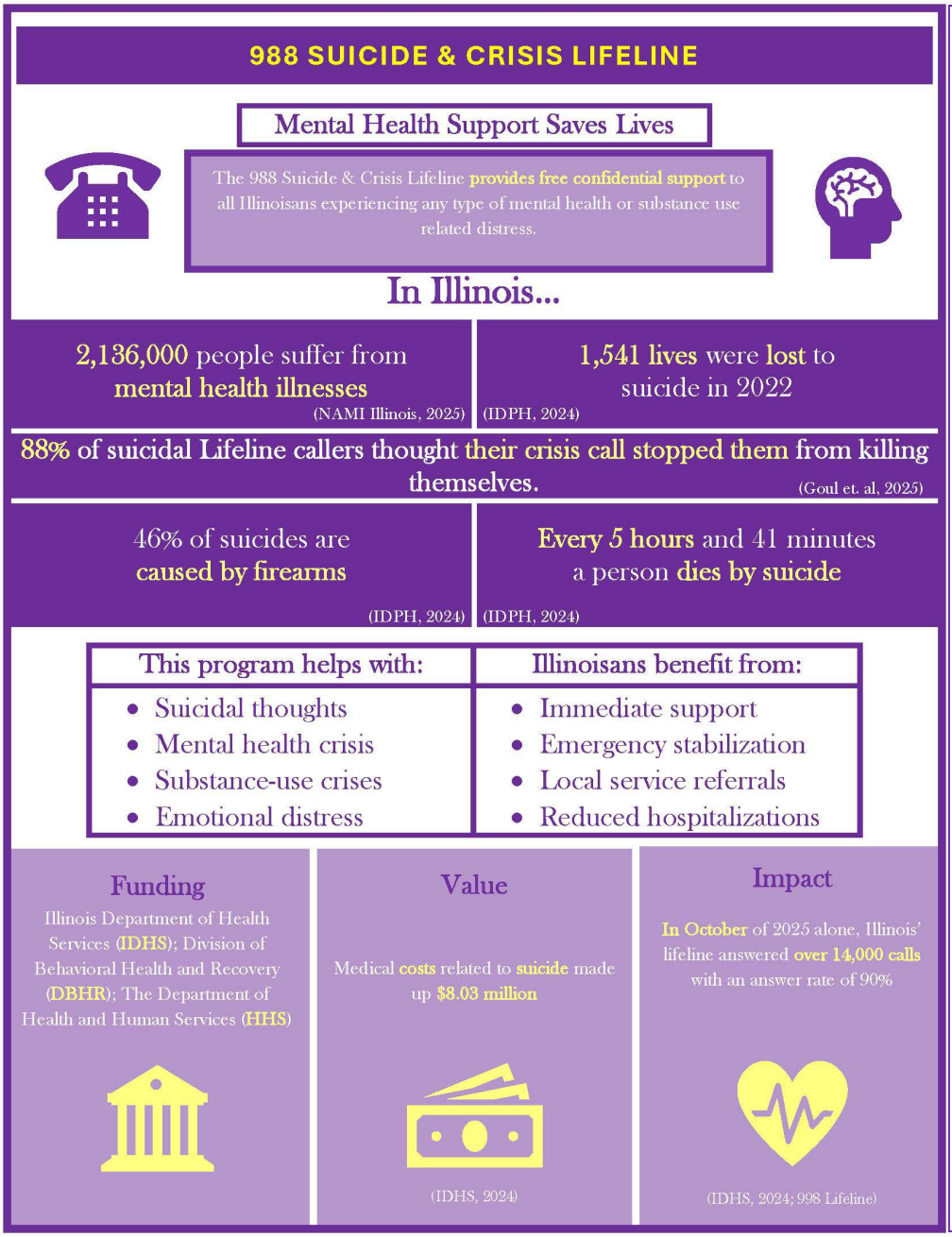


Tobacco Prevention & Control[49-56]

The health risks of smoking and secondhand smoke exposure are well-documented, including poor reproductive health outcomes, cardiovascular diseases, chronic obstructive pulmonary disease (COPD), and cancer. A 2010 report suggested that annual direct costs attributable to smoking in Illinois were in excess of $12.7 billion, including workplace productivity losses of $2.9 billion, premature death losses of $5 billion, and direct medical expenditures of $4.8 billion.

The Illinois Tobacco Quitline is a free resource is to help people quit smoking, vaping, or other tobacco. More than half (57%) of callers completing Quitline enrollment reported having Medicare as their primary health insurance. Callers who reported having at least one mental health condition, including but not limited to bipolar disorder, anxiety disorder, and depressive disorder, comprised 47% of those enrolling, and 25% of callers identified as Black or African American (non-Hispanic). These enrollment statistics suggest downstream savings in Medicare spending on tobacco-related chronic disease treatment, and promising outcomes in addressing health disparities.

April 2025, the CDC's Office on Smoking and Health, which supported state-level tobacco control programs, was dismantled. Several major funding streams are expected to end in April 2026, including funds for tobacco disparities grants and those from the National Tobacco Control Program cooperative agreement ($2.4M annually), which is not likely to be renewed due to staff shortages at the federal level.



988 Suicide & Crisis Lifeline[57-63]

Suicide is the 11th leading cause of death in Illinois, and the 3rd leading cause of death among young adults 15 to 34 years of age, resulting in more than 1,000 deaths annually.

The 988 Suicide & Crisis Lifeline is a free 24/7, year-round access point to statewide community-based crisis resources. The lifeline is supported through the coordinated efforts of IDHS (administration), IDPH (promotion, training, and strategy), and the Illinois Suicide Prevention Alliance (planning and data). Together, these agencies ensure sustainable funding, workforce development, and integration with mobile crisis teams, creating a comprehensive system for immediate response and long-term suicide prevention.

Early intervention programs like this reduce trauma to individuals and their families and are far less expensive than hospitalization and emergency response associated with untreated mental health crises. While the HHS budget has not proposed cuts to 988 funding levels, IDHS has recently taken up the mantle to continue specialized 988 service for LGBTQIA+ young people amidst targeted elimination of the service at the federal level. LGBTQIA+ youth are disproportionately at risk for suicide and other mental health issues, accounting for 10% of all 988 contacts nationwide. Given year-over-year increases in demand since the service launched three years ago, sustainability concerns persist as substantial federal reductions threaten call center capacity.

External Threats to Public Health

Since January 2025, the federal government has taken several major steps that will significantly impact public health in Illinois:

Federal Policy Changes

Withdrawal from the World Health Organization (WHO)

- On day one of the new administration, the President initiated U.S. withdrawal from WHO and **restricted federal engagement with global health partners**.
- This reduced international disease surveillance, hindered global disease mitigation efforts, and created gaps in early detection of emerging health threats.

Major Disruptions at the U.S. Department of Health and Human Services (HHS)

- Appointment of Secretary Robert F. Kennedy, Jr. marked a sharp ideological shift.
- HHS implemented **deep staffing cuts (approximately 25% of its workforce)** through reductions in force and forced retirements.
- Large **reductions in federal medical research funding**, including critical work on mRNA vaccines and cancer therapies.
- Entire Advisory Committee on Immunization Practices (ACIP) was fired and replaced with many individuals who had previously espoused **vaccine skepticism.** ACIP has since rolled back some longstanding, evidence-based vaccine recommendations without new compelling scientific evidence.
- Proposed federal budget cuts exceeding 25% and a complete departmental reorganization pose **threats to emergency response capacity**.
- **Weakened CDC and NIH support to states**, forcing Illinois to self-coordinate functions previously led by federal agencies.

Passage of the One Big Beautiful Bill Act (OBBBA)

- Introduced **new federal requirements that reduce access** to Medicaid and SNAP that will likely increase food insecurity, reduce preventive care access, and increase uncompensated healthcare and social-service costs.
  - **Medicaid:** First-ever federal work requirements are expected to decrease coverage and disrupt continuity of care.
  - **SNAP:** New state-level match requirement creates substantial funding gaps; Illinois will be forced to either significantly increase state spending or reduce nutrition benefits for low-income residents.

