# Public Health Advocacy Resource Guide 2024

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Preface

Illinois employs a decentralized approach to delivering public health services*. Public health services in Illinois are delivered primarily by county and municipal local health departments (LHD). Many LHDs are state-certified and receive grant funding by the Illinois Department of Public Health and the Illinois Department of Human Services. However, LHDs operate autonomously and in collaboration with adjacent LHDs and are not direct extensions of the State. Within the confines of applicable law and rule, LHDs generally determine how to deliver services in their respective areas of jurisdiction. The independent nature of LHDs is an important distinction made here to ensure that decision makers understand LHDs are active participants in the legislative process and may have different opinions about proposed legislation than State agencies. It is important to include LHDs in the development and evaluation of proposed legislation that affects public health to ensure their ability to deliver timely, effective and affordable services.

* https://www.cdc.gov/publichealthgateway/sitesgovernance/index.html accessed 6-23-21

What is public health?

Public health is “the science and art of preventing disease, prolonging life, and promoting health through the organized efforts and informed choices of society, organizations, public and private communities, and individuals.”

— CEA Winslow **


What is the purpose of this advocacy resource guide?

The purpose of this guide is to provide legislators and other decision makers with information and data to help them make informed decisions regarding public health issues.

This guide was developed by the DuPage County Health Department.
Executive Summary

The following is an Executive Summary of potential actions to address the problems and concerns outlined in this document.

Substance Use Prevention

Vaping flavor ban

- A very important step to addressing the youth vaping epidemic is removing non-tobacco flavored vaping products from the market.
- Provide more funding for a statewide education campaign targeting teens on the dangers of vaping.

Increase funding for substance use prevention

- Support adequate funding for all federal agencies and programs that promote substance misuse prevention, treatment, recovery support and research.
- Ensure that the Drug-Free Communities program remains intact in the Office of National Drug Control Policy (ONDCP) and is funded at the highest possible level.
- Ensure that the Community-Based Coalition Enhancement Grant program in the Comprehensive Addiction and Recovery Act is funded at the highest possible level and remains intact in ONDCP.
- Ensure that the Sober Truth on Preventing Underage Drinking Act is funded at the highest possible level.
- Ensure that the Center for Substance Abuse Prevention is funded at the highest possible level.
- Ensure that the Substance Abuse Prevention and Treatment Block Grant is funded at the highest possible level.

Cannabis marketing restrictions

- Limits should be enacted on marijuana industry advertising, especially marketing directed towards youth.
- Restrictions should be enacted regarding marijuana potency.
- Limits and prohibitions should be enacted regarding kid-friendly colors, shapes, flavors and products.
- Delivery services should be prohibited.
- Overall amount of marijuana storefronts should be reduced and limited.
• Support the sharing of a significant portion of the tax revenue with the DuPage County Health Department to further fund substance use programs.

**Kratom**

• Ban the sale, possession, and use of kratom for all persons in the State of Illinois.

**Behavioral Health Treatment**

**Increase Medicaid reimbursement rates for mental health and substance use treatment**

• Reimbursement rates for outpatient substance use treatment should be amended to match those of outpatient mental health treatment.

• The substance use billing process should be amended to match that of mental health, which allows for all treatment to be reimbursed through managed care Medicaid versus the substance use model that uses a blend of managed care Medicaid and their own internal outdated system.

**Allow inmates to maintain insurance for treatment while in jail**

• Section 1905(a)(A) of the Social Security Act should be amended to allow for the continuation of federal benefits such as Medicaid, Medicare and Children’s Health Insurance Plan for pre-trial detainees.

• Section 1905(a)(A) of the Social Security Act should be amended to apply only to post-adjudicated individuals who have gone through due process. The continuation of these benefits aligns with an individual’s U.S. Constitutional rights to due process and equal protection under the Fifth and 14th Amendments.

• Allow H.R. 955 (Medicaid Reentry Act of 2021) to provide Medicaid payment for medical services furnished to an incarcerated individual during the 30-day period preceding the individual’s release.

• H.R. 3074, which was introduced in 2023, seeks to amend title XIX of the Social Security Act to remove the Medicaid coverage exclusion for inmates in custody pending disposition of charges, and for other purposes.
Streamline mental health and substance use regulations

Allow substance use treatment in a community setting and not restrict to office-based services

Amend Rules 140, 2060 to reduce administrative burden

• Combine the current administrative rules for substance use and mental health and create one set of administrative rules to cover both areas. At a minimum, it is important that the revision process for Rule 2060 be completed (unlike the uncompleted process in 2007), and it should align with the mental health codes more closely.

• “Off-site exceptions” should be removed.
  o Rule 2060 currently states that an off-site exemption must be requested from the Illinois Department of Human Services - Substance Use Prevention and Recovery to provide substance use treatment outside of the approved treatment office/location. The rules governing mental health do not have this same requirement. Organizations would be able to see clients outside of the treatment office without the additional burden of seeking state approval.
  o Unfortunately, the current proposed changes to Rule 2060 still require this “off-site exemption” step. Rule 2060 should reflect the same approach as the mental health rules and allow organizations to freely bring treatment to other locations to make treatment more readily accessible.

• Support other proposed changes:
  o Update staff qualifications to incorporate licensed marriage and family therapists and licensed physician extenders as professional staff.
  o Enhance staff training requirements.
  o Ensure telehealth is available post-emergency rule.

Building an Ideal Behavioral Health System

• Support for the Crisis Recovery Center, to be built on the DuPage County Health Department campus, is imperative to improving the behavioral health crisis system.

• Support an increase in Medicaid Reimbursements for behavioral health services.

• Support modernized and transformational funding models such as per diem or bundled rates for crisis services.
• Ensure pilot projects are provided funding, in yearly appropriations, to treat the problems associated with behavioral health.

• Eliminate regulatory barriers that interfere with building a system that serves the population and provide incentives to entities that provide services. For example, financial reimbursement models should be amended to support staffing and client services providing 24 hours per day/seven days per week crisis center operations.

Increasing Public Health Capacity

Behavioral Health Workforce Shortage

As described in the Illinois Behavioral Health Workforce Education Center Task Force report, there are a few key strategies to address the problem:

• Establishing resources to develop an infrastructure available to support and coordinate behavioral health workforce development efforts.

• Establishing new financing systems that consider the cost of providing services and enables employee compensation commensurate with required education and levels of responsibility.

• Funding the Community Behavioral Health Care Professional Loan Repayment Program Act (HB 5109, P.A. 100-0862) and The Psychiatric Access Incentive Act.

• Broadening the Concept of “Workforce” – The state should expand the capacity in peer recovery and other non-traditional behavioral health roles and should authorize community-based agencies with certified peer specialists to bill for certain Medicaid substance use and mental health services.

• Expanding programs, like telehealth and crisis intervention, that can extend the reach of the existing workforce.

• Leveraging the requirements of consent decrees and settlement agreements for specific populations in need of behavioral health care to accelerate workforce development and collect more actionable data.
The Senate Behavioral and Mental Health Committee passed SB 1979 to create the Behavioral Health Workforce Education Center of Illinois. It will be important to support this bill as it moves to the full Senate to implement the above recommendations.

Public health infrastructure - Sustainable funding
- Develop strategies to increase the allocation from the Comprehensive Local Health Department Grant for the DuPage County Health Department up to the $19.16 per capita to provide local public health officials with an additional $1.1 million to stabilize the local health department and assure the public health infrastructure is minimally funded to address the increasingly complex and multiple public health needs of residents.

Infection Prevention staff at long-term care (LTC) facilities
- Advocate for and support programs that encourage infection prevention education and training of healthcare workers.
- Advocate for and support funding for dedicated infection prevention staffing in LTC facilities to protect healthcare workers and facility residents.
- Advocate for and support infection prevention prioritization by LTC facility leadership, medical providers, and multidisciplinary staff.
- Support efforts to maintain adequate personal protective equipment and develop or operationalize infection prevention tools for future pandemics.

State fund sharing and distribution transparency
- The specific funding award formula, outcomes, methodology and process for the Local Health Protection Grant should be made appropriately transparent to local health departments.
- By the end of 2024, IDPH should engage local health department stakeholders at a minimum to include the Northern Illinois Public Health Consortium and Illinois Association of Public Health Administrators to address at a minimum the following issues:
  o Amend, update, and share the grant funding award formula.
  o Ensure the grant agreements are executed prior to the start of the grant period.
Ensure the payment of grant funds within 30 days of the execution of the grant agreement.

Ensure transparency and include annual increases to grant amounts to adjust for inflation.

### Student Loan Reimbursement

- Amend Community Behavioral Health Care Professional Loan Repayment Program (23 IL Admin. Code 2753) by adding a definition of “underserved” health professional shortage area (HPSA) that includes certified local public health agencies that receive more than 50% Medicaid funding for clients to ensure the DuPage County Health Department is included in primary care, dental health, and mental health HPSAs. This definition would be helpful if applications are accepted in the future.

- Further amend Community Behavioral Health Care Professional Loan Repayment Program (23 IL Admin. Code 2753) to add these additional positions to the program eligibility list:
  - Registered nurses
  - Licensed social workers (LSW)
  - Licensed professional counselors (LPC)
  - Community health workers
  - Staff credentialed by Illinois Medicaid as a:
    - Mental Health Professional (MHP)
    - Qualified Mental Health Professional (QMHP)
    - Rehabilitative Services Associate (RSA)
    - Licensed Practitioner of the Healing Arts (LPHA)

### Public Health Issues

#### Improve Maternal and Infant Health and Mortality

- Analysis shows that the United States has the highest rates of avoidable mortality because people are not receiving timely, high quality care in an equitable way particularly by race and socioeconomical status.

- The path to progress can begin by improving our nation’s maternal health data infrastructure by collecting, sharing, and linking transparent data on individuals, the care they receive and
their non-clinical needs in a standardized order. Efforts should be made to advance a research agenda that identifies effective, evidence-based best practices in maternal health with a priority addressing clinical, environmental, and socioeconomic factors.

- Interventions to improve outcomes can be made by healthcare professionals to screen and treat women at risk for preterm births through public funding to increase access to treatment through outreach, care coordination and other supports including investments in home visiting, prenatal education, and support groups. Offering women improved tools to navigate health and birthing options can provide additional support such as midwives or doulas, reduce C-sections, improve breastfeeding rates, and ensure greater health literacy and childbirth education.

- Improving the quality of care provided to pregnant women can include creating a standardized assessment for mothers and infants akin to Apgar scores, address maternal and infant mental health, and training healthcare providers to address inequity and improve cultural humility. The cost to avert maternal mortality is estimated between $800 and $1,500 or as low as $0.50 per capita per year.

