Partnership for a Healthy Community
Board Meeting

January 25, 2023
1:00pm-2:30pm
OSF Center for Health | Route 91

AGENDA

1. **Approve 11/16/2023 meeting minutes** (Action) **(Pages 2-5)**

2. **Committee Updates**
    a. HEAL **(Pages 6-8)**
    b. Mental Health **(Pages 9-12)**
    c. Obesity **(Pages 13-18)**
        i. Adolescent Digital Platform Plan (Action)
    d. Data Team **(Pages 19-59)**
    e. Website & Social Media
    f. Performance Management
        i. Substance Use **(Pages 60-81)**

3. **Healthcare Collaborative**

4. **Learning Collaborative**

5. **Board Business**
    a. Annual Report (Discussion)
    b. Annual Meeting Agenda Development (Discussion)
    c. Timeline (Discussion)
    d. CHNA Draft (Discussion)

6. **Miscellaneous**
    a. Illinois Youth Survey and Local Participation

Next Meeting:
Thursday, February 22, 2023
1:00pm-2:30pm
OSF Center for Health | Route 91

Partnership for a Healthy Community Board
Meeting Minutes
November 16, 2023

Members Present:	Phil Baer	Amy Fox
	Sally Gambacorta	Holly Bill
	Jay Collier	Rebecca Crumrine
	Nicole Robertson	Tricia Larson
	Hillary Aggertt	Monica Hendrickson
	Kate Green	Lisa Fuller
	Ann Campen	Craig Maynard
Others Present:	Amy Roberts	

Approval of 10/26/23 Meeting Minutes

Ms. Fox made a motion to approve the minutes from the October 26, 2023 meeting. Motion was seconded by Ms. Robertson. Motion carried (12,0).

Ms. Fox introduced and welcomed Ms. Crumrine to her first Board meeting.

Committee Updates

HEAL

Ms. Crumrine stated they met on November 9th and noted that they will have a HEAL Team news coming out in December. They went over the different initiatives going on with the Food System Partners. The Healthy Eating team decided to work on a holiday campaign to be released tomorrow. This will run from November 17th through the end of December on every Friday on social media. They will be switching from a healthy holiday swap idea to a recipe video, called "Happy Healthy Holidays". The group is waiting on moving pieces for the education and gardens. Dr. Kelly is working to create a standardized evaluation for baseline data. The Active Living team has been looking at different apps, Ms. Fox stated that they had looked at Walker Tracker and Move Spring. She added that Ms. Aggertt is putting together criteria to assess the apps and they'll be meeting to discuss pricing. The Take a Walk Wednesdays has wrapped but will be sharing ideas from the Riverplex for fitness. In 2024, Move it Mondays will be started up again.

Ms. Fuller entered the meeting at 1:10pm.

Mental Health

Ms. Bill stated that the group met on November 14th and is continuing to meet a large group monthly. They are planning some partner presentations to learn more about different agencies, upcoming are Trillium Place and OSF Strive. The team has now split into subgroups that are meeting outside of the big group, Jonathan is leading Telehealth and Dawn is leading Culturally Adaptative Healthcare. There is a comprehensive list of telepsych, telehealth, and telemed providers on the website now and they will continue to keep the list updated. They are looking for more resources for trainings for culturally adaptive healthcare, if anyone has any good trainings, please share with Ms. Bill. She also noted that the Suicide Prevention group, stating that Coroner Harwood will be

presenting at their December meeting following the uptick in overdose attempts among teens in Tazewell. Mental Health First Aid has provided in the packet, a broader mental health request, previously it was more specific to suicide prevention. They are hoping to streamline the requests with this.

Obesity

Mr. Baer stated that the Adults subcommittee met earlier this month and the Peds group will not meet until later this month. He stated they were able to secure $5000 from the OSF Foundation to help with implementation of Strong People Healthy Living programming. They have 2 facilitators identified and are looking to get them enrolled in training. They are looking at the Procter Center downtown and also the Park District. They are moving forward with logistical items now. They are also working towards recruitment. Once the training is completed, more information will be known.

Data Team

There was no update from the Data Team.

Website & Social Media

Ms. Aggertt stated that the Tri-County Health Department PIOs are meeting on November 30th to discuss a media policy that is currently in place and adapt it to be more user-friendly. They are working to streamline a process for a marketing plan and pull all the pieces together. Ms. Aggertt and her intern have been working on the website to get it how they want it since the hired vendor did not pan out. Ms. Aggertt would like to coordinate an updated picture of the Board at the Annual meeting for the website.

Performance Management

Cancer

Ms. Robertson said they are working to put together a year-end report. Last Saturday was National Lung Cancer Screening Day and thanks to OSF and Carle they had just over 100 low dose CT scans that were done that day. They are currently collecting the final numbers. They had a significant number of walk-ins along with appointments and it was only the second time doing this on a national level. The lung cancer screening guidelines have been updated, taking out the 15 years since quit criteria for eligibility, now it's just a current or former smoker, which they estimate that will be about 5 million eligible individuals still within the 50 to 80 years age range and 20 year pack history. ACS is wrapping up as well and continuing to look at transportation and lodging support for patient resources. Ms. Fuller added that having the event on Saturday is the best option to get the most agency involvement.

Ms. Green entered the meeting at 1:26pm.

Healthcare Collaborative

Ms. Hendrickson circled back on the 211 discussion from the previous meeting. She added that she met with Ms. Zammuto to discuss what does findhelp.org provide that 211 does not. With 211, the operators do data entry into the referral system, so they collect the data for warmer handoffs. This discussion will be moved to the Healthcare Collaborative to understand usage and potentially what are the gaps with 211 and what can it move in to. Findhelp.org is limited and 211 is limited to how many resources/providers they could list, they do not want to list every single resource. There could be further efforts to update findhelp.org and should there be a referral system with a warm handoff? OSF has a current contract with 211 for the providers at OSF with their consults.

Learning Collaborative

Ms. Fox and Mr. Baer will work to continue scheduling these presentations. Ms. Fox shared that the Heartland Healthcare Coalition shared their report on diabetes for the Peoria area. This would be good information for any committee looking at weight, obesity, activity, etc. This was already sent out the Board prior to the meeting.

Board Business

Annual Meeting & Report

Ms. Fox stated they would shoot for March 2024 for the annual meeting. Ms. Fuller will look to see if the Spalding building is available. Ms. Fox also suggested the Community Foundation Room, will look into other spaces. The group decided on Thursday, March 7, 2024 from 9-11am for the annual meeting. The annual report articles will be due by February 14, 2024 and Kim from TCHD will work to compile the Partnership annual report.

MAPP Timeline Next Steps

Ms. Fox had binders for Board members present and if you didn't not receive one, please let Ms. Fox know. She stated this is not the entirety of the MAPP process, but an overview. She added that she has not heard from Dr. Weinzimmer or Dr. Donohue about their updated timelines but will circle back with them. Ms. Fox stated getting the Health Equity piece from the very start and how to drive things, which is the second orange document, but also considering all the data for the community assessment. She noted that the first document in the binder is an overview of the entire process, but the 3 sections behind it are the ones to be started on right away.

Transition of Leadership

Ms. Fox stated they would be transitioning leadership with Ms. Aggertt stepping into Ms. Fox's place which will happen in the first quarter. Also, according to the bylaws, it states there are 2 Chairs and a Vice Chair, which hasn't been filled. Ms. Fox added it would be nice to have a Vice Chair at this time and said that if anyone has a desire to serve in that role to let Ms. Fox or Mr. Baer know and an official vote will have to be done.

2024 PFHC Board Meeting Schedule

The 2024 Partnership Board meeting schedule was included in the packet. This time still works for the majority of the Board members. They will still hold these in person with a virtual option, but hope the majority comes in person. Amy Roberts will send out an updated calendar invite for next year's meeting dates.

Miscellaneous/Member Announcements

The December 2023 Partnership Board meeting has been cancelled, but due to some IT issues, it may not be cancelled on your calendar.

Mr. Baer noted that his role within the Medical Center is changing to Director of Medical Imaging and Ms. Fuller is currently interviewing for a Director of Community Outreach. He stated he can maintain his commitment to the Board and carry through his term. He plans to onboard the new Director to work with the Obesity group.

Ms. Crumrine announced the 12 Days of Giving, the full list has been put out to encourage people to donate healthier options. She added that there is a toolkit available to host a food drive. Ms. Fox

stated that the committees are working very hard to share events and other items on the Partnership Facebook page.

Healthy Eating and Active Living (HEAL) December 2023

HEAL is defined in the CHNA as healthy eating, active living, access to food and food insecurity.

Healthy eating is an eating plan that emphasizes fruits, vegetables, whole grains and fat-free or low-fat milk and milk products; includes a variety of protein foods, is low in added sugars, sodium, saturated fats, trans fat and cholesterol and stays within in daily caloric needs. Education, lifestyle interventions and food access positively affect healthy eating.

Active living means doing physical activity throughout the day. Any activity that is physical and includes bodily movement during free time is part of an active lifestyle.

Access to food refers to the ability of an individual or household to acquire food. Transportation, travel time, availability of safe, healthy foods and food prices are factors to food access.

Food insecurity is as a lack of consistent access to enough, nutritious food for every person in a household to live an active, healthy life.

Goal: Improve overall healthy eating and physical activity in the Tri-County Region.

Objective HE1: By December 31, 2025, increase accessibility of healthy food in the Tri-County Region through the support of community gardens by 10%.

Intervention Strategy: Gardening: Increase Vegetable Consumption among Children (HE)

Tasks & Tactics	Evaluation Plan	Target & Data	Monthly Recap	Upcoming Work	Issues/Challenges
HE 1: Gather baseline data around community gardens and school-aged programming.	Complete a comprehensive list establishing locations of community gardens and school aged gardening programs.	37 gardens By January 2024, recruit Woodford County community gardens.	No progress made on this during the month – wanted to wait until after growing season to make outreach – list completed with contacts during growing season	Mike to begin outreach to all the gardens. Any gardens he can't reach or needs help with, he will reach out to Extension.	n/a – collecting data associated with collected list of gardens
	# of children/families accessing the community gardens	April 2023 – Identify # of children and families that accessed the garden			
HE 2: Implement garden-based learning sessions focused on gardening and healthy eating.	# of children/families attending information sessions about gardening and healthy foods.	April 2023 – Identify # of children and families that attended garden-based learning	Mike & Rebecca gave feedback via email about first survey drafts. Meeting with Dr Kelly & Megan scheduling for January to review further together and determine next steps	Waiting to schedule meeting for next steps	n/a – season of year and working on standardizing evaluation has this a bit in wait

	Increase healthy eating knowledge through pre/post test evaluation per session by 75%				
HE 3: Promote campaigns focused on healthy eating and access to healthy foods.	# of healthy eating and community gardening campaigns in the Tri-County Region.	April 2023- Identify number of campaigns completed in 2022.	Completed 12 Days of Giving Campaign – go.illinois.edu/12daysofgiving. Focused on healthy donations to our pantries during the holidays. Toolkit updated and released – go.illinois.edu/12daysofgivingtoolkit. Discuss the possibility of a weekly post schedule for food Friday's on the partnership page. Idea of Pantry/Find Food – 1st Friday, Nutrition Tip – 2nd Friday, Federal Food – 3rd Friday, Recipe – 4th Friday - Maybe work on this in the new year Happy HEALTHY Holidays 11/17 through 12/29 Fridays at 1pm ongoing on the facebook page. Team identified 3 recipes that will be recorded and shared. Also created 4 Holiday Swap posts.	Discuss next campaign as a group. Check back in with Tri-County WIC to see if the Kids Cook Monday Campaign has been talked about some more. Figure out regular schedule and how this could work.	n/a

Additional comments

- Diabetes Prevention Program – Hope Chest - Pekin, Wednesdays 10-11am
- Diabetes Prevention Program – Fondulac Library - Thursdays
- Diabetes Prevention Program – Creve Coeur Public Library

Goal: Improve overall healthy eating and physical activity in the Tri-County Region.

Objective HE2: By December 31, 2025, increase adults reporting exercising 1-5 days a week among the Tri-County Region by 1%

Intervention Strategy: Physical Activity- Increase physical activity through social supports to improve fitness of adults in the tri-county area. (PA)

Tasks & Tactics	Evaluation Plan	Target & Data	Monthly Recap	Upcoming Work	Issues/Challenges
PA 1: Increase data collection focusing on adult physical activity in the Tri-County Region.	# of establishments collecting adult physical activity data in the Tri-County Region.		Amy/Hilary researched apps to track physical activity; Walker Tracker or Move Spring. Marketing plan committee: Erin Luckey, Amaya, Kim L, Christian met to discuss "Let's Move Tri-County" marketing plan.	Amy/Hillary will review and seek product demonstration and	N/A

				will share with team.	
PA 2: Recruit additional Tri-County partner participation in the HEAL action team	Increase # of partners recruited by 6 new organizations.	*Baseline: 9 partners (different organizations)* 2023	No new partners this month.	Need to create a recruitment plan.	N/A
PA 3: Create promotional campaigns to promote physical activity in the Tri-County Region	Increase the number of physical activity campaigns in the Tri-County Region.	*Baseline: 4 campaigns* 2023 – 1 campaign: Take A Walk Wednesdays	Move it Monday Campaign will begin in January through March 2024 – "Find the time to fit in fitness" 12 weeks		N/A
PA4: Create social support events focused on increasing physical activity in the Tri-County Region.	Increase the number of adults attending each event by 50%	*Baseline – 1 events* 2023 – 1 Event: Hunger Action Walk	Team discussed data collection outside of events – What could be collected from programs data: DPP – minutes of PA per participant; Fit & Strong – pre/posts changes in PA; Group Exercise – number of people, membership numbers; Illinois WiseWoman Program – Pre/Post changes in PA.	Shanita and Hillary will request a meeting with Dr. Kelly to further discuss.	The word "events" in tactic.
Additional comments • Fit & Strong being offered by TCHD– 23 participants. 24 weeks for 2 times per week. Waiting list started for next session.					

Mental Health

Mental Health is defined in the CHNA as depression, anxiety and suicide. Mental health includes depression, anxiety and suicide. Though substance use is not explicitly included in the scope of this priority, PFHC Board recognizes a complex relationship exists between mental health and substance use. The PFHC Board supports continued efforts to reduce substance use in the Tri-County.

Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest. A diagnosis of depression includes symptoms that must last at least two weeks and represent a change in previous level of functioning; **Anxiety** involves an intense, excessive and persistent feeling of fear or dread, beyond a normal reaction to stress or nervousness, which can interfere with daily life; **Suicide** is when a person inflicts self-harm with the goal of ending their life and die as a result.

Goal: Improve the mental health, specifically suicide, depression, and anxiety, within the Tri-County Region.

Objective MH1: By December 31, 2025, decrease the number of suicides in the tri-county area by 10%

Objective MH2: By December 31, 2025, increase the proportion of children and adults with mental health problems in the tri-county areas who get treatment by 10%.

Intervention Strategy: Culturally-Adapted Health Care (CAHC)

Monthly Recap- All Activities

The December meeting took place on 12/19/23 as a virtual meeting.

WHOLE GROUP DISCUSSION: Trillium Place Access Center, Tony Mills, presented at this meeting. The new telepsych services provider list was shared and is posted online. Please join if you are interested in learning more. Working on completing the annual successes and gearing up for the annual presentation. Some highlights we noted – 50 unique participants attended meetings in 2024, representing 23+ different organizations and a total of over 292 volunteer hours for the main committee alone- not including steering committee and sub-committees.

SUB GROUPS- CAHC and Telepsych have been meeting separately, with Jonathan G leading Telehealth and Dawn R leading CAHC. If you are interested in joining either or both of these committees please let Amy Roberts or one of the leads know. Dawn is asking for additional CAHC resources – please send to her if you have any.

