BUILDING HEALTHIER COMMUNITIES 2030

THE SUBURBAN COOK COUNTY COMMUNITY HEALTH ASSESSMENT AND IMPROVEMENT PLAN – SUMMARY

Cook County Public Health
DEPT. of
A division of Cook County Health

BUILDING
HEALTHIER
COMMUNITIES

TABLE OF CONTENTS

PRIORITY AREAS

Chronic Disease

Maternal & Child Health

Mental Health & Substance Use

INTRODUCTION

The Cook County Department of Public Health (CCDPH) created the Building Healthier Communities 2030 Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) to understand and improve residents' health in suburban Cook County. This process looks at how healthy people are, what affects their health, and where there are unfair differences between groups. It also helps choose the most important health problems to focus on and sets goals and actions to improve them with help from community partners. Together, these efforts guide public health work over five years. This summary presents the key findings in clear, accessible language, highlighting community demographics, chronic disease, maternal health, and mental health, while illustrating how factors such as income, neighborhood conditions, and access to resources influence overall health and well-being.

Throughout this document, population groups are described using commonly used race and ethnicity categories in public health and Census-based data. References to Black, White, Asian, and similar groups generally reflect the non-Hispanic population within those racial categories. Hispanic/Latino refers to ethnicity rather than race, and individuals who identify as Hispanic or Latino may belong to any racial group. These categories are presented this way to help clarify patterns in the data and should be read as analytical groupings rather than rigid or mutually exclusive identities.

BACKGROUND AND METHODS

Cook County's top health issues identified in the Community Health Assessment (CHA) are informed by several data sources: surveys, community member input, partner input, and publicly reported health indicators.

SURVEYS

Suburban Cook County Health Survey:

- 32,000 adults from Suburban Cook County completed this survey
- The survey was available in English and Spanish
- Survey topics included health care access, alcohol and substance use, housing, and chronic disease

Suburban Cook County Youth Risk Behavioral Survey:

- Students enrolled in grades 9-12 across suburban Cook County public high schools participated
- Survey topics included mental health, safety, and emotional support

COMMUNITY INPUT

Community Input Survey:

- 1,800 adults from Suburban Cook County completed this survey
- The survey was available in English, Spanish, Chinese, and Polish
- Residents were asked their opinions on community resources, top health needs, and opportunities for improvement

Community Member Focus Groups:

- 46 focus groups conversations were held
- Focus group participation focused on hearing from residents who are often left out of health studies
- Focus group participants shared what is working well in their communities, the health challenges they face, barriers that make it hard to stay healthy, and ideas for a healthier future

PARTNER INPUT

Partner Input Survey:

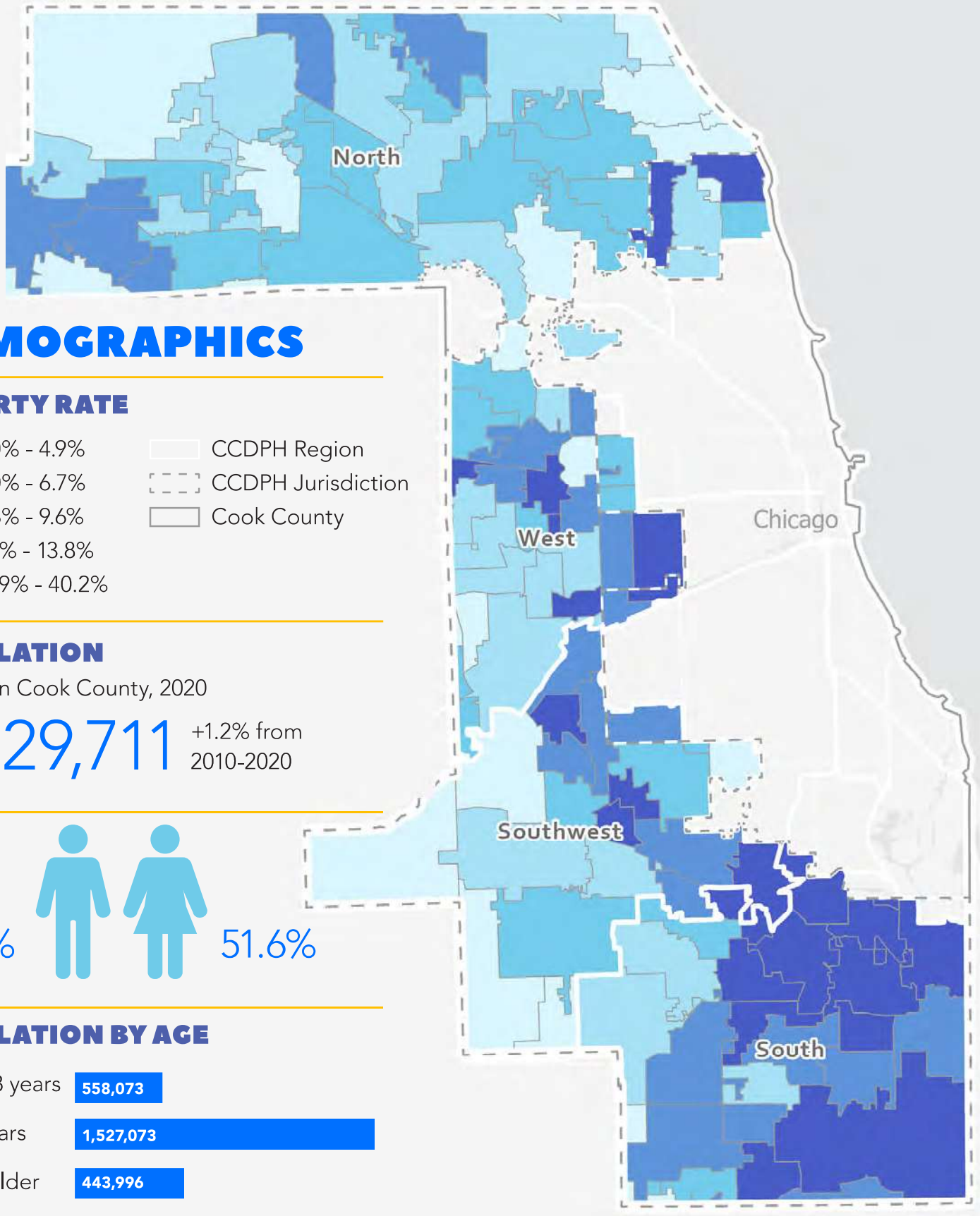
- 18 partner organizations completed the survey
- The survey asked organizations about the biggest health and social issues in the community, what affects health (like jobs, education, and neighborhoods), and what programs or policies are needed to improve health
- The survey also looked at how ready organizations are to support health equity, share data, work with partners, and stay involved in community health efforts