- Promotion of good health and prevention measures is more effective than avoidance of death. This can be done by improving access to care for all women including expanding Medicaid to improve early prenatal care and extend postpartum coverage, increase birthing centers in rural areas and healthcare deserts in metropolitan areas, and expanding provider reimbursement for services not currently covered such as midwives and breastfeeding support. The United States has improved maternal and infant mortality in the last decade; however, a more effective approach could further decrease the gap if preventative health, education, and equity for all are improved.

### Vaccine Hesitancy

- Encourage health care providers to follow guidance from the U.S. Centers for Disease Control and Prevention regarding talking with parents about vaccines for their children.

- Encourage research into and use of additional evidence-based guidance i.e. motivational interviewing for health care providers’ discussions with vaccine hesitant parents.

- Launch a targeted, stakeholder-informed and evidence-based public awareness campaign to promote the benefits of timely vaccination and risks of refusal and delay.
Encourage residents to ensure sources of vaccine information are reliable and accurate, especially from online sources, by checking that the information comes from a credible source and is updated on a regular basis. While searching for vaccine information, consider guidance from these credible sources:

- Primary care physicians.
- CDC Vaccines & Immunizations: www.cdc.gov/vaccines.
- The Immunization Action Coalition suggests questions you should ask at www.immunize.org.
- The National Network for Immunization Information (NNii) suggests questions to ask when evaluating information.
- The University of California San Francisco’s Evaluating Health Information page lists “Red Flags” every consumer needs to know.
- The Medical Library Association translates medical jargon (Medspeak) into language everyone can understand.

### Unpasteurized Milk

- Educate legislators, parents, caregivers, clinicians, and the general public about the risks from consuming unpasteurized milk and milk products and that the risks of illness or death from consuming them far outweigh potential perceived benefits.
- Encourage legislators to oppose increasing availability of unpasteurized milk and milk products.
- Educate parents and caregivers about risks of illnesses and death linked to unpasteurized milk consumption among adults over 65, children, and people with compromised immune systems to reduce illnesses and fatalities among these populations.
- Educate clinicians to improve awareness and understanding about risks of illnesses and death linked to unpasteurized milk consumption toward prevention counseling, early recognition, diagnosis, and illness management.
Substance Use Prevention
Background

An important step in addressing the youth vaping epidemic is removing non-tobacco flavored vaping products from the market. These products are attractive to youth and have been shown to initiate kids to tobacco use and addiction.

How does it affect the United States?

- In a 2014 national study, 81.5% of current youth e-cigarette users said they used e-cigarettes “because they come in flavors I like.”

- Flavors improve the taste and mask the harshness of tobacco products, making it easier for kids to try these products and ultimately become addicted.

- E-cigarettes that blend fruity, sweet, and cooling tastes are very popular among young users, with 74.8% reporting using blended flavors and 57.9% used concept flavors (vague names that do not directly identify a flavor) in the past month. This highlights that the only way to end this crisis is to eliminate all flavored e-cigarettes.

- E-cigarettes pose serious risks to the health of young people. The United States Surgeon General has concluded that youth use of nicotine in any form, including e-cigarettes, is unsafe. Nicotine is highly addictive and can harm adolescent brain development, particularly the parts of the brain responsible for attention, memory, and learning.

- More than 80% of youth who have used tobacco report that they began with a flavored product and 97% of youth who vape use flavors.

- Data shows that menthol has effectively replaced mint, which was previously one of young people’s favorite flavors.

- Sales of menthol e-cigarettes increased by almost $60 million and its market share more than doubled after it was exempted from federal restrictions that removed only some flavored e-cigarettes from the market.

How does it affect Illinois?

- Among Illinois high school students in 2021, 38% reported having ever used an electronic vapor product (including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens); and 16.7% reported currently using an electronic vapor product.

- E-cigarette use by high school seniors is higher than cigarette use was 10 years ago. Between 2016 to 2018, e-cigarette use in Illinois increased from 18.4% to 26.7% among high school seniors, a 45% increase; a 15% increase was seen among 8th grade students; and a 65% increase among 10th grade students.
E-cigarettes put youth at risk for addiction and possibly worse asthma outcomes, yet almost 40% of 10th and 12th grade youth believe there is low or no risk of negative health effects.\(^7\)

**How does it affect DuPage County?**

- In DuPage County, 1% of 8th graders, 6% of 10th graders and 12% of 12th graders report using a vaping product within the past 30 days according to the 2022 Illinois Youth Survey.\(^8\)
- 17% of DuPage County 12th graders report that they believe there is little or no risk with using e-cigarettes.\(^8\)

**How can we address the problem?**

- A very important step to addressing the youth vaping epidemic is removing non-tobacco flavored vaping products from the market.
- Provide more funding for a statewide education campaign targeting teens on the dangers of vaping.

**References**


Substance Use Prevention

Increase Funding for Substance Use Prevention

Public Health Advocacy Resource Guide 2024
Increase Funding for Substance Use Prevention
Background
Research over the last two decades has shown that drug addiction is both preventable and treatable. It is vital that prevention be a critical component of national, state and local drug use strategies because addiction is a developmental disorder that can begin in adolescence, sometimes as early as childhood, and can be mitigated by preventing and increasing the age of initiation among youth. Among individuals aged 18 to 30 admitted to treatment facilities, 74% began substance use at age 17 or younger.¹

How does it affect the United States?

- Substance misuse exacts an enormous financial toll on the United States (U.S.). Annually, the U.S. spends $740 billion on costs related to crime, lost productivity and health care. However, every $1 invested in effective substance use prevention programs will result in savings of between $2 and $20.¹

- Despite this, federal funding for drug prevention has been cut severely in the past decade. Between FY 2009 and FY 2019, substance use prevention funding has been cut by 34.4%.¹

- The 2018 Monitoring the Future Survey found substantial, statistically significant increases in vaping among 8th, 10th, and 12th graders. Additionally, attitudes toward marijuana continue to change. Fewer students than ever before perceive a great risk from smoking it occasionally. Disapproval of this activity is also declining. As the nation works to meet these challenges and continues to grapple with the opioid epidemic, it is critical that funding for evidence-based substance use prevention remains a priority.¹

The graph below demonstrates the prevalence of past 30-day use, in Drug Free Communities (DFC) - funded communities, declined significantly across all substances (alcohol, tobacco, marijuana) and school levels (middle and high school) between DFC coalitions’ first and most recent data reports.²

![Graph showing percentage change in past 30-day prevalence of alcohol, tobacco, and marijuana use and prescription drug misuse in DFC communities.]
How does it affect Illinois?

- Illinois legalized recreational marijuana for adult use in 2020. The marijuana industry is investing billions of dollars into marketing their product and changing perception around marijuana use.
- Investing in prevention and education is needed now more than ever to protect youth from substance use.

How does it affect DuPage County?

- DuPage County currently receives funds from the Drug Free Communities grant, Sober Truth on Preventing Underage Drinking Act grant and Comprehensive Addiction and Recovery Act grant. These grants allow DuPage to focus on prevention of substance use. Continued funding of these grants will allow DuPage to continue making an impact in youth substance use prevention.
- Since being funded with a Drug Free Communities grant in 2014, substance use rates among DuPage County youth has declined.\(^3\)

### Past 30-Day Use Rates Among DuPage County 12th Graders, Illinois Youth Survey

<table>
<thead>
<tr>
<th>Substance</th>
<th>2014</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>45%</td>
<td>36%</td>
</tr>
<tr>
<td>Marijuana</td>
<td>24%</td>
<td>19%</td>
</tr>
<tr>
<td>Cigarettes</td>
<td>10%</td>
<td>2%</td>
</tr>
<tr>
<td>Rx</td>
<td>5%</td>
<td>2%</td>
</tr>
</tbody>
</table>

- DuPage County PLT received a Drug Free Communities grant in 2014.
- Since being funded, substance use rates among DuPage County 12th graders have declined across the board.

How can we address the problem?

- Support adequate funding for all federal agencies and programs that promote substance misuse prevention, treatment, recovery support and research.
- Ensure that the Drug-Free Communities (DFC) program remains intact in the Office of National Drug Control Policy (ONDCP) and is funded at the highest possible level. The most recent update of the DFC program, conducted by ICF International, proves that the program is effective. From first report to most recent report for the FY 2016 grant recipients, rates of substance use for all grantees have declined significantly in DFC communities.
• Ensure that the Community-Based Coalition Enhancement Grant program in the Comprehensive Addiction and Recovery Act (CARA) is funded at the highest possible level and remains intact in ONDCP. The CARA Enhancement Grant program provides enhancement grants of $50,000 per year for three years to current and former DFC program grantees.

• Ensure that the Sober Truth on Preventing Underage Drinking (STOP) Act is funded at the highest possible level. These grants of up to $50,000 for up to four years fund current and past DFC grantees to enhance their underage drinking prevention efforts. STOP Act grantees are data-driven, know their community epidemiology and are capable of implementing the multi-sector interventions required to prevent and reduce alcohol use.

• Ensure that the Center for Substance Abuse Prevention (CSAP) is funded at the highest possible level. CSAP provides national leadership in the development of policies, programs and services to prevent the onset of substance misuse. It promotes effective substance misuse prevention practices that enable states, communities, and other organizations to utilize and implement evidence-based prevention knowledge and strategies effectively.

• Ensure that the Substance Abuse Prevention and Treatment (SAPT) Block Grant is funded at the highest possible level. The SAPT Block Grant is the most important source of funding for states’ substance misuse prevention, treatment, and recovery systems. 20% of the block grant is set aside for primary prevention services. This set-aside is the largest single source of funding in each state’s prevention infrastructure.

Resources
- Community Anti-Drug Coalitions of America, 625 Slaters Lane Suite 300, Alexandria, VA 22314, USA.

References
Substance Use Prevention

Public Health Advocacy Resource Guide 2024
Background

A recent study found that living near a marijuana dispensary and viewing ads increased the likelihood of use of marijuana and frequency of youth use. Furthermore, another recent study found roughly one in three youths (aged 15-19) living in legalized states have engaged with marijuana ads on social media. Those who engaged with marijuana promotions were five times more likely to report past-year use.

How does it affect the United States?

- One in three youth (aged 15-19) who live in states with recreational marijuana, engaged with marijuana advertisements on social media.¹
- Adolescents who engaged with marijuana promotions had five times higher odds of marijuana use.¹
How does it affect Illinois?

