BUILDING HEALTHIER COMMUNITIES 2030

SUBURBAN COOK COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN

June 24, 2026 – June 24, 2030

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

BUILDING
HEALTHIER
COMMUNITIES

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A division of Cook County Health
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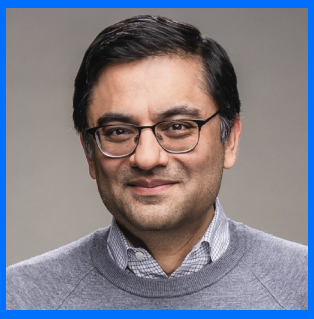
A SHARED COMMITMENT TO HEALTH EQUITY IN SUBURBAN COOK COUNTY

Toni Preckwinkle



Dr. Kiran Joshi

Dr. Erik Mikaitis

This plan is about people: the neighbors, the families, and the communities that make suburban Cook County strong.

Building Healthier Communities 2030 (BHC2030) is suburban Cook County's Community Health Assessment and Improvement Plan (CHA/CHIP) conducted every 5 years. BHC2030 is a community planning process and fulfills state and national public health requirements, including Illinois Department of Public Health and Illinois Project for Local Assessment of Needs expectations and the Public Health Accreditation Board accreditation standards, while grounding those mandates in the lived experiences of suburban Cook County residents. More than a statutory requirement, this plan reflects a shared commitment to accountability, equity, and measurable action.

BHC 2030 reflects a shared commitment by the Cook County Department of Public Health and its many community partners to advance health equity through coordinated, community-informed, and accountable action.

This plan serves as a collective vision that aligns policy, public health, and community to improve the conditions that shape health and well-being across our communities. It is also a practical roadmap that will guide Cook County Department of Public Health's work to improve the health of suburban Cook County communities from now through 2030.

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June 22, 2026

BOARD OF HEALTH APPROVAL LETTER

Building Healthier Communities 2030 (BHC 2030) Community Health Improvement Plan for suburban Cook County – Cook County Department of Public Health

On behalf of the Cook County Board of Commissioners, acting in their capacity as the Cook County Board of Health, I am pleased to affirm the approval of the Building Healthier Communities 2030 (BHC 2030) Community Health Assessment and Improvement Plan for implementation during the 2026–2030 planning cycle. The plan was submitted to the Cook County Board of Commissioners (item and approved

BHC 2030 was developed in accordance with the Illinois Project for Local Assessment of Needs (IPLAN) process and fulfills the community health planning requirements established by the Illinois Department of Public Health (IDPH) for local health department certification.

By this letter, the Cook County Board of Health formally approves the Building Healthier Communities 2030 (BHC 2030) Community Health Assessment and Improvement Plan and authorizes its submission to the Illinois Department of Public Health as the official Community Health Improvement Plan for suburban Cook County for the period of 2026–2030.

Sincerely,

Toni Preckwinkle

Toni Preckwinkle, President

Grounded in Community, Shaped by Partnership

This CHA/CHIP was developed through a robust, collaborative process that centered the voices and lived experiences of residents, community-based organizations, healthcare providers, local governments, and cross-sector partners. **Their expertise and trust were essential in identifying both the challenges communities face and the solutions needed to address them.**

Aligned with County Strategy and Public Accountability

The priorities and strategies outlined in this plan align with Cook County's Policy Roadmap, the Cook County Health Strategic Plan, and broader countywide goals focused on equity, justice, and inclusive governance. By coordinating assessment, planning, and implementation across agencies, **this CHA/CHIP strengthens our ability to respond to community health needs across the full continuum of prevention, care, and recovery.**

Data-Informed Decisions

Designed as a living document, the plan reflects data-informed decision-making to determine where Cook County Department of Public Health will focus, measurable outcomes, and flexibility to adapt as conditions evolve. **Transparency, shared ownership, and accountability will guide implementation, ensuring progress is tracked and strategies are refined over time.**

> *"Every resident of Cook County deserves the opportunity to achieve their highest level of health, regardless of race, zip code, or income. This Community Health Assessment and Improvement Plan advances that vision by centering health equity as both a value and an action framework."*
>
> **Toni Preckwinkle**

Advancing Access Through Equitable Systems

Across all the strategies outlined, this plan prioritizes improving access to high-quality, equitable healthcare and prevention services. Our efforts focus on strengthening coordinated systems of care in suburban Cook County that support mental health and substance use recovery, prevent and reduce chronic disease, and improve maternal and child health outcomes before, during, and after pregnancy.

Upstream Drivers of Health

Health outcomes are shaped not only by healthcare, but by housing, transportation, economic stability, education, safety, and food access. Addressing these factors requires integrated approaches that expand preventive care, support community-based providers, and improve the environments where people live, learn, work, and age.

Naming Structural Racism and Advancing Equity

Health inequities in suburban Cook County are not accidental. They are the result of historic and ongoing policies and systems that have marginalized communities of color and created unequal access to opportunity. This plan recognizes that structural racism has played a role in creating health differences across communities, and it commits CCDPH to addressing the underlying systems and conditions that shape health, not just individual behaviors.

Equity is embedded as both a value and an action framework throughout this plan, guiding how priorities are set, resources are allocated, and progress is measured. By centering community voice, addressing intergenerational trauma, and focusing on prevention and healing, **this work seeks to change conditions, not place responsibility on individuals.**

Priority Areas: From Challenge to Action

Chronic Disease

Preventable chronic disease is driven by inequitable access to care, unhealthy community conditions, and limited availability of affordable, nutritious food. We will expand equitable access to healthcare and preventive services, improve community conditions that support healthy living and climate resilience, and increase access to fresh, affordable, and culturally relevant food in historically marginalized communities.

Maternal and Child Health

Persistent disparities in maternal and child outcomes linked to gaps in care and unmet social and environmental needs. We will strengthen equitable, high-quality care before, during, and after pregnancy, expand culturally responsive maternal and pediatric care, and advance accountability.

Mental Health and Substance Use

Fragmented systems and limited access to timely, equitable mental health and substance use care, compounded by intergenerational trauma. We will work toward strengthened coordination across community-based organizations, healthcare providers, and government partners to reduce barriers, integrate crisis care with community-based prevention, and support healthy beginnings, strong connections, and safe environments.

"Advancing health equity requires sustained leadership, collaboration, and community partnership. We remain committed to supporting the implementation of this plan and to working alongside residents, community-based organizations, and all our partners to build healthier, more equitable communities."

Dr. Kiran Joshi, CCDPH

THANK YOU:

This plan was developed in close partnership with residents, community-based organizations, healthcare providers, and cross-sector leaders. The CHA/CHIP 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.

Sign up to receive BHC 2030 updates

COMMUNITY HEALTH ASSESSMENT

Purpose Statement

The Community Health Assessment (CHA) for suburban Cook County is designed to identify and understand the most pressing health needs, community strengths, and opportunities that shape the well-being of residents across diverse communities. Led by the Cook County Department of Public Health (CCDPH) in partnership with community stakeholders, the CHA provides a foundation for evidence-informed decision-making and strategic action to improve population health and advance health equity.

The CHA is developed through a collaborative and inclusive process that integrates both quantitative data—such as health outcomes, social and economic conditions, and environmental factors—and qualitative insights drawn from community voices, lived experiences, and local knowledge. Meaningful community engagement is central to this work, ensuring that residents, particularly those most affected by health inequities, play an active role in defining health priorities and identifying needed changes.

Findings from the CHA directly inform the Cook County 2030 Community Health Improvement Plan (CHIP), which establishes shared priorities, measurable goals, and coordinated strategies across sectors. This process aligns the efforts of public health, healthcare systems, community-based organizations, and local governments to address the root causes of poor health, reduce disparities, and promote racial and health equity.

Ultimately, the CHA is more than a report—it is a roadmap for collective action and accountability. It will guide investments, inform policy decisions, and support programs that strengthen health, resilience, and opportunity for all communities in suburban Cook County.

Methods

The Community Health Improvement Plan (CHIP) for suburban Cook County is grounded in a comprehensive Community Health Assessment (CHA) that integrates both primary and secondary data to identify priority health needs, inequities, and opportunities for action. CCDPH used a mixed-methods approach that combined population-based surveys, community and partner input, and routinely collected health and administrative data. Together, these sources provide a balanced understanding of health outcomes, health behaviors, social and environmental conditions, and community capacity across suburban Cook County, ensuring that CHIP strategies are informed by both quantitative evidence and lived experience.