PUBLIC DATA

Public Data Sources:

- CCDPH used many public data sources in order to show health patterns and understand differences between communities
- Data included sources such as Illinois Department of Public Health (IDPH), hospital discharge data, Illinois National Electronic Disease Surveillance System (I-NEDSS), and the US Census Bureau

Many of the indicators described in this assessment are shared on CCDPH's Suburban Cook County Health Atlas. The atlas offers population data along with a wide range of other health outcomes and health behavior indicators. Users can explore interactive maps and charts or download datasets directly from the site to support planning, research, and community health improvement efforts.



DEMOGRAPHICS

POVERTY RATE

- 0.0% - 4.9%
- 5.0% - 6.7%
- 6.8% - 9.6%
- 9.7% - 13.8%
- 13.9% - 40.2%
- CCDPH Region
- CCDPH Jurisdiction
- Cook County

POPULATION

Suburban Cook County, 2020

2,529,711 +1.2% from 2010-2020

SEX

48.4% 51.6%

POPULATION BY AGE

Under 18 years	558,073
18-64 years	1,527,073
65 and older	443,996

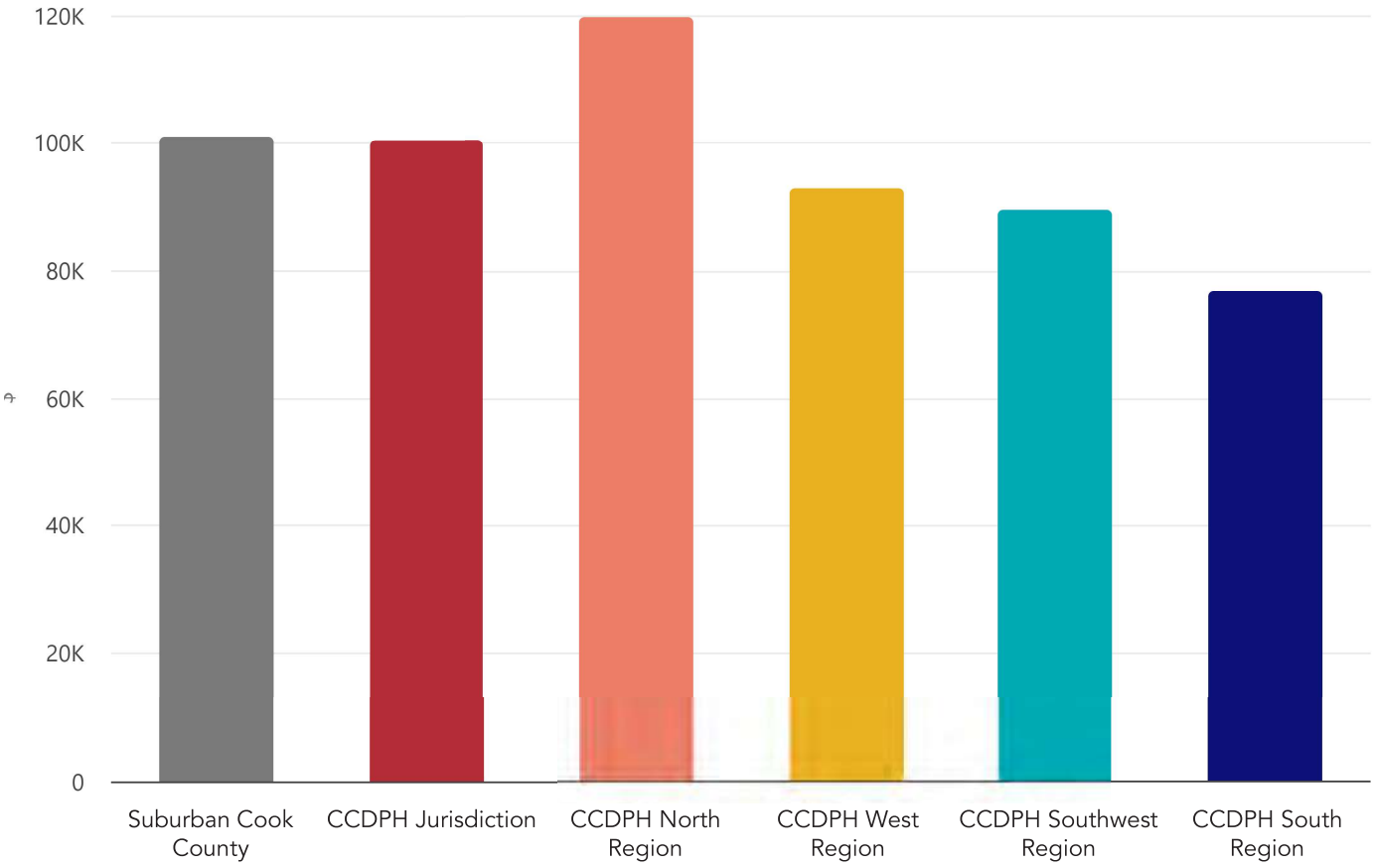
The fastest growing age group in Suburban Cook County is 65 and older

DEMOGRAPHICS

Across suburban Cook County, there are differences between communities in income, poverty, and unemployment. Many northern communities, like Barrington, Northbrook, Inverness, Winnetka, and Wilmette, have much higher incomes, often over $150,000, and also have very low unemployment and poverty rates.