- In 2020, Illinois legalized the recreational use of marijuana for everyone 21 years and older.
- Since legalization, marketing of marijuana has been largely unregulated in the state.
- Billboards, online advertising, marijuana signage on storefronts and marketing that is appealing to children (using animals, bright colors, or pop culture) have been seen regularly all over the state.

Examples of advertising and promotions that may be in conflict with Section 55-20 of IL Cannabis Regulation & Tax Act that prohibits promotion of overconsumption and prohibits including any image designed or likely to appeal to minors, including cartoons, toys, animals, or children, or any other likeness to images, characters, or phrases that is designed in any manner to be appealing to or encourage consumption of persons under 21 years of age.

How does it affect DuPage County?

- 1% of 8th graders, 6% of 10th graders, and 14% of 12th graders in DuPage County report using marijuana in the past 30 days, as reported by the 2022 Illinois Youth Survey.²
- 44% of DuPage County 12th graders believe there is no or slight risk associated with marijuana use.²
How can we address the problem?

- Limits should be enacted on marijuana industry advertising, especially marketing directed towards youth.
- Restrictions should be enacted regarding marijuana potency.
- Limits and prohibitions should be enacted regarding kid-friendly colors, shapes, flavors and products.
- Delivery services should be prohibited.
- Overall amount of marijuana storefronts should be reduced and limited.
- Support the sharing of a significant portion of tax revenue with the DuPage County Health Department to further fund substance use programs.

Resources

- Alcohol Research Group, Public Health Institute, 6001 Shellmound St., Suite 450 Emeryville, CA, 94608, USA.
- Boston University School of Public Health, Department of Health Law, Policy, and Management, 715 Albany St., Boston, MA, 02118, USA.
- Department of Health Promotion and Policy, University of Massachusetts Amherst School of Public Health and Health Sciences, 338 Arnold House, 715 North Pleasant Street, Amherst, MA, 01003, USA.
- Department of Pediatrics, University of Wisconsin – Madison School of Medicine and Public Health, 600 Highland Ave, Madison, WI, 53792, USA.

References

Substance Use Prevention

Public Health Advocacy Resource Guide 2024
Background

In the State of Illinois, it is legal to buy, sell, and use kratom for persons 18 years of age and older. Two states bordering Illinois have banned the sale, possession, and use of kratom for all persons.

Kratom is a tropical tree native to Southeast Asia. Consumption of its leaves produces both stimulant effects (in low doses) and sedative effects (in high doses), and can lead to psychotic symptoms, and psychological and physiological dependence. Kratom leaves contain two major psychoactive ingredients (mitragynine and 7-hydroxymytragynine).

There are no U.S. Food and Drug Administration (FDA)-approved uses for kratom, and the agency has received concerning reports about the safety of kratom. The FDA is concerned that kratom, which affects the same opioid brain receptors as morphine, appears to have properties that expose users to the risks of addiction, abuse, and dependence.
How does it affect the US?
The FDA has not approved kratom for any medical use. In addition, the U.S. Drug Enforcement Agency has listed kratom as a Drug and Chemical of Concern.²

- In 2019, approximately 68,000 adolescents in the U.S. used kratom.⁴
- In relation to use of other drugs for the same age group, in 2019 the past 12-month prevalence of kratom use (0.27%) was found to be higher than the prevalence of heroin use (<0.05%).⁴
- The increased “popularity” of kratom, based on the results from adults and other surveys, might be explained by its multiple easy-to-use presentations, ease of purchase via the internet by individuals of all ages, perception that this substance provides a “legal high,” and its easy availability, as it is increasingly being used by middle-aged people in their home environments, potentially facilitating access for adolescents at home.⁴

Kratom was not added to the National Survey on Drug Use and Health until 2019.⁵ Due to marketing of kratom that claims it is a nonaddictive alternative for opioids without risk, mothers do not know the potential of risk if they use kratom.⁶ In a qualitative study of pregnant or parenting mothers with substance use disorder, mothers expressed their concern on effects of substance use on their infant and were motivated to discontinue use for the sake of their child(ren).⁷

How does it affect Illinois and DuPage County?
States that share border with Illinois where it is illegal to buy, sell and use:
- Indiana
- Wisconsin

In Illinois: Kratom is legal to buy, sell and use for those 18+ in most parts of Illinois. Kratom is banned in the cities of Jerseyville, Alton, Glen Carbon, and Edwardsville for anyone at any time.

How can we address the problem?
- Ban the sale, possession, and use of kratom for all persons in the State of Illinois.
References:


Background

Mental health and substance use disorders collectively fall under the broader scope of “behavioral health.” However, reimbursement for substance use disorders is significantly lower than reimbursement for mental health disorders. Additionally, while treatment providers typically address these areas of disorders concurrently (often utilizing the same trained clinical staff), organizations are required to establish and maintain systems to submit billing through different billing systems.

Example:

An approved treatment provider can treat a client who has both a mental health and substance use disorder. However, the reimbursement rates differ significantly depending on if being billed under mental health versus substance use:

<table>
<thead>
<tr>
<th>Treatment Type</th>
<th>Individual Counseling</th>
<th>Group Counseling</th>
<th>Evaluation</th>
<th>Case Management*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Treatment**</td>
<td>$139.36</td>
<td>$26.48</td>
<td>$111.36</td>
<td>$133.28</td>
</tr>
<tr>
<td>Substance Use Treatment***</td>
<td>$102.36</td>
<td>$38.80</td>
<td>$107.68</td>
<td>$79.28</td>
</tr>
<tr>
<td>Percent Difference</td>
<td>-30.6%</td>
<td>37.7%</td>
<td>3.3%</td>
<td>-50.8%</td>
</tr>
</tbody>
</table>

* Medicaid does not currently reimburse for case management provided in substance use treatment. A separate contract must be obtained from SUPR by a provider to receive reimbursement. Additionally, the billing to the contract is a separate process from billing for Medicaid, which contributes to additional administrative burden. The rate noted is the reimbursement if a treatment provider has a contract from SUPR.

** Effective April 1, 2023; rates are for Masters level, on-site.

*** Effective January 1, 2024; no differentiation in rates based on degree/credential.
How does it affect Illinois & DuPage County?

Reimbursement differences

Treatment organizations often have clinical staff who are trained and credentialed to treat both mental health and substance use. Reimbursement rates for substance use treatment that are lower than the mental health reimbursement rates only further exacerbate financial difficulties for organizations who try to create programs that can treat both mental health and substance use.

Reimbursement process

- There is also additional administrative burden created through the state’s billing system. For mental health, all treatment activities are submitted for reimbursement through a single system. However, for substance use, the process for being reimbursed depends on what type of activity is being provided and also requires that the organization obtain a state contract to be reimbursed for specific services.

- For example, if an organization provides one hour of therapy to a client with MCO Medicaid, the billing is submitted directly to the MCO. However, if that same client receives one hour of case management, the state requires that it be billed through their “Division’s Automated Reporting & Tracking System” (DARTS).* If that same client requires the same treatment for mental health, the organization is able to simply submit for reimbursement through the MCO, with no additional contract required.

- In the private insurance sector, a provider is able to submit for mental health and substance use treatment reimbursement through a single billing process.

How do we address this problem?

- Reimbursement rates for outpatient substance use treatment should be amended to match those of outpatient mental health treatment.

- The substance use billing process should be amended to match that of mental health, which allows for all treatment to be reimbursed through managed care Medicaid versus the substance use model that uses a blend of managed care Medicaid and their own internal outdated system.

References

Behavioral Health Treatment
Allow Inmates to Maintain Insurance for Treatment while in Jail

Background

Across America, the double standard created by the Medicaid Inmate Exclusion Policy is putting undue strain on our local judicial, law enforcement, public safety, and human services systems. This conflict in legislation and federal policy results in higher rates of recidivism, increased healthcare costs and poorer health outcomes for residents. This policy drives the over-incarceration of those suffering from mental health and substance use disorders, as county jails have become the largest behavioral health facilities in the nation.¹

How does it affect the United States?

• The Social Security Act (Sec. 1905(a)(A)) prohibits use of federal funds and services, such as Veterans Affairs, Children’s Health Insurance Program and Medicaid, for medical care provided to “inmates of a public institution.” The federal law does not differentiate between a convicted inmate and a person incarcerated prior to conviction.¹

• The Medicaid Inmate Exclusion Policy only applies to individuals confined inside the jail. Federal rules prohibit states from billing Medicaid for any inmate care unless the covered individual requires a hospital stay of at least 24 hours.¹

• Individuals who are presumed innocent under the Constitution are also denied federal benefits pursuant to rights outlined in the Due Process (5th Amendment) and Equal Protection (14th Amendment) clauses of the United States (U.S.) Constitution. Approximately two-thirds of the local jail population are being held prior to trial and have not been convicted of a crime. On any given day, local jails house approximately 465,000 non-convicted individuals.¹

• This situation removes access to Children’s Health Insurance Program benefits. More than 9,000 youths in juvenile facilities and awaiting trial are impacted by this situation.¹

• This situation limits access to veteran’s health benefits. In effect the veteran loses access to a VA medical care facility while incarcerated until such time as he or she is unconditionally released. More than half of justice-involved veterans have either mental health conditions, such as post-traumatic stress disorder, depression, anxiety, or substance use disorders.¹
How does it affect Illinois?

- Across the nation, there is a growing reliance on local jails to serve as “one-stop” treatment centers for individuals suffering from mental health, substance abuse, and other chronic illnesses.\(^1\)

- County jails are now some of the largest behavioral health care providers in our communities, funding and operating hospitals and health care treatments within the walls of local jails.\(^1\)

- County governments operate 2,875 of our nation’s 3,160 local jails. Each year, local jails admit approximately 11 million individuals, with a daily population of 740,000. The total annual jail population is 18 times the annual population of federal and state prisons.\(^1\)

- Our national mental health crisis is concentrated in our local jails. Serious mental illnesses are three to four times more common among local jail inmates than the general population. The U.S. Department of Justice found that the local jail population has a higher prevalence of chronic health conditions than the general population.\(^1\)

- County jails are paying to fill this gap for individuals who are awaiting trial and local taxpayers are paying for it. The full cost is shifted to local taxpayers, rather than the traditional federal-state-local government partnership for safety-net services.\(^1\)

- Individuals who can afford to “bail out” remain eligible for federal health care benefits. As written, the law does not differentiate between inmates that are being held prior to conviction and those that have been convicted and are serving a sentence.\(^1\)

- If you can afford to go home, you keep your health benefits. If not, you lose them. This means that an innocent individual who is held in jail due to their inability to pay will likely face a gap in health care coverage upon release until they are able to reenroll in their federal health benefits.\(^1\)

How does it affect DuPage County?