Primary data—information collected directly from residents, organizations, or communities for the purpose of this assessment—played a central role in elevating community voice and identifying lived experiences that are not captured in routine data systems. Adult health behaviors and access to care were assessed through the Suburban Cook County Health Survey, while adolescent health behaviors and well-being were captured through the Suburban Cook County Youth Risk Behavior Survey of public high school students. In addition, CCDPH participated in region-wide Community Context and Community Partner Assessments conducted through the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 framework. Together, these efforts gathered direct input from residents and organizations on community strengths, challenges, and priorities, with intentional outreach to populations and organizations serving groups most affected by health inequities. Findings from these primary data sources helped contextualize quantitative trends and informed the selection of CHIP focus areas.

Secondary data—information originally collected for administrative, surveillance, or research purposes and analyzed for this assessment—were used to measure health outcomes, service utilization, and broader structural conditions that influence health. These sources included vital statistics, hospital discharge data, reportable disease surveillance, U.S. Census and American Community Survey data, and environmental and health system datasets from state and federal partners. CCDPH analyzed these data to monitor trends over time, identify geographic and demographic inequities, and develop locally relevant indicators across chronic disease, maternal and child health, mental health and substance use, infectious disease, and social determinants of health. Many of these indicators are publicly available through the Suburban Cook County Health Atlas to promote transparency and support ongoing community planning.

To contextualize findings and support accountability, CCDPH compared local data with state and national benchmarks, including Healthy People 2030 objectives. While each data source has limitations—such as reliance on self-reported survey data, reporting lags, or incomplete coverage—CCDPH mitigated these challenges by triangulating across multiple datasets and applying standardized analytic methods. Collectively, these data informed the identification of priority issues, shaped CHIP goals and strategies, and established a foundation for monitoring progress toward more equitable health outcomes across suburban Cook County.

Identifying Community Health Issues

The assessment process utilized a mixed-methods approach combining quantitative data analysis, community surveys, focus groups, and structured discussions with local stakeholders. CCDPH utilized the three assessments from MAPP 2.0 to identify community issues. Those assessments included the Community Status Assessment (quantitative), the Community Context Assessment (qualitative), and the Community Partner Assessment (qualitative). As a member of the Alliance for Health Equity, CCDPH leveraged the Community Context Assessment conducted by the Alliance for Health Equity through the Illinois Public Health Institute for our 2030 CHA/CHIP. From these assessments, community health issues were surfaced through:

- A multilingual community survey disseminated digitally and in person
- Focus groups facilitated by members of the Alliance for Health Equity
- A community partner survey distributed digitally
- A review of secondary data focused on public health domains informed by IPLAN's data categories; demographics and socioeconomic characteristics, general health and access to care, chronic disease, maternal and child health, mental health and substance use, infectious disease, and environment/occupation/injury control.

Key health challenges identified included chronic disease disparities, mental health and substance use concerns, maternal and child health inequities, and the pervasive impacts of structural racism.

Community Participation

Throughout the process, CCDPH convened the *Building Healthier Communities 2030 Steering Committee*, which included representatives from nonprofit organizations, philanthropy, local government, healthcare, schools, advocacy organizations, and priority population groups (i.e., Black, Latine, immigrant, and older adults). Although several sectors and populations were represented, we recognize that gaps still exist in priority populations such as the LGBTQIA+ community, people with disabilities, people experiencing homelessness, and youth. To address these gaps, CCDPH will seek out community members from these specific communities and/or community partners who serve these communities during the implementation phase over the next five years of this plan. Additionally, strategies from our mental health and substance use and chronic disease health priorities include interventions inclusive of the above populations.

In mid-July 2025, CCDPH held a community convening to inform and engage community partners in the planning process. Over 50 community partners were represented, some filling the gaps of the priority populations not initially represented on the steering committee. The community members selected which of the three health priority work groups they would participate on for the CHIP. Together, community members with the guidance of CCDPH, co-developed goals, objectives, and strategies for the suburban Cook County public health system to focus on for the next five years. Community members were not just informants, but also co-creators of knowledge and strategy.

Analysis By Grouping

Demographics and Socioeconomic Characteristics

CCDPH's jurisdiction lies within the Westchester health region, one of six state-defined health regions in Illinois. The Westchester region covers nine northeastern Illinois counties—Cook, DuPage, Grundy, Kane, Kankakee, Kendall, Lake, McHenry and Will—making it the smallest region by land area (approximately 5,000 square miles) but the most populous. With an estimated 8.7 million residents, the region accounts for nearly 70 percent of the state's total population. Fourteen local health departments operate within this region, including five located in Cook County: the Chicago Department of Public Health, the City of Evanston Department of Health and Human Services, the Village of Oak Park Department of Public Health, the Stickney Township Public Health District, and the Village of Skokie Health Department. Suburban Cook County refers to all areas of Cook County outside the Chicago city limits, regardless of whether those areas are directly served by CCDPH or by another local health agency.

With an estimated residential population of 2.5 million, CCDPH is the second-largest jurisdiction among local health departments in the Bellwood health region, following only the Chicago Department of Public Health (CDPH), which serves 2.7 million residents. CCDPH's jurisdiction covers roughly 693 square miles—about 70 percent of Cook County's total land area—and includes 120 municipalities, 114 in full and portions of six others. An estimated 104,874 residents, or 4.6 percent of the population, live in unincorporated areas outside these municipalities. The jurisdiction also encompasses 27 townships, 10 Cook County commissioner districts, and four CCDPH health districts (north, west, southwest, and south). These four health districts are used to assess social and demographic patterns across the jurisdiction and to organize reporting on disease incidence, prevalence, and other health indicators.

The demographic and socioeconomic patterns in suburban Cook County show a region that is growing older, becoming more racially, ethnically, and linguistically diverse, and experiencing very different levels of opportunity from one community to the next. Northern suburbs and some western communities tend to have higher incomes, more educational attainment, greater neighborhood opportunity, and more stable housing conditions. In contrast, many southern—and some western and southwest—communities face concentrated hardship, including lower incomes, higher poverty and unemployment, greater housing cost burden, and higher social vulnerability. These differences shape who is most at risk for poor health and where public health investments, services, and partnerships are most needed.

- Population change is uneven: the North, West, and Southwest Districts grew modestly between 2010 and 2020, while the South District lost residents, especially children and working-age adults, contributing to an older age structure and shrinking tax base in many southern communities.
- Suburban Cook County is aging rapidly, with large increases in residents age 65 and older in every district and declining numbers of children, which raises the age dependency ratio and increases demand for long-term services, caregiving supports, and age-friendly community planning.
- Racial and ethnic diversity has increased across the region, with strong growth in Hispanic and Asian populations and declines in the non-Hispanic White population; at the same time, districts remain sharply segregated, with the North and Southwest districts majority White, the South majority Black, and the West having the highest share of Hispanic residents.
- Educational attainment, income, poverty, unemployment, and housing conditions follow a consistent geographic pattern: northern suburbs and a few western communities show high levels of education and income and low hardship, while many

South and select West and Southwest municipalities experience persistent economic disadvantage, higher hardship index scores, and greater housing cost burden.

- Composite indices such as the Social Vulnerability Index (SVI), Area Deprivation Index (ADI), and Child Opportunity Index (COI) confirm and sharpen these patterns, showing clusters of high vulnerability and low opportunity in parts of the South, Southwest, and West Districts and pockets of need even within otherwise advantaged areas; these tract-level insights point to specific neighborhoods where targeted, equity-focused public health strategies will be most important.

General Health and Access to Care

Our analyses show that general health and access to care in suburban Cook County reflect both meaningful overall progress and deep, persistent inequities that are concentrated in communities with long histories of disinvestment. Many residents live long lives, have health insurance, and report regular access to primary care and preventive services, indicating that health systems function well for a substantial portion of the population. At the same time, these gains are not shared equitably. Large gaps in mortality, life expectancy, years of potential life lost, self-reported health, and provider availability persist along clear racial, ethnic, and geographic lines—most notably between the North District and many communities in the South, West, and parts of the Southwest. Together, these patterns show that countywide improvements can occur alongside stagnation or worse outcomes in specific populations, underscoring the need to both sustain effective systems and make targeted investments in communities facing the greatest barriers to prevention, timely treatment, and high-quality care.