Strained Federal–State Partnership

- Illinois has already initiated **litigation to preserve expiring grant funds**.
- Federal programs historically supporting state public health infrastructure may not be renewed, **weakening safety nets** for emergency preparedness, disease control, and health promotion.
- Illinois' capacity to sustain core public health functions is at heightened risk as **federal backstops become unreliable**.

Severe Funding Cuts & Workforce Shortages

- **Over 100 public health programs and funding lines would be eliminated** under the President's proposed FY 2026 budget, including 61 programs at CDC and 40 programs at SAMHSA.
- Proposed federal budget reductions (e.g., a **53% cut to CDC and related programs**) threaten outbreak response, chronic disease prevention, and core public health services.
- State and local **health departments are rapidly laying off staff**, freezing hiring, and losing critical infrastructure from these financial constraints.

- There are notable **shortages across key public health roles**, including nurses, epidemiologists, and analytics professionals; recruitment is hindered by stagnant or grant-restricted funding.
- **Competition from other industries** and lack of long-term job security limits both recruitment and retention.
- The Department of Education (ED) **proposed changes to the definition of "professional degrees" to exclude public health**, subjecting students to student loan caps and threatening future workforce capacity.

Politicization & Polarization

- **Public health measures have become highly politicized**, leading to resistance to vaccinations, mask mandates, and epidemiologic guidance.
- **Health officials face harassment, doxxing, and violence**, prompting resignations and compromising emergency responses during crises.

Misinformation & Disinformation

- Social media-driven **health misinformation incites hostility and mistrust in public health** and compromises emergency response. "Infodemics" is a term used to describe how the spread of misinformation behaves like a virus in digital and physical environments. This phenomenon complicates public health messaging and leads to confusion, causing harmful risk-taking behaviors. When people are unsure about what they need to do to protect their health and the health of people around them, it can lengthen the amount of time it takes to recover from an outbreak.
- **National government organizations removed over 8,000 webpages and approximately 3,000 data sets** to comply with executive orders in January 2025. While some content has since been restored, this act has deeply shaken confidence in the accuracy and accessibility of federally administered datasets.

Recommendations

The HiAP Workgroup acknowledges the outstanding work being done across the state to make Illinois the healthiest state in the nation. We strongly endorse existing and planned strategies that support and increase access to basic necessities that enable health: safe and affordable housing; access to nutritious food; clean air, water, and soil; access to healthcare; quality education; and living wages. We encourage readers to refer to prior HiAP annual reports for specific recommendations on these issues.

Most relevant to the workgroup's charge to improve health outcomes through policy, the following recommendations seek to transform the existing public health infrastructure to better support disease prevention and management, monitoring and early action, workforce capacity and development, evaluation and continuous improvement, and resources and cross-sector partnerships for HiAP. Categorization of Healthy Illinois 2028 objectives across these recommendations are provided in Appendix III.

Disease Prevention & Management

- **Health Education Across the Life Course**
  A lack of familiarity with the full contributions of public health in addressing social and structural determinants of health (SSDOH) challenges the success of health interventions. Adults with low health literacy incur healthcare costs four times higher, with 6% more hospital visits and stays that are two days longer on average, costing the system more than $25 billion annually[64]. Equipping residents of all ages with an understanding of how their health is influenced by their environment and behaviors before they require medical attention is a valuable approach to prepare them to co-create solutions that maintain their community's health. Here, we provide an implementation roadmap for policy-driven strategies to create a sustainable, system-wide foundation for public health education, equipping all residents with the knowledge and agency to address SSDOH throughout their lives.

    1. Schools districts and institutions of higher education should integrate SSDOH principles in their existing K-12 and postsecondary curricula.
    2. Convene stakeholders to incorporate SSDOH into future revisions of physical development and health standards. Stakeholders should include educators, public health officials, community leaders, professional associations, and parents.
    3. Secure funding for curriculum development, professional training, and community education efforts.
    4. Strengthen partnerships between universities, schools, and NGOs to co-create age-appropriate modules and training based on best practices.
    5. Negotiate agreements with accrediting bodies to embed SSDOH competencies into licensure and professional development frameworks.
    6. Launch inclusive campaigns and community forums to promote understanding of structural health impacts.
    7. Develop metrics to evaluate implementation, knowledge dissemination, and health equity outcomes; refine strategies based on results.

- **Public Health Communications**

Research on the COVID-19 “infodemic” shows that misinformation reduced vaccine uptake, hindered outbreak control measures, disrupted access to care, increased public fear and stress, and slowed effective responses. Beyond pandemics, however, misinformation more broadly exacerbates health inequities. Relying solely on ad hoc communications is insufficient for a state as diverse as Illinois. Research on social media-based public health campaigns shows that communications are most effective when messages are (1) tailored to specific populations (by age, language, location), (2) co-designed with members of those communities (to ensure cultural relevance and trust), (3) directly address misinformation (myth-busting), (4) leverage trusted messengers (e.g., community leaders or influencers), and (5) are evaluated systematically for impact.

Well-designed, sustained public health communication is not just a “nice to have,” it is a disease prevention and management strategy in itself. Here are concrete recommendations to institutionalize public health communications that ensure Illinois can deliver clear, trusted, and equitable public health information under any conditions.

1. **Permanent staffing and coordination:**
    a. Strengthen the Public Health Communications Division within IDPH.
    b. Provide ongoing appropriations for staffing, training, data systems, monitoring tools, translation, and regional support. Establish a funding mechanism that is tied to tobacco, alcohol, and prescription drug ad revenue.
    c. Encourage inter-jurisdictional coordination so state, county, and local agencies work from shared messaging frameworks and communications protocols.

2. **Shared statewide messaging standards**:
    a. Adopt statewide messaging frameworks grounded in research, such as de Beaumont’s Communicating About Public Health Toolkit or those offered by the Public Health Communications Collaborative.
    b. Require IDPH and local health departments to integrate these guides into communications plans for both routine programming and emergencies.
    c. Provide training and technical assistance through a statewide learning collaborative.

3. **Continuous monitoring for misinformation**:
    a. Build or procure social-listening tools that continuously monitor trending misinformation and sentiment across platforms.
    b. Train communications staff at IDPH and local health departments in early detection, risk assessment, and rapid response.
    c. Establish a centralized misinformation response protocol, including message templates and guidance on rapid myth correction.

4. **Community partnership networks**:
    a. Encourage all public health agencies to develop communications plans in collaboration with community-based organizations, local leaders, and trusted messengers.

b. Dedicate funding to translation services, accessibility adaptations, and culturally relevant formats.

5. **Evaluation and learning systems:**
    a. Require communications strategies to include evaluation metrics: reach, comprehension, behavior change, and equity impacts.
    b. Publish annual statewide communications reports across jurisdictions.
    c. Maintain a shared repository of what worked, what did not, and lessons learned.

Monitoring & Early Action

As a major transportation hub and Great Lakes state, Illinois has added pressure to manage disease for the health of the nation. Constant travel to and from our state increases demand on surveillance systems and makes urgent the need to have modern, well-resourced public health infrastructure.

- **System Modernization & Integration**
  Illinois needs modern, connected data systems that reduce administrative burden and lower long-term costs. Modernization goes beyond upgrades in technology to include workflow improvements and coordination so agencies can act quickly and collaborate more efficiently. As Illinois leans into innovative technologies (e.g., AI integration), developing a workforce that has the knowledge and skills to use them effectively and ethically is paramount. It will also be essential to protect sensitive health data and ensure privacy so that residents can trust how their health information is collected and used.
- **Data Collection & Quality Assurance**
  Improved data collection is especially necessary in areas where under reporting of health status is common due to stigma, fear, or limited access to care. This not only requires system modernization, but development of a workforce to manage advanced surveillance tools and interpret complex datasets. It also entails preparing professionals who can build strong, trusting community relationships that facilitate cooperation with data collection efforts. Finally, adopting common data standards to link clinical, laboratory, and environmental data sources seamlessly are key to translating information across health systems for rapid response.