Tasks & Tactics	Evaluation Plan	Target/Data	Monthly Recap	Upcoming Work	Issues/Challenges
CAHC 1: Promote awareness and education trainings quarterly that are focused on improving cultural competence related to mental health care	60% of individuals who register for the event(s) will complete the training		Continued promotion of MHFA training being offered in the tri-county area. Other training resources were added to the form on the website to increase mental health trainings for community. New	Explore virtual options for MHFA. First CAHC subcommittee group meeting to occur Jan 18th at 11. (December meeting was rescheduled)	MHFA is held as in-person training and needs to be explored more for virtual options due to being full day training. Time to complete training in-person has been identified as a barrier. *Open for discussion
	More than 50% of the individuals who attended the sessions will self-report improvement in behaviors after cultural competence training(s)				
	More than 70% of the individuals who attended the session will self-report improvement in attitudes after cultural competence training(s)				

			trauma-informed care training added by Regional Office of Education.	Explore other training curriculum that is accessible and free to utilize.	
CAHC 2: Provide tailored educational trainings bi-annually to healthcare professional in the tri-county region	Establish baseline, increase # providers completing cultural competence trainings by 10%		Subgroup to explore options for annual or bi-annual options.	First CAHC subcommittee upcoming	*Open for discussion
CAHC 3: Create policies to support matching patient race/ethnicity/cultural/sexual orientation backgrounds to provider	Increase # providers/systems that have policies to support cultural competence by 10%		Subgroup to explore options for policies.		*Open for discussion
CAHC 4: Make culturally- and linguistically adapted materials and marketing available	Improve patient experience ratings (likelihood to recommend) by 1%		Subgroup to explore options for marketable materials.		*Open for discussion
Additional Comments					

Goal: Improve the mental health, specifically suicide, depression, and anxiety, within the Tri-County Region.

Objective MH1: By December 31, 2025, decrease the number of suicides in the tri-county area by 10%

Objective MH2: By December 31, 2025, increase the proportion of children and adults with mental health problems in the tri-county areas who get treatment by 10%.

Intervention Strategy: Telemedicine (TELMED)

Tasks & Tactics	Evaluation Plan	Target/Data	Monthly Recap	Upcoming Work	Issues/Challenges
TELMED 1: Establish baseline, inventory available telemedicine among tri-county	Complete inventory list of all telemedicine access.	(MET) Inventory complete for	*a comprehensive resource list has been created and is being	*List added to PFHC website	*List updated on PFHC website

		telepsych providers.	shared with the System of Care committee; SOC will meet with local care coordinators who help connect family to mental health and social services via IRIS		
TELMED 2: Disseminate information through 10 promotional campaigns on how to access (mental health) telemedicine	Increase # patients engaged in mental health telemedicine by 10%	(IN PROGRESS) 10 promotional campaigns launched	*Steering committee is working with OSF and Carle to determine messaging options for promoting telepsych *We are planning on social media launch and was discussed at last week's subcommittee meeting. Subcommittee will help develop screens to promote services (similar to ITFC (Tobacco) team.	*Would like to create a calendar for social media to promote telepsych and mental health resources in the tri-county; waiting on Trillium to approve first promotional post for Access Center	*Need to determine what resources we can push out for OSF and Carle- any other entities we should consider? Branding is an issue- if we push through PFHC, we don't want to have a lot of logos, so considering how to push resources without getting into a branding concern. And, if you have contacts at entities for who we can work with would be helpful.
TELMED 3: Support the development of structured partnerships for community healthcare organizations to provide telemedicine	Increase # new patients enrolled in telemedicine by 10%	(IN PROGRESS) Dr. Sara Kelly is collecting data from both hospitals to determine baseline	*Trillium Place is moving towards 2 APNs for services at the Jefferson facility and are looking forward to increasing access for patients; the contract with the Psych providing telepsych is ending 12/31. // OSF is using provider collaborators and have a licensed psych as a collaborator to discuss	*Baseline data and 10% goal by end of Q1	*Telepsych baseline data has not been determined to date but should be determined by end of Q1

			cases when APNs are providing telepsych services. *Trillium contracted Tele Psychiatrist ended 12/29/23 so now the 2 APNs are providing services.		
TELMED 4: Expand number of locations for community members to access telemedicine mental health care (community settings, OSF Strive, libraries, Wraparound Center, etc.)	Increase # telemedicine community access points by 10%	(NOT STARTED)	N/A	*Need to have a conversation with leaders from MH orgs to determine feasibility	*Open for discussion- Need to have a conversation with leaders from MH orgs to determine feasibility
TELMED 5: Provide more than 100 residents access to mental health telemedicine appointments who are either medically underserved or live in rural areas	Reduce # hospital readmissions among individuals who engage in telemedicine by 30%	(IN PROGRESS) Dr. Sara Kelly is collecting data from both hospitals to determine baseline			*Baseline data has not been determined to date but should be determined by end of Q1

Additional Comments

The **Suicide Prevention Workgroup, Mental Health First Aid Cadre, and Substance Use Committees** are continuing to meet.

- Suicide Prevention Workgroup met with Ben Brewer from PC Coroner's Office to review updated suicide data; will continue to monitor data as they have a new system that allows better tracking
- If any suicide prevention education/training/support is needed please reach out to Holly or use the form on the website: Partnership for a Healthy Community - Mental Health & Suicide Prevention (healthyhoi.org) This includes trauma-informed schools; suicide prevention for veterans, schools, public; youth/adult Mental Health First Aid; form is sent to Holly and disseminated to appropriate community agency contact; most training opportunities are provided at no cost as funding allows
- **NEW:** Vaping toolkit created for schools; created by Hult Center and vetted by Substance Use committee (see attached)

Obesity Workgroups - December 2023 Updates

Obesity is defined in the CHNA as overweight and obese.

Obesity includes individuals who are overweight or obese. A weight that is higher than considered healthy for a given height, determined by Body Mass Index, is classified as overweight or obese. Prevalence of overweight and obesity is a risk factor for chronic disease and raises the risk of developing diabetes, heart disease or hypertension. **Reducing overweight and obesity, preventative screenings and clinical therapies can reduce the risk of chronic disease.**

Goal: Reduce the proportion of residents with obesity in the Tri-County Region.

Objective O1: By December 31, 2025, reduce the proportion of adolescents with obesity in the TriCounty Region by 1%.

Intervention Strategy: Digital Health Interventions for Adolescents with Obesity (DHIAO)

Tasks & Tactics	Evaluation Plan	Target/Data	Monthly Recap	Upcoming Work	Issues/Challenges
DHIAO 1: Identify baseline data, definitions and programming for digital health interventions in the tri-county area.	# of data points collected		**Adult Obesity initiative moved forward with OSF paying for JoAn G. from the PPD to take the online course for Strong People Strong Bodies Living Well certification.** **Met with OSF Grant writers to discuss opportunity: "Innovation for Healthcare" Grant through partnership with Bradley and OSF. Is a $50k grant to support developing solutions to health challenges in Central Il Communities. Team will work**	JoAn completed certification for Living Well. The course was very statistic driven and overview of obesity and lifestyles of the United States. Course offered Sample Scorecard for Senior Fitness Test, which include normal values. On Thursday, Jan. 18th Meta will share course details with the committee on how to proceed further with class. The 12-week course to be taught will be 2x week 30 minutes exercise and 30 minutes nutrition.	The week of Feb. 12 JoAn should receive Stong People Leader guide, participant guide, and health journal sample. This is included in the $500 overhead price. Any additional guide is an additional fee. Leader resource store is all additional cost. The leader guide that we are waiting on will tell us how to teach each class. It is still a bit challenging to decide the best location to offer this course. More discussion will take place on Jan. 18th.
	Define "Digital Health Interventions"	How Clinical?			
	Identify programming currently being offered.	To be reviewed and researched			

			with Grant Writers on application	Assessments will be completed at the beginning and end of 12-week session. **Will need an update on Grant application process.** **In personTeam meeting Jan 11** **Will explore clinical pathways in January meeting in person. Availability in Epic.** **Promote Well Program** **Promote successes from Dr. Christison's Program** **Get Fitbit Trackers over to her and track some of those successes**	note that as of 8/2023, waiting list is at 400+ for OSF's Health Kids U Biggest issue is getting buy in from PCP's to commit to modified obesity treatment as kids wait for availability into Tertiary care
DHIAO 2: Promote through education and awareness utilizing social media communication.	# of promotional campaigns performed through the TriCounty Region.		Social Media/Advertisement (Need Outside Source) • Need page made to share links or QR codes (Place on Hult's Center or Partnership's website easily.) • Educational Piece • Counseling		

			• Information about diet- 1 on 1 with dietician • Web series on basics (? Database to put these items on.) • Have items available online with the ability to submit questions. • Ability to submit questions. • Interactive Worksheets if applicable. Collective Groups/ Branding *Keep doing whatever it is your doing, but we would like to share together on Partnership*		
DHIAO 3: Collaborate with healthcare providers for enrollment.	% of individuals completing digital health program report improved weight related measures. 10-15% improvement in BMI % retention of registered individuals for one month of the program		**Ashley Fischer has a dot phrase that explains the medications at a patient level and the advantages and disadvantages of each- brought up during the child wellness visit stating guidelines changes for Adolescent obesity. Dr. Fischer has offered to teach a revised/ condensed evidence based format for having adolescent obesity conversation in around 10 minutes.- considering making a video for providers to model after.**	• YEAR 1 • Identify care pathways and gaps • Develop evidence-based practice toolkit for tri-county use • YEAR 2 • Protocols and plan in place for sustainability • Provide education/training to providers to increase their comfort level in managing patients with obesity • YEAR 3	

				• Maintain toolkit • Offer continuing education/training as requested • Add more resources to address patients' health-related social needs and other health concerns	
DHIAO 4: Promote behavioral change through use of technology devices.	Pre / Post changes is behavior		**-Potential to collaborate and expand on Hult Center program utilizing wearable devices / step counters/ Holly's intern is working through two apps to see if they fit our needs**		
DHIAO 5: Personalize program with Text Messaging, Health coaching calls, or Tele Visits	Pre/ Post changes in Biometrics		Exploring further with Grant opportunity, will update further at end of January*	**-Further explore Epic Care Companion as option for digital component**	
Additional Comments					

Objective O2: By December 31, 2025, reduce the proportion of adults (women) with obesity in the TriCounty Region by 2%.

Intervention Strategy: Strong People Healthy Weight (SPHW)

Tasks & Tactics	Evaluation Plan	Target/Data	Monthly Recap	Upcoming Work	Issues/Challenges
SPHW 1: Collect Baseline data / ptogram information	# of establishments collecting adult physical activity data in the Tri-County Region.		**Initial facilitator course purchased.** **Second facilitator identified** **Our project has received a $5,000 grant from the OSF SFMC Foundation to help**	**Facilitator to complete on line training** **Purchase training for second facilitator**	

			support implementation of this program.	**Confirm Sites to host program** **Prep Sites** **Develop Class Schedule** **Market to communities** **Finalize plan with January workgroup meeting**	
SPHW 2: Develop recruitment campaign in the tri-county area.	Increase # of individuals registering for programs				
	# of promotional campaigns performed in the tri-county area.				
SPHW 3: Provide a Leadership workshop to educate and inform about program.	# of participants in the workshop				
SPHW4: Partner with community resources to establish class locations.	% of retention of registered individuals through completion of program.				
	# of individuals completing SPHW program report having improved weight related measures.				
	Enrollment of 25 participants quarterly within the tri-county area.				
SPHW5: Share success stories of the program within the tri-county program	# of pre/post test changes in biometrics and behavior.				
Additional Comments					

Q4
2023

QUARTERLY REPORT

PFHC DATA TEAM

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SUMMARY

The Data Team for the Partnership For A Healthy Community (PFHC) is charged with assessing the health problems and needs for the Tri-County region. The goal of the Data Team is to track progress and challenges in the Tri-County region and provide timely feedback to the communities and board members on a variety of health metrics, including selected health interventions. The three health priority areas identified by the PFHC are explored in the following report: HEAL (healthy eating, active living), obesity, and mental health. Additional measures related to social determinants of health and mortality and provided quarterly to gain further insight into population health in the region. Utilizing public health surveillance measures along with programmatic measures, the Data Team uses a systematic process to identify the implementation of the selected programs. The programmatic outcomes for each selected health intervention for the three priority areas are continuously reviewed to ensure the effectiveness and ongoing improvement through identification of current challenges or needs.

The data team is comprised of a diverse set of stakeholders working collaboratively to provide updates to the community. The Data Team meets monthly to discuss updated public health surveillance measures, progress of selected health interventions, needs and challenges for the committees related to the health priorities and those that are in performance management. Below is a list of Data Team members and their respective organization, in alphabetical order.

Name	Organization
Hillary Aggertt, MS	Woodford County Health Department
Sarah Donohue, PhD, MPH	University of Illinois College of Medicine Peoria
Sally Gambacorta, MA, MS	Carle Health
Megan Hanley, MPH	Tazewell County Health Department
Monica Hendrickson, MPH	Peoria City/County Health Department
Sara Kelly, PhD, MPH	University of Illinois College of Medicine Peoria
Amanda Sutphen, MS	OSF HealthCare
Tracy Terlinde, MPH	Peoria City/County Health Department
Larry Weinzimmer, PhD	Bradley University

For additional information, contact Sara Kelly, PhD, MPH: skelly88@uic.edu

HEAL

HEAL is defined as **h**ealthy **e**ating, **a**ctive **l**iving, access to food and food insecurity.

Healthy eating is an eating plan that emphasizes fruits, vegetables, whole grains and fat-free or low-fat milk and milk products; includes a variety of protein foods, is low in added sugars, sodium, saturated fats, trans fat and cholesterol and stays within in daily caloric needs. Education, lifestyle interventions and food access positively affect healthy eating. **Active living** means doing physical activity throughout the day. Any activity that is physical and includes bodily movement during free time is part of an active lifestyle.

Access to food refers to the ability of an individual or household to acquire food. Transportation, travel time, availability of safe, healthy foods and food prices are factors to food access.

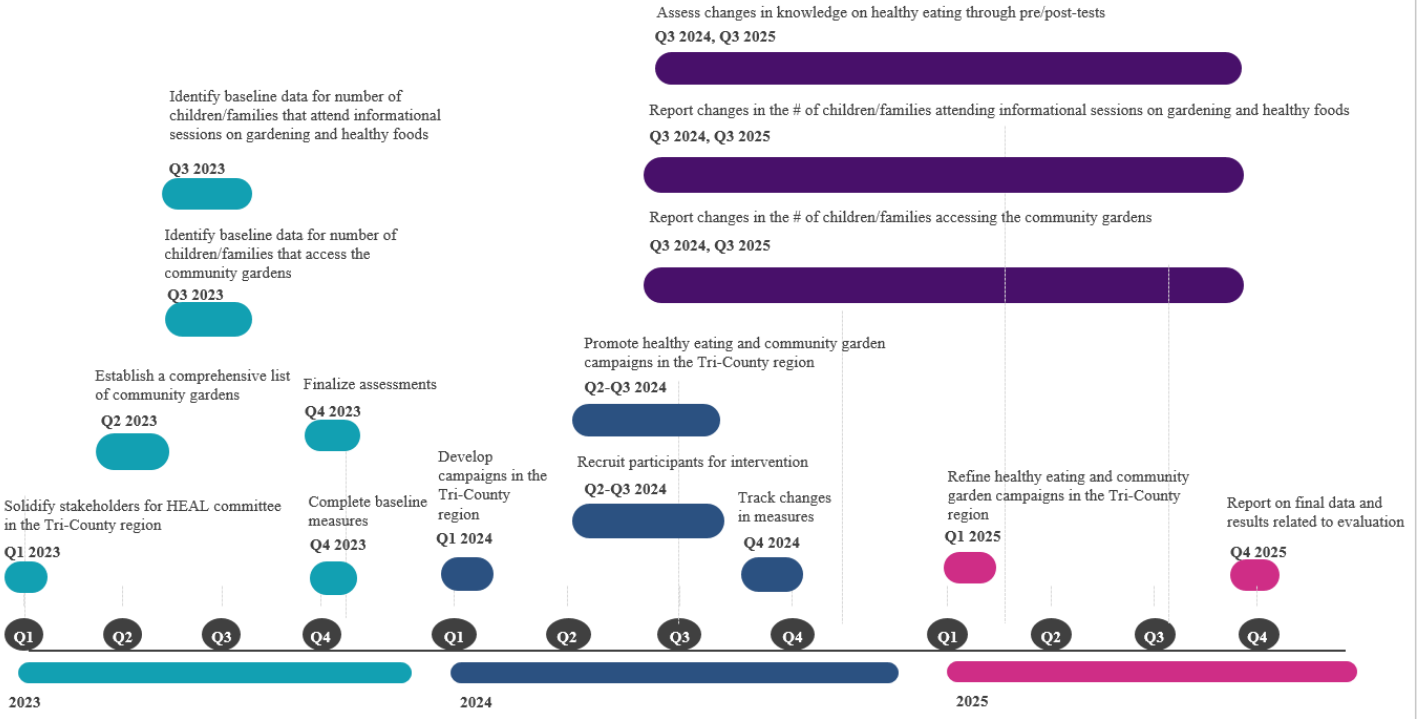
Food insecurity is as a lack of consistent access to enough, nutritious food for every person in a household to live an active, healthy life.