- All-cause mortality, life expectancy, and years of potential life lost (YPLL) consistently point to the same inequities: Black residents and many South District communities experience the highest death rates, the shortest lifespans, and the largest burden of early deaths, while Asian and many northern suburbs have the most favorable outcomes.
- Self-reported health status and health-care satisfaction closely mirror these patterns, with residents of high-opportunity northern suburbs more likely to feel healthy and very satisfied with their care, and residents of high-hardship communities in the South, West, and Southwest less likely to report good health or positive care experiences.
- Health insurance coverage is generally strong, but gaps remain—especially for Hispanic/Latine residents, who have the highest uninsured rates in suburban Cook County and statewide, and for low-income residents who rely heavily on Medicaid and are vulnerable to policy changes and enrollment disruptions.
- Access to providers and preventive services is uneven: most residents report having a primary care provider and many northern and southwest suburbs have very high routine checkup rates, yet several South and West District communities have far fewer providers per resident and some of the lowest rates of routine care use.
- District- and neighborhood-level differences across all indicators highlight priority areas for action, pointing to the need for targeted investments in primary care, maternal and reproductive health, dental care, and community-based outreach in the South, West, and selected Southwest communities to close gaps and advance health equity across suburban Cook County.

Chronic Disease

Chronic diseases such as heart disease, cancer, diabetes, and stroke remain leading causes of illness and death in suburban Cook County, but their impact is not shared equally across communities. Mortality data, emergency department visits, and adult and youth survey findings all point to the same pattern: Black residents and people living in the South Health District experience the highest burdens, while Asian residents and those in the North District generally have the most favorable outcomes. Diet-related, coronary

heart disease, and diabetes mortality rates are highest in communities with long-standing challenges related to income, food access, and health care, and several South and Southwest municipalities show especially high diabetes mortality. Emergency department data reveal that many chronic conditions are not well controlled, particularly among Black residents and in the South District, where avoidable emergency department use is common. Adult and youth survey findings add important context by showing that food insecurity, physical inactivity, tobacco and e-cigarette use, and lower access to preventive care are also concentrated in communities already facing the greatest chronic disease burden. Taken together, these data underscore the need for targeted, place-based prevention efforts, stronger chronic disease management, and policies that improve neighborhood conditions, access to healthy food, and high-quality primary care in the communities with the highest risk.

- 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.
- 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.
- 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.
- 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.
- 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.

Maternal and Child Health

Maternal and child health in suburban Cook County reflects both encouraging progress and persistent challenges that disproportionately affect some communities. Many indicators including teen births, smoking during pregnancy, and infant mortality have improved over the past decade, and breastfeeding rates at hospital discharge remain high across most groups. However, racial and geographic inequities remain deeply rooted and are not random or inevitable. Longstanding structural racism expressed through residential segregation, unequal investment in neighborhoods, differential access to quality health care, and cumulative economic and environmental disadvantage has shaped the social and health conditions that influence pregnancy and birth outcomes across suburban Cook County. As a result, Black residents consistently face the highest rates of maternal and infant mortality, preterm birth, low birth weight, chronic health conditions before pregnancy, and maternal care–related emergency department use. Differences in early and adequate prenatal care across racial and district lines further underscore how unequal access to timely and supportive care persists. Together, these patterns show that while overall outcomes are moving in a positive direction, sustained, equity-centered public health strategies are needed to address the structural drivers of inequity and ensure all families in suburban Cook County have healthy pregnancies, safe births, and strong starts for their children.

- 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.
- 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.
- 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.

Mental Health and Substance Use

Mental health and substance use in suburban Cook County reflects both serious challenges and clear inequities across communities. Mortality data show rising opioid overdose deaths, especially among men, and higher drug- and firearm-related deaths in West and South Health Districts and among Black residents. Emergency department data echo these patterns, with Black residents experiencing the highest rates of mental health, substance use, and injury-related visits, while Asian residents have the lowest rates, and White and Hispanic residents fall in between. Adult survey data suggest that most residents report good access to care and feel safe in their neighborhoods, yet financial strain, psychological distress, and substance use remain more common in some racial and ethnic groups than others. Youth survey results add another layer of concern: many high school students report poor mental health, depression, and exposure to violence, even as some substance use behaviors decline. Racial and ethnic inequities also exist for youth, with Black high school students attempting suicide at three times the rates than their White peers. Together, these findings show that mental health and substance use outcomes are shaped by unequal social and economic conditions, highlighting the need to pair clinical and crisis responses with long-term, place-based prevention strategies.

- 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 mortality has increased sharply since 2010, with men experiencing more than three times the overdose death rate of women in recent years.
- 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.
- 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.

Infectious Disease

The 20th century witnessed historic gains in curbing morbidity and mortality caused by infectious disease, thanks to invaluable tools such as antibiotics and vaccination campaigns. Today, indicators in suburban Cook County show a mixed picture of progress which illustrates ongoing challenges for public health. While some diseases or infections which had been on the rise for several years are starting to stabilize or even decline (STI, hepatitis C), others have firmly plateaued (tuberculosis) or are trending up (vaccine-preventable diseases, foodborne illness) despite having effective prevention strategies . In addition, new infectious agents with epidemic or pandemic potential remain a constant threat. Finally, patterns of disease reflecting historic and structural inequities are stubbornly entrenched in many regions of suburban Cook County. If we are to maintain the hard-fought gains of the past and eliminate disproportionate disease burden in our communities, it is more crucial than ever to support sustained public health interventions. Public health must not only rely on past successes but also continue to advocate for further investment and creative solutions in the fight against infectious diseases. Local effort is particularly necessary as federal funding supporting prevention of infectious diseases becomes more unreliable.

- For many reportable infectious diseases, declines observed during the COVID-19 pandemic have disappeared, and rates have now returned to or exceed pre-pandemic levels.
- Novel interventions such as curative treatments for hepatitis C or doxycycline post-exposure prophylaxis for STIs, among other factors, may be helping to turn the tide on once-intractable epidemics.
- Progress for other diseases has stalled, such as for tuberculosis, or is reversing course, such as for vaccine preventable diseases, and will require additional investment and new ways of educating and communicating to make sure hard-fought ground is not lost.
- New infectious disease threats continue to emerge, such as multidrug-resistant organisms, that require intensive public health responses to contain and mitigate.
- Disparities exist across almost all infectious disease indicators with Black and brown residents and communities typically affected at higher rates compared to other sub-populations within suburban Cook County.

Environment, Occupation and Injury Control

Our findings show that where people live, work, travel, and go to school in suburban Cook County strongly shapes their chances to stay safe and healthy. Built environment indicators reveal that some communities offer well-maintained sidewalks, good transit access, and safe streets, while others struggle with poorer infrastructure, heavier traffic risks, and lower feelings of safety. Environmental justice data point to higher air pollution, hazardous sites, and drinking water concerns in many West, South, and Southwest suburbs, often the same areas where residents face higher injury, violence, and heat vulnerability. At the same time, school safety, interpersonal violence, and firearm injury data highlight serious and unequal risks for young people and communities of color. Together, these patterns underscore the need for coordinated planning that improves physical environments, reduces injury and violence, and builds climate resilience, with a clear focus on the neighborhoods and populations carrying the greatest burden.

- Environmental and climate burdens—such as air pollution, hazardous sites, drinking water violations, and heat vulnerability—are highest in many west, south, and southwest communities, while many northern suburbs experience much lower combined risk.
- Unintentional injuries, especially falls and motor vehicle crashes, remain a major cause of emergency department visits and deaths, with older adults, children, and Black residents experiencing the highest rates.

- Intentional injuries, including homicide, firearm-related injury, interpersonal violence, and legal intervention injuries, fall most heavily on Black residents, young adults, and men, revealing deep inequities tied to structural and neighborhood conditions.
- Youth safety is a growing concern: many students report feeling unsafe at school, experiencing bullying, or surviving sexual assault, with especially high risks among lesbian, gay, or bisexual youth, female students, and Black students.
- Communities with stronger walkability, better sidewalk conditions, safer streets, and higher child opportunity scores tend to show lower injury and environmental burdens, suggesting that investments in the built environment, environmental cleanup, and community safety can produce broad health benefits across the county.

Suburban Cook County Sentinel Events Key Findings

Sentinel events are specific, preventable health outcomes whose occurrence signals potential gaps in access to care, prevention, or the broader systems that support community health. As applied by IDPH through its IQuery/IPLAN framework, sentinel indicators traditionally focus on conditions considered preventable or controllable with regular primary care, such that their occurrence can be interpreted as an early warning of inadequate access to care. Building on this foundation, the following key findings apply the sentinel events concept more broadly, examining not only preventable conditions but also the leading causes of death, behavioral health concerns, and the social and environmental factors that serve as warning signals about the health and well-being of communities across suburban Cook County.