- **Decision Support Systems & Dashboards**
  User-friendly dashboards and decision-support tools can help state and local leaders respond faster, communicate risks more effectively, and make data-driven decisions. For example, the Illinois State Cancer Registry (ISCR) tracks cancer cases and identifies possible clusters, improving odds of success for early prevention and treatment interventions.

  Dashboards depend on extensive behind-the-scenes work to make data digestible, which can be just as important as the technology itself. Large-scale surveys such as the Behavioral Risk Factor Surveillance System (BFRSS) and the Healthy Illinois (HIL) survey provide important data for public health decisions at the state and national level. Expanding local data capacity and archiving, as well as investing in the workforce

responsible for collecting, managing, and analyzing data, are increasingly important to Illinois' response to health risks, as we have witnessed a 13% decrease in publicly available CDC datasets since January 21, 2025.[65]

- **Laboratory Capacity**
  Enhanced laboratory capacity, including faster testing and improved equipment, will help Illinois detect threats earlier and respond before outbreaks escalate.

Evaluation & Continuous Improvement

Because prevention outcomes are often unseen in the short term, evaluation provides the evidence needed to show that proactive, population-based strategies are far more cost-effective than retroactively treating disease. In short, evaluation tells us how well a program is working, how it can be improved, and at what cost. Several challenges hinder evaluation in public health, including complex and weak metrics for determining the economic value of interventions, limited interdisciplinary partnerships, and inadequate funding for building evaluation capacity. In a constrained budget environment, Illinois must invest in strong systems and infrastructure metrics, including quality of data, workforce and developmental capacity, systems integration, and cross-sector collaboration, to support effective evaluation and continuous improvement.

- **Metrics to Determine ROI of Public Health Interventions**
  Return on investment (ROI) is a core economic metric that is increasingly used to assess the value of public health interventions and inform policies. However, calculating ROI is complex, as variations in methodology present risks of inaccuracy and misinterpretation. Thus, researchers recommend standardization to improve reliability. Metrics that are typically used to calculate ROI of public health interventions and key data providers are provided below.

$$\text{ROI} = \frac{\text{Benefits} - \text{Costs}}{\text{Costs}} \times 100\%$$

Costs

- **Program budgets, staffing costs, and operational expenses**
  - *Provided by: State or local health departments*
- **Detailed expenditure reports and cost allocation data**
  - *Provided by: program administrators & finance offices*

Monetary Benefits

- **Healthcare Costs Avoided**
  - *Medicaid/Medicare Claims Data (Centers for Medicare & Medicaid Services)*
  - *State Health Insurance Programs*
  - *Hospital Systems & Health Information Exchanges*
- **Productivity Gains**
  - *Wage data (Bureau of Labor Statistics (BLS))*
  - *Absenteeism and productivity metrics (Employer records)*
- **Value of Lives Saved / Quality of Life**
  - *Willingness-to-pay thresholds or economic valuation studies (often from academic research or federal guidelines like those from CDC or OMB)*
- **Social Benefits (e.g., reduced crime, improved education)**
  - *State Departments of Education*
  - *Justice Departments*
  - *Community-based organizations*

Here we provide several policy-driven strategies to improve collection and sharing of cost and benefit data for economic evaluations, which build on steps Illinois has already taken to improve public health data sharing and governance.

1. **Strengthen Legal Framework for Data Sharing**

   Illinois Action: Access to Public Health Data Act (HB 2039) - provisions requiring state agencies to share key datasets (hospital discharge, syndromic surveillance, prescription monitoring) with local health departments, overriding previous legal ambiguities.

   Enhancement Strategy: Expand this framework to explicitly include economic evaluation data (e.g., cost and utilization data) and clarify permissible uses for ROI and cost-benefit analyses.

2. **Formalize Data Governance Structures**

   Illinois Action: IDPH Data Governance Board & Data Modernization Advisory Committee - bodies that set standards for data collection, privacy, and interoperability.

   Enhancement Strategies:

   - Adopt statewide data stewardship policies for economic evaluation datasets.
   - Require standardized cost and benefit reporting formats across agencies.
   - Implement a Master Data Use Agreement for sharing financial and health outcome data between state and local entities.

3. **Enhance Interoperability and Infrastructure**

   Illinois Action: Illinois Interoperability Project & CDC Data Modernization Initiative - focuses on integrated systems for health and human services.

   Enhancement Strategies:

   - Invest in interoperable platforms that link health, labor, and education data for monetizing benefits like productivity gains.
   - Use federal interoperability standards (e.g., CDC Core Data Use Agreement) to streamline cross-sector data exchange.

4. **Privacy and Security Safeguards**

   Illinois Action: Protect Health Data Privacy Act (HB 4093) and HISPC recommendations - these policies emphasize consent, transparency, and compliance with state and federal laws.

   Enhancement Strategies:

   - Develop tiered access protocols for sensitive cost and claims data.
   - Require anonymization and aggregation for ROI-related datasets.
   - Provide clear public communication on how data is used for policy decisions.

5. **Funding and Workforce Capacity**

   Illinois Action: Healthy Illinois 2028 & IPHI Legislative Agenda - calls for appropriations to strengthen data systems and evaluation capacity.

Enhancement Strategies:

- Secure dedicated funding for economic evaluation and data modernization.
- Train local health departments in cost-benefit and ROI analysis through statewide capacity-building programs.

- **Partnerships to Support Evaluation Work**

Effective public health evaluation relies on strong cross-sector partnerships to build capacity, enhance processes, and support equitable, community-centered outcomes. Here, we outline the diverse partners that comprise a comprehensive evaluation ecosystem, their contributions, and the actions the state can take to facilitate a more robust infrastructure for better-informed policymaking that achieves both efficiency and improved health outcomes.

1. **Academic Partners - research capacity and analytic expertise**

Action:
- Establish state-funded research collaboratives with universities to conduct cost-effectiveness and ROI studies.
- Create data sharing agreements that allow academic institutions to access de-identified health and cost data for modeling.
- Offer grant incentives for applied research that supports state health priorities (e.g., chronic disease prevention, maternal health).

Policy Lever:
- Include economic evaluation requirements in state-funded research RFPs.
- Formalize partnerships through Memoranda of Understanding (MOUs).

2. **Healthcare Systems - provide clinical outcomes, healthcare utilization trends, and cost data**

Action:
- Mandate participation in statewide health data exchange for cost and utilization data.
- Provide legal protections and standardized agreements for sharing claims and cost data for evaluation purposes.
- Incentivize hospitals and insurers through value-based payment models that reward evidence-based interventions.

Policy Lever:
Amend state health regulations to include economic evaluation as part of quality improvement reporting.

3. **Governmental Agencies - supply administrative data and systems-level coordination**

Action:
- Charge IDPH to establish a cross-sector partnership to examine the economic impact of public health interventions.
- Require economic evaluation components in state health improvement plans and grant programs.
- Develop centralized data governance policies for interoperability across health, labor, and education sectors.

Policy Lever:
Advocate for legislation similar to Washington's WSIPP model to institutionalize cost-benefit analysis in budgeting.

4. **Nonprofits and Community-Based Organizations (CBOs) - qualitative insights and cultural context**

Action:
- Provide capacity-building grants for CBOs to collect cost and outcome data.
- Develop community data hubs where nonprofits can share intervention outcomes for inclusion in statewide ROI analyses.

Policy Lever:
Include economic evaluation reporting requirements in state-funded community health contracts.

5. **Other Key Stakeholders (employers, philanthropy, private sector)**

Action:
- Engage employers in workforce productivity data sharing for monetizing benefits.
- Encourage philanthropic organizations to fund economic evaluation pilots for innovative interventions.