The overall goal is to improve healthy eating and physical activity in the Tri-County region through two interventions: one focused on healthy eating and one focused on physical activity.

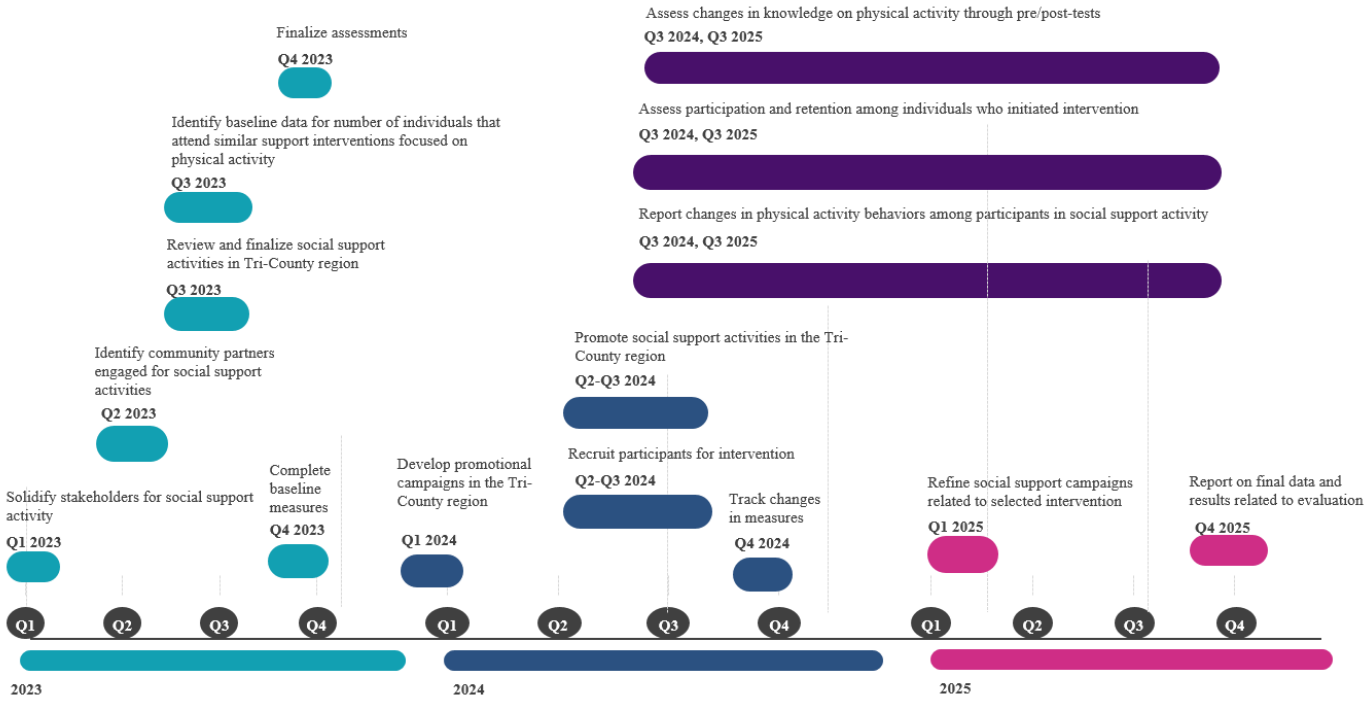
Evaluation metrics for each intervention

Roadmap of HEAL interventions

HEALTHY EATING



PHYSICAL ACTIVITY



Programmatic outputs

Intervention Strategy: Gardening: Increase Vegetable Consumption among Children (HE)

Objective: By December 31, 2025, increase accessibility of healthy food in the Tri-County Region through the support of community gardens by 10%.				
Tasks & Tactics	**Evaluation Plan**	**Target & Data**	**Monthly Recap (11/23)**	**Upcoming Work**
HE 1: Gather baseline data around community gardens and school-aged programming.	• Complete a comprehensive list establishing locations of community gardens and school aged gardening programs. • # of children/families accessing the community gardens	37 gardens By January 2024, recruit Woodford County community gardens. April 2023 – Identify # of children and families that accessed the garden	No progress made on this during the month – wanted to wait until after growing season to make outreach – list completed with contacts during growing season	• Mike to begin outreach to all the gardens. Any gardens he can't reach or needs help with, he will reach out to Extension.
HE 2: HE 2: Implement garden-based learning sessions focused on gardening and healthy eating.	• # of children/families attending information sessions about gardening and healthy foods. • Increase healthy eating knowledge	April 2023 – Identify # of children and families that attended garden-based learning	Meeting with Dr. Kelly & Megan to refine the standard evaluation. This evaluation will be used to help keep track of our baseline data with programs happening in	• Rebecca needs to check in on evaluation and OSF Cancer Center as a potential partner for programming

	through pre/post test evaluation per session by 75%		gardens. Briefly discussed spaces for programming. However, we are waiting on full scheduling currently due to the season.	
HE 3: Promote campaigns focused on healthy eating and access to healthy foods.	• # of healthy eating and community gardening campaigns in the Tri-County Region.	April 2023- Identify number of campaigns completed in 2022.	Release of 12 Days of Giving Campaign. Focused on healthy donations to our pantries during the holidays. Toolkit updated and released. Discuss the possibility of a weekly post schedule for food Friday's on the partnership page. Idea of Pantry/Find Food – 1st Friday, Nutrition Tip – 2nd Friday, Federal Food – 3rd Friday, Recipe – 4th Friday - Maybe work on this in the new year – Use December Meeting to talk about how we could work on this For now – Rebecca brought up doing a holiday campaign. There had been discussion with YMCA but not able to make schedules work to talk. Team decided a Happy Healthy Holiday Campaign could be a good thing to do for Fridays starting 11/17 through 12/29. Team identified 3 recipes that will be recorded and shared. Also will create 4 Holiday Swap posts.	Happy Healthy Holidays: Emily with Peoria WIC working on swaps. Becca – working on templates for campaign. Mike, Becca, Emily to create videos for recipes. Kim – to post on partnership page/approve items 12 Days of giving – posting on page: Kim. Release of campaign via email blasts & press release. Hoping that some partners will host a campaign too!

Intervention Strategy: Physical Activity- Increase physical activity through social supports to improve fitness of adults in the Tri-County area. (PA)

Objective: By December 31, 2025, increase adults reporting exercising 1-5 days a week among the Tri-County Region by 1%				
Tasks & Tactics	**Evaluation Plan**	**Target & Data**	**Monthly Recap (11/23)**	**Upcoming Work**
PA 1: Increase data collection focusing on adult physical activity in the Tri-County Region.	# of establishments collecting adult physical activity data in the Tri-County Region	Amy/Hilary researched apps to track physical activity; Walker Tracker or Move Spring. Marketing plan committee: Erin Luckey, Amaya, Kim L, Christian met to discuss "Let's Move Tri-County" marketing plan.	Amy/Hillary will review and seek product demonstration and will share with team by end of November.	
PA 2: Recruit additional Tri-County partner participation in the HEAL action team	Increase # of partners recruited by 6 new organizations	Baseline: 9 partners (different organizations) 2023	No new partners this month.	• Need to create a recruitment plan.
PA 3: Create promotional campaigns to promote physical activity in the Tri-County Region	Increase the number of physical activity campaigns in the Tri-County Region	*Baseline: 4 campaigns 2023 – 1 campaign: Take A Walk Wednesdays*	Take A Walk Wednesdays promotion on social media ended. The reach was 10,776 on Facebook. Move it Monday Campaign will begin in January through March 2024 – "Find the time to fit in fitness" 12 weeks	• Working on Holiday campaign to include Physical Activity. • Will promote Riverplex's 12 days of Fitmas
PA4: Create social support events focused on increasing physical activity in the Tri-County Region.	Increase the number of adults attending each event by 50%	*Baseline – 1 events* 2023 – 1 Event: Hunger Action Walk	Team discussed data collection outside of events – What could be collected from programs data: DPP – minutes of PA per participant; Fit & Strong – pre/posts changes in PA; Group Exercise – number of people, membership numbers; Illinois WiseWoman Program – Pre/Post changes in PA.	• Shanita and Hillary will rmeet with Dr. Kelly to further discuss.

Current challenges or needs for selected interventions

Healthy Eating (HE)

- No issues or challenges- beginning to work on baseline data.
- Given the season of year, they are standardizing the evaluation during this time prior to implementation.

Physical activity (PA)

- Would like to reword PA4 to exclude the word "events."

Public health surveillance data

Healthy Eating (HE)

	Peoria	Tazewell	Woodford	Illinois	United States
Food Environment Index [1]	6.9	8.0	8.9	8.5	7.0
% food insecure[2]	12.5	9.2	6.9	8.3	12.0
% limited to healthy foods[3]	13.2	9.3	4.7	4.8	6.0

Data sources:

1. 2019 & 2020 USDA Food Environment Atlas; Map the Meal Gap from Feeding America.
2. 2020 Map the Meal Gap from Feeding America
3. 2019 USDA Food Environment Atlas

Food environment index is a measure of factors that contribute to a healthy food environment on a scale from 0 (worst) to 10 (best).

Food insecurity is measured by the percentage of population who lack adequate access to food.

Limited access to healthy foods is measured by the percentage of population who are low-income and do not live close to a grocery store.

Physical activity (PA)

	Peoria	Tazewell	Woodford	Illinois	United States
% physical inactive[1]	24.4	22.8	20.5	24.4	22.0
Access to exercise opportunities[2]	79.3	84.1	75.5	90.4	84.0
No leisure-time physical activity[3]	28.7	24.6	22.8	24.3	23.0

Data sources:

1. 2020 Behavior Risk Factor Surveillance System (BRFSS)
2. 2022 & 2020 ArcGIS Business Analyst and Living Atlas of the World; YMCA; US Census TIGER/Line Shapefiles
3. 2021 Behavior Risk Factor Surveillance System (BRFSS)

Measures in tables using BRFSS data depicts the age-adjusted percentage of adults for the Tri-County region in comparison to Illinois and the US.

Access to exercise opportunities measures the percentage of individuals in a county who live reasonably close to a location for physical activity. Locations for physical activity are defined as parks or recreational facilities.

Note: Additional measures related to HEAL are provided at the end of the obesity section in this report.

OBESITY

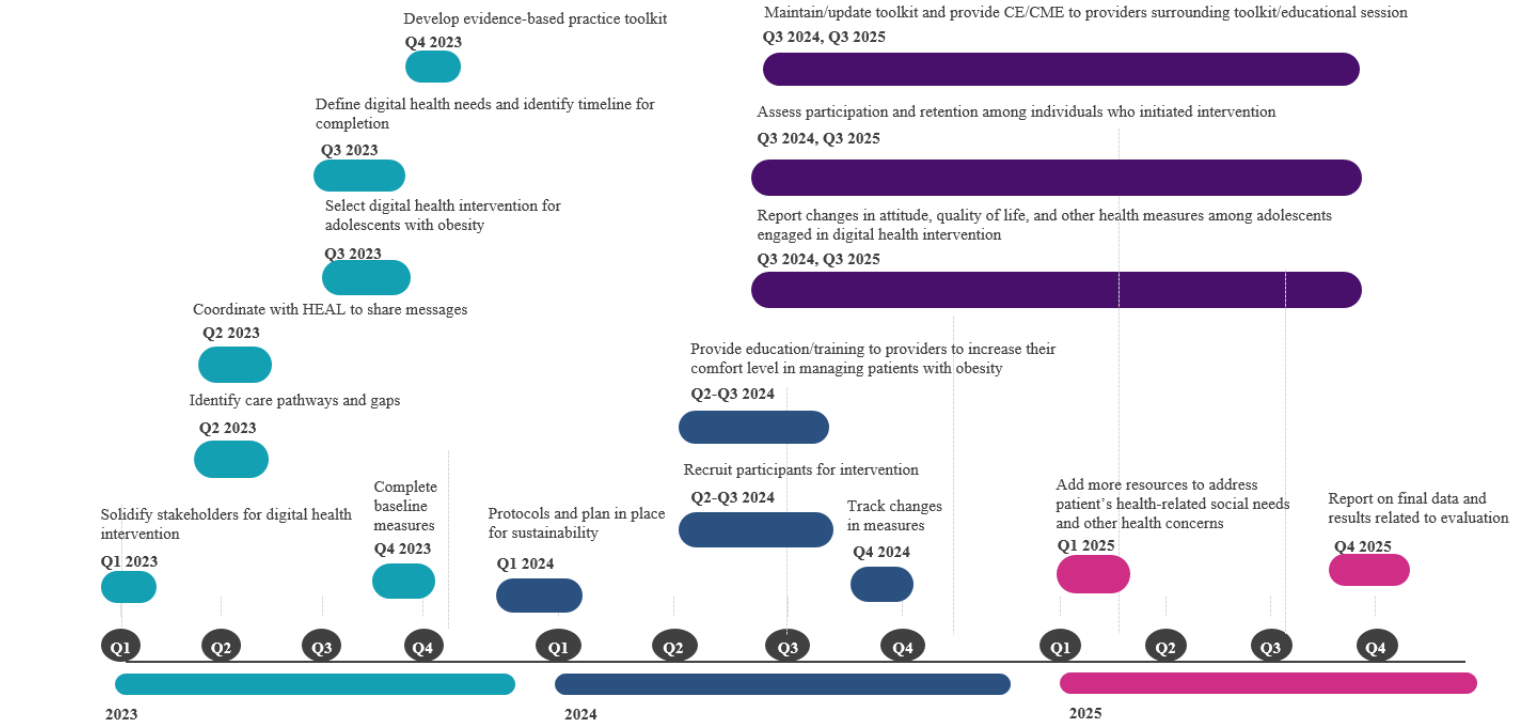
Obesity is defined in the CHNA as overweight and obese.