- Healthcare Access and Workforce Shortages: Access to care is a cross-cutting determinant that shapes nearly every outcome described below, influencing whether the sentinel events in this assessment can be prevented, detected early, or effectively managed. Closures of healthcare facilities, shortages of behavioral health providers, and limited access to primary care in some suburban communities therefore serve as early warning indicators of worsening population health across all of the categories that follow.
- Opioid Overdose: Drug overdose remains a significant public health concern in suburban Cook County, although overdose mortality has begun to stabilize following viosharp increases during the COVID-19 pandemic. Synthetic opioids, particularly fentanyl, continue to drive the majority of overdose deaths, with disproportionately higher mortality rates among Black residents.
- Unintentional Injury: Unintentional injury remains a leading cause of premature death, driven largely by drug poisonings, motor vehicle crashes, and falls. Older adults experience a disproportionate burden of fall-related injuries, while overdose-related deaths account for a growing share of injury mortality among working-age adults.
- Violent Crime: Violent crime rates increased during and immediately following the COVID-19 pandemic and remain elevated in several south and west suburban communities. Firearm-related violence continues to contribute substantially to injury, mortality, community trauma, and perceptions of safety.
- Youth Mental Health: Increasing reports of anxiety, depression, suicidal ideation, and behavioral health concerns among youth signal a growing public health challenge. School-based data and community assessments continue to identify youth mental health as a priority concern across suburban Cook County.
- Behavioral Health Crises: Emergency department visits and hospitalizations related to mental health conditions have increased in recent years, particularly among adolescents and young adults. Access to affordable, culturally responsive behavioral health services remains a challenge in many communities.
- Cancer Mortality: While mortality from screenable cancers has declined steadily over time across the population, substantial racial and ethnic disparities

persist. Black residents within suburban Cook County continue to experience markedly higher screenable cancer mortality than other groups, and this gap has remained wide throughout the period, even as overall rates have fallen. These persistent inequities point to ongoing differences in access to screening, timely diagnosis, and treatment across communities.

- Chronic Disease Mortality: Heart disease, stroke, diabetes, and hypertension continue to contribute substantially to morbidity and mortality throughout suburban Cook County. Chronic disease burden is concentrated in communities experiencing higher rates of poverty, limited access to care, and adverse social determinants of health, with Black residents experiencing disproportionately higher mortality rates.
- Maternal and Infant Health: Maternal and infant health outcomes continue to demonstrate significant inequities across suburban Cook County. Black women experience substantially higher rates of severe maternal morbidity and pregnancy-related complications, while Black infants experience infant mortality rates that exceed those of White infants by several-fold.
- Infectious Disease and Vaccine-Preventable Illness: While the acute impacts of the COVID-19 pandemic have diminished, disparities in vaccination coverage and disease burden persist. Respiratory illnesses, including COVID-19, influenza, and RSV, continue to disproportionately affect older adults, individuals with chronic conditions, and communities with lower healthcare access.
- Housing Instability and Homelessness: Rising housing costs, eviction risk, and homelessness are increasingly recognized as drivers of poor health outcomes. Housing insecurity is associated with chronic disease, mental health challenges, and reduced healthcare access.
- Food Insecurity: Despite being located within a resource-rich region, many suburban communities experience barriers to affordable, nutritious food. Food insecurity contributes to chronic disease risk and poor health outcomes, particularly among children, older adults, and low-income households.
- Chronic Disease-Related Hospitalizations: High rates of avoidable hospitalizations and emergency department visits for conditions such as diabetes, hypertension, asthma, and heart disease may indicate challenges with prevention, disease management, and healthcare access.
- Respiratory Disease and Asthma Burden: Asthma-related emergency department visits and hospitalizations remain elevated in some south and west suburban communities, often reflecting environmental exposures, housing conditions, and barriers to preventive care.
- Extreme Weather and Climate-Related Health Events: Increasing frequency of extreme heat events, flooding, poor air quality, and severe weather presents emerging health risks, particularly for older adults, individuals with chronic diseases, and communities with limited resources.

Prioritization of Issues

Following the data analysis and discussions with the steering committee of health issues in suburban Cook County, a participatory prioritization process was held in early 2025. Using consensus-building techniques such as the Technology of Participation's Consensus Workshop Method, our steering committee members reviewed data from the seven data categories, and ranked issues based on severity, disparities, and feasibility of impact. Priority areas were selected through a deliberative voting process and confirmed by CCDPH leadership. The inclusive and iterative process ensured that the voices of historically marginalized communities shaped both the identification and selection of health priorities. This approach reflects CCDPH's commitment to shared leadership, transparency, and equity in public health practice.

Community groups that participated in the process are listed in the table below.

- Active Transportation Alliance
- AgeOptions
- Alliance to End Homelessness in Suburban Cook County
- American Heart Association
- Anointed Touch Massage
- Arab American Family Services
- Be Strong Families
- Birth to Five Illinois
- Blue Cross Blue Shield of Illinois
- Catholic Charities
- CEDA (Community and Economic Development Association)
- Center of Concern
- Chicago Food Policy Action Council
- Cook County Bureau of Economic Development
- Cook County Commissioner's Office
- Cook County Commissioner Michael Scott Jr.'s Office
- Cook County Commissioner Sean M. Morrison's Office
- Cook County Dept. of Environment & Sustainability
- Cook County Justice Advisory Council
- Cook County Dept. of Public Health
- Cook County Dept. of Transportation & Highways
- Cook County Health
- CountyCare
- EverThrive Illinois
- Forest Preserves of Cook County
- Greater Chicago Food Depository
- Health in Partnership
- Illinois Action for Children
- Illinois Alliance to Promote Opportunities for Health
- Illinois Head Start Association
- Illinois Public Health Institute
- Kids Above All
- Loyola Medicine / Loyola University Medical Center
- Lurie Children's Hospital
- NAMI Metro Suburban
- NAMI South Suburbs
- National Kidney Foundation of Illinois
- Northwest Center Against Sexual Assault
- Now Prosper Coaching & Consulting LLC
- Rincon Family Services
- Riveredge Hospital
- PASO – West Suburban Action Project
- Pillars Community Health
- Playworks
- Proviso Partners for Health
- Quinn Center

- Real Foods Collective
- Respiratory Health Association
- SGA Youth & Family Services
- Sisters Working It Out
- South Suburban Mayors & Managers Association
- Stickney Public Health District
- TASC Inc.
- TCA Health
- Under Carrey's Care Corp.
- University of Illinois Extension
- West40

Priorities identified by CCDPH through its local health assessment and planning processes show strong alignment with the Illinois State Health Improvement Plan(SHIP), which was developed to reflect the common priorities identified in local community health needs assessments. These aligned priorities specifically target: (1) chronic disease, each of which are described briefly below with respect to their alignment with the SHIP; (2) maternal and child health; and (3) behavioral health (which includes both mental health and substance use).

Priority 1 Alignment: Chronic disease

The chronic disease findings from CCDPH's health assessment also closely align with the Healthy Illinois 2021 Health Priority Action Team Goals summarized in the Illinois SHIP priority on behavioral health, which emphasizes prevention, equity, and stronger community–clinical linkages. The persistent racial and geographic disparities documented in suburban Cook County—particularly higher burdens among Black residents and South Health District communities—mirror SHIP's focus on improving opportunities for healthy eating (e.g., Goal 2: Increase opportunities for healthy eating), active living (e.g., Goal 3: Increase opportunities for active living), tobacco-free living (e.g., Goal 1: Increase opportunities for tobacco-free living), and access to preventive and primary care in communities facing the greatest barriers (e.g., Goal 4: Increase community-clinical linkages to reduce chronic diseases).

The CHA's evidence of poorly controlled chronic conditions, high avoidable emergency department use, and early risk factors among youth reinforces SHIP strategies that call for upstream, place-based prevention and systems-level interventions that integrate health care with improvements to neighborhood conditions, food access, and the built environment. Together, the findings support SHIP's framing of chronic disease as both a clinical and community issue, requiring coordinated action across health systems, public health, and policies that address social determinants of health.