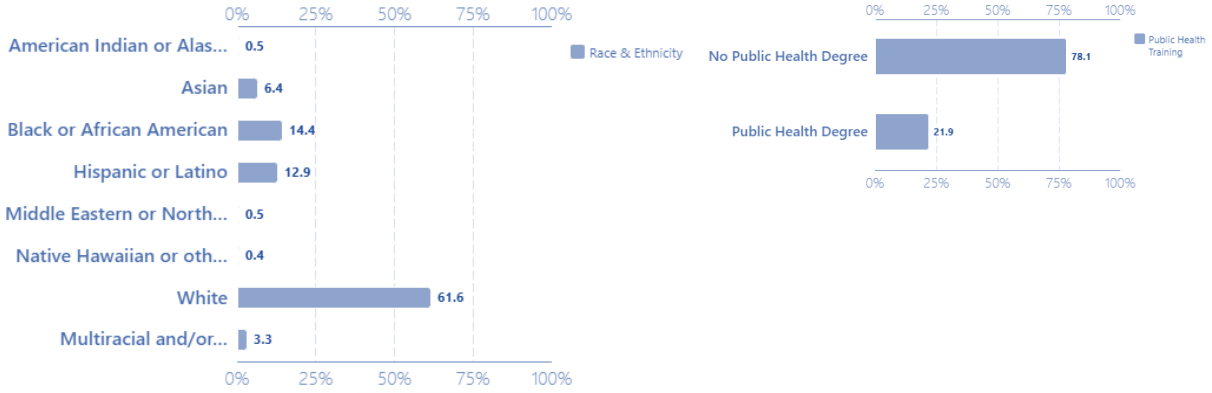
Policy Lever:
Offer tax incentives for private entities that contribute data or resources to state evaluation initiatives.

Workforce Capacity & Development

A report from the deBeaumont Foundation indicates that state and local health departments require a minimum of 80,000 additional full-time equivalent positions, representing a nearly 80% increase, to provide the necessary infrastructure and public health services to meet community needs. Between 2017 and 2021, state and local public health agencies across the U.S. lost 46% of their employees. As public health has historically been underfunded and understaffed, reductions in funding have worsened the instability of public health jobs, workforce shortages, and skillset gaps.

Given the Department of Education's proposed change to the professional degree definition and potential caps of $100,000 on federal loans for students pursuing public health degrees effective July 2026, it is important to note that only 21.9% of the public health workforce has a public health degree. These changes may deter people from pursuing a career in public health, further straining the current public health workforce due to burnout. With financial challenges being the top reason for withdrawal from school, this, along with other factors such as federal changes to SNAP benefit requirements for college students, compounds the barriers disadvantaged students already face in pursuing higher education. The lack of workforce diversity is also a barrier to addressing health disparities, with only 38.4% of the public health workforce self-identifying as non-white[66]. Less diversity in the public health workforce and fewer workers to address health gaps in underserved communities means slowed innovation, reduced productivity, and poorer health outcomes for Illinois residents.

Public Health Workforce Diversity and Educational Attainment



Source: Public Health Workforce Interest and Needs Survey (PH WINS), 2024 Findings

Members of the public health workforce contribute to the delivery of at least one of the essential public health functions and represent occupations from various non-public health backgrounds. The primary domains of public health and health promotion encompass a wide range of disciplines and focus areas aimed at improving population health and preventing disease as illustrated below.

- **Sustainable Workforce Pathways**

  As we increasingly require specialized knowledge to address gaps in our infrastructure, we must strategize to create sustainable pathways to the public health workforce. Here we provide some potential strategies:

  Early and continuous exposure

  Prior to the pandemic, most people were uninformed about public health as a discipline and viable career path. During the pandemic, there was an unprecedented increase in applications to schools and programs in public health. The evidence is clear: the first step to building sustainable pathways is to raise awareness of public health as a versatile and essential contributor to our health systems. A few ways to do this are:

  - School districts should integrate public health curriculum modules into K-12 STEM, civics, and health classes (e.g., CDC's "Public Health 101" modules show strong impact on awareness and career interest).
  - Expand health career exploration programs, public health summer camps, and high school–college bridge programs. Educate high school counselors on public health as a discipline and associated career pathways.
  - Develop dual credit or articulation pathways from community colleges to public health bachelor's programs.

  Paid, structured experiential learning programs (internships, apprenticeships, fellowships)

  Multiple national assessments show that paid experiential programs are among the strongest predictors of entering and staying in the public health workforce, especially among first-generation, low-income, and underrepresented students. Evidence-based models include:

  - CDC Public Health Associate Program (PHAP)
  - HRSA Public Health Training Centers
  - New York / California state-funded public health apprenticeships
  - Public Health Corps (Minnesota)

  What Illinois can do:

  - Require and fund paid internships and practicums in local and state health departments.
  - Create registered public health apprenticeships, especially for environmental health, community health workers (CHWs), epidemiology assistants, and data technicians.
  - Offer "learn-and-earn" models that allow students to work while completing certificates or degrees.

  Financial supports such as loan repayment or tuition incentives

  Research consistently shows that financial supports improve recruitment and retention, especially for prospective trainees from rural and underserved areas. Proven models Illinois may use as benchmarks include:

- State-run Public Health Service Loan Repayment (e.g., Oregon, Kansas).
- HRSA NHSC-style incentives for non-clinical workers serving high-need communities.
- Tuition assistance or free master's-level public health training tied to service commitments.

Recruitment from adjacent fields

Given shortages, evidence shows a strong return on hiring mid-career professionals from adjacent fields and upskilling them. Fields with proven crossover success include:

- Social work
- Education
- Criminal justice
- Urban planning
- Data science / informatics
- Communications / behavioral science
- Environmental sciences

Robust academic–public health partnerships to create training-to-hire pathways

Empirical studies and PHIG evaluation findings show that strong partnerships create a self-reinforcing talent pipeline. Potential strategies:

- Co-develop training hubs where students complete rotations at local health departments.
- Create joint faculty-practitioner appointments, allowing skills transfer in both directions.
- Support shared data systems and "real-world" practice-based teaching.

Modernize job classifications and paths for advancement

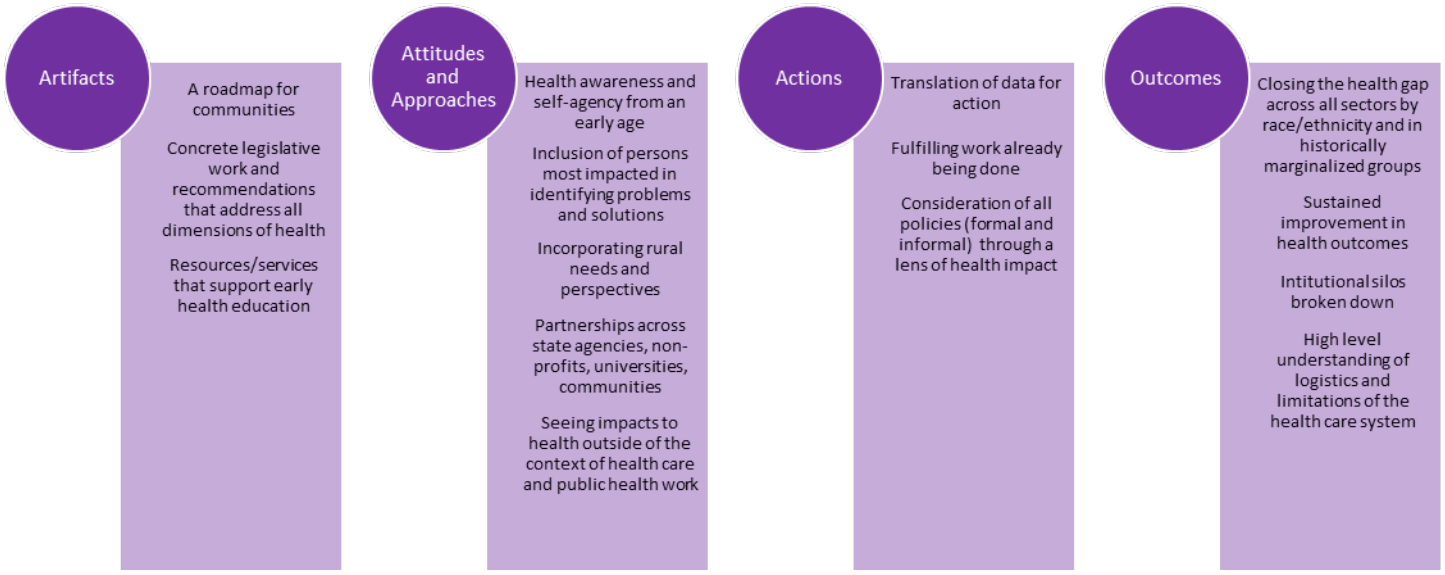
Outdated state and county civil service structures are consistently cited in national reports as barriers to recruitment, and evidence shows that workers remain longer not only when they are paid and treated fairly, but also when they see clear advancement paths. Here are some potential strategies to address these issues:

- Modernize job titles to match current skill needs (informatics, communications, behavioral science, community engagement, resilience planning).
- Allow market-adjusted salaries for hard-to-fill positions (epidemiology, IT, nursing).
- Reduce hiring timelines; streamline entry into civil service.
- Adopt or adapt PHAB/CDC competency frameworks for workforce skills.
- Create tiered job families (e.g., Public Health Technician > Analyst > Specialist > Program Manager).
- Recognize stackable credentials (CHW, data analytics, environmental health tech, public health preparedness, etc.).
- Encourage TEA-style career ladder initiatives (similar to K-12 systems).