- In a random snapshot of the daily DuPage County Correctional Facility census, 85% of those detained were non-convicted individuals.\(^2\) County jails are now some of the largest behavioral health care providers in our communities, funding and operating hospitals and health care treatments within the walls of local jails.
How can we address the problem?

- Section 1905(a)(A) of the Social Security Act should be amended to allow for the continuation of federal benefits such as Medicaid, Medicare, and Children’s Health Insurance Plan for pre-trial detainees.

- The language in Section 1905(a)(A) of the Social Security Act should be amended to apply only to post-adjudicated individuals who have gone through due process. The continuation of these benefits aligns with an individual’s U.S. Constitutional rights to due process and equal protection under the Fifth and 14th Amendments.

- H.R. 955 (Medicaid Reentry Act of 2021) would allow Medicaid payment for medical services furnished to an incarcerated individual during the 30-day period preceding the individual’s release.

- H.R. 3074, which was introduced in 2023, seeks to amend title XIX of the Social Security Act to remove the Medicaid coverage exclusion for inmates in custody pending disposition of charges, and for other purposes.
Resources


References

Background

Illinois currently separates the oversight of mental health and substance use programs between two separate divisions under the Illinois Department of Human Services: Substance Use Prevention and Recovery (SUPR), and the Division of Mental Health (DMH). As a result, there are different administrative rules that govern outpatient mental health and substance use treatment. For substance use treatment, the main rule that places the overall structure/requirements for substance use treatment is Title 77: Public Health, Chapter X: Department of Human Services, Subchapter d: Licensure, Part 2060 Alcoholism and Substance Abuse Treatment and Intervention Licenses.*

Part 2060 was adopted in 1996. A 2007 revision of the rule was not completed. There is an effort underway to provide recommended updates to this rule, as it is out-of-date, creates additional administrative burden, and significantly differs with endorsed approaches from rules that have been more recently updated by DMH.

How does it affect Illinois & DuPage County?

- Providers often treat both mental health and substance use issues concurrently, and the field of “behavioral health” includes both mental health and substance use.
- Clinical practices frequently treat both types of disorders with the same clinical staff. However, since the rules are completely different between the divisions that govern mental health and substance use, there is considerable additional administrative burden placed on organizations who must separate processes based on a diagnosis. Items such as documentation requirements, licensure requirements, and billing/reimbursement are all different.

How do we address this problem?

In the best of scenarios, the administrative rules for substance use and mental health would be combined and one set of administrative rules should be created to cover both areas. At a minimum, it is important that the revision process for Rule 2060 be completed (unlike the uncompleted process in 2007), and it should align with the mental health codes more closely.
The following items are not exhaustive recommended changes, but rather highlights from the list of recommended changes:

- **“Off-site exceptions” should be removed.**
  - Rule 2060 currently states that an off-site exemption must be requested from SUPR to provide substance use treatment outside of the approved treatment office/location. The rules governing mental health do not have this same requirement. Organizations can see clients outside of the treatment office without the additional burden of seeking state approval.
  - Unfortunately, the current proposed changes to Rule 2060 still require this “off-site exemption” step. Rule 2060 should reflect the same approach as the mental health rules and allow organizations to freely bring treatment to other locations to make treatment more readily accessible.

- **Support for other proposed changes:**
  - Updating staff qualifications to incorporate licensed marriage and family therapists and licensed physician extenders as professional staff.
  - Enhancement of staff training requirements.
  - Ensuring telehealth is available post-emergency rule.

**References**

Behavioral Health Treatment
Background

An Ideal Behavioral Health System is more than a program. It is an organized set of structures, processes, and services that are in place to meet all types of urgent and emergent behavioral health crisis needs in a defined population or community in an effective and efficient manner.

How does it affect the United States?

Nearly 50 million adults experienced a mental illness in 2020 with almost five percent reporting thoughts of suicide. More than half of adults with mental illness do not receive treatment, totaling 28 million people. Almost half of the people with a perceived unmet need reported that they did not receive treatment because they could not afford it. In 2016, average hospital stays in the U.S. cost $7,100 and lasted 6.4 days for patients with mental and/or substance use disorders. This is despite a general absence of procedures or surgeries during a hospitalization for symptoms of serious mental illness.1, 2, 3

Over 60% of youth with major depression do not receive any mental health treatment. 11.5% of youths in the U.S. have severe major depression. 16% of youths reported a major depressive episode in the previous year.

A contributing factor to the lack of treatment is the continuing shortage of mental health providers to help both youth and adults. In the U.S., there are 350 individuals for every one mental health provider.1

How Does it Affect Illinois?

For every 100 patients with a serious mental illness, there were approximately 47 hospitalizations in the U.S. in 2014. In Illinois this number is approximately 1.5 times higher. The average length of stay for these hospitalizations is longer than hospital stays for other conditions. Relatively little progress has been made in reducing the length of stay for a serious mental illness over the last decade. This imposes a large financial cost on the health care system and potentially diverts resources away from other sites of care.3

People living with mental illness are more likely to encounter the criminal justice system and be arrested, suggesting that mental illness is a factor in incarceration risk. Whereas state and federal prisons have resources to provide mental health care to prisoners who were not receiving this before incarceration, local jails appear particularly unable to meet the health care needs of people with mental illness. In 2017, the overall cost of incarceration of the 7,800 prisoners with serious mental illness in the State of Illinois exceeded $250 million per year.3
DuPage County’s age-adjusted hospitalization rates due to mental health, suicide, and intentional self-injury are all hovering around the median value or worse compared to Illinois counties. As shown in Figure 1, DuPage County has seen slow but steady increases in deaths as a result of opioid overdoses, with 112 such deaths in 2020 and total overdose deaths of 150 in 2022.

Additionally, DuPage County's age-adjusted hospitalization rate due to substance use is again around the median value for all Illinois counties. The DuPage County Health Department receives about 45,000 calls to its behavioral health crisis unit on a yearly basis.

A large percentage of the U.S. adult prison and jail inmate population currently experiences serious psychological distress compared to the noninstitutionalized population. Additionally, these mental health issues are observed at higher rates in local jails than in prisons, with the jail population experiencing serious psychological distress at a rate of 26% as compared to six percent for the general non-institutionalized population, and 15% for state prison inmates.

It is especially important to address this issue locally, since in a random snapshot of the daily DuPage County Correctional Facility census, 85% of those detained were non-convicted individuals who may have lost their federal health care benefits upon incarceration.
How can we address the problem?

DuPage County Health Department (DCHD) has been building a behavioral health crisis system over the last decade. DCHD has robust behavioral health services that are available to community members 24/7. Our current system consists of the national model of “Someone to Call, Someone to Respond, and Somewhere to Go.” “Someone to call” includes our County Crisis Hotline and the national 988 hotline. “Someone to respond” is our Mobile Crisis Response (MCR) program. This program is available to respond to adults and youth in the community who are having a mental health crisis and provide intervention and linkage to ongoing care. Currently, our “Somewhere to Go” is our 12-bed crisis residential unit. This unit is available for adult residents and provides recovery and support services in an unlocked, voluntary unit. DCHD will be expanding our “Somewhere to Go” services with the development of our Crisis Recovery Center. This new center will allow a place to go for youth and adults having a mental health crisis and receive immediate assessment and evaluation by a mental health professional. The facility will also allow adults who are having a substance use crisis to have a place to go, a place for sobering, and a place to receive other withdrawal management services.

The following action steps would be beneficial:

- Support for the Crisis Recovery Center, to be built on the DCHD campus, is imperative to improving the behavioral health crisis system.
- Support an increase in Medicaid Reimbursements for behavioral health services.
- Support modernized and transformational funding models such as per diem or bundled rates for crisis services.
• Ensure that pilot projects are provided funding, in yearly appropriations, to treat the problems associated with behavioral health.

• Eliminate regulatory barriers that interfere with building a system that serves the population and provide incentives to entities that provide services. For example, financial reimbursement models should be amended to support staffing and client services providing 24 hours per day/seven days per week crisis center operations.

References
Increasing Public Health Capacity
Behavioral Health Workforce Shortage

Background
There is a national behavioral healthcare workforce shortage that is impacting the ability for providers to meet the mental health and substance use needs of their communities. This workforce shortage has been building throughout the last several years and is now at a crisis level due to the increased behavioral health struggles resulting from the COVID-19 pandemic.

How does it affect the United States?

• The Census Bureau reported that 30% of American adults had symptoms consistent with an anxiety or depression diagnosis. While the pandemic has exacerbated underlying mental health issues for many Americans, barriers to receiving mental health care have existed for years. A central issue is the lack of availability of mental health care professionals.¹

• An estimated 122 million Americans, or 37% of the population, lived in 5,833 mental health professional shortage areas. The nation needs an additional 6,398 mental health providers to fill these shortage gaps.¹
How does it affect Illinois?

- 40.94% of Illinois residents live in a mental health professional shortage area.¹
- Mental Health America ranks Illinois 29th in the country in mental health workforce availability based on its 480-to-1 ratio of population to mental health professionals, and the Kaiser Family Foundation estimates that only 23.3% of Illinoisans’ mental health needs can be met with its current workforce. Long wait times for appointments with psychiatrists — 4 to 6 months in some cases — high turnover, and unfilled vacancies for social workers and other behavioral health professionals have eroded the gains in insurance coverage for mental illness and substance use disorder under the Affordable Care Act and parity laws.²
- Community mental health centers have long argued that low Medicaid reimbursement rates limit capacity and do not allow for expanding access to services or cover the costs of recruiting and retaining teams for evidence-based behavioral health practices like Assertive Community Treatment.²
- Insufficient numbers of behavioral health professionals, the absence of an action plan on behavioral health workforce development, inadequate training in evidence-based practices, and the resulting restrictions on access to high-quality, community-based behavioral health services, were the key motivating factors for creating the Illinois Behavioral Health Workforce Education Center Task Force.²

How does it affect DuPage County?

Similar to what is listed in the resources above, DuPage County providers are having the same struggles of recruiting behavioral health staff. DuPage County Health Department regularly has open positions and in the last year, has had significant staffing shortages causing concern for having enough staff to cover our normal operations.

How can we address the problem?

As described in the Illinois Behavioral Health Workforce Task Force report, there are a few key strategies to address the problem:

- Establishing resources to develop an infrastructure available to support and coordinate behavioral health workforce development efforts.
- Establishing new financing systems that consider the cost of providing services and enables employee compensation commensurate with required education and levels of responsibility.
- Funding the Community Behavioral Health Care Professional Loan Repayment Program Act (HB 5109, P.A. 100-0862) and The Psychiatric Access Incentive Act.
• Broadening the Concept of “Workforce” – The state should expand the capacity in peer recovery and other non-traditional behavioral health roles and should authorize community-based agencies with certified peer specialists to bill for certain Medicaid substance use and mental health services.