Priority 2 Alignment: Maternal and child health

Lastly, the maternal and child health findings from CCDPH's health assessment also align closely with the Healthy Illinois 2021 Health Priority Action Team Goals summarized in the Illinois SHIP, particularly its emphasis on equity, access to quality care (e.g., Goal 1: Assure accessibility, availability, and quality of preventive and primary care for all women, adolescents, and children, including children with special health care needs, with a focus on integration, linkage, and continuity of services through patient-centered medical homes), and improved birth outcomes (e.g., Goal 2: Support healthy pregnancies and improve birth and infant outcomes). The documented overall improvements in indicators such as teen births, smoking during pregnancy, and infant mortality reflect progress consistent with SHIP goals to support healthy pregnancies and strengthen preventive care, while the persistent racial and geographic inequities mirror SHIP's explicit focus on eliminating disparities and centering equity in maternal and child health decision-making (e.g., Goal 3: Assure that equity is the foundation of all maternal and child health decision making; eliminate disparities in maternal and child health outcomes).

The CHA's identification of higher maternal and infant mortality, chronic pre-pregnancy conditions, and greater maternal care–related emergency department use among Black residents reinforces SHIP strategies that call for better integration, continuity, and quality of care across the prenatal, perinatal, and postpartum periods. By explicitly linking these inequities to structural racism and unequal social and economic conditions, the CCDPH findings further support SHIP's cross-cutting emphasis on addressing social determinants of health and ensuring that sustained, coordinated, and equity-centered approaches guide maternal and child health improvement efforts statewide.

Priority 3 Alignment: Mental health and substance use

The mental health and substance use-related health findings from CCDPH's health assessment align closely with the Healthy Illinois 2021 Health Priority Action Team Goals summarized in the Illinois SHIP priority on behavioral health, particularly its emphasis on reducing deaths due to behavioral health crises, improving community-based care, and addressing inequities. The documented increases in opioid overdose deaths, racial and geographic disparities in violence- and substance-related mortality, and elevated emergency department use among Black residents directly mirror SHIP goals to reduce overdose and suicide mortality and to narrow treatment gaps through stronger community-based systems and more effective transitions from emergency and institutional care.

In addition, CCDPH's identification of youth mental health concerns, exposure to violence, and persistent racial inequities reflects SHIP priorities around early intervention, improving behavioral health literacy (e.g., Goal 1: Improve the collection, utilization and sharing of behavioral health-related data in Illinois), and strengthening responses to community violence (e.g., Goal 6: Improve response to community violence). The assessment's conclusion—that behavioral health outcomes are shaped by unequal social and economic conditions and require place-based, prevention-oriented strategies—reinforces SHIP's cross-cutting focus on social determinants of health, equity, and coordinated data-driven action across state and local systems.

COMMUNITY HEALTH IMPROVEMENT PLAN

Introduction

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.

To ensure accountability and alignment with state and federal requirements, this CHIP has been developed in accordance with Section 600.400(d), (f), (g), and (h) of Subpart D: Practice Standards issued by the Illinois Department of Public Health (IDPH). It also aligns with compliance standards outlined in the Public Health Service (PHS) Act, Sections 330(a)(b), 330(h)(2), and 330(k)(3)(K), and applicable federal regulations (42 CFR 51c.102(h) and (j), 42 CFR 56.102(l) and (o), and 42 CFR 51c.303(l)) as administered by the Health Resources and Services Administration (HRSA). These standards guide our responsibility to meaningfully engage communities, ensure transparency, and use evidence-based approaches to improve health outcomes.

At the same time, CCDPH recognizes that public health plans must be accessible and understandable to the people they are meant to serve. Historically, technical language and policy terminology have created barriers to engagement, especially for communities with varying health literacy levels. As part of our ongoing commitment to inclusion, CCDPH is intentionally moving away from overly technical language in our public communications. This CHIP reflects that shift. While we include required regulatory language for accountability, the remainder of the document uses clear, plain, and community-centered wording to ensure that residents, partners, and organizations can easily understand the priorities, strategies, and opportunities for collective action.

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.

Statement of Purpose

The purpose of the suburban Cook County Community Health Improvement Plan (CHIP), branded as Building Healthier Communities 2030, is to serve as a strategic roadmap for improving the quality of life and health outcomes of our community through a collaborative, data-driven, and equity-centered approach. Rooted in the voices and lived experiences of residents, the CHIP identifies the most pressing health priorities and outlines coordinated strategies to address the social, environmental, and structural determinants that influence them. This plan is a product of inclusive community partner engagement including public health, healthcare, education, housing, business, and community-based organizations. It reflects a shared commitment to advancing health equity, addressing structural barriers to achieving optimal health, and creating conditions where everyone can thrive.

The CHIP will be used as a guiding framework for all members of suburban Cook County's public health system to align resources, set measurable objectives, and coordinate community-wide action around our key focus areas: chronic disease, mental health and substance use, and maternal and child health. Grounded in community-identified solutions, it includes SMARTIE goals (Specific, Measurable, Achievable, Relevant, Time-bound, Inclusive, and Equitable) to track progress, ensure accountability, and drive sustainable impact. The plan will be reviewed and updated regularly to respond to emerging needs and changing conditions, reinforcing our community's resilience and adaptability.

By bringing together the knowledge and strengths of many partners, the CHIP focuses on improving health for everyone in suburban Cook County. We place special attention on communities that have faced long-standing barriers to good health. This plan looks at both today's challenges and the deeper issues that shape health, such as poverty and racism.

We are committed to being open about our work, listening to community voices, and continuing to learn and improve as we move forward. The CHIP is designed to be a "living" plan, meaning it will grow and adapt over time based on what residents and partners share with us. Our goal is to support communities in moving from ideas to action, and from action to real, meaningful change.

Methods

The development of the suburban Cook County Community Health Improvement Plan (CHIP) was guided by a commitment to shared leadership, transparency, and meaningful community partnership. From the start, CCDPH was intentional about creating this plan with community members and partners, not for them. The process began with assessing the needs and strengths of suburban Cook County using the three health assessment tools from the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 planning framework. These health assessments included the Community Context Assessment, a qualitative assessment that explores the strengths, assets, lived experiences, and forces of change in communities. The next assessment was the Community Partner Assessment, a qualitative assessment with the goal of assessing each community partner's capacities, skills, and strengths to improve community health and achieve health equity. The third assessment was the Community Status Assessment, a quantitative assessment with the goal of collecting data on the status of the community, such as demographics and health status. This assessment helps communities look upstream in identifying inequities and their relation to systems of power, privilege, and oppression.

After conducting these assessments between April 2024 and April 2025, the results were triangulated and analyzed to see themes and patterns. From these themes, the steering committee voted using an online, anonymous poll to rank the themes that we should focus on for the 2026-2030 CHIP. The top three health issues selected from the poll to become the health priorities for the plan were mental health and substance use, chronic disease, and maternal and child health. CCDPH then hosted a large community convening in July 2025, where community-based organizations, local leaders, and health partners came together to learn about the community health assessment and improvement plan for suburban Cook County and participate in the development of goals for each priority. Their insights helped shape the direction of the three health priority areas: Mental Health and Substance Use, Maternal & Child Health, and Chronic Disease.

Following the convening, CCDPH held three priority-focused meetings for each health area, where community partner teams worked closely with CCDPH staff to create goals, objectives, and strategies. These meetings were facilitated by trained subject matter experts from CCDPH who use the Technology of Participation (ToP®) facilitation method. They blended ToP's *focused conversation and consensus-building* approaches to ensure all voices were heard and that the final recommendations reflected shared agreement.

To develop strong, measurable objectives, the teams used several guiding frameworks. The MAPP 2.0 guidelines informed the development of SMARTIE objectives (Specific, Measurable, Achievable, Relevant, Time-bound, Inclusive, and Equitable). CCDPH also followed IPLAN requirements for measurable impact objectives and referenced evidence-based strategies from the Illinois Department of Public Health (IDPH) State Health Improvement Plan (SHIP 2028) and the National Association of County and City Health Officials (NACCHO).

Ensuring a mix of upstream and downstream approaches was also a priority. Each team used the Socioecological Model (SEM) to identify strategies at multiple levels—including individual behaviors, community and organizational practices, and broader policy, system, and environmental changes. This helped ensure the CHIP includes solutions that address both immediate needs and long-term root causes of health inequities.

Once the draft CHIP was completed, it went through a comprehensive internal review, followed by a final review from the CCDPH Steering Committee. The plan was presented to and approved by the Cook County Board of Health in June 2026.

This collaborative and community-driven process ensures the CHIP reflects the experiences, priorities, and hopes of suburban Cook County residents and partners.