MEDIAN HOUSEHOLD INCOME, 2023

Suburban Cook County and comparison



ated on Metopio | metop.io/i/exqkxw8p | **Data source:** U.S. Census Bureau: American Community Survey (ACS) (Table B1901 I)
dian household income: Income in the past 12 months.

Chronic Disease

Chronic diseases remain a major contributor to illness and death, and their distribution reflects decades of differential access to prevention, healthy environments, and clinical care. Community-level conditions such as food environments, walkability, and availability of primary care play a critical role.

Key Findings

- The impact of chronic disease varies across populations and neighborhoods. Higher rates of deaths and emergency room visits are seen among Black residents and in the South Region, while lower rates are observed among Asian residents and in the North Region—reflecting differences in community conditions and access to care.
- Youth survey results highlight early risks for future chronic disease that are shaped by social and environmental conditions. Black and Hispanic students are more likely to face barriers to physical activity, healthy beverage choices, tobacco-free environments, and dental care compared with White and Asian students.
- Challenges in managing chronic conditions outside the hospital are more common among Black residents and South Region communities, highlighting gaps in primary care access, continuity of care, and supportive resources.

Contributing Factors

- Deaths from heart disease and diabetes are strongly linked to neighborhood conditions, like access to healthy food, income, and availability of preventive care. The highest rates are in South and Southwest Regions.
- Adult survey results show that chronic disease is more common in communities where people have less access to healthy food, safe places to be active, preventive care, and reliable transportation.
- Work and workplaces can contribute to chronic disease. Personal, environmental and occupational risk factors can cause or worsen chronic diseases. Furthermore, interactions between these types of risks can have combined effects, can increase susceptibility to disease, can result in take-home exposures, and create transgenerational effects. Chronic diseases also affect one's work ability and income by way of earnings potential, providing for needs, healthcare expenditures, and economic hardship.

Maternal & Child Health

Maternal and child health outcomes demonstrate overall improvement, but persistent inequities tied to access to care, neighborhood conditions, and chronic stressors remain. Communities with fewer maternity care resources and higher economic hardship continue to experience the poorest outcomes.

Key Findings

- Maternal and infant deaths are highest among Black residents. Black mothers die at more than three times the rate of Hispanic/Latino and White mothers, and Black infants die at about three to four times the rate of infants in other groups.
- Emergency room visits and hospital stays related to maternal care have increased since 2016. Black residents have the highest rates, suggesting gaps in preventive and routine care.
- Most parents start breastfeeding at hospital discharge, but rates are lowest among Black parents, highlighting differences in postpartum support.

Contributing Factors

- Early and adequate prenatal care has improved overall but is still lowest for Black residents and people in the South and West Regions, showing unequal access to important care during pregnancy.
- Chronic health conditions before pregnancy—like obesity and high blood pressure—have increased for all groups since 2010, with the highest rates among Black residents, raising the risk of complications.
- Work and workplaces can contribute to maternal and child health. Employers should establish supportive workplaces, policymakers implement protective measures, healthcare providers conduct screenings, and pregnant women must stay informed and mitigate job-related risks. Additionally, paid parental leave is key to protecting maternal and child health.

Mental Health & Substance Use

Behavioral health needs continue to grow and are shaped by economic stress, access to care, exposure to violence, housing instability, and structural racism. These pressures affect communities differently across the county.

Key Findings

- Deaths related to mental health and substance use—like drug overdoses, firearm injuries, and homicides—are highest among Black residents and in the West and South Regions. Suicide deaths are highest among White residents.
- Opioid overdose deaths have risen sharply since 2010. In recent years, men die from overdoses at more than three times the rate of women.
- Emergency room visits for mental health issues, substance use, assaults, firearm injuries, and self-harm are highest among Black residents and lowest among Asian residents, showing clear racial and geographic differences.
- Suicide rates among Black residents increased from 4.5 per 100,000 in 2018 to 10.7 per 100,000 in 2023.

Contributing Factors

- Adult survey results indicate that most people have good access to primary care, while access to mental health care is a challenge. Higher rates of cannabis use, binge drinking, psychological distress, and lack of bank accounts among certain racial and ethnic groups show uneven mental health, substance use, and financial stress risks.
- Youth survey results show many high school students report poor mental health, depression, and feeling unsafe at school. Hispanic and Black students face higher exposure to violence and substance use related risks, highlighting the need for early and culturally appropriate support for young people and addressing upstream drivers of behavioral health.
- Long-term patterns of workplace conditions are major determinants of one's mental health and contribute to mental health and suicide risk. Workplace conditions include excessive workloads or work pace, inadequate pay, job insecurity, violence, discrimination, and harassment.

The Cook County Department of Public Health (CCDPH) is proud to present the suburban Cook County Building Healthier Communities 2030 Community Health Improvement Plan (CHIP), a roadmap created with and for the communities we serve. This plan reflects our shared commitment to improving health, advancing equity, and building stronger, more connected communities across suburban Cook County.

This CHIP is not just a plan; it is an invitation. With community voices at its center, it charts a path toward healthier, more equitable futures for all who call suburban Cook County home. We look forward to partnering with you to bring this vision to life.

Priority 1: Chronic Disease

GOAL 1:

Improve access to affordable and culturally appropriate healthcare and preventive care in historically marginalized communities to prevent and control chronic diseases.

Outcome Objective: Outcome objectives are goals for how much health problems should be reduced. They must be measurable.

Impact Objective: Impact objectives are goals for how much risk factors should be reduced. They must be measurable.

Intervention Strategy: The intervention strategies chosen must be proven to influence the levels of risk factors.

OUTCOME OBJECTIVE

By 2030, reduce heart disease-related emergency department visitation rates among adults by 2% per year (Data Source: Suburban Cook County Health Atlas).

By 2030, reduce cancer-related emergency department visitation rates among adults by 2% per year (Data Source: Suburban Cook County Health Atlas).