• Expanding programs, like telehealth and crisis intervention, that can extend the reach of the existing workforce.

• Leveraging the requirements of consent decrees and settlement agreements for specific populations in need of behavioral health care to accelerate workforce development and collect more actionable data.

The Senate Behavioral and Mental Health Committee passed SB 1979 to create the Behavioral Health Workforce Education Center of Illinois. It will be important to support this bill as it moves to the full Senate to implement the above recommendations.

Resources


References


Increasing Public Health Capacity
Background

According to Healthy People 2020, public health infrastructure provides communities, states and the nation the capacity to prevent disease, promote health, and prepare for and respond to both acute (emergency) threats and chronic (ongoing) challenges to health. Infrastructure is the foundation for planning, delivering, evaluating, and improving public health.¹

Every public health service and system of care depends on the presence of basic infrastructure. Every public health program (e.g. immunizations, infectious disease monitoring/containment, food safety, injury prevention) requires three critical components:

a. Public health professionals who are competent in cross-cutting and technical skills.

b. Up-to-date information systems.

c. Public health organizations with the capacity to assess and respond to community health needs.²

Public health infrastructure assures the necessary foundation is in place for undertaking the 10 basic responsibilities of public health, defined as the 10 Essential Public Health Services. Assuring that health departments at every level possess these skills is now part of the U.S. Public Health Accreditation Board certification process.³
How does it affect the United States?

• At the same time, federal funding for emergency preparedness and response programs administered by the Centers for Disease Control and Prevention (CDC) has been slashed by 50% over the past decade, according to Trust for America’s Health (TFAH), the nonpartisan health policy research organization. That same TFAH study highlighted other concerning trends as well, such as a general decline in funding for the Strategic National Stockpile as well as the Hospital Preparedness Program. That program is the sole source of federal funding for emergency response by regional health care systems, and had its budget slashed from $515 million in 2004 to $275.5 million in 2020.

• The Centers for Disease Control and Prevention is the primary federal provider of public health funding to states. For FY 2021, CDC’s budget (aside from supplemental COVID response funding) was $7.8 billion, down one percent from the previous year, and continues to be insufficient to meet the country’s public health needs. Over the last decade (FY 2012 – 21) the CDC’s core budget fell by two percent when adjusted for inflation. That decrease in spending happened over a 10-year period in which the U.S. population grew, the number and severity of weather-related emergencies increased, and the number of Americans grappling with substance abuse, suicide and chronic diseases also grew. Anemic funding for CDC has meant that effective programs fail to reach all 50 states, and there has been little investment in cross-cutting infrastructure and capabilities.4

How does it affect Illinois?

• Illinois ranks 45th out of 51 states and the District of Columbia with the State funding investment of $19.16 per capita in 2020. The U.S. average sits at $22.83 per capita. By simply bringing Illinois up to the national average with investments in the public health system, it would increase the total amount in the state by $3.65 per capita for a total increase, if directed to state and local health departments, of an additional $4.6 million.5

How does it affect DuPage County?

• The DuPage County Health Department’s (DCHD) largest, and most reliable source of funding remains the public health tax levy assessed and collected from DuPage County residents, which makes up slightly less than 33% of the proposed CFY2022 budget proposal. It reflects an investment of approximately $17 per capita by local resources.
As a certified and accredited health department in the State of Illinois, DCHD is also eligible to apply for and receive funding through the Illinois Department of Public Health (IDPH), for public health infrastructure programs and services. The award from IDPH for the Comprehensive Local Health Department Grant for the State’s 2023 fiscal year is $873,554, which represents an additional $0.94 per capita for support of public health infrastructure locally—which leaves a gap of $1.22 per capita to bring DuPage County up to the State’s average of $19.16 per capita. All additional funding for DCHD services is derived from grant funding that is targeted to specific health conditions/needs, billing insurance for services, or other fees that are assessed for services.

How can we address the problem?

- Develop strategies to increase the allocation from the Comprehensive Local Health Department Grant for the DuPage County Health Department up to the $19.16 per capita to provide local public health officials with an additional $1.1 million to stabilize the local health department and assure the public health infrastructure is minimally funded to address the increasingly complex and multiple public health needs of residents.

Resources

- Public Health Accreditation Board, 1600 Duke Street, Suite 200, Alexandria, VA 22314, USA
  https://phaboard.org/.
- Trust for America’s Health, 1730 M St. NW, Suite 900, Washington, DC 20036, USA.
- These include:
  - Increase the CDC’s base appropriation.
  - Invest in cross-cutting public health foundational capabilities at state, local, tribal, and territorial health agencies.
  - Invest in sustained public health data modernization.
  - Fund the CDC to support state and local public health laboratories.
  - Recruiting and retaining the public health workforce.
  - Restore and grow the Prevention and Public Health Fund https://www.tfah.org/.

References

Increasing Public Health Capacity
Background

Long-term care (LTC) facilities provide a variety of services, both medical and personal care, to people who are unable to live independently. With residents in LTC settings suffering an estimated 1.6 million to 3.8 million infections and resulting in 388,000 deaths each year, the problem of healthcare-associated infections (HAIs) demands that prevention be part of future planning and policy decisions in such settings.\(^1\)

In addition to increased illnesses and deaths, HAIs overburden payers, including the government, to the level of up to $2 billion annually. Costs include care at the facilities and for the residents transferred between the LTC facility and hospital. Patients with HAIs account for a large portion of transfers between LTC facilities and hospitals.

COVID-19 revealed the problems associated with insufficient infection prevention staffing in LTC facilities impacted by a virus reaching pandemic proportions. According to the Centers for Medicare and Medicaid, as of October 2022, over 1.2 million residents of LTC facilities contracted COVID-19. Of those residents, 158,468 (approximately 12%) died. Making infection prevention more difficult is the fact that over 1.3 million staff of LTC facilities contracted COVID-19 and 2,732 (approximately 0.2%) of those cases resulted in death.\(^2\)

Despite restricting visitors from entering LTC facilities during the initial phases of the COVID-19 pandemic, infection was often introduced into LTC settings through staff members who entered the facility and returned to the community on a daily basis, exacerbating challenges to control the spread of the virus, particularly in settings with highly vulnerable populations.

How does it affect the United States?

HAIs in residents of long-term care (LTC) facilities are common, costly, and associated with significant morbidity and mortality. Most HAIs can be prevented through appropriate infection prevention and control (IPC) practices.

In 2018:

- There were 69,000 regulated post-acute and long-term care service providers in seven major sectors, including 15,600 nursing homes, that served 9.5 million people in the United States (U.S.).
- There were 1.66 million nursing home beds and 1.32 million nursing home residents with an occupancy rate of 80% in the U.S.
- Of the 1.32 million nursing home residents, 83.1% were aged 65 years and older.
- 81.1% of residents that stayed fewer than 100 days at nursing homes were age 65 years and older.
• 84.6% of residents that stayed 100 days or more at nursing homes were age 65 years and older.
• There were 660,000 full-time equivalent nursing and social work employees at nursing homes in the U.S.³

Residents aged 65 years and older account for a disproportionate number of infections in LTC settings.⁴

These HAIs cost $38–$137 million for antimicrobial therapy and $637 million to $2 billion for hospitalizations due to infections each year. The U.S. Centers for Disease Control and Prevention recognize that reducing HAI is a priority that extends to all LTC facilities, considering that most HAIs can be prevented through appropriate infection prevention and control practices.⁵

The lack of qualified staff dedicated to implementing a program that investigates, controls, provides education, and keeps infection from spreading was among the ten most frequently cited health deficiencies at nursing homes from 2005 – 2014.⁶

**How does it affect Illinois?**

The State of Illinois operates the Medicaid program and sets rates through the Illinois Department of Healthcare and Family Services. Increased costs due to infections are often paid through Medicaid.

The additional hospitalizations and deaths result in human losses and financial impact to patients, their families, health care providers, and health care insurers.

In 2020, there were 517 skilled nursing facilities with 81,742 licensed and/or certified beds in Illinois.⁷

In 2020, 161 immediate jeopardy (IJ) cases were cited and 329 directed plans of corrections were imposed. This is significantly higher than 2019 when the Illinois Department of Public Health cited 19 IJ cases and imposed five directed plans of corrections. The increases were mainly attributed to the COVID-19 Focused Infection Control Surveys that were completed in 2020.⁷

To reduce HAIs and their secondary impacts, aggressive action is needed to keep new resistance from developing and prevent resistant infections from spreading in LTC facilities and further into communities, workplaces, and households.⁸

**How does it affect DuPage County?**

DuPage County has 46 LTC facilities with a total of 5,637 certified skilled beds and 3,759 total average number of residents per day.⁹,¹⁰

There are an estimated 3,162 employees working at skilled nursing care facilities in DuPage County.¹¹
Illinois Department of Public Health is responsible for nursing home licensing and infection control guidance. The DuPage County Health Department works closely with LTC facilities on early detection, timely response, and ongoing prevention of outbreaks. DCHD also maintains guidance on its website regarding 1) the duty to report communicable diseases and the time periods required for such reports according to Illinois law and 2) current infection prevention and control guidance references and resources for LTC facilities.

DuPage County, in addition to being home to 46 LTC facilities, also owns and operates the Kenneth Moy DuPage Care Center. The Care Center is not independently operated on resident billing and relies on the County Board to provide additional funding.

**How can we address the problem?**

- Advocate for and support programs that encourage infection prevention education and training of healthcare workers.
- Advocate for and support funding for dedicated infection prevention staffing in LTC facilities to protect healthcare workers and facility residents.
- Advocate for and support infection prevention prioritization by LTC facility leadership, medical providers, and multidisciplinary staff.
- Support efforts to maintain adequate personal protective equipment and develop or operationalize infection prevention tools for future pandemics.
Resources


References

Increasing Public Health Capacity
Background

Illinois uses a decentralized approach to delivering public health services. Public health services in Illinois are delivered primarily by county and municipal local health departments (LHD). Many LHDs are state-certified and receive grant funding by the Illinois Department of Public Health (IDPH), Illinois Department of Human Services, and other sources to provide timely, effective, and affordable public health services. It is important for LHDs to understand how state funds are allocated and distributed to them to ensure residents receive the intended benefits from such funding. Better transparency is needed for LHDs to understand how funds are shared and distributed. Better transparency will allow LHDs to help make recommended funding award and distribution changes to better serve clients.