Obesity includes individuals who are overweight or obese. A weight that is higher than considered healthy for a given height, determined by Body Mass Index (BMI), is classified as overweight or obese. Prevalence of overweight and obesity is a risk factor for chronic disease and raises the risk of developing diabetes, heart disease or hypertension. **Reducing overweight and obesity, preventative screenings and clinical therapies can reduce the risk of chronic disease.**

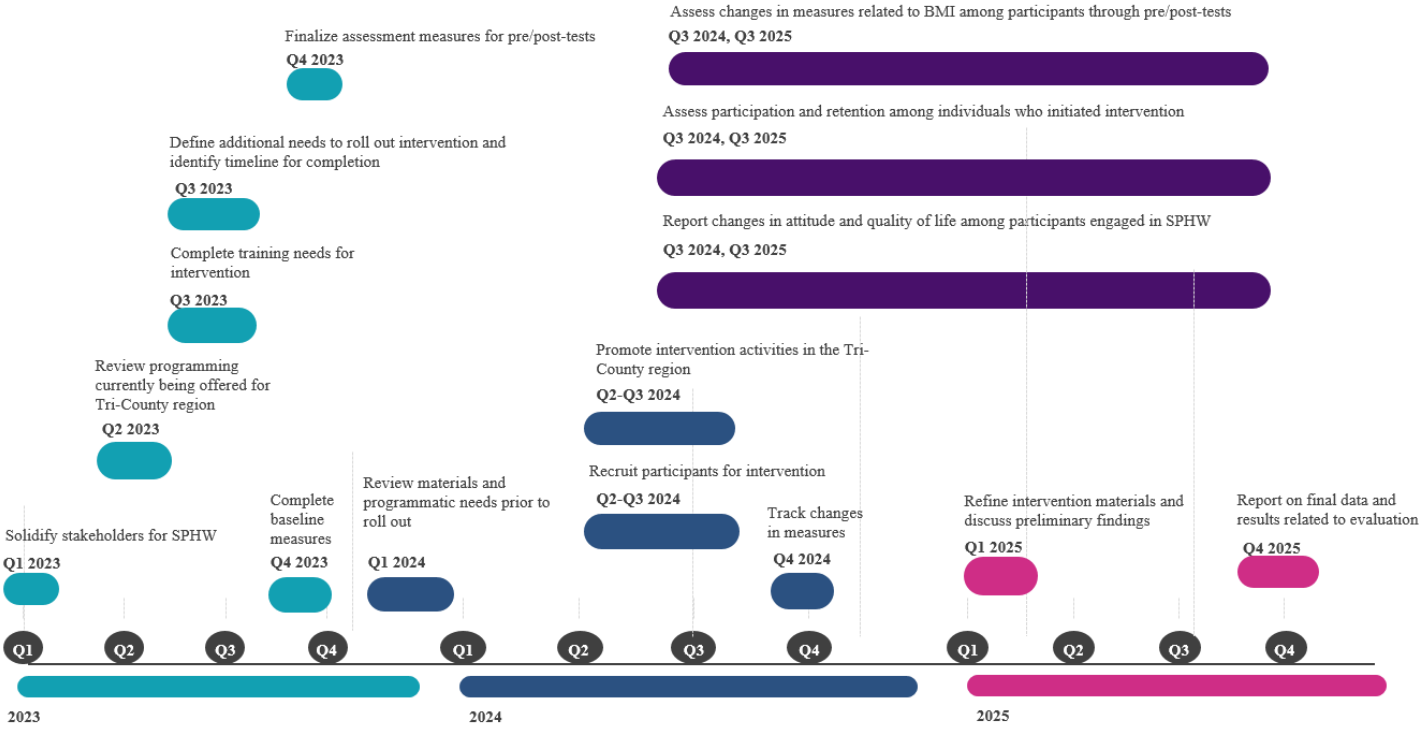
The overall goal is by the end of 2025, to reduce the proportion of residents with obesity in the Tri-County region.

Evaluation metrics for each intervention

Roadmap of obesity interventions



OBESITY: STRONG PEOPLE HEALTHY WEIGHT (SPHW)



Programmatic outputs

Intervention Strategy: Digital Health Interventions for Adolescents with Obesity (DHIAO)

Objective: By December 31, 2025, reduce the proportion of adolescents with obesity in the TriCounty Region by 1%.				
Tasks & Tactics	**Evaluation Plan**	**Target/Data**	**Monthly Recap (12//23)**	**Upcoming Work**
DHIAO 1: Identify baseline data, definitions and programming for digital health interventions in the tri-county area.	• # of data points collected • Define "Digital Health Interventions" • Identify programming currently being offered		Meeting with workgroup and OSF On Call for discussion on leveraging EPIC. Care Companion module may have promise as it is currently set up to send out updates and education to patients including peds care plans. Met with OSF Grant writers to discuss opportunity: "Innovation for Healthcare" Grant through partnership with Bradley and OSF. Is a $50k grant to support developing solutions to health challenges in Central Il Communities. Team will work with Grant Writers on application	• Will need an update on Grant application process. • In person team meeting Jan 11 • Will explore clinical pathways in January meeting in person. Availability in Epic. • Promote Well Program • Promote successes from Dr. Christison's Program • Get Fitbit Trackers over to her and track some of those successes
DHIAO 2: Promote through education and awareness utilizing	• # of promotional campaigns performed through the		Social Media/Advertisement (Need Outside Source) • Need page made to share links or QR codes (Place on	•

social media communication.	TriCounty Region.		Hult's Center or Partnership's website easily.) • Educational Piece • Counseling • Information about diet-1 on 1 with dietician • Web series on basics (? Database to put these items on.) • Have items available online with the ability to submit questions. • Ability to submit questions. • Interactive Worksheets if applicable. Collective Groups/ Branding *Keep doing whatever it is your doing, but we would like to share together on Partnership*	
DHIAO 3: Collaborate with healthcare providers for enrollment.	• % of individuals completing digital health program report improved weight related measures. • 10-15% improvement in BMI • % retention of registered individuals for one month of the program		Dr. Christison shared tools and algorithms with Carle and they are working on sharing with leadership for approval, then distribution of materials and education for providers; toolkits being created Ashley Fischer has a dot phrase that explains the medications at a patient level and the advantages and disadvantages of each- brought up during the child wellness visit stating guidelines changes for Adolescent obesity. Quick talk of guidelines of why they have changed how science has changed on what causes obesity. If interested, they can look at the dot phrase and schedule a follow-up visit to talk about which one they would want to try. (Victoza is chosen frequently) – Takes approx. 8 minutes to talk about, doesn't need to take 20 min.- 1 hr	• **YEAR 1**: Identify care pathways and gaps, develop evidence-based practice toolkit for tri-county use • **YEAR 2**:Protocols and plan in place for sustainability, Provide education/training to providers to increase their comfort level in managing patients with obesity • **YEAR 3**: Maintain toolkit, Offer continuing education/training as requested, Add more resources to address patients' health-related social needs and other health concerns
DHIAO 4: Promote behavioral change through use of technology devices.	Pre / Post changes is behavior		Potential to collaborate and expand on Hult Center program utilizing wearable devices / step counters/ Holly's intern is working through two apps to see if they fit our needs	•
DHIAO 5: Personalize program with Text Messaging, Health coaching calls, or Tele Visits	Pre/ Post changes in Biometrics			• Further explore Epic Care Companion as option for digital component

Intervention Strategy: Strong People Healthy Weight (SPHW)

Objective : By December 31, 2025, reduce the proportion of adults (women) with obesity in the Tri-County Region by 2%.				
Tasks & Tactics	**Evaluation Plan**	**Target/Data**	**Monthly Recap (12/23)**	**Upcoming Work**
SPHW 1: Collect Baseline data / program information	• # of establishments collecting adult physical activity data in the Tri-County Region		Initial facilitator course purchased. Second facilitator identified	• Facilitator to complete on line training

			Our project has received a $5,000 grant from the OSF SFMC Foundation to help support implementation of this program.	• Purchase training for second facilitator • Confirm Sites to host program • Prep Sites • Develop Class Schedule • Market to communities • Finalize plan with January workgroup meeting
SPHW 2: Develop recruitment campaign in the tri-county area.	• Increase # of individuals registering for programs • # of promotional campaigns performed in the tri-county area			
SPHW 3: Provide a Leadership workshop to educate and inform about program**.**	• # of participants in the workshop			
SPHW4: Partner with community resources to establish class locations.	• % of retention of registered individuals through completion of program • # of individuals completing SPHW program report having improved weight related measures • Enrollment of 25 participants quarterly within the tri-county area			
SPHW5: Share success stories of the program within the tri-county program	• # of pre/post test changes in biometrics and behavior			

Current challenges or needs for selected interventions

Adolescent:

- As of August 2023, there are 400+ children on the waiting list for OSF's Health Kids U

Strong People Healthy Weight (SPHW):

- As discussed at August board meeting, funding for program spread will be an ongoing issue. Investigated potential for grant funding. Discussion with OSF Grant Writers, recommended OSF Foundation and have had initial discussion with Jacob from Foundation. He recommends escalation to President for potential local foundation funding at SFMC.

Public health surveillance data

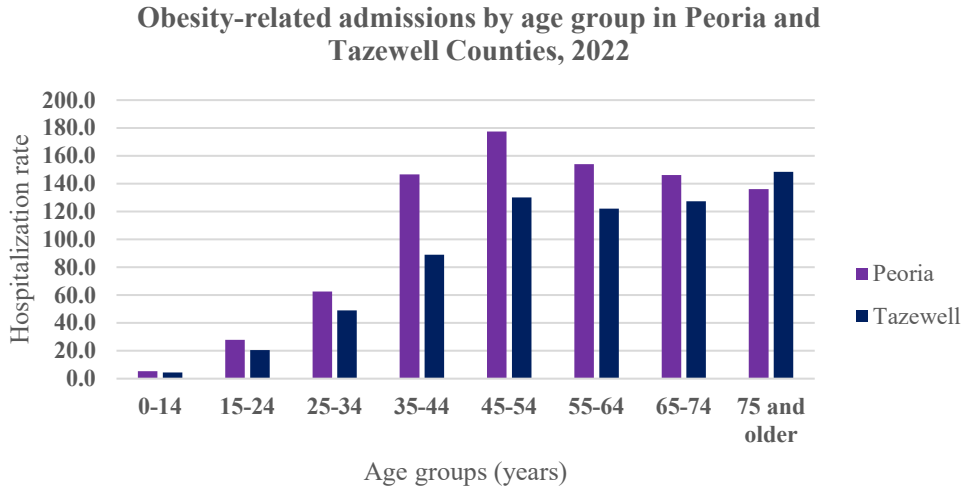
	Peoria	Tazewell	Woodford	Illinois	United States
Obesity among adults	36.1	35.6	33.9	33.9	33.0

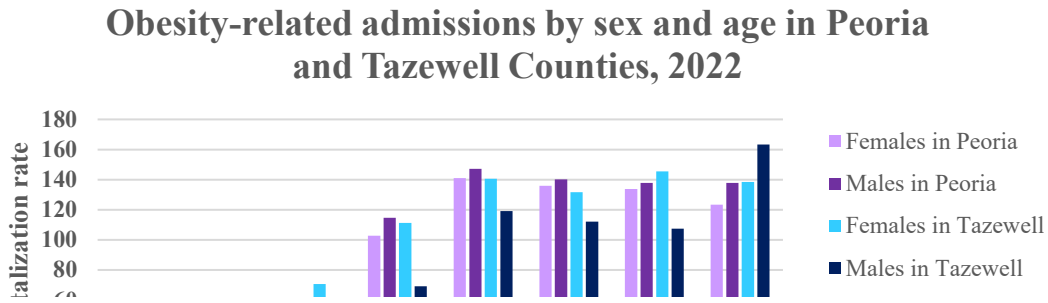
Data sources:

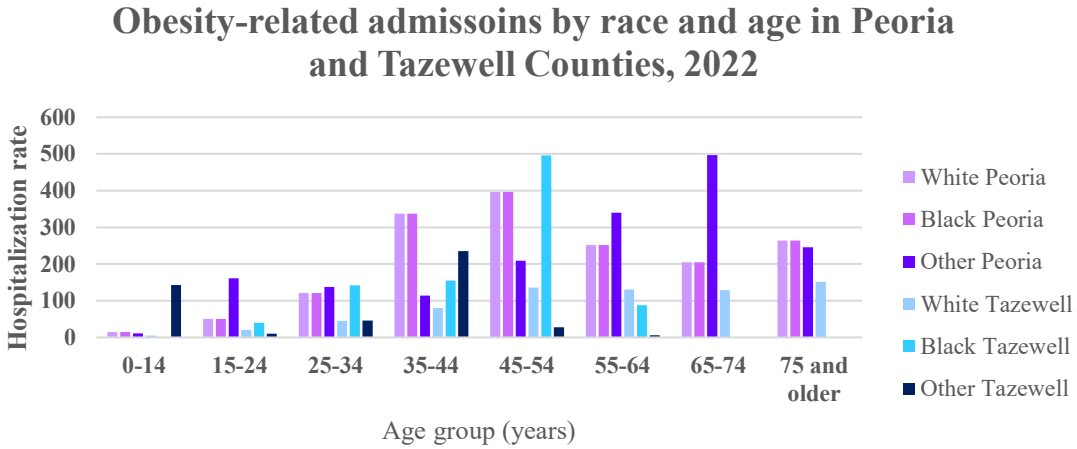
1. 2021 Behavior Risk Factor Surveillance System (BRFSS)

ESSENCE data

Obesity-related hospital admissions were pulled from the Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) for Peoria and Tazewell Counties during 2022. We identified age-adjusted obesity-related admission rates based on the International Statistical Classification of Disease and Related Health Problems, Tenth Revision codes X66. We further explored differences in rates by age, sex, and racial group to better understand the populations at highest risk for negative health outcomes related to each outcome. Hospitalization rate depicts the proportion of hospital visits for each population in 2022.







Additional health metrics related to obesity

	Peoria	Tazewell	Woodford	Illinois	United States
Cholesterol screening among adults	80.7	81.4	82.2	84.7	84.3
High cholesterol among adults who have been screened	28.3	28.7	28.7	28.1	31.0
High blood pressure among adults	31.1	30.1	28.3	27.2	29.6
Diagnosed with diabetes (adults)	10.1	8.4	7.8	9.7	9.9
Coronary heart diseases (adults)	5.4	5.1	4.8	5.2	5.2
Stroke (adults)	2.9	2.6	2.4	3.1	2.8

Data sources:

1. 2021 Behavior Risk Factor Surveillance System (BRFSS)

Measures in tables using BRFSS data depicts the age-adjusted percentage of adults for the Tri-County region in comparison to Illinois and the US.

MENTAL HEALTH

Mental Health is defined as depression, anxiety and suicide in the CHNA.

Mental health includes depression, anxiety and suicide. Though substance use is not explicitly included in the scope of this priority, PFHC Board recognizes a complex relationship exists between mental health and substance use. The PFHC Board supports continued efforts to reduce substance use in the Tri-County.

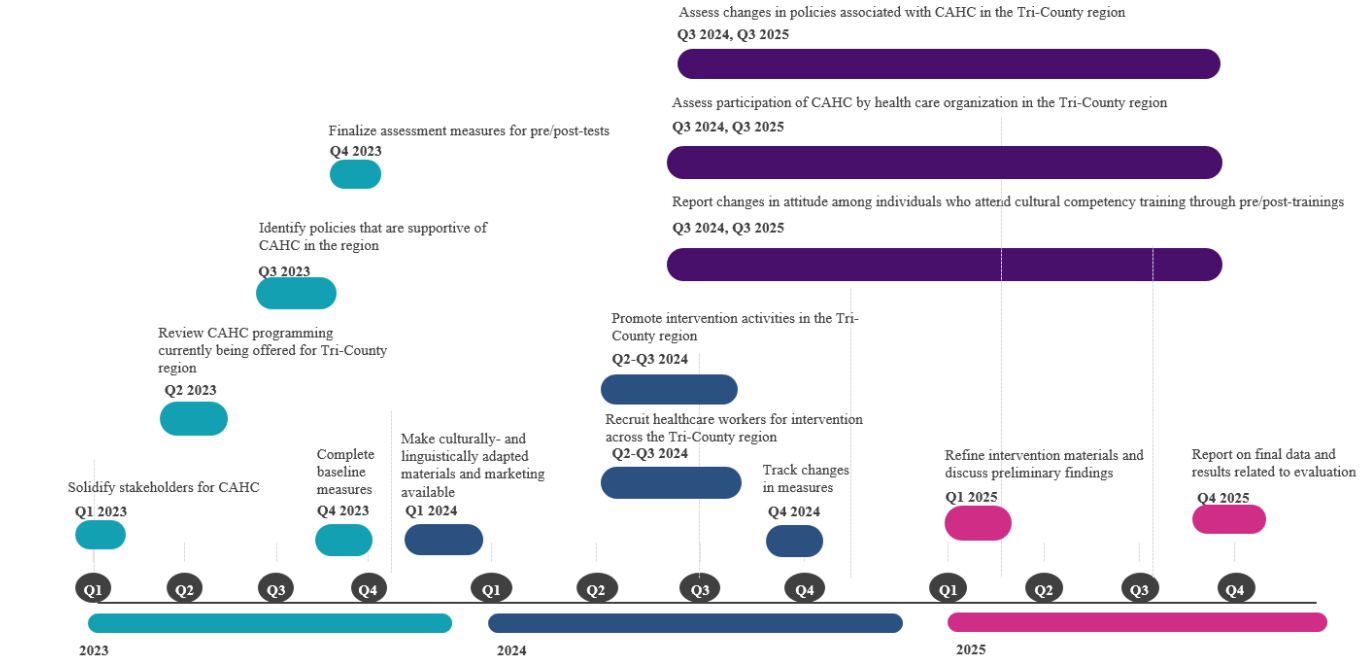
Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest. A diagnosis of depression includes symptoms that must last at least two weeks and represent a change in previous level of functioning; **Anxiety** involves an intense, excessive and persistent feeling of fear or dread, beyond a normal reaction to stress or nervousness, which can interfere with daily life. **Suicide** is when a person inflicts self-harm with the goal of ending their life and die as a result.