By 2030, reduce diabetes-related emergency department visitation rates among adults by 2% per year (Data Source: Suburban Cook County Health Atlas).

IMPACT OBJECTIVE

By 2030, reduce the percentage of suburban Cook County residents who report not having a usual primary care provider by 5% (Data Source: Suburban Cook County Health Survey).

By 2030, reduce the percentage of suburban Cook County residents age 18 to 64 years who report not having health insurance coverage by 3% (Data Source: American Community Survey).

STRATEGIES

- Preserve and protect Medicaid and other health insurance eligibility and coverage through outreach, education, and advocacy.
- Enhance navigator programs to support insurance enrollment and care coordination and support individuals who are uninsured in connection with benefits counseling and healthcare resources (e.g. Federally Qualified Health Centers (FQHCs), free and charitable clinics, hospital charity care programs, etc.).
- Promote organizational health literacy practices that improve processes, communications, and services at government agencies, community-based organizations, and health care institutions to improve access and care.

Priority 1: Chronic Disease

STRATEGIES (Continued)

- Promote the Cook County Paid Leave Ordinance to ensure employees can take paid time off for healthcare appointments.*
- Employers and policymakers should establish supportive workplaces and protective measures to mitigate workers' risk of chronic disease."
- Promote and expand participation in free community-based health screenings (including breast and cervical cancer screenings for eligible women and free colon and prostate cancer screenings for men).*
- Promote and expand evidence-based health education programs (e.g. Diabetes Prevention Program, Diabetes Self-Management Program, Chronic Disease Self-Management Education, Asthma Self-Management Education, etc.) and educational resources for caregivers.
- Promote and expand evidence-based tobacco cessation resources.
- Promote asthma-friendly environments in schools and daycares, including asthma-friendly cleaning products, outdoor access for children with asthma, removing triggers, education for school personnel, increased access to asthma medication in schools, and awareness of state law (Public Act 100-0726).
- Strengthen Community Health Worker and care coordination capacity (training, tools, resources).
- Expand reimbursable services for Community Health Workers to allow them to support broader populations in navigating, health, social services and other systems (e.g. 1115 waiver, Medicare Physician Fee Schedule).
- Support the maintenance of 2-1-1 referral lists for healthcare and social service providers in suburban Cook County.*
- Expand use of the 2-1-1 line among suburban Cook County residents to increase referral to chronic disease related resources and services (e.g. healthcare, housing, food, etc.) through outreach and awareness efforts.*
- Support the development and launch of the Cook County Community Information Exchange (CIE) to increase coordination and collaboration between community-based organizations, healthcare providers, and government agencies.

*These strategies are aligned with strategies for the behavioral health and maternal child health priority areas.

Priority 1: Chronic Disease

GOAL 2:

Improve access to safe, affordable, and inclusive infrastructure and programs that support physical activity, stable and healthy homes, and climate resilience to prevent and reduce the burden of chronic diseases.

Outcome Objective: Outcome objectives are goals for how much health problems should be reduced. They must be measurable.

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OUTCOME OBJECTIVE

By 2030, reduce heart disease-related mortality rates by 2% per year
(Data Source: Suburban Cook County Health Atlas).

By 2030, reduce cancer-related mortality rates by 2% per year
(Data Source: Suburban Cook County Health Atlas).

By 2030, reduce diabetes-related mortality rates by 2% per year
(Data Source: Suburban Cook County Health Atlas).

By 2030, reduce asthma-related mortality rates by 2% per year
(Data Source: Suburban Cook County Health Atlas).

By 2030, reduce stroke-related mortality rates by 2% per year
(Data Source: Suburban Cook County Health Atlas).

IMPACT OBJECTIVE

By 2030, reduce the percentage of adults who report participating in no physical activity or exercise by 10%
(Data Source: Suburban Cook County Health Survey).

By 2030, reduce the percentage of youth who report participating in no physical activity or exercise by 15%
(Data Source: Suburban Cook County Youth Risk Behavior Survey).

STRATEGIES

- Promote evidence-based programs that support physical activity in historically disinvested communities (e.g. Forest Preserve of Cook County's Wellness in the Woods Programs, fall-prevention programming for seniors, etc.).
- Promote and enforce smoke-free outdoor public places like parks, campuses, etc. to reduce exposure to second-hand smoke.

STRATEGIES (Continued)

- Improve walking and biking access to everyday destinations like K-12 schools, parks, trails, etc. by increasing pedestrian and bicycle facilities and improving infrastructure on adjacent suburban Cook County roadways (e.g. installing or improving lighting, wayfinding signage, accessible sidewalks, etc.).
- Preserve and restore existing parks and green space and acquire land to support development of recreation areas, parks, and green spaces that feel safe and inclusive, prioritizing areas where open space is limited (e.g. Metropolitan Water Reclamation District of Greater Chicago Suburban Green Schoolyard Pilot Program).
- Promote development and implementation of local American Disabilities Act (ADA) transition plans to improve pedestrian infrastructure for walking and wheeling in suburban Cook municipalities (e.g. promote the Great Lakes ADA Center's Accessible Cities Project tools and resources).
- Advance local and County policies, plans, and design standards that provide safe active transportation options and address gaps in transportation networks to ensure equitable access for suburban Cook County residents (e.g. Cook County Long Range Transportation Plan, Cook County Bike Plan, Cook County Safety Action Plan, Complete Streets Policies, etc.).
- Improve public transit service and expand paratransit, community charters, and other accessible transportation options that prioritize seniors, people living with disabilities, and low-income residents.
- Increase equitable funding for transportation infrastructure in suburban Cook County (e.g. INVEST IN COOK, Surface Transportation Program, etc.) that integrates health considerations and/or equity factors and eliminates barriers to accessing these funds.

Priority 1: Chronic Disease

GOAL 2:

Improve access to safe, affordable, and inclusive infrastructure and programs that support physical activity, stable and healthy homes, and climate resilience to prevent and reduce the burden of chronic diseases.