Resources and Cross-sector Partnerships for Health in All Policies

Health in All Policies (HiAP) advocates for the participation of lawmakers, government agencies, community-based organizations, businesses, and individuals in addressing complex health challenges in planning, processes, and policy at all levels. As suggested by our legislative mandate, IDPH and the UIC School of Public Health are uniquely positioned and trained to co-lead this work, but resources and strategic partnerships are needed to sustain it.

- **Resources**
  When the Health in All Policies Workgroup first convened, members shared their visions of what success would look like. Their insights were categorized into artifacts (tangible products), attitudes and approaches (underpinning principles, processes, and behaviors), actions (specific activities), and outcomes (downstream results).

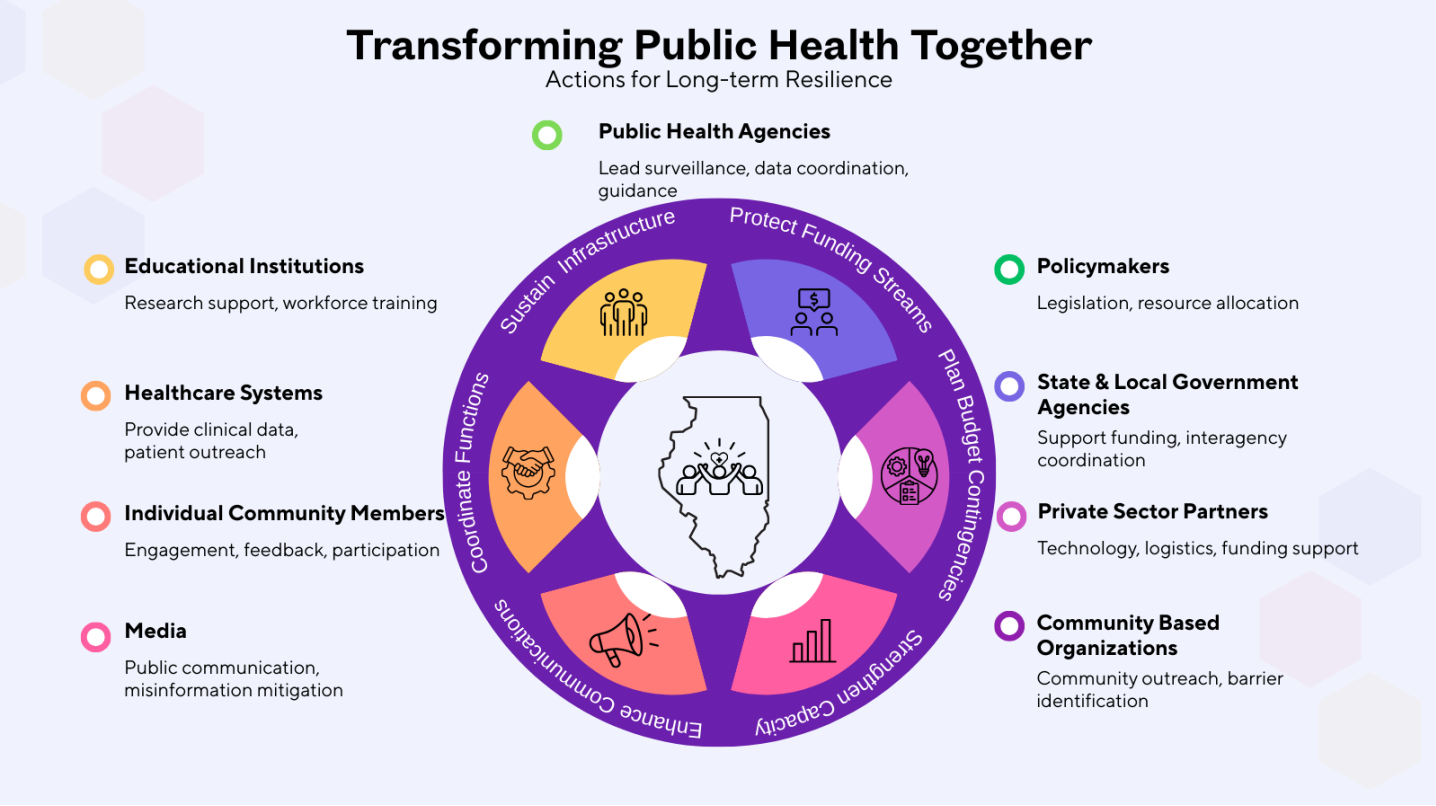


Achieving this vision requires that we:

- Build capacity for cross-sector leadership and policy interventions.
- Ensure administrative support and high-level direction setting and coordination.
- Engage with and develop plans to inform, and be informed by, individuals with lived experience.
- Identify best practices for delivering and evaluating interventions.
- Establish and maintain governmental and community partnerships that support advocacy and drive the development of policy.[67]

Implementation and scaling of HiAP efforts in Illinois can be strengthened with funding for: salary and fringe benefits for coordinating personnel, meeting expenses, in-state travel, report preparation costs, community outreach and engagement costs, training development and delivery, and technical assistance.

- **Cross-stakeholder and Community Partnerships**
  Public health works with government agencies, healthcare systems, educational institutions, community-based organizations, private sector partners, policymakers, media, and advocates for vulnerable populations to advance health in every facet of policy and practice. The illustration below shows how these cross-sector partnerships leverage shared expertise and resources across disciplines to advance health equity, build resilient communities, and improve opportunities for everyone to achieve optimal health.



Here are a few potential high-impact, low investment approaches Illinois can take that encourage cross-sector collaboration to improve health outcomes in both systematic and community-centered ways:

1. Routinize health and equity considerations across sectors by incorporating a **standard equity decision tool** into existing agency workflows for significant actions (e.g., rulemaking, ≥$5M grants, ≥$25M capital). California, Minnesota, New Jersey, New York, Oregon, and Washington have statewide tools (e.g., templates, frameworks, and metrics) that may be adopted and scaled in Illinois.
2. Encourage **cross agency health impact reviews** (HIR)/assessments for major statewide investments to leverage capacity and existing resources, prevent unintended health harms, and identify mitigation strategies early.
3. Incorporate "**score and reward" protocols** into state RFPs and grants to prioritize proposals that demonstrate cross agency collaboration and community co-governance.

Conclusion

For more than a century, the Illinois Department of Public Health has protected the well-being of every community in our state – quietly, consistently, and often invisibly. Today, IDPH and its partners remain committed to advancing the priorities of Healthy Illinois 2028, strengthening prevention, equity, and resilience across every community in our state. Yet this work is at a crossroads. Federal shifts in priorities and funding threaten the programs and infrastructure that keep Illinois residents safe, particularly in a political climate where episodic, crisis-driven support can no longer be counted on.