What is meant by transparency?

Transparency is the clarity of information. Transparency involves relevant information sharing between agencies, governing bodies, and the general public. Clarity of the information being shared will make for transparency.

How does it affect the United States?

There are several regulations that create accountability and transparency for financial awards at the federal level.

One set of requirements within the Code of Federal Regulations is the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (“Uniform Guidance”), codified at 2 CFR 200 that establishes uniform administrative requirements, cost principles, and audit requirements for Federal awards to non-Federal entities, as described in § 200.101. Federal awarding agencies must not impose additional or inconsistent requirements, except as provided in §§ 200.102 and 200.211, or unless specifically required by Federal statute, regulation, or Executive order.

Another set of requirements is the Federal Funding Accountability and Transparency Act of 2006 which requires information disclosures of entities and organizations receiving federal funds through a single publicly accessible website.

Fiscal transparency informs citizens how government and tax revenues are spent and is a critical element of effective public financial management. Transparency provides citizens a window into government budgets and those citizens, in turn, hold governments accountable. It underpins market confidence and sustainability.
How does it affect Illinois?

77 Ill. Adm. Code 615 contains provisions for the Local Health Protection Grant (LHPG) administered by IDPH. The LHPG is relied upon by many certified LHDs to help provide a portion of funding for local public health services. The LHPG is a non-competitive, formula-based grant program. All eligible applicants receive a grant award.6

The LHPG is used to provide these services to Illinois residents:

- Infectious Disease
  - Communicable disease investigations and mitigations
  - Sexually transmitted infection and disease prevention, treatment, management, and control including expedited partner therapy
  - Tuberculosis prevention, treatment, and investigations
  - Childhood immunizations
  - Epidemiology services
  - PrEP site initiatives for HIV Infection
  - Inspection of pools and spas

- Food Protection
  - Food establishment inspections
  - Foodborne illness and complaint investigations
  - Re-inspection of cited facilities after inspections

- Potable (drinking) Water
  - Transient and non-transient community water well inspections
  - Promoting safe drinking water
  - Contaminated groundwater sampling

- Private Sewage
  - Septic system inspections
  - Septic discharges/odor investigations
  - Review of sewage disposal system construction plans

The Illinois Legislature adopted Public Act 98-706 (30 ILCS 708/) named the Grant Accountability and Transparency Act. This Act is intended to increase the accountability and transparency in the use of grant funds from whatever source and to reduce administrative burdens on both State agencies and grantees.
by adopting federal guidance and regulations applicable to such grant funds; specifically, the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (“Uniform Guidance”), codified at 2 CFR 200.³

The Act, per 30 ILCS 708 Sect. 25, states that on or before July 1, 2017, the Governor’s Office of Management and Budget, with the advice and technical assistance of the Illinois Single Audit Commission, shall adopt supplemental rules including criteria to define mandatory formula-based grants and discretionary grants.

The Act further contains a provision under 30 ILCS 708 Sec. 30 (13) to document in Catalog of State Financial Assistance, among other data, assistance considerations, including an explanation of the award formula, matching requirements, and the length and time phasing of the assistance (emphasis added). However, an adequate explanation of the award formula is not listed for the LHPG in the Catalog of State Financial Assistance.⁸

77 Ill. Adm. Code 615.210 (c) contains a portion of the methodology for grant funding awards for the LHPG which is provided as follows:

• After reserving amounts from previous years’ awards, adjusted for inflation, additional funds are to be allocated to achieve the following cumulative allocation:
  A) 50% of the annual LHPG funds shall be allocated based upon the populations of the LDHs jurisdictions.
  B) 50% of the annual Grant funds shall be allocated based upon the numbers of persons with income below 200% of the Federal Poverty Level within LDHs jurisdictions.

However, grant funding awards have not included adjustments for inflation.

Illinois rules further allow IDPH to establish a minimum grant award level annually. The rules contain a provision that the minimum grant award shall not be less than $50,000. It is not known if IDPH has ever changed the minimum grant award or what basis they may have used to change this amount. For State Fiscal year ending June 30, 2023, grant awards ranged from $2.9 million to $64,000 for a total of $19.4 million statewide.

The specific methodology used to award funding from this grant is vague, incomplete, needs greater transparency, and needs reevaluation to ensure citizens intended to receive benefits from this program are indeed receiving those benefits.
How does it affect DuPage County?

The DuPage County Health Department (DCHD) was awarded $873,554 from the LHPG for State Fiscal Year (SFY) 2023 and $1,100,000 for SFY 2024 which is $0.94 and $1.19 per capita respectively. While the overall funding increase is an improvement, disparities exist when comparing per capita amounts awarded around the state. Of the 97 entities awarded a LHPG in SFY 2024, 94 will be receiving more than DCHD per capita. The state-wide median per capita award in SFY 2024 is $3.73 while DCHD will be receiving $1.19 per capita.

It is important to note that the LHPG funds only a portion of program costs. The total cost of the programs is significantly more than provided by the LHPG. However, there is substantial effort required to operate programs mandated by the LHPG rules especially during illness outbreak investigations for which no additional compensation is provided. Additionally, LHPG program rules have significantly increased operating requirements for the required programs since the grant program began, again without adequate additional compensation being provided to LHDs.

Illinois’ administrative rules include a provision that the IDPH may impose a maximum allowable annual percentage change (% increase or % decrease) in the total grant award for participating local health departments. Such limits shall not be imposed from one year to the next without granting the Illinois Association of Public Health Administrators and the Northern Illinois Public Health Consortium (NIPHC) advance notice and an opportunity to comment. NIPHC has not been invited to provide such comments.

The DCHD is a member of NIPHC.

Lastly, over the past ten years, there have been several instances when the LHPG agreement has not been executed with DCHD prior to the start of the grant period and the grant payment was received significantly after the start of the grant period.

How can we address the problem?

The specific funding award formula, outcomes, methodology and process for the LHPG should be made appropriately transparent to LHDs.
State Fund Sharing and Distribution Transparency

By the end of 2024, IDPH should engage local health department stakeholders at a minimum to include NIPHC and Illinois Association of Public Health Administrators to address at a minimum the following issues:

- Amend, update, and share the grant funding award formula.
- Ensure the grant agreements are executed prior to the start of the grant period.
- Ensure the payment of grant funds within 30 days of the execution of the grant agreement.
- Ensure transparency and include annual increases to grant amounts to adjust for inflation.

Resources

- Illinois Grant Accountability and Transparency Act (GATA)
  https://gata.illinois.gov/
  accessed July 7, 2023
- Illinois Administrative Rules for GATA
  https://www.ilga.gov/commission/jcar/admincode/044/04407000sections.html
  accessed July 12, 2023

References

Increasing Public Health Capacity

Public Health Advocacy Resource Guide 2024
Student Loan Reimbursement to Decrease Public Health Workforce Shortage

Background

Health Professional Shortage Areas (HPSAs) are geographic areas, population groups, or health care facilities that have been designated by the federal Health Resources and Services Administration as having a shortage of health professionals. There are three main categories of HPSAs: primary care, dental health, and mental health.¹

Federal and state programs distribute resources based on the designation of HPSAs. At the federal level, the National Health Service Corps (NHSC) Loan Repayment Program (LRP) utilizes HPSAs. The NHSC LRP offers primary medical, dental, and mental and behavioral health care clinicians the opportunity to have their student loans repaid, while earning a competitive salary, in exchange for serving in urban, rural, or tribal communities with limited access to care.¹,²

In Illinois, another program that utilizes HPSAs is the Community Behavioral Health Care Professional Loan Repayment Program (23 IL Admin. Code 2753) which is intended to provide loan repayment assistance to qualified mental health and substance use professionals in an effort to recruit and retain them to practice in underserved or rural areas and to address this State’s community-based behavioral health care workforce shortage that causes disparities in access to critical mental health and substance use services.³

As of September 2022 in the United States (U.S.):
- 65.6% of Primary Care HPSAs were in rural areas.
- 67.1% of Dental Health HPSAs were in rural areas.
- 60.6% of Mental Health HPSAs were in rural areas.⁴

Rural communities have faced barriers to healthcare for decades. It is important that they continue to receive funding and support. As the above data demonstrates, rural communities receive the majority of HPSA designations. The remaining 33 to 40% of HPSAs in metropolitan and suburban communities require policy updates to address ambiguity in the Illinois definition of underserved HPSAs and the expansion of eligible job classifications in the Illinois Community Behavioral Health Care Professional Loan Repayment Program.

How does the issue affect the United States?

- The National Health Service Corps (NHSC) was started in 1972 and aimed to attract healthcare workers to underserved communities.⁵ The difference between 2023 and 1972 was the ability for communities to qualify as an HPSA, especially for communities that were not rural. When the NHSC was first created, the population of the U.S. was approximately 205 million, and in 2023 the population was almost 340 million.⁶ Whether to designate a community as an HPSA was more complex in 2023
because there were many areas that still experienced challenges in health workforce employment recruitment and retainage even if they were not classified as an underserved or rural area.

- California has provided useful lessons regarding how HPSAs are classified that could be applied on a national basis to be more inclusive with health care workforce recruitment and retainage in underserved communities in urban, suburban, and rural areas. A 2006 study by The Central Valley Health Policy Institute at California State University, Fresno identified a number of factors that created difficulties in recruiting personnel. According to many clinics, they were ineligible for the loan repayment programs because “the Bureau of Health Professions’ definition of a Health Professional Shortage Area,” was too narrow. Loan repayment programs, according to a 2021 study by the California Health Care Foundation, have had the “most immediate impact on access,” and show the worker retention rates are higher with loan repayment programs.5,7

How does it affect Illinois?

- The launch of the New Behavioral Health Workforce Education Center is a step forward for Illinois to better recruit and retain behavioral health professionals. According to the Secretary of the Illinois Department of Human Services, Grace B. Hou, in March 2023, “Illinois is projected to have a shortfall of more than 3,300 behavioral health providers by 2030 if there is no intervention.” Equal attention must also be paid to retaining employees once they are recruited because without a high retention rate, recruiting health care personnel will be an endless cycle.8
- In Illinois, there are 131 primary care and 135 mental health HPSA Facilities.9
- In Illinois, there are about 3.9 million people on Medicaid.10, 11

How does it affect DuPage County?