The overall goal is to improve mental health, specifically in regards to suicide, depression, and anxiety within the Tri-County region. Specifically, the following long-term objectives are going to be worked on through two selected health interventions: culturally adapted health care (CAHC) and telemedicine (TELMED).

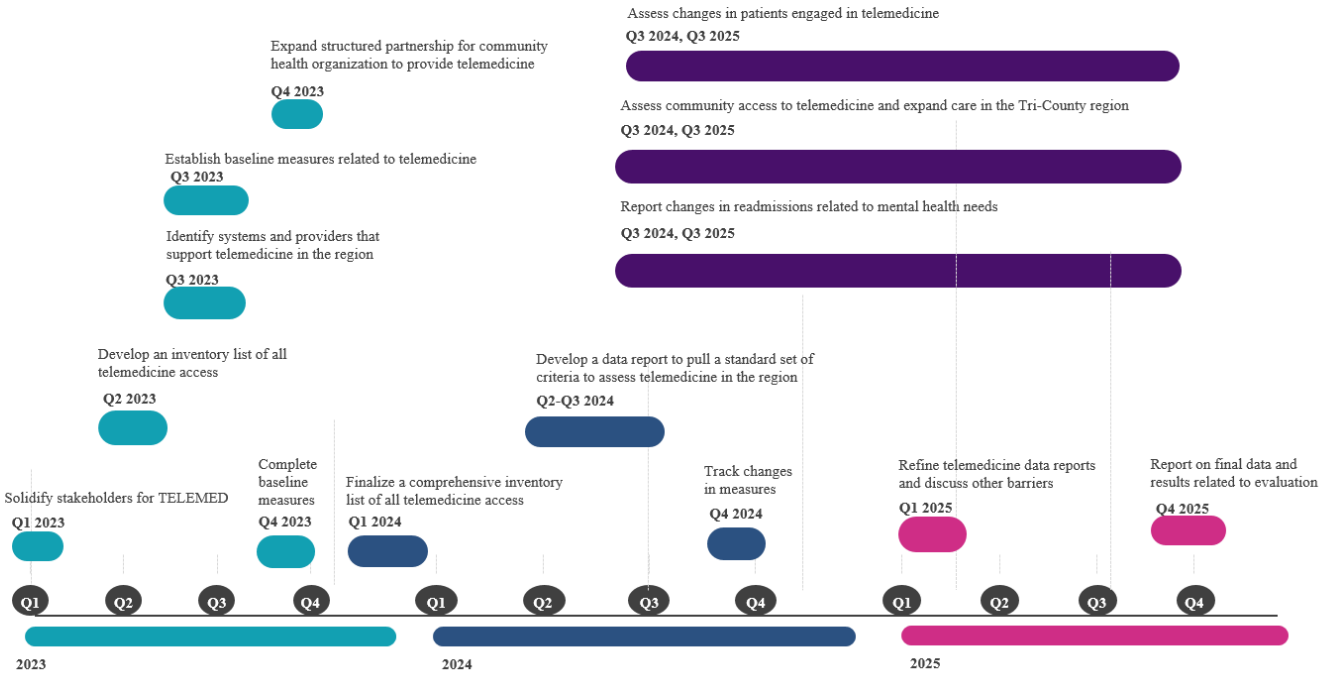
- *By December 31, 2025, decrease the number of suicides in the Tri-County area by 10%.*
- *By December 31, 2025, increase the proportion of children and adults with mental health problems in the Tri-County areas who get treatment by 10%.*

Evaluation metrics for each intervention

Roadmap of mental health interventions



MENTAL HEALTH: TELEMEDICINE



Programmatic outputs

Intervention Strategy: Culturally-Adapted Health Care (CAHC)

Tasks & Tactics	Evaluation Plan	Target/ Data	Monthly Recap (12/23)/ Upcoming Work
CAHC 1: Promote awareness and education trainings quarterly that are focused on improving cultural competence related to mental health care	60% of individuals who register for the event(s) will complete the training More than 50% of the individuals who attended the sessions will self-report improvement in behaviors after cultural competence training(s) More than 70% of the individuals who attended the session will self-report improvement in attitudes after cultural competence training(s)		•OSF: Advance cultural competency for BH mission partners // 100% SFMC BH mission partners will complete Cultural Competency (D.Lockbaum) •What is Carle's plan (if any) for this? JG, I thought you said that you already had a plan in place. What kind of trainings? What are the outcomes? Who are you serving and by when? Can this be expanded/offered to others in the tri-county? •What about other clinics? Heartland, etc? Do they have any trainings or CAHC work planned? •Who else do we need to bring to the table for this initiative? •At the end of Year 1, what does success look like? Year 2? Year 3?
CAHC 2: Provide tailored educational trainings bi-annually to healthcare professional in the tri-county region	Establish baseline, increase # providers completing cultural competence trainings by 10%		•What is Carle's plan (if any) for this? JG, I thought you said that you already had a plan in place. What kind of trainings? What are the outcomes? Who are you serving and by when? Can this be expanded/offered to others in the tri-county? •What about other clinics? Heartland, etc? Do they have any trainings or CAHC work planned?

CAHC 3: Create policies to support matching patient race/ethnicity/cultural/sexual orientation backgrounds to provider	Increase # providers/systems that have policies to support cultural competence by 10%		•What is Carle's plan (if any) for this? JG, I thought you said that you already had a plan in place. What kind of trainings? What are the outcomes? Who are you serving and by when? Can this be expanded/offered to others in the tri-county? •What about other clinics? Heartland, etc? Do they have any trainings or CAHC work planned? •In regard to improving the diversity of providers, we should remember that paraprofessionals can be used in some cases.
CAHC 4: Make culturally- and linguistically adapted materials and marketing available	Improve patient experience ratings (likelihood to recommend) by 1%		•What is OSF's plan for this? •What is Carle's plan (if any) for this? JG, I thought you said that you already had a plan in place. What kind of trainings? What are the outcomes? Who are you serving and by when? Can this be expanded/offered to others in the tri-county? •What about other clinics? Heartland, etc? Do they have any trainings or CAHC work planned?

Intervention Strategy: Telemedicine (TELMED)

Tasks & Tactics	Evaluation Plan	Target/Data	Monthly Recap (12/23)/ Upcoming Work
TELMED 1: Establish baseline, inventory available telemedicine among tri-county	Complete inventory list of all telemedicine access.		•OSF: Increase utilization of BH telemedicine from baseline by 2% (Baseline TBD) (D.Lockbaum and T.Bromley) •What is Carle's plan for telemedicine? •See the list that Access Center provided in May 2023. •What about other clinics? Heartland, etc? Do they have any trainings or CAHC work planned? •Who else do we need to bring to the table for this initiative?
TELMED 2: Disseminate information through 10 promotional campaigns on how to access (mental health) telemedicine	Increase # patients engaged in mental health telemedicine by 10%		•What is OSF's plan for telemedicine (if any) for this? •What is Carle's plan for telemedicine? •See the list that Access Center provided in May 2023. •What about other clinics? Heartland, etc? Do they have any trainings or CAHC work planned? •Who else do we need to bring to the table for this initiative?
TELMED 3: Support the development of structured partnerships for community healthcare organizations to provide telemedicine	Increase # new patients enrolled in telemedicine by 10%		•What is OSF's plan for telemedicine (if any) for this? •What is Carle's plan for telemedicine? •See the list that Access Center provided in May 2023. •What about other clinics? Heartland, etc? Do they have any trainings or CAHC work planned? •Who else do we need to bring to the table for this initiative?
TELMED 4: Expand number of locations for community members to access telemedicine mental health care (community settings, OSF	Increase # telemedicine community access points by 10%		•What is OSF's plan for telemedicine (if any) for this? •What is Carle's plan for telemedicine?

Strive, libraries, Wraparound Center, etc.)			•See the list that Access Center provided in May 2023. •What about other clinics? Heartland, etc? Do they have any trainings or CAHC work planned? • Who else do we need to bring to the table for this initiative?
TELMED 5: Provide more than 100 residents access to mental health telemedicine appointments who are either medically underserved or live in rural areas	Reduce # hospital readmissions among individuals who engage in telemedicine by 30%		•What is OSF's plan for telemedicine (if any) for this? •What is Carle's plan for telemedicine? •See the list that Access Center provided in May 2023. •What about other clinics? Heartland, etc? Do they have any trainings or CAHC work planned? •Who else do we need to bring to the table for this initiative?

Current challenges or needs for selected interventions

Culturally Adapted Health Care (CAHC)

- Leader-driven and requires hospital leaders and clinical leaders to support efforts and drive participation. Need to identify Carle & OSF's plan for trainings like this

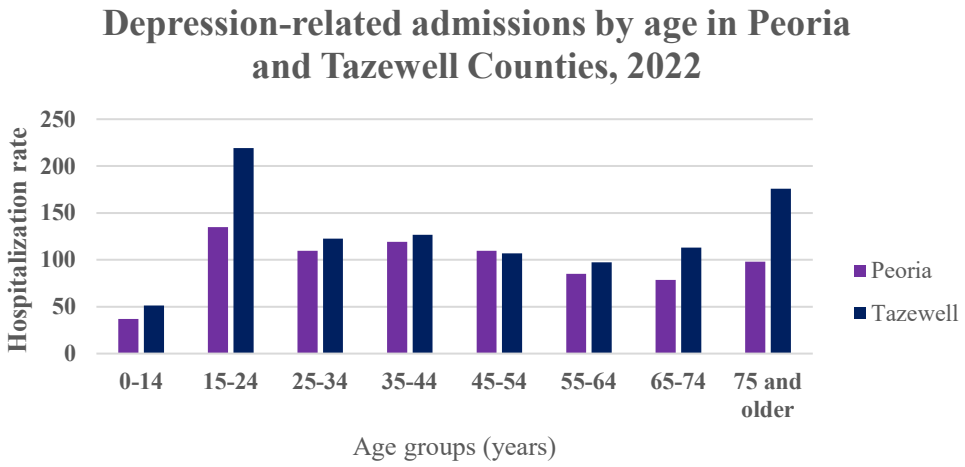
Telemedicine (TELMED)

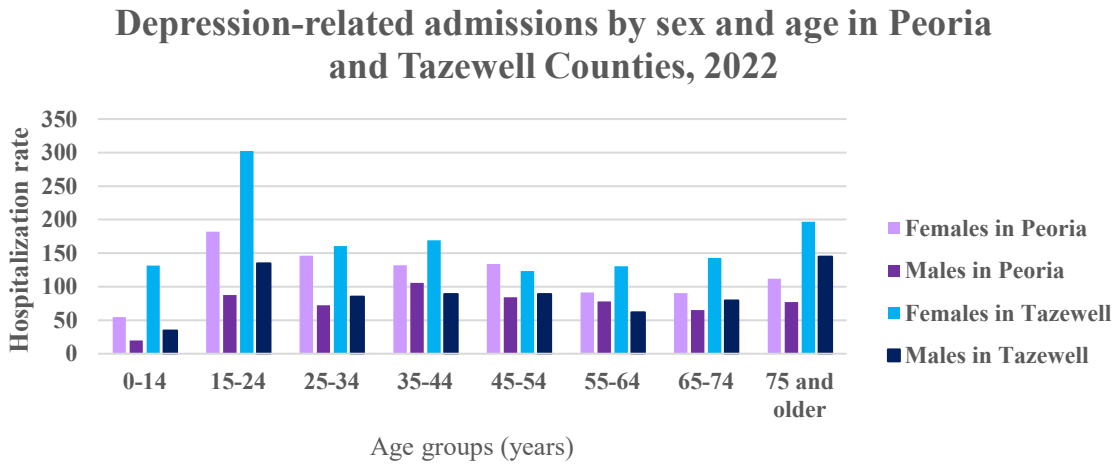
- Medicare changes that will impact hospitals providing telehealth (private providers will be able to continue).
- Need to identify what success is at Years 1-3
- Currently working on obtaining data from healthcare sources

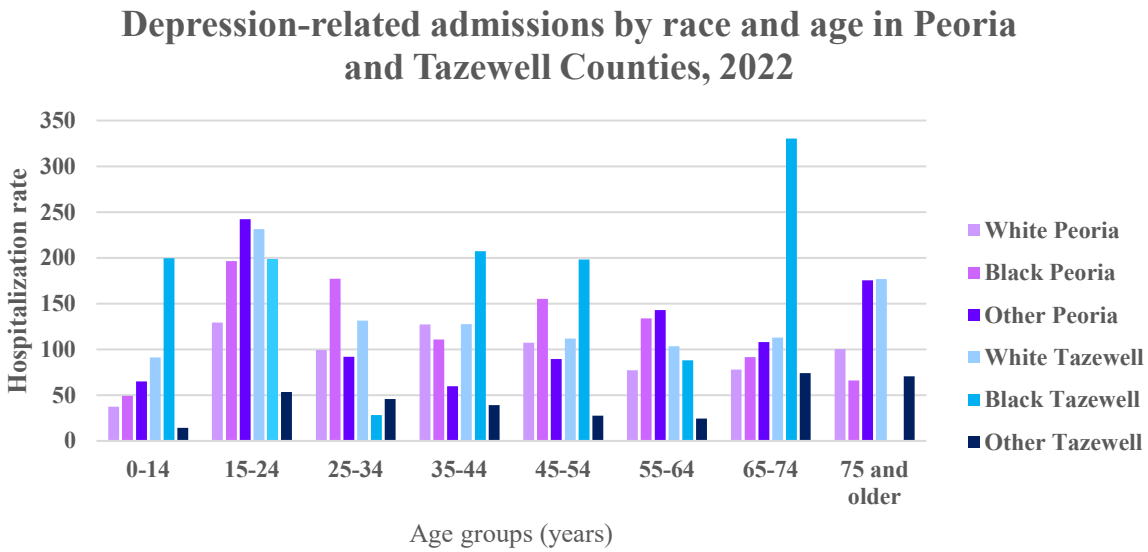
Public health surveillance

Hospital admissions related to mental health were pulled from the Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) for Peoria and Tazewell Counties during 2022. We identified age-adjusted mental health-related admission rates based on the International Statistical Classification of Disease and Related Health Problems, Tenth Revision codes F32, F33 (depression), F41 (anxiety), and X60-X84, Y87.0,U03 (suicide). Given the needs of each diagnosis is likely different we identified hospital admissions for each area: depression, anxiety, and suicide separately. We further explored differences in rates by age, sex, and racial group to further understand the populations at highest risk for negative health outcomes related to each outcome. Hospitalization rate depicts the proportion of hospital visits for each population in 2022.