Illinois has both a duty and an opportunity to act. As a national hub and a recognized public health and economic development leader in the Midwest, our decisions carry weight far beyond our borders. A strong public health system not only improves health outcomes, it strengthens our workforce, stabilizes our economy, boosts productivity, reduces avoidable costs across sectors, and enhances the overall quality of life for every Illinoisan. The value of public health is societal, economic, and generational. How we invest today will shape how public health workers, and the vital work they perform, are valued tomorrow.

Our state's diversity, from Chicago's urban density to the wide rural expanse of southern and central Illinois, demands consistent, sustained investment, not piecemeal or reactive support. Illinoisans depend every day on the unseen work of public health: clean water, safe food, disease surveillance, community partnerships, emergency preparedness, and the prevention strategies that extend life expectancy and keep families thriving. These systems do not build themselves in a crisis – they must be maintained now, before the next emergency tests our readiness.

The future of prevention is in our hands. By safeguarding stable funding, strengthening the workforce, and sustaining the programs that are already delivering measurable gains, Illinois can secure a healthier, more prosperous future for all residents and continue to lead the nation in what is possible when public health and public policy work hand in hand. Public health has taken care of Illinois for generations – **now it is time for Illinois to take care of public health** through investment in:

- Surveillance & Response
- Workforce Capacity & Development
- Disease Prevention & Management
- Evaluation & Continuous Improvement
- Resources and Cross-sector Partnerships for HiAP

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Appendices

Appendix I: Acronym Guide

ACA – Affordable Care Act
ACF – Administration for Children and Families
ACIP – Advisory Committee on Immunization Practices
AHRQ – Agency for Healthcare Research and Quality
ASPE – Office of the Assistant Secretary for Planning and Evaluation
ASTHO – Association of State and Territorial Health Officials
BRFSS – Behavioral Risk Factor Surveillance System
CDC – Centers for Disease Control and Prevention
CMS – Centers for Medicare and Medicaid Services
ED – U.S. Department of Education
ELC – Epidemiology and Laboratory Capacity Cooperative Agreement
FQHC – Federally Qualified Health Center
HFS – Illinois Department of Healthcare and Family Services
HHS – U.S. Department of Health and Human Services
HiAP – Health in All Policies
HISPC – Health Information Security and Privacy Collaboration
HPV – Human Papilloma Virus
HRSA – Health Resources and Services Administration
IDHS – Illinois Department of Human Services
IDPH – Illinois Department of Public Health
IHHA – Illinois Health and Hospital Association
IPHI – Illinois Public Health Institute
ISCR – Illinois State Cancer Registry
IWSS – Illinois Wastewater Surveillance System
MAHA – Make America Healthy Again
MAT – Medication-Assisted Treatment
MCH – Maternal and Child Health
MMRC – Maternal Mortality Review Committee
MOUs – Memoranda of Understanding
Mpox – Monkeypox (Mpox), a viral zoonotic disease
NIH – National Institutes of Health
NWSS – National Wastewater Surveillance System
OBBBA – One Big Beautiful Bill Act
PHAB – Public Health Accreditation Board
PHIG – Public Health Infrastructure Grant
PPE – Personal Protective Equipment
RIF – Reduction in Force
ROI – Return on Investment
RSV – Respiratory Syncytial Virus
SAMHSA – Substance Abuse and Mental Health Services Administration

SHA – State Health Assessment
SHIP – State Health Improvement Plan
SNAP – Supplemental Nutrition Assistance Program
SSDOH – Structural and Social Determinants of Health
STEM – Science, Technology, Engineering, and Mathematics
SUD – Substance Use Disorder
TEA – Teacher Education Alliance
UIC SPH – University of Illinois Chicago School of Public Health
VFC – Vaccines for Children Program
WHO – World Health Organization
WSIPP – Washington State Institute for Public Policy

Health in All Policies (HiAP) Workgroup Agenda
May 16, 2025
12-2pm CST
1603 W. Taylor St, Suite 1136, Chicago, IL 60612
Zoom Meeting ID: 853 0277 0168
Passcode: cFFW8aNT
Find your local call-in number: https://uic.zoom.us/u/kbqjhH7J3G
Phone Passcode: 34273385
Enter open comment period submissions HERE

Meeting Objectives

- Narrow the focus of the 2025 annual report.

12:00-12:10pm	Opening Remarks	Wayne H. Giles, Dean & Professor University of Illinois Chicago School of Public Health (UIC SPH) Sameer S. Vohra, Director Illinois Department of Public Health (IDPH)
12:10-12:15pm	Approval of October 24, 2024 Minutes	Wayne H. Giles, Dean & Professor UIC SPH
12:15-12:25pm	Open Comment Period	Janice Phillips, Assistant Director IDPH
12:25-12:35pm	Updates on Federal Budget	Matthew R. Smith, Chief Policy Officer IDPH
12:35-1:00pm	Group Discussion *What have you/your org experienced given the changes that have occurred?*	HiAP Alliance Members
1:00-1:05pm	**Break**	
1:05-1:15pm	Annual Report 2025 Focus *Proposed: The Value and Importance of Investment in Health*	Wayne H. Giles, Dean & Professor UIC SPH
1:15-1:55pm	Group Discussion *What are the most salient investments Illinois can make to support health during this time?*	HiAP Alliance Members
1:55-2:00pm	Closing Remarks	Wayne H. Giles, Dean & Professor UIC SPH Sameer S. Vohra, Director IDPH

The Health in All Policies Alliance works to facilitate cross-sector communication and work with policy makers and stakeholders to foster a culture of health equity and support efforts to make Illinois the healthiest state in the nation. We do this by examining the health of the residents of the state of Illinois and making recommendations to the Illinois General Assembly to improve and prevent threats to health through policy, practice, and partnership.

*The Health in All Policies Act (410 ILCS 155/10) identifies the following **areas of focus** for our work:*

(A) Access to safe and affordable housing.
(B) Educational attainment.

(C) Opportunities for employment.
(D) Economic stability.
(E) Inclusion, diversity, and equity in the workplace.
(F) Barriers to career success and promotion in the workplace.
(G) Access to transportation and mobility.
(H) Social justice.
(I) Environmental factors.
(J) Public safety, including the impact of crime, citizen unrest, the criminal justice system, and governmental policies that affect individuals who are in prison or released from prison.

Health in All Policies (HiAP) Workgroup Meeting Minutes
May 16, 2025
1pm-3pm CST
1603 W. Taylor St, Suite 1136
Chicago, IL 60612

Member Organization Representatives Present: Delrice Adams, Rashmi Chugh, Prince Danso-Odei, Brandy Evans, Lisa Harries, Elizabeth Irvin, Dorian Manion (IDHFS delegate), Wendy Nussbaum, Janice Phillips, Conny Moody (IPHA delegate), Elizabeth Vogt, Sameer Vohra, Teschlyn Woods

Other Guests Present: Jennifer Epstein (IDPH), Eugenia Olison (IDPH), Matthew Smith (IDPH)

Facilitator: Antoniah Lewis-Reese (UIC)

I. **Opening Remarks, Introductions, & Attendance** (Wayne H. Giles, Dean & Professor UIC SPH)

II. **Approval of October 24, 2024 Minutes**
- Motion to approve October 24th minutes; Seconded; Approved

III. **Open Comment Period** (Janice Phillips, Assistant Director IDPH)
- No comments

IV. **Federal Budget Updates** (Matthew Smith, Chief Policy Officer, IDPH)

Matthew Smith provided updates on federal budget proposals, highlighting significant proposed cuts to Medicaid, SNAP, and climate tax credits, as well as changes to health savings accounts and tax exemptions. The House Budget Committee failed to pass the proposed bill, and its final form remains uncertain due to ongoing negotiations in both the House and Senate. M. Smith emphasized that the legislative process is complex and may take time. There is a working deadline of July 4th for passage and the bill will require the President's signature for the changes to take effect.

The group discussed potential impacts on various programs, including health services, environmental protection, and public health initiatives. Concerns were raised about the federal restructuring of HHS agencies. Members expressed the need for innovative partnerships to address health challenges.

V. **2025 Annual Report** (Wayne Giles, Dean, UIC SPH)

Dean Giles shared the importance of investing in public health as the focus of the 2025 annual report. The group discussed the timeliness of this theme given the need for innovative partnerships and cross-agency collaboration and communication to address health challenges as traditional systems are being challenged.