ⓘ **Outcome Objective:** Outcome objectives are goals for how much health problems should be reduced. They must be measurable.

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ⓘ **Intervention Strategy:** The intervention strategies chosen must be proven to influence the levels of risk factors.

IMPACT OBJECTIVE

By 2030, reduce the percentage of households that are housing cost burdened in suburban Cook County by 3% (Data Source: American Community Survey).

STRATEGIES

- Proactively identify and address health hazards in the home (e.g. healthy homes/lead abatement programs, municipal lead service line replacement plans and initiatives, etc.).
- Advance adoption and implementation of smoke-free housing policies in multi-unit properties.
- Advocate for an increase in the supply and equitable distribution of affordable housing, permanent supportive housing, accessible housing, and crisis housing (e.g. project-based voucher programs, senior housing, building preservation actions, shelter development, etc.).
- Promote resources for housing stability services, including tailored services for populations made vulnerable (e.g. permanent supportive housing resources, rental assistance programs, home modification programs for those living with disabilities, Medical-Legal Partnerships, etc.).
- Sustain and expand existing home weatherization and energy efficiency programs for income-eligible residents.
- Support fair housing policies and practices and promote free legal aid services to prevent eviction, foreclosure, consumer debt, and tax deed issues (e.g. Cook County Legal Aid for Housing and Debt).

Priority 1: Chronic Disease

GOAL 2:

Improve access to safe, affordable, and inclusive infrastructure and programs that support physical activity, stable and healthy homes, and climate resilience to prevent and reduce the burden of chronic diseases.

Outcome Objective: Outcome objectives are goals for how much health problems should be reduced. They must be measurable.

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Intervention Strategy: The intervention strategies chosen must be proven to influence the levels of risk factors.

IMPACT OBJECTIVE

By 2030, reduce the number of exceedance days due to criteria pollutant concentrations (such as Ozone and PM 2.5) that affect people living with chronic diseases by 25% (Data Source: IL EPA and Cook County DES).

STRATEGIES

- Advance Cook County Environmental Justice Policy and support defining environmental justice factors/ criteria for areas in suburban Cook County.
- Advance policy initiatives that increase protections against occupational temperature-related illness and injury.
- Increase investments and secure sustainable financing to support implementation of green infrastructure and green production processes, hazard mitigation plans, climate resiliency planning, and environmental risk assessments, prioritizing environmental justice areas.
- Support and promote low and/or zero emission travel options including use of public transportation, electric buses, ride sharing, walking or biking options in suburban Cook County.
- Advance local green infrastructure policies and improvements in historically disinvested communities to manage stormwater, improve water quality, and combat climate change.
- Increase resources directed to populations made vulnerable (e.g., seniors, homebound individuals, people experiencing homelessness, etc.) during extreme weather conditions (e.g. creating an optional database for wellness checks).

Priority 1: Chronic Disease

GOAL 3:

Improve access to local, fresh, affordable, culturally relevant, healthy food and nutrition resources to prevent and reduce the burden of diet-related chronic diseases.

Outcome Objective: Outcome objectives are goals for how much health problems should be reduced. They must be measurable.

Impact Objective: Impact objectives are goals for how much risk factors should be reduced. They must be measurable.

Intervention Strategy: The intervention strategies chosen must be proven to influence the levels of risk factors.

OUTCOME OBJECTIVE

By 2030, reduce diet-related chronic disease mortality rates for suburban Cook County residents by 15% (Data Source: Suburban Cook County Health Atlas).

IMPACT OBJECTIVE

By 2030, reduce the percentage of youth reporting consuming less than five servings of fruit and vegetables by 6% (Data Source: Suburban Cook County Youth Risk Behavior Survey).

By 2030, reduce the percentage of adults reporting consuming less than five servings of fruit and vegetables by 10% (Data Source: Suburban Cook County Health Survey).

By 2030, reduce the percentage of adults who reported being worried about food running out sometimes or often by 5% (Data Source: Suburban Cook County Health Survey).

STRATEGIES

- Increase awareness of and participation in food access programs (e.g. SNAP, WIC, CACFP, Summer EBT) and free after-school and summer meal resources through outreach, education, and supporting program enrollment and referral to nutrition resources.
- Advocate for increased funding levels for food access programs (e.g. SNAP, WIC, CACFP, Summer EBT) and school meal programs (e.g. healthy school meals for all) to expand participation and healthy food access.
- Promote and expand participation in community-based food access programs (e.g. meal delivery, produce prescriptions, etc.) and Food Is Medicine Initiatives (medically tailored meals, nutrition education services, etc.) and increase reimbursement for these programs (e.g. 1115 waiver).
- Promote the Cook County Class 7d Incentive to encourage the operation of food retailers in historically disinvested communities.
- Promote local food rescue and recovery networks to improve food access and reduce food waste.
- Increase suburban Cook County food retailers and farmers markets that are accepting SNAP/participating in Link Match.

Priority 1: Chronic Disease

STRATEGIES (Continued)

- Expand access to local, healthy, sustainable, just, and humane food that is procured, served, and sold at Cook County Departments and other community anchor institutions like higher education institutions, supported by Cook County Good Food Purchasing Policy.
- Increase investments in local food producers and businesses, especially BIPOC producers and businesses, supported by Cook County Good Food Purchasing Policy.
- Identify publicly owned lands suitable for local food production that can benefit emerging food businesses in suburban Cook County.
- Assess current zoning regulations around commercial food production, urban agriculture, and food sales across suburban Cook County and disseminate zoning reform best practices and recommendations.

Priority 2: Maternal and Child Health

GOAL 1:

Elevate the quality and continuity of maternal care through field-based education, promotion, and provider support by promoting equitable access to quality care and support before, during, and after pregnancy.

ⓘ **Outcome Objective:** Outcome objectives are goals for how much health problems should be reduced. They must be measurable.

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ⓘ **Intervention Strategy:** The intervention strategies chosen must be proven to influence the levels of risk factors.