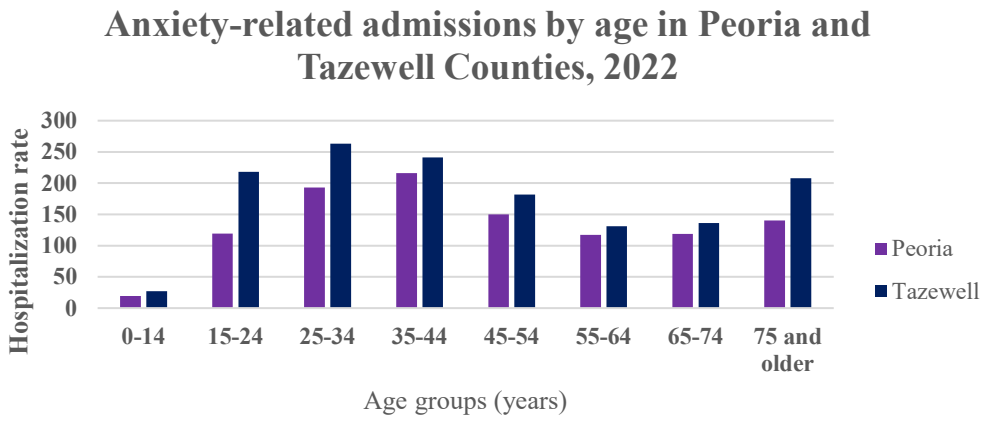
Depression

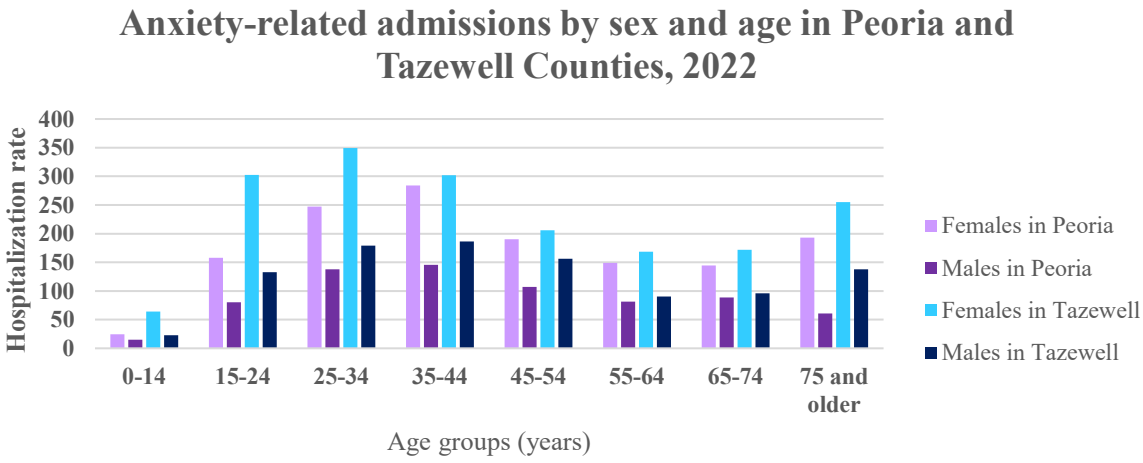

Depression-related admissions by age in Peoria and Tazewell Counties, 2022
Hospitalization rate
250
200
150
100
50
0
0-14
15-24
25-34
35-44
45-54
55-64
65-74
75 and older
Age groups (years)
Peoria
Tazewell

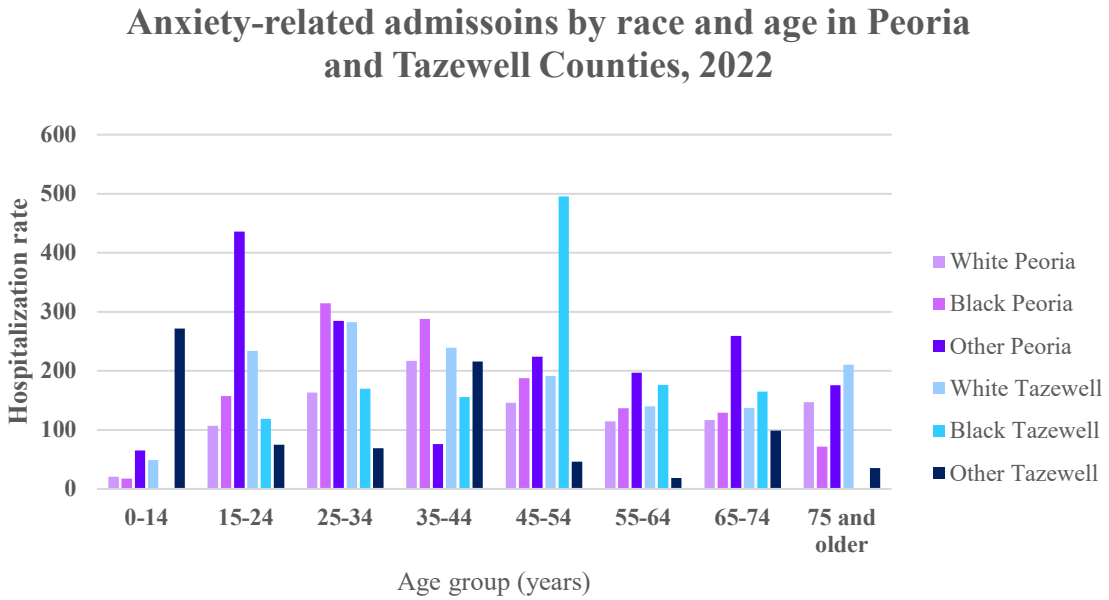

Depression-related admissions by sex and age in Peoria and Tazewell Counties, 2022
Hospitalization rate
350
300
250
200
150
100
50
0
0-14
15-24
25-34
35-44
45-54
55-64
65-74
75 and older
Age groups (years)
Females in Peoria
Males in Peoria
Females in Tazewell
Males in Tazewell


Depression-related admissions by race and age in Peoria and Tazewell Counties, 2022
Hospitalization rate
350
300
250
200
150
100
50
0
0-14
15-24
25-34
35-44
45-54
55-64
65-74
75 and older
Age groups (years)
White Peoria
Black Peoria
Other Peoria
White Tazewell
Black Tazewell
Other Tazewell

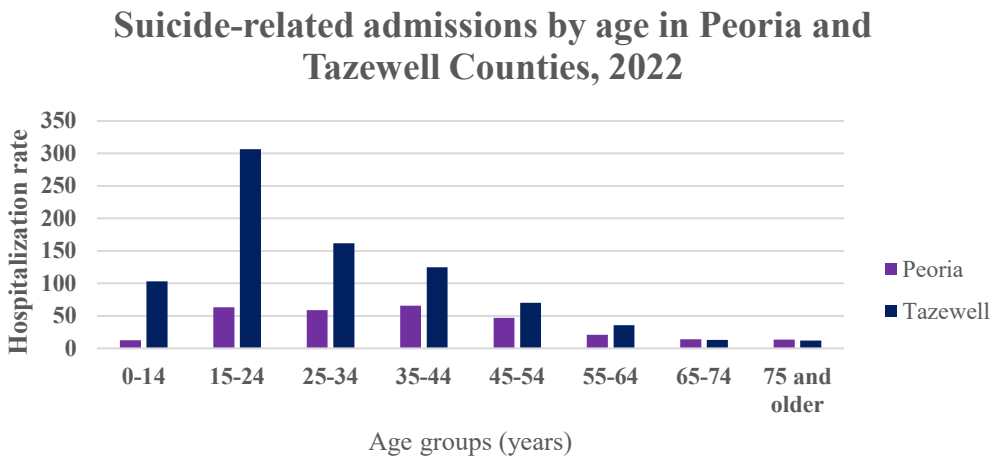
Anxiety

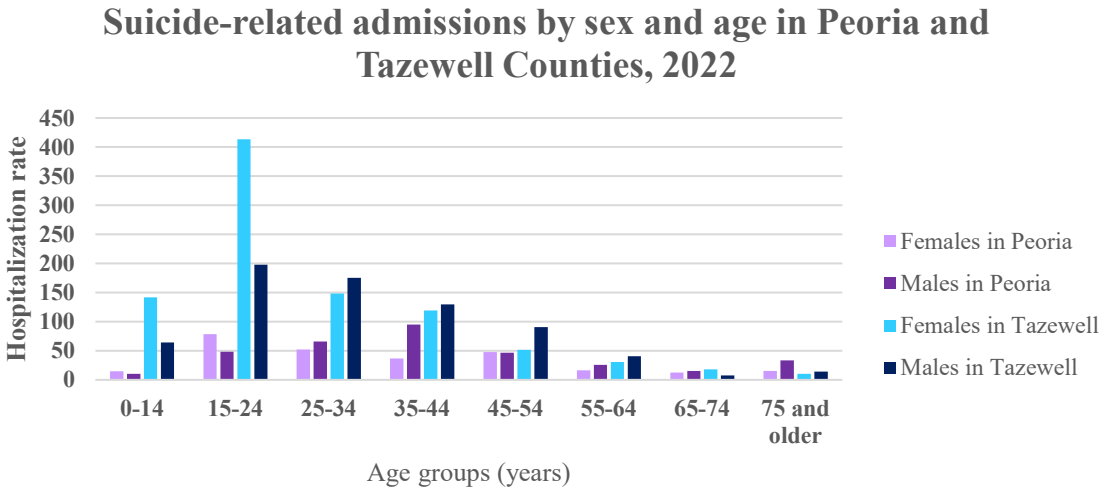

Anxiety-related admissions by age in Peoria and Tazewell Counties, 2022
Hospitalization rate
300
250
200
150
100
50
0
0-14
15-24
25-34
35-44
45-54
55-64
65-74
75 and older
Age groups (years)
Peoria
Tazewell

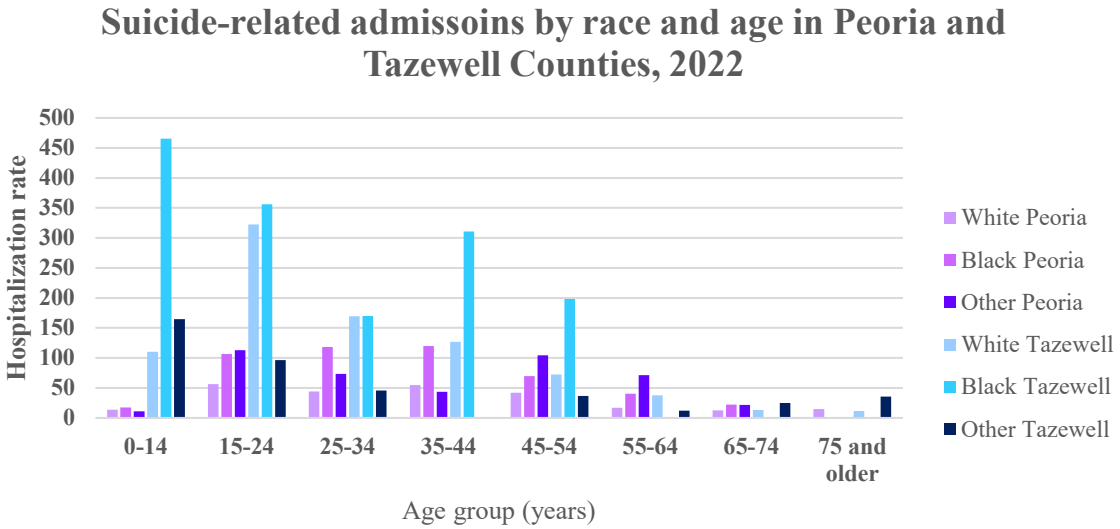

Anxiety-related admissions by sex and age in Peoria and Tazewell Counties, 2022
Hospitalization rate
400
350
300
250
200
150
100
50
0
0-14
15-24
25-34
35-44
45-54
55-64
65-74
75 and older
Age groups (years)
Females in Peoria
Males in Peoria
Females in Tazewell
Males in Tazewell


Anxiety-related admissoins by race and age in Peoria and Tazewell Counties, 2022
Hospitalization rate
600
500
400
300
200
100
0
0-14
15-24
25-34
35-44
45-54
55-64
65-74
75 and older
Age group (years)
White Peoria
Black Peoria
Other Peoria
White Tazewell
Black Tazewell
Other Tazewell

Suicide


Suicide-related admissions by age in Peoria and Tazewell Counties, 2022
Hospitalization rate
350
300
250
200
150
100
50
0
0-14
15-24
25-34
35-44
45-54
55-64
65-74
75 and older
Age groups (years)
Peoria
Tazewell


Suicide-related admissions by sex and age in Peoria and Tazewell Counties, 2022
Hospitalization rate
450
400
350
300
250
200
150
100
50
0
0-14
15-24
25-34
35-44
45-54
55-64
65-74
75 and older
Age groups (years)
Females in Peoria
Males in Peoria
Females in Tazewell
Males in Tazewell


Suicide-related admissoins by race and age in Peoria and Tazewell Counties, 2022
Hospitalization rate
500
450
400
350
300
250
200
150
100
50
0
0-14
15-24
25-34
35-44
45-54
55-64
65-74
75 and older
Age group (years)
White Peoria
Black Peoria
Other Peoria
White Tazewell
Black Tazewell
Other Tazewell

Additional health metrics related to mental health

	Peoria	Tazewell	Woodford	Illinois	United States
Mental health status					
Mental health not good for 14+ days in the past month [1]	15.9	15.7	14.9	13.5	15.2
Average number of mentally unhealthy days[2]	3.5	3.9	3.7	3.2	4.4
% of adults who report mental distress[2]	13.0	13.1	12.6	10.2	14.0
Mental health diagnosis					
Depression among adults[1]	21.2	22.0	21.0	17.3	19.8
Additional measures of mental health (substance use)					
Binge drinking among adults[1]	16.4	18.1	18.8	16.0	16.7
Alcohol-impaired Driving Deaths (% of driving deaths with alcohol involvement) [3]	37.2	18.2	33.3	28.8	27.0

Data sources:

1. 2021 Behavior Risk Factor Surveillance System (BRFSS)
2. 2020 Behavior Risk Factor Surveillance System (BRFSS)
3. 2016-2020 Fatality Analysis Reporting System (FARS)

The data in the table above depicts the age-adjusted percentage of adults for the Tri-County region in comparison to Illinois and the US.

Poor mental health days measures the average number of mentally unhealthy days reported in past 30 days (age-adjusted).

Depressive disorder measures the percentage of adults (age-adjusted) who have ever been told they had a depressive disorder (i.e., lifetime measure).

Binge drinking among adults measures the percentage of adults reporting binge drinking in the past 30 days. Binge drinking is defined as a woman consuming more than four alcoholic drinks during a single occasion or a man consuming more than five alcoholic drinks during a single occasion.