Members emphasized the importance of providing historical context and explaining how federal and state funding complement each other in improving public health. Content and recommendations for the report will be aligned with priorities outlined in Healthy Illinois 2028. The report deadline is 12/31 and will be shared with IDPH for review by 12/1.

VI. Group Discussion (HiAP Alliance Members)

The group engaged in discussion about the most salient investments Illinois can make to support health during this time. Programs that support aging populations, particularly those tied to the Administration for Community Living and the 1915C Medicaid waiver, were highlighted due to concerns around funding for transportation and respite services, legal services, and caregiver supports. Other programs discussed included those tied to the protection of groundwater and drinking water, laboratories, immunizations, respiratory illness surveillance, and occupational health and safety. Cross-agency workforce reductions were also a major concern.

VII. Closing Remarks (Dr. Sameer Vohra Director of IDPH)

Health in All Policies (HiAP) Workgroup Agenda
October 7, 2025
10:30am-12:30pm CST
1603 W. Taylor St, Suite 1136, Chicago, IL 60612
Enter open comment period submissions HERE

Meeting Objectives

- Approve the proposed outline of the 2025 annual report
- Discuss opportunities for policy intervention
- Generate recommendations

10:30-10:40am	Opening Remarks	Wayne H. Giles, Dean & Professor University of Illinois Chicago School of Public Health (UIC SPH) Sameer S. Vohra, Director Illinois Department of Public Health (IDPH)
10:40-10:45am	Approval of May 16, 2025 Minutes	Wayne H. Giles, Dean & Professor UIC SPH
10:45-10:55am	Open Comment Period	Janice Phillips, Assistant Director IDPH
10:55-11:00am	Annual Report Outline Review	Antoniah Lewis-Reese, Senior Director of Strategic Initiatives, UIC SPH
11:00-11:05am	Report Outline Discussion and Approval	HiAP Alliance Members
11:05-11:10am	**Break**	
11:10am-11:50pm	Federal Budget Updates and Impact to Public Health in Illinois	Matthew Smith, Chief Policy Officer, IDPH Dorian Manion, Confidential Assistant to the Director, Illinois Department of Healthcare and Family Services
11:50-12:25pm	Group Discussion *What initiatives or programs will most impact our ability to advance the priorities of Healthy Illinois 2028 if disrupted?*	HiAP Alliance Members
12:25-12:30pm	Closing Remarks	Wayne H. Giles, Dean & Professor UIC SPH Sameer S. Vohra, Director IDPH

The Health in All Policies Alliance works to facilitate cross-sector communication and work with policy makers and stakeholders to foster a culture of health equity and support efforts to make Illinois the healthiest state in the nation. We do this by examining the health of the residents of the state of Illinois and making recommendations to the Illinois General Assembly to improve and prevent threats to health through policy, practice, and partnership.

*The Health in All Policies Act (410 ILCS 155/10) identifies the following **areas of focus** for our work:*

- *(A) Access to safe and affordable housing.*
- *(B) Educational attainment.*
- *(C) Opportunities for employment.*
- *(D) Economic stability.*
- *(E) Inclusion, diversity, and equity in the workplace.*
- *(F) Barriers to career success and promotion in the workplace.*
- *(G) Access to transportation and mobility.*
- *(H) Social justice.*
- *(I) Environmental factors.*
- *(J) Public safety, including the impact of crime, citizen unrest, the criminal justice system, and governmental policies that affect individuals who are in prison or released from prison.*

Health in All Policies (HiAP) Workgroup Meeting Minutes
October 7, 2025
10:30am-12:30pm CST
1603 W. Taylor St, Suite 1136
Chicago, IL 60612

Member Organization Representatives Present: Stacy Baumgartner, Rashmi Chugh, Prince Danso-Odei, Deanna Durica, Wayne Giles, Mackenzie Hess, Isabella Hurtado, Elizabeth Irvin, Marcus Johnson, Jeffrey Judge (IBSE delegate), Dorian Manion (IDHFS delegate), Mahi Mahmood (IDHS delegate), Wendy Nussbaum, Janice Phillips, Conny Moody (IPHA delegate), Elizabeth Vogt, Sameer Vohra, Teschlyn Woods, Alyssa Williams

Other Guests Present: Chad Brose (IDPH), Jennifer Epstein (IDPH), Nolan Downey (GCFD), Isabel Hynes (UIC), Eugenia Olison (IDPH), Lauren Slavic (UIC), Matthew Smith (IDPH), Sydney Thao (UIC)

Facilitator: Antoniah Lewis-Reese (UIC)

I. **Opening Remarks, Introductions, & Attendance** (Wayne H. Giles, Dean & Professor UIC SPH)

II. **Approval of May 16, 2025 Minutes**
- Motion to approve May 16th minutes; Seconded; Approved

III. **Open Comment Period** (Janice Phillips, Assistant Director IDPH)
- No comments

IV. **Annual Report Outline Review** (Antoniah Lewis-Reese, Sr. Dir., Strategic Initiatives UIC SPH)

Antoniah Lewis-Reese shared the outline for the 2025 annual report, which will focus on the importance of investing in public health. The report will describe the impact of potential budget cuts on the continued advancement of Healthy Illinois 2028 and emphasize critical areas of investment for health. Members were asked to forward any data or reports that would help support development, and make referrals to subject matter experts as appropriate.

The report is due December 31, 2025. Primary audiences are the Illinois General Assembly, IDPH, and Illinois Board of Health. Secondary audiences include municipal governments and communities. The report will be developed by UIC in collaboration with IDPH. UIC will share a draft for IDPH review by December 1, 2025.

V. **Budget Updates and Impacts to Public Health** (Matthew Smith, Chief Policy Officer, IDPH; Dorian Manion, Confidential Assistant to the Director, IDHFS)

Recent federal actions, including a government shutdown, implementation of H.R. 1, and proposed rescissions, pose significant risks to Illinois' ability to advance Healthy Illinois 2028 priorities. While congressional appropriations proposals for HHS reflect relatively modest cuts, broader policy shifts enacted through reconciliation threaten core systems that support health equity and prevention.

The most disruptive impacts stem from Medicaid and SNAP policy changes. Over the next decade, H.R. 1 provisions are expected to reduce Medicaid expenditures by $51 billion and reduce Medicaid enrollment by up to 500,000 Illinoisans. Enrollment reductions will be driven by

work requirements, more frequent eligibility redeterminations, cost sharing, and reductions to provider taxes that underpin hospital financing. These changes jeopardize access to preventive care, chronic disease management, behavioral health services, maternal and infant health supports, and disease surveillance capacity.

SNAP changes are similarly consequential: with 90% of SNAP recipients also enrolled in Medicaid, administrative disruptions risk compounding food insecurity and health instability, undermining progress across multiple Healthy Illinois 2028 priority areas. Nolan Downey of the Greater Chicago Food Depository emphasized that SNAP is one of the most effective anti-hunger and health interventions, and procedural losses or cost shifts to states could drive millions of meals out of reach for Illinois families. Food depositories would face unsustainable strain, worsening food insecurity and related health outcomes statewide.

Group discussion emphasized that disruptions to Medicaid coverage, SNAP benefits, rural health infrastructure, immunization programs, and public health workforce capacity would most severely constrain statewide progress. Participants also identified policy intervention opportunities at the state and agency levels, including mitigating administrative burdens through improved eligibility systems, strengthening outreach and communications, pursuing federal waivers and pilot funding to support coverage retention, and coordinating cross-agency strategies to buffer SNAP and Medicaid impacts. Continued federal advocacy and documentation of local impacts, especially in rural and high-need communities, were identified as critical near-term actions.

VI. Closing Remarks (Sameer Vohra, Director of IDPH; Wayne H. Giles, Dean & Professor UIC SPH)

Appendix III

SHIP Goals and Objectives

CD.1) Increase opportunities for tobacco-free living

CD.1.1) Reduce the percentage of Illinois adults and youth reporting using commercial tobacco products (including e-cigarettes, vaping, combustible tobacco products, smokeless tobacco, etc.).