OUTCOME OBJECTIVE

By 2030, reduce the maternal death rate in suburban Cook County by at least 5%, with a focus on narrowing Black and Latina maternal mortality disparities (Data Source: Suburban Cook County Health Atlas).

IMPACT OBJECTIVE

By 2030, increase the percentage of pregnant people in suburban Cook County who begin prenatal care in the first trimester from 75% to 82%, with targeted outreach to Medicaid-eligible, Black, Latino, and immigrant birthing people (Data Source: Suburban Cook County Health Atlas).

STRATEGIES

- Through continued implementation of the CCDPH Healthy Beginnings – Maternal and Child Health Program, provide community-based navigation, culturally tailored education, and emotional support in families' preferred language, while connecting them to essential resources and promoting early prenatal care.
- Educate clinicians, CHWs, doulas, and partner staff on best practices in cardiovascular health, obesity, mental health, substance use disorder, trauma-informed care, and contraceptive services through the CCDPH maternal & child health resource website, *Every Mother Every Child,* complemented by field-based coaching and culturally tailored resources.
- Support clinical providers and community-based partners in adopting screening workflows, referral processes, and crisis pathways to improve patient-centered care to promote early engagement in maternal and child health services.
- Advocate for expanded Medicaid coverage for doulas and perinatal support and ensure continuous insurance during pregnancy and postpartum to promote early prenatal care.
- Develop a maternal health equity dashboard with race, ethnicity, language, and ZIP code–disaggregated data to monitor progress and enhance the use of Health Atlas Maternal and Child Health Indicators within a shared measurement and accountability framework.

Priority 2: Maternal and Child Health

GOAL 2:

Reduce preventable illnesses by promoting access to high-quality, culturally responsive pediatric care and addressing social determinants of health.

Outcome Objective: Outcome objectives are goals for how much health problems should be reduced. They must be measurable.

Impact Objective: Impact objectives are goals for how much risk factors should be reduced. They must be measurable.

Intervention Strategy: The intervention strategies chosen must be proven to influence the levels of risk factors.

OUTCOME OBJECTIVE

By 2030, increase by 5% the proportion of children under age five in suburban Cook County who attend recommended well-child visits to support age-appropriate growth and development (Data Source: Healthy People 2030).

IMPACT OBJECTIVE

By 2030, raise immunization coverage for vaccine-preventable illnesses among children under age one by 10% (Data Source: MMWR).

STRATEGIES

- Through continued implementation of the CCDPH Healthy Beginnings Program, interventions will educate families during home visits on the importance of timely well-child visits and routine immunizations, while implementing universal risk assessment and care coordination to identify barriers early and connect families to needed supports.
- Strengthen and evaluate referral pathways to increase utilization of the Healthy Beginnings program, ensuring families are consistently linked to culturally-responsive pediatric care and social determinant supports; use ongoing data monitoring to identify gaps, improve outreach effectiveness, and reduce preventable illness among children under five.
- Educate birthing families on safe sleep via CPASS/SUID Partnership, postpartum warning signs/depression, immunizations, nutrition, early development, and plans of safe care for substance-exposed infants—delivered via community events, home visits, and multilingual toolkits.
- Build partnerships with pediatric providers, trusted messengers and community organizations to advance vaccine equity through culturally tailored outreach.
- Promote consistent messages through Every Mother Every Child, seasonal campaigns, and partner channels; integrate stigma-reduction for mental health/SUD.

Priority 2: Maternal and Child Health

STRATEGIES (Continued)

- Promote postpartum care access by integrating interventions from Healthy Beginnings, the Lead Poisoning Prevention Program, the Vision and Hearing Program, and the Perinatal Hepatitis B Program to provide comprehensive maternal and infant health support.
- Promote and expand participation in free, community-based health screenings by strengthening outreach, education, and referral pathways through the Illinois Breast and Cervical Cancer Program. This includes increasing access to high-quality breast and cervical cancer screenings for eligible women and ensuring men are connected to free colon and prostate cancer screening opportunities.
- Expand bilingual community health worker and navigator support to build trust and improve communication with diverse families to ensure children receive timely well-child visits, immunizations, and developmental screenings for healthy growth and development; expand access and increase participation in free school-aged vision and hearing.
- Advocate for policies that enhance care coordination to improve child wellness and vaccine access through partnerships with hospitals, clinics, schools, and community services.

Priority 2: Maternal and Child Health

GOAL 3:

Strengthen shared awareness and consistent messaging about maternal and child health resources, risk factors, and protective practices while strengthening accountability through education, training, Plans of Safe Care, and birth equity measurement.

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ⓘ **Intervention Strategy:** The intervention strategies chosen must be proven to influence the levels of risk factors.

OUTCOME OBJECTIVE

By 2030, increase the percentage of suburban Cook County residents who report awareness of maternal and child health resources and risk factors by 50%, with focused outreach in Black and Latino communities (Data Source: Illinois Department of Public Health).

IMPACT OBJECTIVE

By 2030, ensure that 50% of community-serving organizations, educators, and public health partners who are engaged in maternal and child health promotion in suburban Cook County receive annual training on culturally relevant care, health literacy, and equity-centered communication practices (Data Source: Illinois Department of Public Health).

STRATEGIES

- Facilitate adoption of plans of safe care and post-discharge coordination pathways with hospitals, pediatrics, and CBOs; distinguish these workflows from abuse/neglect reporting to increase trust and uptake.
- Promote the Cook County Paid Leave Ordinance by increasing community, provider, and employer awareness of how paid leave can be used for prenatal care, postpartum visits, and well-child appointments.*
- Employers and policymakers should establish supportive workplaces and protective measures to support workers' maternal and child health.
- Conduct ongoing, culturally relevant outreach and education for community-serving organizations and public health partners in suburban Cook County, with targeted focus on Black and Latino communities, to increase awareness of maternal and child health resources, risk factors, and equity-centered communication practices.

*This strategy is aligned with strategies for the behavioral health and chronic disease prioritiy areas.