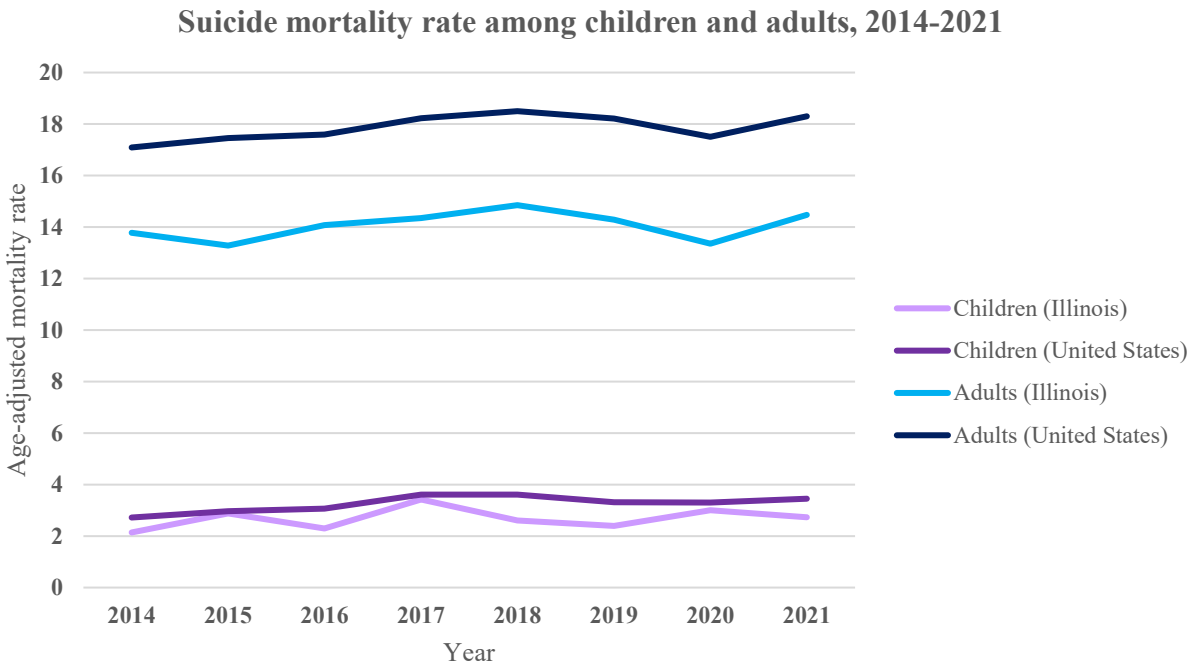
Alcohol-impaired driving deaths is a percentage of motor vehicle crash deaths with alcohol involvement. Alcohol-Impaired Driving Deaths are reported for the county of occurrence. This is because it is more likely that the drinking behavior that led to the driving crash happened where the accident occurred rather than in the county where the people involved in the crash reside.

Suicide mortality data for the Tri-County region

	Peoria	Tazewell	Woodford	Illinois	United States
Suicide mortality rate	15.1	13.4	15.2	10.9	14.0

Data sources:
1. 2014-2020 NCHS

Suicide mortality rate is the number of deaths due to suicide per 100,000 population and is age-adjusted.



Data sources:
1. 2014-2021 CDC annual mortality files. Suicide ICD-10 codes included: X60-X84, Y87.0,*U03

Further examination of national suicide data

Suicide mortality rates are highest among adults aged 85 years or older (22.39 per 100,000) followed by those 25 to 75 to 84 years (19.6 per 100,000), and 34 years of age (19.5 per 100,000). Younger groups have consistently had lower suicide rates than middle-aged and older adults. When examining suicide mortality rates by race/ethnicity and sex, the highest age-adjusted suicide mortality rate was among American Indians and Alaskan Natives. Much lower rates were found among Black or African Americans and Asians and Pacific Islanders. The most common method of death by suicide was firearms (55%), followed by suffocation/hangings (26%) and poisonings/overdoses (12%).

ADDITIONAL MEASURES RELATED TO COMMUNITY HEALTH

Population

	Peoria	Tazewell	Woodford	Illinois	United States
Population estimates	178,383	129,911	38,128	12,582,032	333,287,557
Age (%)					
Persons under 5 years	6.5%	5.1%	5.5%	5.4%	5.6%
Persons under 18 years	23.6%	21.8%	23.5%	21.6%	21.7%
Persons 65 years and over	18.6%	20.1%	19.4%	17.2%	17.3%
Sex (%)					
Female	51.2%	50.3%	49.7%	50.5%	50.4%
Race and Hispanic (%)					
White alone	72.5%	95.4%	96.6%	76.1%	75.5%
Black or African American	19.3%	1.6%	0.8%	14.7%	13.6%
American Indian and Alaskan Native	0.5%	0.4%	0.3%	0.6%	1.3%
Asian	4.4%	1.0%	0.8%	6.3%	6.3%
Two or more races	3.3%	1.7%	1.4%	2.2%	3.0%
Hispanic or Latino	5.7%	2.8%	2.0%	18.3%	19.1%
White alone, not Hispanic or Latino	67.9%	93.0%	94.8%	59.5%	58.9%
Other population statistics					
Veterans	8,870	7,720	2,009	537,552	17,431,290
Foreign-born persons (%)	6.3%	1.6%	1.7%	14.1%	13.6%

Data source:

1. 2022 American Community Survey, Census.

Social determinants of health (SDOH)

	Peoria	Tazewell	Woodford	Illinois	United States
Educational attainment					
% completed high school [1]	92.2	93.2	94.3	89.9	89.0
% completed some college[1]	71.5	70.7	76.6	70.7	67.0
Socioeconomic status					
Median household income[2]	$56,500	$65,427	$85,085	$72,215	$69,700
% unemployed[3]	7.2	5.0	4.0	6.1	5.4
Housing					
% of population with severe housing problems[1]	13.6	9.1	9.2	16.1	17.0
% homeowners[1]	65.7	76.4	81.2	66.5	65.0
% with severe housing cost burden[1]	13.1	8.8	8.0	13.9	14.0
Insurance					
% uninsured[4]	7.1	5.7	5.3	8.4	10.0
Additional measures					
% with broadband access[1]	84.4	85.8	87.0	86.9	87.0
Social association rate[5]	13.0	13.8	15.8	9.8	9.1
Income inequality[1]	5.3	4.0	4.2	5.0	4.9
Residential segregation index[1]	58.9	65.0	52.8	71.5	63.0
Access to care					
Primary care physicians ratio[6]	719:1	2,144:1	2,005:1	1,232:1	1,310: 1
Mental health provider ratio[7]	365:1	459:1	2,730:1	344:1	340:1
Other primary care provider ratio[7]	402:1	1,534:1	1,365:1	946:1	810:1

Data sources:
1.2017-2021 American Community Survey, 5-year estimates
2.2021 Small Area Income and Poverty Estimates
3.2021 Bureau of Labor Statistics
4.2020 Small Area Health Insurance Estimates
5.2020 County Business Patterns
6. 2020 Area Health Resource File/American Medical Association
7.2022 CMS, National Provider Identification

Income Ratio: Ratio of household income at the 80th percentile to income at the 20th percentile.

Residential segregation index: index of dissimilarity where higher values indicate greater residential segregation between Black and white county resident.

Health care provider ratio is the ratio of population to the number of providers.

SDOH measures by race

	Peoria	Tazewell	Woodford	Illinois
Median household income[1]				
Black	$31,696	$29,968	SUPP	$43,183
Hispanic	$50,479	$63,094	$100,500	$63,833
White	$63,265	$69,463	$75,903	$80,001

Data sources:
1. 2021 Small Area Income and Poverty Estimates

SUPP: Data are suppressed when there is not sufficient data and/or do not meet the criteria for confidentiality constraints.

SDOH measures related to children

	Peoria	Tazewell	Woodford	Illinois	United States
Poverty					
% children in poverty[1]	22.0	12.4	8.2	15.9	17.0
Additional					
% disconnected youth[2]	9.3	4.5	SUPP	6.3	7.0
Juvenile arrest rate[3]	24.9	4.3	4.3	8.2	24.0
Scores/grade performance measures					
Average reading score/grade performance[4]	2.8	3.1	3.3	3.0	3.1
Average math score/grade performance[4]	2.7	3.1	3.3	2.9	3.0

Data sources:
1.2021 Small Area Income and Poverty Estimates
2. 2017-2021 American Community Survey, 5-year estimates
3. 2019 Easy Access to State and County Juvenile Court Case Counts
4. 2018 Stanford Education Data Archive

SUPP: Data are suppressed when there is not sufficient data and/or do not meet the criteria for confidentiality constraints.

Scores/grade performance is the average grade level performance in the county for 3rd graders on reading/math standardized tests.

SDOH measures related to children by race

	Peoria	Tazewell	Woodford	Illinois
% children in poverty[1]				
Black	44.0	52.5	5.6	35.5
Hispanic	20.9	4.2	6.2	19.2
White	9.2	10.0	5.5	9.1

Average reading score/grade performance[2]				
Black	2.0	2.5	SUPP	2.5
Hispanic	2.3	2.9	SUPP	2.7
White	3.2	3.1	SUPP	3.3
Average math score/grade performance[2]				
Black	2.0	2.3	SUPP	2.3
Hispanic	2.3	2.8	SUPP	2.6
White	3.2	3.1	SUPP	3.2

Data sources:
1.2021 Small Area Income and Poverty Estimates
2. 2018 Stanford Education Data Archive

SUPP: Data are suppressed when there is not sufficient data and/or do not meet the criteria for confidentiality constraints.

Scores/grade performance is the average grade level performance in the county for 3rd graders on reading/math standardized tests.

Additional measures related to health status

	Peoria	Tazewell	Woodford	Illinois	United States
Health status					
Fair or poor self-rated health status among adults[1]	15.3	13.2	11.9	14.4	15.2
Physical health not good for more than 14+ days in the past month[1]	10.9	10.3	9.5	10.2	10.3
Average number of physically unhealthy days in the past month[2]	3.0	2.8	2.6	2.7	3.0
Chronic conditions					
Arthritis among adults[1]	22.4	22.5	22.1	19.3	22.2
Chronic kidney disease among adults[1]	2.9	2.6	2.5	2.2	2.7
Chronic obstructive pulmonary disease among adults[1]	6.4	6.1	5.5	4.9	5.7
Asthma among adults[1]	10.3	9.8	9.5	8.8	9.7

Data sources:
1. 2021 Behavior Risk Factor Surveillance System (BRFSS)
2. 2020 Behavior Risk Factor Surveillance System (BRFSS)

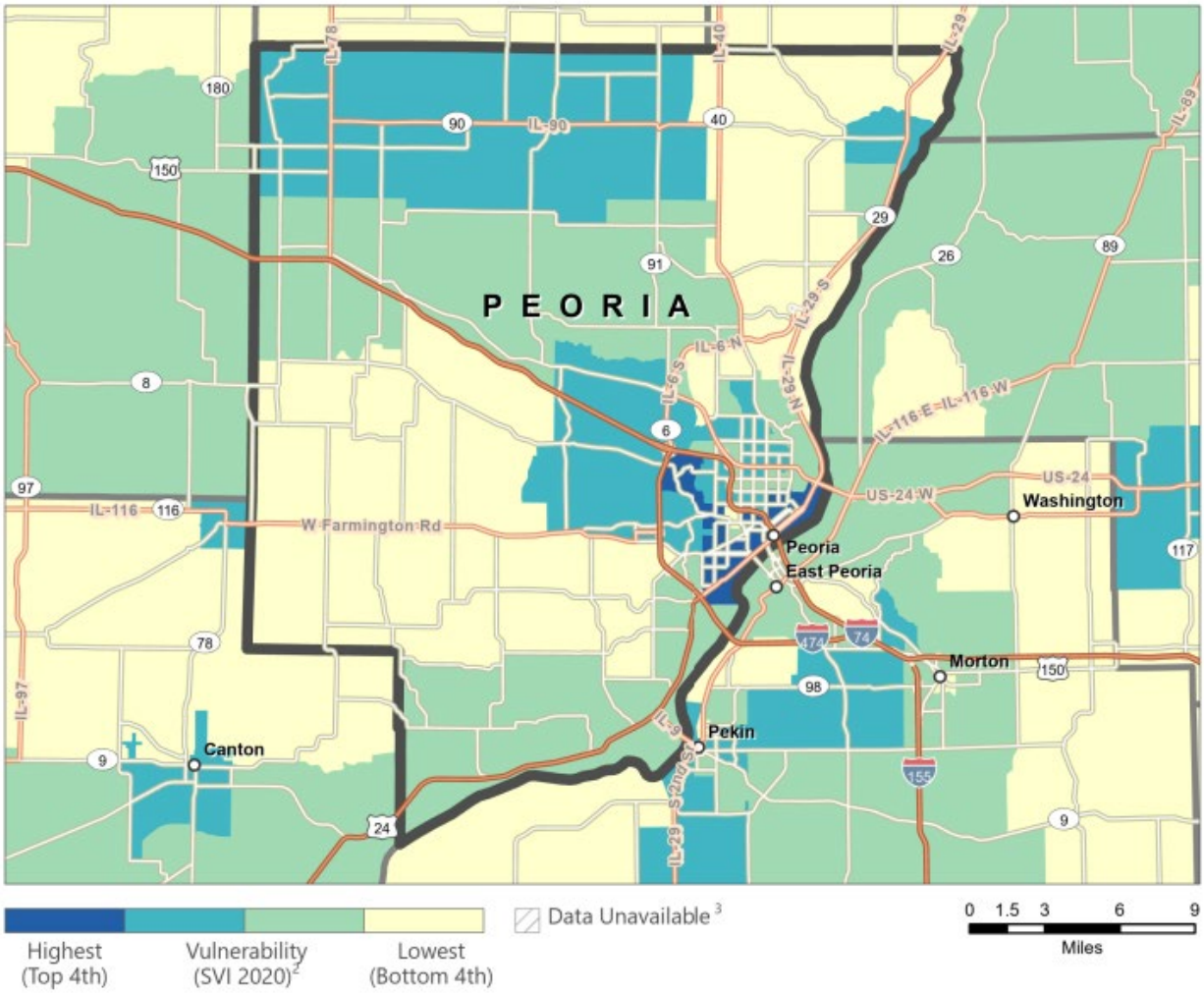
The data in the table above depicts the age-adjusted percentage of adults for the Tri-County region in comparison to Illinois and the US.

Poor health days measures the average number of mentally unhealthy days reported in past 30 days (age-adjusted).

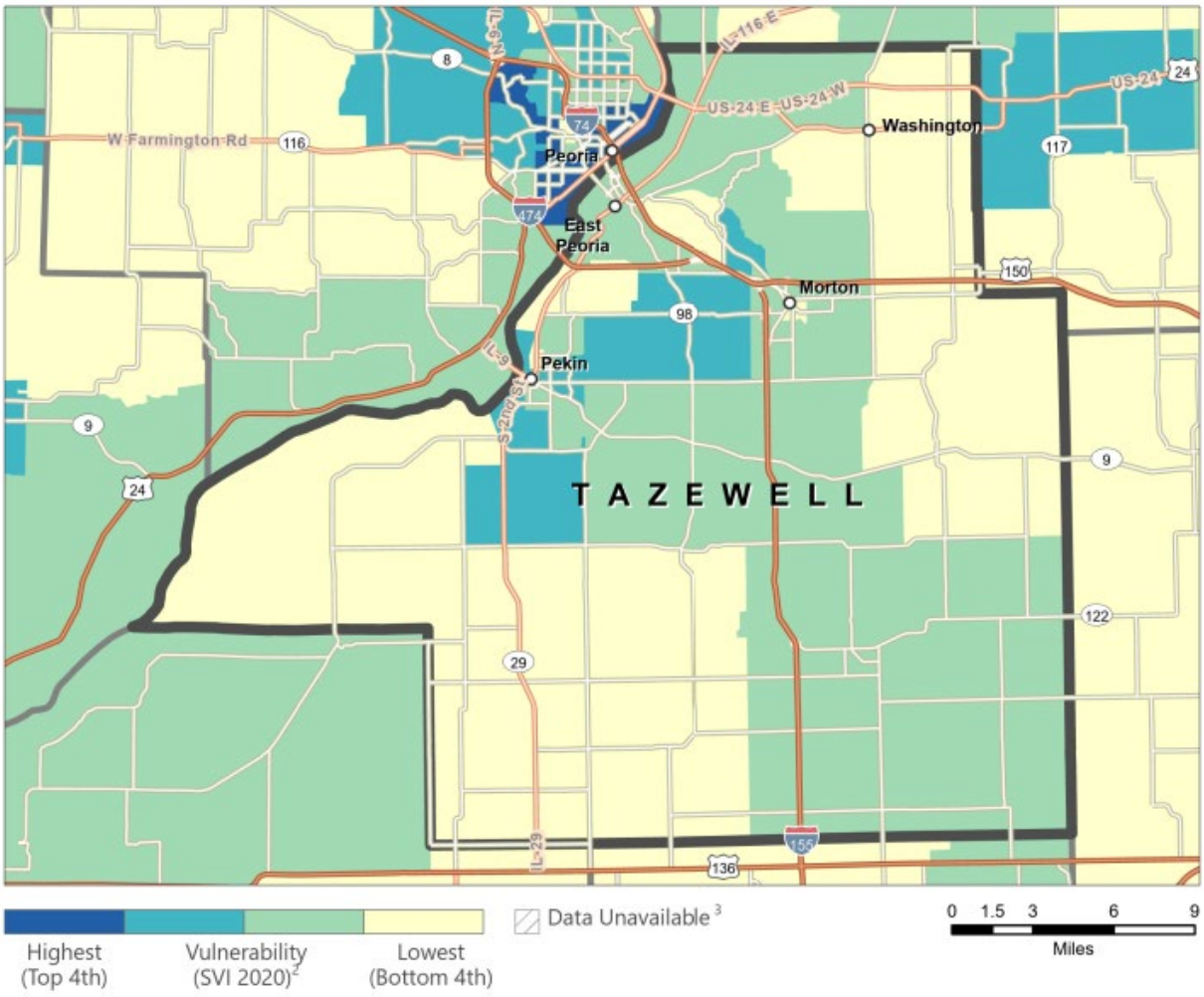
Social Vulnerability Index

The Social vulnerability index (SVI) was assessed for the Tri-County region. SVI refers to the communities' capacity to prepare and respond to stressful or hazardous events such as natural disasters or disease outbreaks. This comprehensive measure was developed by the CDC and is derived from 16 factors related to poverty, lack of access to transportation, and housing environment.