CD.1.2) Strengthen public health infrastructure through funding, surveillance, and workforce capacity for tobacco prevention.

CD.1.3) Reduce secondhand smoke in cars, housing, outdoor spaces, etc.

CD.2) Decrease preventable chronic diseases through nutrition

CD.2.1) Increase the number of local organizations/businesses that implement institutional policy and systems change that support the consumption of nourishing foods.

CD.2.2) Increase access to sufficient, affordable, nourishing, culturally responsive, and consumed food, including by maximizing access to and participation in nutrition assistance programs.

CD.2.3) Expand healthy lifestyle services provision and promotion, including in schools and health professional programs, and ensure advice aligns with learners' lives, conditions, and cultural needs and preferences.

CD.3) Increase opportunities for active living

CD.3.1) Improve access to physical activity in schools.

CD.3.2) Improve workplace wellness to encourage and to improve access to active lifestyles for adults.

CD.3.3) Improve the built environment to increase active living in priority communities.

CD.3.4) Develop a cross-sectoral public health campaign to promote and to support active living.

CD.4) Increase community-clinical linkages to reduce the incidence and burden of chronic diseases

CD.4.1) Expand the role of and access to community health workers (CHWs).

CD.4.2) Improve data collection and sharing practices across the public health system.

CD.4.3) Improve access to preventative and disease-management programs.

CD.4.4) Reduce cost barriers.

CD.4.5) Increase assessment of family history, preventative screenings, and lifestyle modifications to prevent onset and to reduce the impact of chronic disease.

ED.1) Decrease disparate health outcomes related to COVID-19 and other communicable and emerging diseases

ED.1.1) Ensure and prioritize equitable access to vaccinations, testing, and treatment for COVID-19 and other emerging diseases.

ED.1.2) Work with communities to build trust in public health system messaging and guidance.

ED.1.3) Increase vaccination, up-to-date vaccination rates, and testing rates in under-resourced populations.

ED.1.4) Decrease disparities in vaccination dissemination in congregate settings and with home-bound individuals.

ED.2) Increase community resilience to communicable and other emerging disease threats

ED.2.1) Increase trust between communities and health departments and reinforce health departments as experts and as a resource for the community.

ED.2.2) Increase availability of and improve access to resources in priority communities as determined by the particular disease (referencing the particular risk factors).

ED.2.3) Build healthy indoor and outdoor environments to reduce disease transmission.

ED.3) Strengthen and improve public health system infrastructure and coordination to prepare for and respond to public health threats

ED.3.1) Develop and implement a timely, partner/field-informed communications plan.

ED.3.2) Coordinate timely emergency preparedness and response activities across departments at all levels (local, state, federal) and across public health system partners.

ED.3.3) Improve data-sharing capabilities across departments and partners.

ED.3.4) Build public health system resource capabilities to increase efficiency and effectiveness.

MAT.1) Improve accessibility, availability, and quality of equitable reproductive health and well-woman/person preventative health care services across the reproductive lifespan

MAT.1.1) Increase the proportion of people of reproductive age who received a preventative medical visit with appropriate sexual and reproductive screening annually.

MAT.1.2) Increase equitable access to the full range of reproductive health services.

MAT.2) Promote a comprehensive, cohesive, and equitable system of care and support services for all birthing persons to have a healthy pregnancy, labor and delivery, and through the first year postpartum

MAT.2.1) Increase the proportion of birthing persons receiving early, adequate, and high-quality prenatal and postpartum care.

MAT.2.2) Decrease the rate of severe maternal morbidity, pregnancy-related mortality, and pregnancy complications in hospital settings.

MAT.2.3) Address social determinants of health and barriers to care for postpartum and pregnant persons.

MAT.3) Promote a comprehensive, cohesive, and equitable system of care and services to improve birth outcomes and support infants' healthy development in their first year

MAT.3.1) Increase access, quality, and coordination across the perinatal continuum.

MAT.3.2) Address social and structural determinants of health (SSDOH) to support infant health.

MAT.4) Strengthen workforce capacity and infrastructure to screen for, assess, and treat mental health conditions and substance use disorders among pregnant/ postpartum persons

MAT.4.1) Reduce the rate of neonatal abstinence syndrome (NAS) at delivery and pregnancy-related mortality ratios for deaths caused by substance use disorders.

MAT.4.2) Decrease the proportion of postpartum persons experiencing depression symptoms and the pregnancy-related mortality ratio due to mental health.

MH.1) Improve the mental health and substance use disorder (SUD) system's infrastructure to support and strengthen prevention and treatment

MH.1.1) Improve data infrastructure to better understand the needs of children, adolescents, and adults, along with the capacity to address these needs.

MH.1.2) Equip the public health workforce to better address behavioral health needs and to provide care more effectively across the lifespan.

MH.1.3) Build capacity for increased integration of mental health and SUD with health care and other services across the continuum of care.

MH.1.4) Increase funding to support the infrastructure development of the mental health and SUD system to meet the needs of children, adolescents, and adults.

MH.2) Reduce mortality due to mental health conditions and substance use disorders through harm reduction and preventative care strategies

MH.2.1) Reduce drug overdose mortality following the recommendations of and utilizing the metrics outlined in the Statewide Overdose Action Plan.

MH.2.2) Reduce the age-adjusted suicide rate for the general population and populations known to experience higher rates.

MH.2.3) Reduce the number of children, adolescents (age 13-17), and young adults (age 18-24) who report experiencing poor mental health for more than one week per month.

MH.2.4) Reduce the incidence and prevalence of morbidity and mortality of substance use among adolescents and adults.

MH.2.5) Increase community interventions to improve prevention and linkage to care.

MH.3) Increase access to age-appropriate community-based care to reduce institutionalized treatment and incarceration

MH.3.1) Reduce emergency department visits, hospitalizations, and incarceration by narrowing the treatment gap (between those who have a disorder and those who receive care) and building and sustaining community-based treatment capacity.

MH.3.2) Increase access to health care and wrap-around services for populations that have disproportionate incarceration rates and lack of access to services, in particular for people of color and vulnerable populations.

MH.4) Improve the resilience and recovery capital of communities experiencing violence

MH.4.1) Increase mental health and SUD outreach and support to communities with the highest rates of violence.

MH.4.2) Increase efforts to prevent and address adverse childhood experiences (ACEs), which can have a tremendous impact on future violence victimization and perpetration and lifelong health and opportunity.

MH.4.3) Improve data collection and surveillance systems around community violence (intentional injury).

MH.4.4) Develop tools and resources to implement a crosscutting approach to prevent community violence.

RPHC.1) Build the public health system's capacity to advance health and racial equity and dismantle oppressive systems

RPHC.1.1) Declare racism as a public health crisis with an appointed advisory committee and required plan development to operationalize.

RPHC.1.2) Allocate resources to address oppressive systems, racist policies, and SSDOH.

RPHC.1.3) Build public health system capacity for authentic community engagement and power-sharing with BIPOC communities.

RPHC.1.4) Build the state's data capacity/ capabilities to better address health and racial equity.

RPHC.2) Develop and maintain a diverse and skilled public health workforce for anti-racist public health to dismantle systems of oppression

RPHC.2.1) Ensure the workforce is representative of the state population in race/ethnicity and all other points of intersectional identity.

RPHC.2.2) Leverage and implement organizational policy to support workforce diversity development.

RPHC.2.3) Expand workforce support infrastructure through programs and opportunities for professional development.

RPHC.2.4) Decrease gaps in public health workforce and leadership diversity.

RPHC.3) Address historical and ongoing practices that perpetuate environmental racism to advance environmental justice

RPHC.3.1) Reduce and prevent environmental hazards in BIPOC communities.

RPHC.3.2) Build the state's capacity to map, track, and assess environmental inequities and plan for addressing them.

RPHC.3.3) Increase investment in healthy, connected, and thriving built environments in BIPOC communities.

RPHC.3.4) Increase investment in healthy, connected, and thriving natural environments in BIPOC communities.