Priority 2: Maternal and Child Health

STRATEGIES (Continued)

- Engage families through health forums, fairs, and trusted messaging, and promote consistent messaging via Every Mother Every Child, seasonal campaigns, and partner channels to increase awareness of maternal and child health resources and risk factors, especially in Black and Latino communities.
- Coordinate and/or participate in community-based learning events, such as baby showers, safe sleep workshops, and crib safety education, to foster trust, engage families, and promote essential maternal and child health practices.
- Provide culturally tailored education, connect families to local resources, and reinforce key messages on infant safety, early development, and healthy parenting to increase health literacy.

Priority 3: Mental Health and Substance Use

GOAL 1:

Bolster capacity among community-based organizations, and strengthen coordination between community-based organizations, treatment providers, government and other partners to address systemic barriers to healing.

Outcome Objective: Outcome objectives are goals for how much health problems should be reduced. They must be measurable.

Impact Objective: Impact objectives are goals for how much risk factors should be reduced. They must be measurable.

Intervention Strategy: The intervention strategies chosen must be proven to influence the levels of risk factors.

OUTCOME OBJECTIVE

By 2030, reduce the rate of behavioral health-related emergency department visits by 3% (Data Source: Suburban Cook County Health Atlas)

IMPACT OBJECTIVE

By 2030, increase new partnerships among community-based organizations, behavioral health providers, and other partners by 10% to strengthen collaboration and expand mental health access (Data Source: Cook County Department of Public Health).

STRATEGIES

- Create a best-practices brief on existing collaborations and mechanisms (protocols, MOUs, bundled funding, shared staff, etc.) to increase understanding of potential mechanisms for cross-organizational systemic support.
- Identify, develop, and implement two collaborative initiatives among community partners that strengthen access to and coordination of mental health services, with intentional support for underrepresented and high-need populations.
- Improve opportunities for equitable collaboration and coordination between community-organizations and healthcare providers in community settings.
- Encourage approaches to collaboration that promote widespread and accessible resource sharing across community partners and providers.

Priority 3: Mental Health and Substance Use

GOAL 1:

Bolster capacity among community-based organizations, and strengthen coordination between community-based organizations, treatment providers, government and other partners to address systemic barriers to healing.

Outcome Objective: Outcome objectives are goals for how much health problems should be reduced. They must be measurable.

Impact Objective: Impact objectives are goals for how much risk factors should be reduced. They must be measurable.

Intervention Strategy: The intervention strategies chosen must be proven to influence the levels of risk factors.

OUTCOME OBJECTIVE

By 2030, reduce the rate of adults who say they did not get the mental health treatment or counseling they needed by 5% (Data Source: Suburban Cook County Health Survey).

By 2030, decrease the rate of public high school students reporting their mental health is not good by 5% (Data Source: Suburban Cook County Youth Risk Behavior Survey).

IMPACT OBJECTIVE

By 2030, increase 2-1-1 use by suburban residents by 10% (Data Source: 2-1-1 Metro Chicago).

STRATEGIES

- Expand use of the NAMI Chicago Helpline and 2-1-1 line among suburban Cook County residents to increase referral to behavioral health resources and services (e.g. healthcare, housing, etc.) through outreach and awareness efforts.*
- Support the maintenance of NAMI Chicago Helpline and 2-1-1 referral lists for healthcare and social service providers in suburban Cook County.*
- Support the development and launch of the Cook County Community Information Exchange (CIE) to increase coordination and collaboration between community-based organizations, healthcare providers, and government agencies.*
- Identify opportunities to work with other helplines and referral systems (e.g. BEACON) for coordinated support.
- Engage base-building organizations and Community Health Workers (CHWs) to raise awareness of behavioral health referral resources and supports.
- Support schools in implementing universal behavioral health screening.

*These strategies are aligned with 2-1-1 and CIE strategies for the chronic disease priority area.

Priority 3: Mental Health and Substance Use

GOAL 1:

Bolster capacity among community-based organizations, and strengthen coordination between community-based organizations, treatment providers, government and other partners to address systemic barriers to healing.

Outcome Objective: Outcome objectives are goals for how much health problems should be reduced. They must be measurable.

Impact Objective: Impact objectives are goals for how much risk factors should be reduced. They must be measurable.

Intervention Strategy: The intervention strategies chosen must be proven to influence the levels of risk factors.

OUTCOME OBJECTIVE

By 2030, reduce the rate of adults who say they did not get the mental health treatment or counseling they needed because of concerns about negative opinions from neighbors or community by 5% (Data Source: Suburban Cook County Health Survey).

By 2030, reduce the rate of adults who say they did not get the mental health treatment or counseling they needed because of concerns about negative effects on their job by 5% (Data Source: Suburban Cook County Health Survey).

IMPACT OBJECTIVE

By 2030, create 2 co-designed programs that reduce stigma around seeking mental health support with community partners.

STRATEGIES

- Reduce stigma around seeking mental health and substance use care and support.
- Create and share culturally responsive resources on common behavioral health concerns and navigating systems of care.
- Create culturally responsive spaces to improve access to behavioral health support outside traditional care systems.
- Support programs co-designed with diverse community partners to normalize seeking support.
- Advocate for sustainable funding to strengthen diversity and representation in the behavioral health workforce.

Priority 3: Mental Health and Substance Use

GOAL 2:

Build a high-quality and equitable mental health and substance use system that incorporates a comprehensive, coordinated crisis care system and community-based prevention programs that supports healthy beginnings, healthy connections, and healthy environments.

Outcome Objective: Outcome objectives are goals for how much health problems should be reduced. They must be measurable.

Impact Objective: Impact objectives are goals for how much risk factors should be reduced. They must be measurable.

Intervention Strategy: The intervention strategies chosen must be proven to influence the levels of risk factors.

OUTCOME OBJECTIVE

By 2030, reduce the rate of behavioral health-related emergency department visits by 3% (Data Source: Suburban Cook County Health Atlas).