- In DuPage County, there were about 165,500 or 17% of residents enrolled in Medicaid in fiscal year 2022.11, 12
- The DuPage County Health Department has about 30,000 clients annually, with over 95% of clients Medicaid funded.
- Yet, in DuPage County, there is only one primary care and one mental health Federally Qualified Health Center HPSA designated by the National Health Service Corps which does not include the DuPage County Health Department.9
- Including the DuPage County Health Department in National Health Service Corps HPSAs is expected to help with recruiting and retaining behavioral health and other employees.
In regards to Illinois’ Community Behavioral Health Care Professional Loan Repayment Program, there is no definition of an “underserved” HPSA in 23 IL Admin. Code 2753 which makes the qualifying portion of this program difficult to navigate. Additionally, the current eligibility list of positions is too narrow and should be expanded:

These are the current eligible behavioral health professional positions:

- Psychiatrist
- Advanced practice registered nurse
- Physician assistant
- Psychologist who holds a doctoral degree (Psy.D or Ph.D.)
- Licensed clinical social worker (LCSW)
- Licensed clinical professional counselor (LCPC)
- CADC-certified substance use professional

These are additional positions not covered by the program that should be added to the eligibility list:

- Registered nurses
- Licensed social workers (LSW)
- Licensed professional counselors (LPC)
- Community health workers
- Staff credentialed by Illinois Medicaid as a:
  - Mental Health Professional (MHP)
  - Qualified Mental Health Professional (QMHP)
  - Rehabilitative Services Associate (RSA)
  - Licensed Practitioner of the Healing Arts (LPHA)

**How can we address the problem?**

- Amend Community Behavioral Health Care Professional Loan Repayment Program (23 IL Admin. Code 2753) by adding a definition of “underserved” HPSAs that includes certified local public health agencies that have more than 50% of their clients funded by Medicaid to ensure the DuPage County Health Department is included in primary care, dental health, and mental health HPSAs.
Further amend Community Behavioral Health Care Professional Loan Repayment Program (23 IL Admin. Code 2753) to add these additional positions to the program eligibility list:

- Registered nurses
- Licensed social workers (LSW)
- Licensed professional counselors (LPC)
- Community health workers
- Staff credentialed by Illinois Medicaid as a:
  - Mental Health Professional (MHP)
  - Qualified Mental Health Professional (QMHP)
  - Rehabilitative Services Associate (RSA)
  - Licensed Practitioner of the Healing Arts (LPHA)
Student Loan Reimbursement to Decrease Public Health Workforce Shortage

References


11. Data USA. Data from the Census Bureau ACS 5-year Estimate. https://datausa.io/profile/geo/dupage-county-il/


Improve Maternal and Infant Health and Mortality

Background

Maternal and infant health outcomes are common indicators of the overall health status of a country, state, or community. Maternal mortality is the death of a woman during pregnancy, at delivery, or shortly after delivery up to one year postpartum. Infant mortality is the death of an infant before their first birthday. Maternal mortality includes heart disease and stroke for leading causes. Obstetric emergencies, like hemorrhage and amniotic fluid embolism cause the most deaths at delivery. The first week after delivery, women are most at risk of severe bleeding, high blood pressure and infection. Cardiomyopathy (weakened heart muscle) is the leading cause of death up to one year after delivery. Leading causes of infant death include birth defects, preterm birth and low birth weight, maternal pregnancy complications, sudden infant death syndrome, and injuries. While some causes for both groups have improved during the last ten years, others are increasing; moreover, more than half can be prevented.

How does it affect the United States?

- The United States (U.S.) is the only industrialized nation in the world where maternal mortality is rising, a reminder of the degree to which public health is neglected.
- The most current data indicates that the U.S.’ international ranking among the 37 countries of the Organization for Cooperation and Development is 25th for maternal mortality and 33rd for infant mortality.
- The U.S. reports the highest maternal mortality rate out of 10 of the wealthiest countries in the world at 14 maternal deaths per 100,000 live births. According to the Centers for Disease Control and Prevention, in 2018, more than 21,000 infants in the U.S. died before their first birthday, resulting in an infant mortality rate of 5.7 deaths per 1,000 live births.

How does it affect Illinois?

- Healthy People, a federal plan for national objectives improving the health of all Americans, set a goal of decreasing infant mortality rates to no more than 6.0 infant deaths per 1,000 live births. The U.S. met this target in 2018 with a rate of 5.7; however, Illinois has not yet achieved the Healthy People objective with an infant mortality rate of 6.5 in 2018.
- Illinois ranked 36th out of the 50 states for infant mortality rate with only 28 states meeting the objective. In 2018, there were 943 infants who died before their first birthday out of approximately 145,000 live births. The overall infant mortality rate for Illinois infants decreased 22% between 2000 and 2018 with approximately two-thirds of all infant deaths occurring during the neonatal period, between 0-27 days after birth.
The Illinois Department of Public Health found that during the period of 2016-2017, one third died from a cause related to pregnancy. The leading cause of pregnancy-related death was mental health conditions, including substance use disorders. The next three causes include chronic medical conditions, hemorrhage, and hypertensive disorders. One-third of pregnancy-related deaths occurred more than two months after pregnancy. Similar to racial inequity rates in the U.S. for maternal and infant mortality, black women in Illinois were about three times more likely to die from pregnancy-related conditions as white women. According to the maternal mortality review committee that investigates cases, 83% of the pregnancy related deaths were potentially preventable.6

How does it affect DuPage County?

• The DuPage County infant mortality rate has fluctuated but remained lower than Illinois and U.S. rates over the last five years, from 3.5 infant deaths per 1,000 live births in 2012 to 3.7 in 2016.7

• While the 2016 infant mortality rate increased from 2012, it remains below the Healthy People 2020 national health goal of 6.0 set by the Centers for Disease Control and Prevention in 2010, and still would be under the Healthy People 2030 goal of 5.0.

How can we address the problem?

• Analysis shows that the U.S. has the highest rates of avoidable mortality because people are not receiving timely, high quality care in an equitable way particularly by race and socioeconomical status.8

• The path to progress can begin by improving our nation’s maternal health data infrastructure by collecting, sharing, and linking transparent data on individuals, the care they receive and their non-clinical needs in a standardized order. Efforts should be made to advance a research agenda that identifies effective, evidence-based best practices in maternal health with a priority addressing clinical, environmental, and socioeconomic factors.9

• Interventions to improve outcomes can be made by healthcare professionals to screen and treat women at risk for preterm births through public funding to increase access to treatment through outreach, care coordination and other supports including investments in home visiting, prenatal education, and support groups. Offering women improved tools to navigate health and birthing options can provide additional support such as midwives or doulas, reduce C-sections, improve breastfeeding rates, and ensure greater health literacy and childbirth education.10
• Improving the quality of care provided to pregnant women can include creating a standardized assessment for mothers and infants akin to Apgar scores, address maternal and infant mental health, and training healthcare providers to address inequity and improve cultural humility. The cost to avert maternal mortality is estimated between $800 and $1,500 or as low as $0.50 per capita per year.¹¹

• Promotion of good health and prevention measures is more effective than avoidance of death. This can be done by improving access to care for all women including expanding Medicaid to improve early prenatal care and extend postpartum coverage, increase birthing centers in rural areas and healthcare deserts in metropolitan areas, and expanding provider reimbursement for services not currently covered such as midwives and breastfeeding support. The U.S. has improved maternal and infant mortality in the last decade; however, a more effective approach could further decrease the gap if preventative health, education, and equity for all are improved.

References


Vaccine Hesitancy

Background

There are vaccines to prevent 22 diseases. Vaccine hesitancy refers to the delay in acceptance or refusal of vaccination despite availability of vaccination services. Vaccine hesitancy is complex and context specific, varying across time, place and vaccines. It is influenced by factors such as complacency, convenience and confidence. Often this reluctance stems from a lack of information or misinformation about vaccines.1,2,3

Vaccines are among the most successful and cost-effective public health tools available for preventing disease and death. In the United States (U.S.), vaccines protect children from many diseases. Yet, in many parts of the world vaccine-preventable diseases are still common. Because diseases may be brought into the U.S. by residents and visitors who travel abroad or from people visiting areas with current disease outbreaks, it’s important that your child is vaccinated. However, some parents remain hesitant about their child being vaccinated. Additionally, some adults are hesitant about being vaccinated. Unvaccinated children and adults put themselves and other children and adults at preventable risk of illness. Vaccines are tested. Vaccines are effective. Vaccines save lives. Vaccines are safe. Vaccines are part of a trustworthy medical system.4,5,6

How does it affect the United States?

- Childhood vaccinations
  • Routine vaccinations during childhood help prevent 14 diseases. Among children born from 1994-2018, vaccinations will prevent an estimated 936,000 early deaths, 8 million hospitalizations, and 419 million illnesses.7
  • Routine immunization of all children born in one year can: prevent 20 million cases of disease, reduce direct health care costs by $13.5 billion and save $68.8 billion in total societal costs. Despite availability and routine recommendation of these vaccines, approximately 42,000 adults and 300 children in the U.S. still die each year from vaccine-preventable diseases.8
  • The shift toward intentional vaccine delay and refusal is directly associated with increased occurrence of preventable diseases for individuals and entire communities. For instance, although the U.S. declared measles eliminated in 2000 and it is no longer endemic in this country, the disease is extremely contagious and can be easily imported when individuals enter the U.S. after having been exposed in other countries. Since 2000, more than 1,500 measles cases have been reported, and 2014 saw the highest number of cases in two decades.8
• Wide geographic variation exists for completion rates of the CDC-recommended seven-vaccine series when comparing these rates by state, metropolitan statistical areas, and counties. State-level completion rates for children born in 2013 (based on data collected through 2016) ranged from a high of 86% in North Dakota to a low of 63% in Nevada with a national average of 77% (the completion rate in Illinois was 79%).

How does it affect Illinois?

• Childhood vaccinations
  • Wide geographic variation exists for completion rates of the CDC-recommended seven-vaccine series when comparing these rates by state, metropolitan statistical areas, and counties. State-level completion rates for children born in 2013 (based on data collected through 2016) in Illinois was 79% with a national average of 77%.

• COVID-19 vaccinations for children and adults
  • An estimated 35.2% of children 6 months to 17 years of age in the U.S. probably or definitely will not get a COVID-19 vaccination.
  • An estimated 9.5% of all adults aged 18 and over in the U.S. probably or definitely will not get a COVID-19 vaccination.

• Other school vaccination requirements in Illinois
  • Children enrolling or entering a child care facility or school in Illinois in 2022-2023 are required to have the following minimum immunizations depending on grade:
    
    - Diptheria
    - Pertussis
    - Tetanus
    - Polio
    - Measles
    - Rubella
    - Mumps
    - Haemophilus influenzae type b
    - Invasive Pneumococcal disease
    - Hepatitis B
    - Varicella
    - Meningococcal disease

  • In 2014-15, 97.7% of all students (2,182,485) complied with school immunization and health examination requirements (as of October 15, 2014).