The three health priorities for Suburban Cook County are listed below. Because the Monitoring and Assessment plan as well as the plan for Awareness and Promotion of each of these health priorities are the same and will be applied across the department, these sections are at the end of health priority three.

Priority 1: Chronic Disease

Priority Selection and Importance to the Community

Chronic Disease was selected as one of the priority areas for suburban Cook County following a comprehensive review of community health assessment (CHA) data and facilitated discussions with the steering committee. The CHA identified chronic diseases such as heart disease, cancer, and diabetes as leading causes of death in suburban Cook County, with significant disparities by race, ethnicity, income, and geography. Black and Latino residents, as well as individuals living in low-income communities, face higher rates of diabetes prevalence, hypertension, obesity, and associated complications compared to White and higher-income populations (Illinois Department of Public Health, 2023).

Local data from the Cook County Health Atlas and partner health systems confirmed that chronic diseases disproportionately affect communities already experiencing structural racism, barriers to care, healthy food, and safe environments for physical activity. Community members engaged in the priority-setting process highlighted the day-to-day challenges of managing chronic disease, particularly where access to preventive care and supportive services is limited.

Committee members emphasized the cross-cutting impact of chronic diseases: they not only affect individuals' quality of life but also have ripple effects on families, workplaces, and healthcare systems.

Ultimately, the selection of Chronic Disease reflects the community's recognition of the urgent need to reduce preventable illness and premature death, while addressing structural inequities in prevention, treatment, and management. The committee affirmed that tackling chronic disease is essential for advancing overall health and equity across suburban Cook County.

Alignment with Healthy People 2030 Objectives

The Chronic Disease priority aligns with multiple Healthy People 2030 Leading Health Indicators, including:

- EH-06: Reduce the amount of toxic pollutants released into the environment
- NWS-01: Reduce household food insecurity and hunger
- HDS-05: Increase control of high blood pressure in adults
- NWS-04: Reduce the proportion of children and adolescents with obesity
- TU-04: Reduce current tobacco use in adolescents
- TU-02: Reduce current cigarette smoking in adults

Alignment with the Illinois State Health Improvement Plan

The suburban Cook County Community Health Improvement Plan shares the Chronic Disease priority with the Illinois State Health Improvement Plan, and aligns with multiple goals of the state plan, including:

- Goal 1: Increase opportunities for tobacco-free living
- Goal 2: Decrease preventable chronic diseases through nutrition
- Goal 3: Increase opportunities for active living
- Goal 4: Increase community-clinical linkages to reduce the incidence and burden of chronic diseases

By prioritizing Chronic Disease, suburban Cook County is advancing strategies that not only prevent illness but also promote equity and resilience in communities most affected.

Priority 1: Chronic Disease

Risk and Contributing Factors

Table 1. Risk Factors for Chronic Disease

RISK FACTOR	HOW THEY INFLUENCE HEALTH OUTCOMES
Poor diet and food insecurity	Increases risk of obesity, diabetes, hypertension, and cardiovascular disease.
Physical inactivity	Associated with obesity, diabetes, and heart disease.
Tobacco and alcohol use	Raises risk of cancer, cardiovascular disease, and liver disease.
Stress and poor mental health	Contributes to hypertension, poor diabetes control, and unhealthy coping behaviors.
Pre-existing conditions	Conditions such as obesity and hypertension exacerbate risks for other chronic diseases.

Table 2. Direct Contributing Factors

DIRECT FACTOR	HOW THEY INFLUENCE RISK FACTORS
Limited access to primary and preventive care	Leads to late detection and poorly managed chronic conditions.
Inadequate availability of healthy foods	Increases reliance on processed and high-calorie diets.
Lack of safe, affordable places for exercise	Contributes to sedentary lifestyles.
Gaps in health insurance coverage	Limits access to routine screenings, medications, and chronic care management.
Language and cultural barriers	Reduce utilization of preventive and treatment services.

Priority 1: Chronic Disease

Table 3. Indirect Contributing Factors

INDIRECT FACTORS	HOW THEY INFLUENCE DIRECT FACTORS
Structural racism and residential segregation	Concentrated poverty and limits access to healthcare, healthy food, and safe environments.
Economic inequities	Restrict opportunities for consistent care, healthy nutrition, and preventive behaviors.
Lack of supportive policies	Insufficient investment in walkable infrastructure, tobacco control, and chronic care coordination.
Underinvestment in community-based resources	Reduces availability of chronic disease education, self-management programs, and support networks.

Population Groups at Risk

- **Black and Latino residents:** Experience higher rates of diabetes, hypertension, obesity, and related complications.
- **Low-income individuals and families:** Have limited access to health care, healthy food, and safe places for physical activity.
- **Older adults:** Are more likely to live with multiple chronic conditions and require coordinated, ongoing care.
- **Immigrant and non-English-speaking residents:** Face cultural, language, and policy-related barriers to prevention, treatment, and chronic disease management.
- **Residents in areas with limited health care and food resources:** Struggle to consistently manage chronic conditions due to geographic inequities in services and supports.

Chronic Disease is a critical public health priority for suburban Cook County. Reducing the burden of chronic conditions requires a multi-faceted approach that addresses individual behaviors, systemic inequities, and environmental determinants of health. By aligning with Healthy People 2030 and tailoring strategies to community needs, suburban Cook County aims to improve quality of life and advance health equity for all residents.

See table for goals, objectives, and strategies to improve chronic disease outcomes in Suburban Cook County.

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 mental health and substance use and maternal and 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.

ⓘ **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 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.).

Priority 1: Chronic Disease

STRATEGIES (Continued)

- Promote and enforce smoke-free outdoor public places like parks, campuses, etc. to reduce exposure to second-hand smoke.
- 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.

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.

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.

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.

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.

STRATEGIES (Continued)

- Increase suburban Cook County food retailers and farmers markets that are accepting SNAP/participating in Link Match.
- 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 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 reported consuming less than 5 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 5 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 Cook County Class 7d Incentive to encourage the operation of food retailers in historically disinvested communities.

Priority 1: Chronic Disease

STRATEGIES (Continued)

- Promote local food rescue and recovery networks to improve food access and reduce food waste.
- Increase suburban Cook food retailers and farmers markets that are accepting SNAP/participating in Link Match.
- 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.

Community Resources — Chronic Disease

Chronic disease prevention and support rely on several community resources in suburban Cook County, including clinics, hospitals, farmers markets, food pantries, park districts, schools, and chronic disease self-management programs. Community health workers, care coordinators, and other public health partners help to support people in managing health conditions. These partners help families access healthy food, safe places for physical activity, screening services, and culturally responsive education for diseases like diabetes, heart disease, and asthma.

Shifts in the national political environment make long-term planning and new funding strategies essential. CCDPH is working with partners to explore alternative funding streams to continue to support this critical work.

Through a cross-functional internal and external team, CCDPH is deepening strategic partnerships with community power-based organizations to co-design and drive solutions that improve health outcomes and shift resources to historically under-invested communities. This approach supports Suburban Cook County in advancing chronic disease prevention efforts that are resilient to federal budget uncertainties and driven by community priorities.

This coordinated approach strengthens compliance with PHAB Domain 4 by supporting community engagement and shared planning, and PHAB Domain 9 by using data to improve programs over time. The goal is a sustainable prevention system where every suburban Cook County resident has the resources needed to live a healthy life, regardless of income or ZIP code.

Priority 2: Maternal and Child Health

Priority Selection and Importance to the Community

Maternal and Child Health (MCH) was chosen as a top priority for suburban Cook County through a thorough, community-centered process. This process combines data from the Community Health Assessment (CHA) with lived experiences shared by residents, healthcare providers, community organizations, and local leaders.

The CHA showed clear and persistent gaps in maternal and infant health outcomes—especially for Black and Latina mothers. Data from the Illinois Department of Public Health (IDPH, 2023) reveal that Black women in Cook County are nearly four times more likely to die from pregnancy-related causes than White women. Infant mortality shows similar inequities: while suburban Cook County's overall infant mortality rate is 5.1 per 1,000 births (slightly above the Healthy People 2030 target of 5.0), the rate for Black infants is more than double, at 10.5 per 1,000 births.

Preterm birth and low-birth-weight rates are also significantly higher among Black and Latina mothers. Early and adequate prenatal care varies widely across communities, with the lowest access in areas experiencing higher poverty, fewer obstetric providers, and more transportation barriers.