IMPACT OBJECTIVE

By 2030, increase 9-8-8 utilization by suburban Cook County residents by 10% (Data Source: Illinois Department of Human Services).

STRATEGIES

- Engage trusted community champions to develop and share clear messaging about crisis care services to promote 9-8-8 and build awareness of the crisis care system.
- Improve access to culturally responsive crisis care in suburban Cook County.
- Improve coordination between service providers for smooth transitions of care and "no wrong door" entry points, as well as for ongoing care and support, in coordination with Community Emergency Services and Supports Act (CESSA) oversight bodies.

Priority 3: Mental Health and Substance Use

GOAL 2:

Build a quality and equitable mental health and substance use system that incorporates a comprehensive, coordinated crisis care system and community-based prevention programs that supports healthy beginnings, healthy connections, and healthy environments.

Outcome Objective: Outcome objectives are goals for how much health problems should be reduced. They must be measurable.

Impact Objective: Impact objectives are goals for how much risk factors should be reduced. They must be measurable.

Intervention Strategy: The intervention strategies chosen must be proven to influence the levels of risk factors.

OUTCOME OBJECTIVE

By 2030, reduce the rate of emergency department visits for substance use by 3% (Data Source: Suburban Cook County Health Atlas).

IMPACT OBJECTIVE

By 2030, distribute 25,000 kits of naloxone (Data Source: Cook County Department of Public Health).

By 2030, create a report that shares risk factors and trends for alcohol and cannabis use in suburban Cook County (Data Source: Cook County Department of Public Health).

STRATEGIES

- Continue to expand access to community-based harm reduction services for opioid-involved overdose.
- Continue to expand access to traditional and low-barrier recovery housing, medication-assisted treatment, post-release care coordination, and other treatment and recovery support services through policy, systems, and other changes.
- Establish a community-based prevention program to reduce the harms of alcohol and cannabis use.
- Continue to use population health data, research, and evaluation to monitor substance use risk factors and outcomes to drive and refine prevention strategies.

Priority 3: Mental Health and Substance Use

GOAL 2:

Build a quality and equitable mental health and substance use system that incorporates a comprehensive, coordinated crisis care system and community-based prevention programs that supports healthy beginnings, healthy connections, and healthy environments.

Outcome Objective: Outcome objectives are goals for how much health problems should be reduced. They must be measurable.

Impact Objective: Impact objectives are goals for how much risk factors should be reduced. They must be measurable.

Intervention Strategy: The intervention strategies chosen must be proven to influence the levels of risk factors.

OUTCOME OBJECTIVE

By 2030, reduce the rate of intentional injury related emergency department visits by 3% (Data Source: Suburban Cook County Health Atlas).

IMPACT OBJECTIVE

By 2030, host at least 2 community forums on suicide prevention (Data Source: Cook County Department of Public Health).

By 2030, update suburban Cook County suicide report with new data (Data Source: Cook County Department of Public Health).

STRATEGIES

- Continue to build a community-based prevention program for suicide that builds upon local priorities and best practices from other local health departments.
- Monitor the implementation of the Safe Gun Storage Act.
- Support resilience through evidence-based education programs in schools and community spaces.
- Drive and refine prevention strategies by continuing to leverage population health data, research, and evaluation to monitor suicide and mental health risk factors and outcomes.

Priority 3: Mental Health and Substance Use

GOAL 3:

Address upstream drivers of intergenerational trauma, mental health, and substance use in suburban Cook County

Outcome Objective: Outcome objectives are goals for how much health problems should be reduced. They must be measurable.

Impact Objective: Impact objectives are goals for how much risk factors should be reduced. They must be measurable.

Intervention Strategy: The intervention strategies chosen must be proven to influence the levels of risk factors.

OUTCOME OBJECTIVE

By 2030, reduce the rate of public high school students reporting persistent sadness or hopelessness by 3% (Data Source: Suburban Cook County Youth Risk Behavior Survey).

By 2030, increase the rate of adults who say they really feel part of their neighborhood by 5% (Data Source: Suburban Cook County Health Survey).

IMPACT OBJECTIVE

By 2030, reduce the rate of suburban Cook County school districts in the top 20% for racial disproportionality for suspensions and expulsions by 5% (Data Source: Illinois State Board of Education).

By 2030, reduce the rate of incarceration of youth and adults by 5% (Data Source: Cook County Criminal Justice Data Dashboard).

STRATEGIES

- Support investments in violence prevention, recidivism reduction, and restorative justice.
- Ensure access to culturally responsive mental health services, social services (e.g. transportation), Know Your Rights trainings, and access to legal services for people who are facing or are at risk of being deported and their families.
- Support implementation of restorative justice in suburban Cook County schools.
- Support base-building organizations working on civic engagement, social connection, and other upstream drivers of behavioral health.
- Conduct up to six listening sessions with youth on where and how they would like to receive mental health support by 2026.
- Examine and elevate ways that upstream drivers impact behavioral health by developing at least three briefs highlighting the ways that structural forces influence behavioral health outcomes by 2027.
- Promote the Cook County Paid Leave Ordinance for behavioral health–related appointments.*
- Employers and policymakers should establish supportive workplaces and protective measures to address workers' mental health and substance use.
- Support the development of recreation areas, parks, and green spaces that feel safe and inclusive, prioritizing areas where open space is limited.*

*These strategies are aligned with strategies for the chronic disease and maternal child health priority areas.

THANK YOU:

This plan was developed in close partnership with residents, community-based organizations, healthcare providers, and cross-sector leaders. BHC 2030 represents a collaborative process that informed every stage of assessment, priority setting, and strategy development. We are deeply grateful to the many partners who contributed their time, expertise, and insight.

Get Involved: Moving Forward Together

Realizing the goals of this plan requires shared action. We invite residents, community partners, healthcare providers, and local governments to engage in implementation, align efforts with CHA/CHIP priorities, and help hold systems accountable for progress. Through continued collaboration, transparency, and learning, we can advance equity, expand access to care, and build healthier communities across suburban Cook County.

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