• COVID-19 vaccinations for children and adults
  • The rate of youth in Illinois not fully vaccinated for COVID-19 is 49.73%.
  • An estimated 12.0% of all adults aged 18 and over in Illinois probably or definitely will not get a COVID-19 vaccination.
Vaccine Hesitancy

How does it affect DuPage County?

■ Childhood vaccinations
  • Wide geographic variation exists for completion rates of the CDC-recommended seven-vaccine series when comparing these rates by state, metropolitan statistical areas, and counties. County-level completion rates for children born in 2013 (based on data collected through 2016) in DuPage County was 83% with a national average of 77%.9

■ COVID-19 vaccinations for children and adults
  • The rate of youth in DuPage County not fully vaccinated for COVID-19 is 35.31%.13
  • The number of people in DuPage County who are COVID-19 vaccination hesitant is estimated to be 6.3%.14

How do we address the problem?

• Encourage health care providers to follow guidance from the U.S. Centers for Disease Control and Prevention regarding talking with parents about vaccines for their children.15

• Encourage research into and use of additional evidence-based guidance i.e. motivational interviewing for health care providers’ discussions with vaccine hesitant parents.16

• Launch a targeted, stakeholder-informed and evidence-based public awareness campaign to promote the benefits of timely vaccination and risks of refusal and delay.

• Encourage residents to ensure sources of vaccine information are reliable and accurate, especially from online sources, by checking that the information comes from a credible source and is updated on a regular basis. While searching for vaccine information, consider guidance from these credible sources:
  o Primary care physicians.
  o CDC Vaccines & Immunizations: www.cdc.gov/vaccines.
  o The Immunization Action Coalition suggests questions you should ask at www.immunize.org.
  o The National Network for Immunization Information (NNii) suggests questions to ask when evaluating information.
The University of California San Francisco’s Evaluating Health Information page lists “Red Flags” every consumer needs to know.

The Medical Library Association translates medical jargon (Medspeak) into language everyone can understand.\textsuperscript{6,17}
Resources


References

Background

Consumption of unpasteurized milk, sometimes called raw milk, can transmit disease-causing microorganisms, known as pathogens, which can cause severe illness and death. Even with strict adherence to sanitation practices during the milking process, pathogens can come into contact with milk from a variety of sources: in or on milking animals, in collection equipment and storage containers, and from airborne sources. Milk may become contaminated during collection, storage, or transportation. Without laboratory testing, there is no means to determine if milk is contaminated with pathogens.

Pasteurization yields milk and milk products that are safe to consume and increases shelf life, which helps promote safety during distribution and short-term storage. Pasteurization is the brief heating of milk to specific temperatures for specific periods of time to destroy pathogens present in milk. Pasteurized milk is as nutritionally healthy to consume as unpasteurized milk. In fact, pasteurized milk is sometimes fortified to increase its nutritional benefits.

Pasteurization of milk is a major success story of modern public health policy.

Consumption of unpasteurized milk can make people ill and lead to severe health outcomes, including death. People most at risk for severe foodborne illness are adults 65 years and older, children younger than 5 years, and people with weakened immune systems. But healthy people of any age can get very sick after drinking raw milk contaminated with harmful germs.\(^1\)\(^2\)

However, some states have acted to increase the availability of unpasteurized milk.

How does it affect the United States?

The U.S. Food and Drug Administration requires all milk and milk products in final package form for direct human consumption be pasteurized before shipping in interstate commerce. The sale of pasteurized milk within each state is governed by state laws.

The U.S. Centers for Disease Control and Prevention (CDC) has conducted studies that show an increase in the number of raw milk–associated outbreaks as more states have allowed the legal sale of raw (unpasteurized) milk. These studies indicate that outbreaks linked to raw milk continue to threaten the public’s health.

Compared with jurisdictions where retail sales were prohibited, those where sales were expressly allowed were estimated to have 3.2 times greater number of illness outbreaks; of these, jurisdictions where sale was allowed in retail stores had 3.6 times greater number of illness outbreaks compared with those where sale was allowed on-farm only.
Illness outbreaks linked to unpasteurized milk disproportionately affected younger people, with over half of illnesses occurring in people aged 19 years and younger.

Illness outbreaks linked to unpasteurized milk can be difficult to identify and trace to a production source. As part of unpasteurized milk sales agreements (such as herd shares), customers may not report product consumption and may withhold information about the origin of the milk, which prevents traceback, identification of a source, and implementation of farm-level interventions.

During 2013–2018, 75 outbreaks with 675 reported illnesses occurred that were linked to unpasteurized milk; of these, 325 illnesses (48%) were among people aged 0–19 years.

Of 74 single-state outbreaks, 58 (78%) occurred in states where the sale of unpasteurized milk was expressly allowed.\textsuperscript{1,2}

For additional information on raw milk laws, visit https://www.cdc.gov/phlp/publications/topic/zoonotic.html

Source: https://www.cdc.gov/foodsafety/rawmilk/nonpasteurized-outbreaks-maps.html
Unpasteurized Milk Facts:

- Unpasteurized milk does not cure lactose intolerance.
- Unpasteurized milk does not cure or treat asthma and allergy.
- Unpasteurized milk is not more effective in preventing osteoporosis than pasteurized milk.
- There are no beneficial bacteria in unpasteurized milk for gastrointestinal health.
- Unpasteurized milk is not an immune system building food and is particularly unsafe for children.
- There are no immunoglobulins in raw milk that enhance the human immune system.
- Unpasteurized milk is not nutritionally superior to pasteurized milk.
- Unpasteurized milk does not contain natural antimicrobial components that make milk safe.
- Unpasteurized milk causes a greater rate of foodborne illness outbreaks than pasteurized milk.3, 4

In short, pasteurized milk is safer to consume than unpasteurized milk.

How does it affect Illinois?

Unpasteurized milk is available to consumers in Illinois via on-farm sales and ‘herd shares.’ Under a herd share arrangement, an individual purchases an ownership interest in a cow or herd, which remains under the care of a farmer, which entitles them to a portion of the unpasteurized milk produced. Herd shares have been used to attempt to circumvent state and federal prohibitions on retail sale of unpasteurized milk. Some states have expressly prohibited herd shares.1

Illinois had 11 permitted unpasteurized milk dairy farms and distribution points in 2021.5

For comparison purposes:

- Illinois had 924 farms with milk cows in 2017.6
- Illinois had 70,900 farms in 2021.7
Figure 2 shows the reported enteric cases of illness in Illinois with self-reported consumption of unpasteurized/raw dairy products by hospitalization status from 2014 – 2022.

**Figure 2**

<table>
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<tr>
<td>2022</td>
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<td>36</td>
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</tbody>
</table>

Source: Illinois-National Electronic Disease Surveillance System

*Data are provisional as of 6/14/2023. Diseases include: Campylobacteriosis; Cryptosporidiosis; Cyclosporiasis; Giardiasis; Hemolytic Uremic Syndrome (HUS) Post Diarrheal; Salmonellosis; Shiga toxin-producing E.coli (STEC)-0157, H antigen unknown; Shiga toxin-producing E. coli (STEC)-0157:H7; Shiga toxin producing E. coli (STEC)- Shiga toxin positive, non-0157 serotype; Shigelliosis; Yersiniosis. There were 44,765 cases of these diseases reported in Illinois residents, including 3,093 cases reported in DuPage County residents, during 2014-2022. The average age of DuPage County resident cases who self-reported consumption of unpasteurized/raw dairy products was 39 years (range: 1 year - 87 years). It is not possible to determine if the source of illness for these individual cases was unpasteurized/raw dairy consumption without identifying a cluster of cases. Consumption of unpasteurized/raw dairy products was self-reported in these cases.

**How does it affect DuPage County?**

DuPage County has about 925,000 residents.⁸

An estimated 25,000 (2.7%) of DuPage County adults are immunocompromised, putting them at greater risk of illness or death from the consumption of unpasteurized milk.¹, ⁹, ¹⁰

An estimated 231,000 (25%) of DuPage County residents are age 0 to 19, putting them at greater risk of illness or death from the consumption of unpasteurized milk.¹¹

Illness outbreaks linked to unpasteurized milk disproportionately affected younger people, with over half of illnesses occurring in people aged 19 years and younger.¹
Figure 3 shows the reported enteric cases of illness in Illinois and DuPage County with self-reported consumption of unpasteurized/raw dairy products from 2017 – 2022. Please also note, the footnotes for Figure 2 and Figure 3 indicate that the average age of DuPage County resident cases with enteric illness who self-reported consumption of unpasteurized/raw dairy products was 39 years (range: 1 year - 87 years).

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<tr>
<th>Hospitalized (n%)</th>
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<tr>
<td>Illinois (including DuPage)</td>
<td>9 (3)</td>
<td>163 (48)</td>
<td>336 (100)</td>
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</table>

Source: Illinois-National Electronic Disease Surveillance System

*Data are provisional as of 6/9/2023. Diseases include: Campylobacteriosis; Cryptosporidiosis; Cyclosporiasis; Giardiasis; Hemolytic Uremic Syndrome (HUS) Post Diarrheal; Salmonellosis; Shiga toxin-producing E. coli (STEC)-O157, H antigen unknown; Shiga toxin-producing E. coli (STEC)-O157:H7; Shiga toxin-producing E. coli (STEC)-Shiga toxin positive, non-O157 serotype; Shigelllosis; Yersiniosis. There were 33,417 cases of these diseases reported in Illinois residents, including 2,391 cases reported in DuPage County residents, during 2017-2022. The average age of DuPage County resident cases who self-reported consumption of unpasteurized/raw dairy products was 39 years (range: 1 year - 87 years). It is not possible to determine if the source of illness for these individual cases was unpasteurized/raw dairy consumption without identifying a cluster of cases. Consumption of unpasteurized/raw dairy products was self-reported in these cases.

How can we address the problem?

- Educate legislators, parents, caregivers, clinicians, and the general public about the risks from consuming unpasteurized milk and milk products and that the risks of illness or death from consuming them far outweigh potential perceived benefits.
- Encourage legislators to oppose increasing availability of unpasteurized milk and milk products.
- Educate parents and caregivers about risks of illnesses and death linked to unpasteurized milk consumption among adults over 65, children, and people with compromised immune systems to reduce illnesses and fatalities among these populations.
- Educate clinicians to improve awareness and understanding about risks of illnesses and death linked to unpasteurized milk consumption toward prevention counseling, early recognition, diagnosis, and illness management.
References