The priority-setting steering committee reviewed health outcomes alongside community voices and stories. Members emphasized that MCH is not only about pregnancy—it affects the long-term health of families and future generations. Healthier mothers and infants help build stronger, more stable communities.

Using criteria such as severity, inequity, community readiness, and alignment with existing resources, Maternal and Child Health consistently ranked among the highest-priority issues. Steering committee members agreed that focusing on MCH offers opportunities for both immediate improvements and long-term change, especially with collaborative, equity-centered approaches.

Ultimately, choosing MCH reflects suburban Cook County's commitment to reducing racial and ethnic disparities, improving birth outcomes, and strengthening systems of care for parents, infants, and families.

Alignment with Healthy People 2030 Objectives

The MCH priority aligns with national Healthy People 2030 goals, including:

- MICH-01: Reduce maternal mortality
- MICH-02: Reduce infant deaths
- MICH-08: Increase early and adequate prenatal care
- MICH-14: Reduce preterm births

These national objectives guide local strategies to ensure that improvements in suburban Cook County reflect evidence-based and nationally recognized best practices.

Priority 2: Maternal and Child Health

Risk and Contributing Factors

Table 1. Risk Factors for Maternal & Child Health

RISK FACTOR	HOW IT INFLUENCES HEALTH
Advanced maternal age or adolescent pregnancy	Higher risk of complications, preterm birth, and low birth weight.
Pre-existing conditions (e.g., hypertension, diabetes, obesity)	Increase risk of maternal complications and poor infant outcomes.
Limited access to prenatal care	Delayed or missed care means unmanaged health risks.
Substance use	Affects fetal development and maternal health.
Mental health conditions	Depression/anxiety during or after pregnancy can affect both parent and child.
Poverty and food insecurity	Limit access to care, nutrition, and supportive services.

Table 2. Direct Contributing Factors

DIRECT FACTOR	HOW IT AFFECTS RISK
Limited provider availability	Fewer OB/GYNs and midwives reduce access to prenatal and postpartum care.
Transportation barriers	Missed appointments and delayed care.
Insurance coverage gaps	High costs or lack of coverage block access to needed services.
Fragmented care coordination	Disconnect between maternal and pediatric care reduces continuity.
Language and cultural barriers	Make navigating care more difficult; reduce culturally responsive care.

Priority 2: Maternal and Child Health

Table 3. Indirect Contributing Factors

INDIRECT FACTOR	HOW IT AFFECTS DIRECT FACTORS
Structural racism and discrimination	Impacts quality of care and outcomes for women of color.
Residential segregation & concentrated poverty	Reduces access to providers and hospitals.
Lack of supportive policies	Limited paid leave and childcare create stress and barriers.
Underinvestment in social services	Fewer supports for housing, nutrition, mental health, and safety.
Stigma around maternal mental health	Prevents individuals from seeking help.

Population Groups at Risk

- **Black mothers:** Face the largest disparities in maternal morbidity, infant mortality, and prenatal care access.
- **Low-income families:** Often live in areas with fewer health resources and face insurance or cost barriers.
- **Immigrant and non-English-speaking families:** Encounter language, cultural, and increasingly legal fears when seeking care.
- **Adolescents and young mothers:** Higher risk of complications and fewer support systems.
- **Families experiencing housing instability:** Struggle with consistent access to prenatal and postpartum care.

Maternal and Child Health is a foundational health priority for suburban Cook County. Improving MCH requires a multi-level approach that strengthens access to care, reduces inequities, and supports families before, during, and after pregnancy.

See table for goals, objectives, and strategies to improve maternal and child health outcomes in Suburban Cook County.

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.

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 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.

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 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 mental health and substance use 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.

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Illinois Department of Public Health. (2025). Illinois' Blueprint for birth equity: A roadmap to improve maternal health outcomes in Illinois. https://dph.illinois.gov/resource-center/reports/2025-blueprint-for-birth-equity.html

Illinois Department of Public Health. (2025). Illinois maternal mortality data report: Analysis of pregnancy-associated deaths in 2021–2022. https://dph.illinois.gov/content/dam/soi/en/web/idph/publications/idph/topics-and-services/life-stages-populations/maternal-child-family-health-services/maternal-health/maternal-mortality-data-report-2025.pdf

CPASS/SUID CCDPH Partnership suid-report.pdf p.19

Community Resources — Maternal and Child Health

Healthy pregnancies and strong early childhood development depend on access to a wide range of community resources across suburban Cook County, including prenatal clinics, birthing centers, doula and lactation support, home-visiting programs, WIC agencies, early learning supports, and referral services.

Through the Healthy Beginnings program, CCDPH nursing staff:

- Educate families on the importance of early prenatal care and well-child visits using digital reminders and home visits
- Connect families to culturally responsive support networks, including doulas, lactation consultants, and home-visiting programs
- Promote vaccine confidence through multilingual, culturally tailored materials and engagement strategies for historically underserved communities

Priority 2: Maternal and Child Health

Access to Resources

CCDPH maintains a dedicated Maternal & Child Health webpage with easy-to-access resources for families planning pregnancy, pregnant individuals, and postpartum caregivers. These resources help families navigate care, understand what to expect, and connect with community-based services, ensuring continuity and support during pregnancy and early childhood.

Policy and Equity

Recent policy advances in Illinois strengthen the healthcare foundation, including Medicaid coverage for birthing people extended to 12 months postpartum, reducing gaps in care during a critical year after birth. However, many essential services still rely on short-term grants and uncertain funding streams.

To address this, CCDPH is working with community-based organizations and power-building groups to co-design programs rooted in equity, strengthen partnerships, and develop innovative funding solutions. These efforts align with PHAB Domain 4 (community engagement and understanding needs) and Domain 9 (continuous quality improvement), ensuring families are supported in ways that reflect their voices, culture, and needs.

Priority 3: Mental Health and Substance Use

Priority Selection and Importance to the Community

Mental health and substance use was selected as a top priority for suburban Cook County through a collaborative process. This decision was based on findings from our Community Health Assessment (CHA) and strong input from community partners. The CHA showed that many people in Suburban Cook County communities are experiencing depression, anxiety, substance use challenges, and even increasing rates of suicide for Black and Latine individuals. See the suburban Cook County Suicide Report for more information at https://cookcountypublichealth.org/wp-content/uploads/2025/10/Suburban-Cook-County-Suicide-Report-2025_final101425_4PM.pdf These concerns are even greater in communities that already face barriers to care, including Black, Latine, immigrant, and low-income residents. People in the communities listed above often struggle to find affordable, timely, and culturally informed behavioral health services. Hospital data shows higher use of emergency departments for mental health and substance for residents of south and western suburban communities, which highlights access to care challenges as well as the impact of structural racism. See the suburban Cook County Crisis Care Assessment for more information. https://cookcountypublichealth.org/wp-content/uploads/2025/11/BH-Crisis-Response-System-Report-NOV-2025_final_111725_web.pdf

The priority-setting process was designed to uplift community voices through our steering committee, which included partners from community-based organizations, healthcare, schools, and local government. Across multiple discussions and votes, behavioral health consistently emerged as a top issue because of its impact on school success, jobs, family stability, and overall community well-being. It also aligns with state and national health improvement goals. Choosing behavioral health reflects suburban Cook County's shared commitment to closing equity gaps, reducing stigma, building stronger systems of support, and addressing upstream drivers of behavioral health outcomes.

Alignment with State and National Plans

This priority aligns with Healthy People 2030, including goals to reduce suicide, increase access to mental health treatment for youth and adults, and reduce overdose deaths.

It also aligns with the 2023–2028 Illinois State Health Improvement Plan, which focuses on improving the mental health and substance use system, expanding prevention, reducing deaths linked to behavioral health conditions, and strengthening community resilience.

Additionally, this priority aligns with other local plans in suburban Cook County, specifically Cook County Department of Public Health Strategic Plan, the Cook County Health Office of Behavioral Health's Regional Behavioral Health Strategic Plan , the Cook County Policy Roadmap, and the Cook County Equity Task Force Report.

Priority 3: Mental Health and Substance Use

Risk and Contributing Factors

Table 1. Risk Factors for Mental Health and Substance Use

RISK FACTOR	HOW IT INFLUENCES HEALTH OUTCOMES
Trauma and Adverse Childhood Experiences (ACEs)	Increase the risk of depression, anxiety, substance use, and suicide.
Poverty	Can lead to housing insecurity and food insecurity, which in turn can contribute to chronic stress, social isolation, and feelings of despair
Discrimination	Increases the risk of depression, anxiety, and substance use.
Substance use	Worsens mental illness and increases risk of overdose.
Social isolation	Raises risk for depression, anxiety, and suicide, especially among youth and older adults.
Stigma	Prevents people from seeking timely care and support.

Table 2. Direct Contributing Factors

DIRECT FACTOR	HOW IT INFLUENCES RISK
Limited number of behavioral health providers	Long wait times and limited access to care.
Gaps in insurance coverage	High costs, confusing or overly burdensome eligibility requirements, or lack of coverage limit access to treatment.
Fragmented care and lack of coordination	Reduces continuity between behavioral health, primary care, and social services.
Transportation challenges	Prevent missed or delayed appointments and create barriers to ongoing care.
Language and cultural barriers	Reduce engagement in care and limit access to culturally responsive services.

Priority 3: Mental Health and Substance Use

Table 3. Indirect Contributing Factors

INDIRECT FACTOR	HOW IT INFLUENCES DIRECT FACTORS
Structural racism and discrimination	Drives inequities in behavioral health access, treatment quality, and outcomes.
Residential segregation and underinvestment	Limits availability of community-based supports and providers.
Limited supportive policies and funding	Reduces access to school-based, community-based, and prevention programs.
Underinvestment in social services	Limits access to housing, employment, and social support essential to mental health.
Criminalization of mental illness and substance use	Creates social isolation and trauma for the person who is incarcerated and their families, limits access to quality behavioral health care.

Mental health and substance use is a critical issue for suburban Cook County. Addressing it requires a broad, multi-level approach that reduces stigma, expands culturally responsive providers and care, strengthens connections between behavioral health, healthcare, schools, and community supports, as well as addresses the structural factors that drive mental health and substance use.

See table for goals, objectives, and strategies to improve behavioral health outcomes in Suburban Cook County.

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.*

*This strategy is aligned with strategies for the chronic disease and maternal and child health priority areas.

Priority 3: Mental Health and Substance Use

Community Resources — Mental Health and Substance Us

Suburban Cook County is home to a broad network of mental health and substance use resources, including community-based organizations, community-based behavioral health providers, health systems, school-based services, Living Rooms, and crisis care providers such and mobile crisis response teams. These organizations serve as essential partners in culturally responsive care, and community-based supports. Community health workers, harm-reduction specialists, faith-based leaders, youth advocates, and grassroots organizers also play critical roles in supporting residents where they live and gather and expanding upstream prevention.

Even with these strengths, behavioral health programs often depend on short-term federal grants. CCDPH and partners are proactively strengthening relationships with local foundations, private funders, and municipalities to create diversified and durable funding pathways.

This work supports PHAB Domain 4 (engaging communities to understand health needs) and PHAB Domain 9 (continuous quality improvement and performance tracking). By listening to community voices, improving coordination, and planning for sustainable funding, behavioral health supports will continue to grow in ways that reflect what residents need and value. The work also aligns with the following national, state, and local plans:

- 2024-2027 Cook County Policy Roadmap, Healthy Communities, Objective 1 & 4
- Cook County Equity Fund Task Force Report, 1.1 & 2.9
- Cook County Health Regional Behavioral Health Strategic Plan 2025-2027, Goal 1.1, 3.1, 3.2, & 3.4
- Cook County Department of Public Health Strategic Plan 2023-2025, Pillar 2
- Healthy Illinois 2028, Mental Health and Substance Use Disorder Goals 1 & 3
- Illinois Children's Mental Health Plan 2022 -2027, Goals 1-5
- Healthy People 2030 – Mental Health and Mental Disorders, Drug and Alcohol Use, Schools, Adolescents, Natural and Built Environment

Monitoring and Assessment (for all three priorities)

The Cook County Department of Public Health (CCDPH) will use a structured, transparent, and data-driven approach to monitor progress and assess the effectiveness of the Community Health Improvement Plan (CHIP). To ensure accountability and community accessibility, CCDPH will maintain a public-facing data dashboard that tracks key indicators for each health priority in the CHIP. This dashboard will include measures related to maternal and child health, behavioral health, and chronic disease, and will be updated regularly to show trends, highlight progress, and identify areas needing additional attention.

CCDPH will also leverage its evaluation platform through the department's contract with Metopio, the preferred vendor endorsed by NACCHO. This platform will allow CCDPH to monitor interventions at the strategy level, assess performance over time, and ensure that actions remain aligned with evidence-based and equity-focused practices. Through Metopio, staff will be able to review implementation milestones, compare strategies across priority areas, and make data-informed decisions about where to adapt, enhance, or phase out activities.

To maintain alignment with broader organizational goals, CCDPH will conduct a crosswalk review between the CHIP, the CCDPH Strategic Plan, and Public Health Accreditation Board (PHAB) standards. This will help ensure that CHIP activities support long-term organizational improvement, reinforce accreditation requirements, and strengthen internal systems that support community health.

Regular monitoring will include quarterly internal reviews, annual partner updates, and opportunities for community feedback. These touchpoints will help CCDPH assess not only whether strategies are being implemented as planned, but also whether they are producing meaningful progress toward reducing inequities and improving health outcomes. This continuous assessment cycle ensures that the CHIP remains a dynamic, responsive plan that evolves with community needs and emerging public health trends.

Awareness and Promotion (for all three priorities)

Effective communication is essential to ensure that the Community Health Improvement Plan (CHIP) is accessible, widely understood, and actionable. This plan outlines how Cook County Department of Public Health with promote this plan. The Community Engagement and Health Education Team, Community Health Promoters, and the Communications Team will collaborate to lead the awareness and promotion of the CHIP. Through these units, CCDPH will regularly share updates, engage residents, and strengthen community trust and participation.

Funding Needs and Sources (for all three priorities)

Successful implementation of Building Healthier Communities 2030 (BHC 2030) will require resources to support program coordination, community engagement, partner convening, communications, implementation activities, data collection and evaluation, technical assistance, and ongoing monitoring of progress toward established goals and objectives. Funding will also support the infrastructure needed to facilitate collaboration among community partners and sustain implementation efforts throughout the 2026–2030 planning cycle.

Funding will be pursued through a combination of:

- Cook County corporate dollars
- Federal, state, and local grant funding opportunities aligned with Chronic Disease, Mental Health and Substance Use, and Maternal & Child Health priorities
- Private foundation funding and philanthropic investments that support health equity, community health improvement, and systems change initiatives
- In-kind contributions from partner organizations, including staff time, meeting space, training resources, communications support, data sharing, volunteer efforts, and other community assets

CCDPH will work collaboratively with partners to identify and leverage funding opportunities that align with BHC 2030 priorities, maximize community impact, and promote long-term sustainability of successful strategies.

Communication Goals

- Increase awareness of CHIP priorities, goals, and progress on intervention strategies.
- Build community ownership and trust through transparent, two-way communication.
- Promote equitable access to CHIP information by using multiple languages, channels, and culturally relevant approaches.

Roles & Strategies

Community Engagement & Health Education Team

- Lead outreach and education campaigns about CHIP priorities and progress.
- Facilitate listening sessions, partner meetings, and workshops to capture feedback and integrate community voice.
- Leverage established partnerships with community-based organizations, community power-building organizations, schools, faith communities, and local leaders to reach priority populations.

Communications Team

- Develop and maintain consistent branding and messaging for all CHIP materials.
- Manage digital platforms (website, social media, newsletters) to provide regular updates.
- Coordinate earned media and press releases to highlight milestones and progress.
- Produce visually engaging content (infographics, videos, fact sheets).

Monitoring & Evaluation

- Track engagement through social media analytics, attendance at events, and partner feedback.
- Adjust communication strategies quarterly, based on evaluation findings and community input.

Community Health Promoters

- Act as trusted messengers by translating and tailoring CHIP objectives and updates to community friendly messaging that reflects lived experiences and neighborhood priorities.
- Provide on-the-ground education and navigation for services connected to CHIP priorities.
- Provide health education materials and workshops on CHIP focus areas
- Ensure materials are culturally appropriate and accessible in multiple languages.

Communication Channels

- **Digital:** social media, email newsletters, county website, video explainers.
- **In-Person:** community forums, health fairs, neighborhood events, presentations at partner organizations.
- **Print:** flyers, posters, fact sheets distributed at clinics, libraries, schools, and community centers.
- **Media:** local press, radio, and culturally specific media outlets.

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