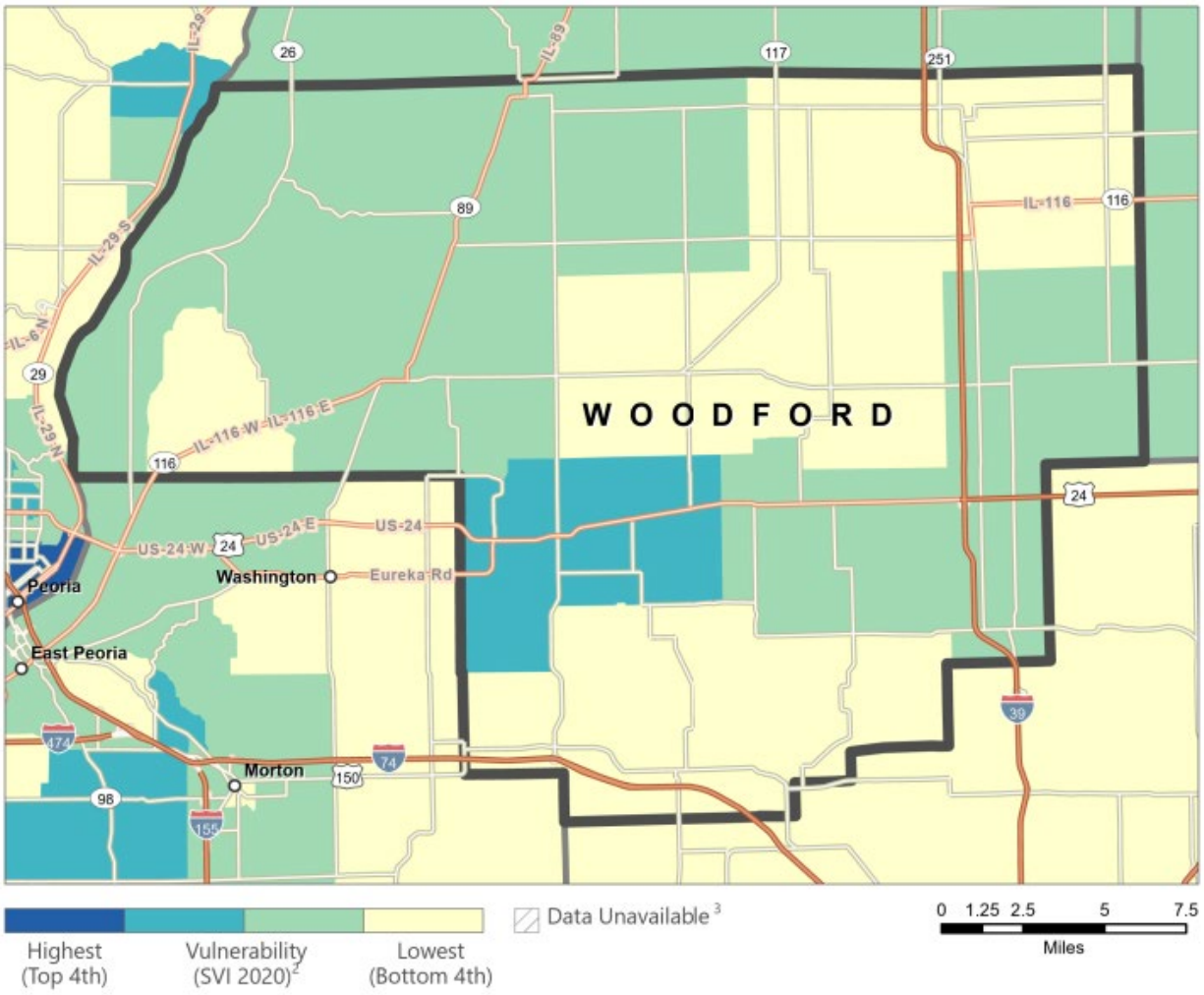
Peoria County, 2020



Tazewell County, 2020



Woodford County, 2020



Prevention

	Peoria	Tazewell	Woodford	Illinois	United States
Medical encounters					
Preventable hospital rate[1]	2,848	2,554	2,161	3,310	2,809
Visits to doctor for routine checkup [2]	77.1	77.1	76.6	77.5	71.8
Vaccinations					
% Vaccinated for influenza[1]	57	59	57	53	51

Data sources:
1. 2020 Mapping Medicare Disparities Tool
2. 2020 Behavior Risk Factor Surveillance System (BRFSS)

Preventable Hospital Stays measures the number of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees.

Visits to doctor for routine checkup is the percentage of adults 18 and older who report that they visited a doctor for a routine checkup during the past 12 months.

% Vaccinated for influenza is the percentage of adults (18+ years) who report they have received an influenza vaccine during the past 12 months.

Prevention measures by race

	Peoria	Tazewell	Woodford	Illinois
Preventable hospital rate per 100,000 [1]				
Black	6,008	11,902	SUPP	6,061
Hispanic	2,000	SUPP	SUPP	3,029
White	2,541	2,563	SUPP	3,007
% vaccinated for influenza				
Black	43	57	SUPP	37
Hispanic	48	56	67	45
White	59	59	57	55

Data sources:
1. 2020 Mapping Medicare Disparities Tool
2. 2020 Behavior Risk Factor Surveillance System (BRFSS)

SUPP: Data are suppressed when there is not sufficient data and/or do not meet the criteria for confidentiality constraints.

Cancer

	Peoria	Tazewell	Woodford	Illinois	United States
Medical encounters					
Cancer diagnosis (excluding skin)[1]	6.2	6.5	6.5	6.9	6.0
Cancer screening					
Up-to-date on colon cancer screening[2]	68.9	67.5	69.5		70.6
Up-to-date on cervical cancer screening[2]	81.4	81.4	81.4		
Up-to-date on breast cancer screening[2]	71.8	72.2	74.4	79.9	77.8

Data sources:
1. 2021 Behavior Risk Factor Surveillance System (BRFSS)
2. 2020 Behavior Risk Factor Surveillance System (BRFSS)

The data in the table above depicts the age-adjusted percentage of adults for the Tri-County region in comparison to Illinois and the US.

Up-to-date on colon cancer screening is the percentage of adults 50-75 years old who report having had a fecal occult blood test (FOBT) during the past year, or a sigmoidoscopy during the past 5 years and an FOBT during the past 3 years, or a colonoscopy during the past 10 years.

Up-to-date on cervical cancer screening is the percentage of females 21-65 years old without a hysterectomy who report having had a Pap test during the past 3 years.

Up-to-date on breast cancer screening is the percentage of females 50-74 years old who report having had a mammogram during the past 2 years.

Mammogram by race

	Peoria	Tazewell	Woodford	Illinois
% with annual mammogram [1]				
Black	36	SUPP	SUPP	32
Hispanic	27	15	SUPP	26
White	40	40	SUPP	39

Data sources:
1. 2020 Mapping Medicare Disparities Tool

SUPP: Data are suppressed when there is not sufficient data and/or do not meet the criteria for confidentiality constraints.

Health risk behaviors

	Peoria	Tazewell	Woodford	Illinois	United States
Health risk behaviors					
Current smoking[1]	16.5	16.2	14.5	12.3	13.8
Sleeping less than 7 hours a night[2]	32.8	31.5	31.0	32.0	33.3
Outcomes related to risky behavior					
Chlamydia prevalence[3]	881.8	274.7	163.8	542.3	481.3
HIV prevalence[3]	251.1	76.9	66.1	336.8	380.0

Data sources:
1. 2022 Behavior Risk Factor Surveillance System (BRFSS)
2. 2021 Behavior Risk Factor Surveillance System (BRFSS)
3. 2020 National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

The data in the table above depicts the age-adjusted percentage of adults for the Tri-County region in comparison to Illinois and the US.

Current smoking is the percentage of adults who report they currently smoke cigarettes either every day or on some days.

Sleeping less than 7 hours depicts the percentage of adults who report they get less than 7 hours or less of sleep in a 24-hour period.

Chlamydia prevalence is the rate of newly diagnosed cases of chlamydia for people aged 13 years and older in a county per 100,000 population.

HIV prevalence is the rate of diagnosed cases of HIV for people aged 13 years and older in a county per 100,000 population.

Maternal and child health

	Peoria	Tazewell	Woodford	Illinois	United States
Teen birth rate					
Teen birth rate[1]	31.6	18.7	10.5	17.8	19.0
% babies born with low birthweight[1]	9.9	6.1	6.4	8.4	8.0

Data sources:
1. 2014-2020 NCHS

The data in the table above represents the percentage of adults (18+ years) and are age-adjusted.

Teen Births is the number of births to females ages 15-19 per 1,000 females in a county.

Babies born with low birthweight is the percentage of live births with low birthweight (<2.500 grams).

Maternal and child health measures by race

	Peoria	Tazewell	Woodford	Illinois
Teen birth rate [1]				
Black	71.2	38.1	SUPP	35.5
Hispanic	35.3	10.3	SUPP	24.6
White	15.7	18.9	SUPP	10.6
% babies born with low birthweight [1]				
Black	15.5	9.6	SUPP	14.2
Hispanic	6.2	8.0	SUPP	7.2
White	7.6	6.0	SUPP	6.9

Data sources:
1. 2014-2020 NCHS

SUPP: Data are suppressed when there is not sufficient data and/or do not meet the criteria for confidentiality constraints.

Dental

	Peoria	Tazewell	Woodford	Illinois	United States
Visits to dentist or dental clinic among adults[1]	64.9	65.0	67.7	68.4	64.5
All teeth lost among adults over 65 years[1]	9.4	10.9	12.3	15.7	13.9
Dentist ratio[2]	1,114:1	1,716:1	5,461:1	1,213:1	1,380:1

Data sources:
1. 2020 Behavior Risk Factor Surveillance System (BRFSS)
2. 2021 Area Health Resource File/American Medical Association

The data in the table above depicts the age-adjusted percentage of adults for the Tri-County region in comparison to Illinois and the US.

Disability

	Peoria	Tazewell	Woodford	Illinois	United States
% of population with a disability[1]	8.8	7.9	6.8	7.5	8.7
Type of disability [2]					
Cognitive disability	14.6	13.7	12.6	13.2	12.6
Hearing disability	7.1	7.0	6.6	7.6	6.1
Independent living disability	8.2	7.2	6.4	7.4	7.1
Mobility disability	14.1	12.6	11.5	13.8	11.9
Self-care disability	3.7	3.0	2.6	3.8	3.6
Vision disability	4.8	3.8	3.3	4.2	4.7

Data sources:
1. 2022 American Community Survey, Census
2. 2021 Behavior Risk Factor Surveillance System (BRFSS)

The data in the table above depicts the age-adjusted percentage of adults for the Tri-County region in comparison to Illinois and the US.

Cognitive disability is the percentage of adults who report difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition.

Hearing disability is the percentage of adults who report they are deaf have serious difficulty hearing.

Independent living disability is the percentage of adults who report difficulty doing errands alone such as visiting a doctor's office or shopping because of a physical, mental, or emotional condition.

Mobility disability is the percentage of adults who report having serious difficulty walking or climbing stairs.

Self-care disability is the percentage of adults who report difficulty dressing or bathing themselves.

Vision disability is the percentage of adults who report they are blind or have serious difficulty seeing, even when wearing glasses.

Mortality

The following ICD-10 codes were used to extract data from CDC WONDER on mortality measures of interest to the Tri-County region.

Cause of death	ICD-10 codes
Top 15 leading causes of death	
Diseases of the heart	I00-I09,I11,I13,I20-I51
Malignant neoplasms	C00-C97
COVID-19	U07.1
Accidents (unintentional injuries)	V01-X59,Y85-Y86
Cerebrovascular diseases	I60-I69
Chronic lower respiratory diseases	J40-J47
Alzheimer disease	G30
Diabetes mellitus	E10-E14
Nephritis, nephrotic syndrome and nephrosis	N00-N07,N17-N19,N25-N27
Influenza and pneumonia	J09-J18
Septicemia	A40-A41
Chronic liver disease and cirrhosis	K70,K73-K74
Parkinson disease	G20-G21
Intentional self-harm	U03,X60-X84,Y87.0
Essential hypertension and hypertensive renal disease	I10,I12,I15
Additional mortality measures	
Drug-related	F11-F16, F18-F19, X40-X44, X60-X64, X85, Y10-Y14
Alcohol-related	E24.4, F10, G31.2, G62.1, G72.1, I42.6, K29.2, K70, K85.2, K86.0, Q86.0, R78.0, X45, X65, Y15
Suicide	X60-X84, Y87.0
Deaths of despair	X60-X84, Y87.0, E24.4, F10, G31.2, G62.1, G72.1, I42.6, K29.2, K70, K85.2, K86.0, O35.4, P04.3, Q86.0, R78.0, X45, Y15, F11-16, X40-44, Y10-14
Homicide	X85–Y09, Y87.1, U01–U02
Firearm-related	W32-W34, X72-X74, X93-X95, Y22-Y24, Y35. 0
Injury-related	U01-U03, V01-Y36, Y85-Y87, Y89

Data source: 2018-2021 Multiple Cause of Death data are produced by the Division of Vital Statistics, National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC), United States Department of Health and Human Services (US DHHS).

Leading causes of death for the Tri-County region

	Deaths	Age-adjusted death rate
Peoria		
Malignant neoplasms	699	105.1
Diseases of heart	498	77.5
Accidents	251	50.7
Chronic lower respiratory diseases	111	15.3
Cerebrovascular diseases	92	13.7
Tazewell		
Malignant neoplasms	497	91.8
Diseases of heart	319	59.8
Accidents	127	34.5
Chronic lower respiratory diseases	107	18.9
Diabetes mellitus	74	13.9
Woodford		
Malignant neoplasms	133	90.6
Diseases of heart	83	57.1
Accidents	37	35.1
Chronic lower respiratory diseases	20	13.2
Cerebrovascular diseases	14	SUPP

Data sources:
1. 2018-2020 CDC WONDER

In the Tri-County region, Peoria County had higher death rates associated with diseases of the heart and malignant neoplasms. Tazewell County had the highest death rate related to chronic lower respiratory disease, and diabetes. Woodford County had higher death rates related to accidents than Tazewell County. However, the age-adjusted death rate associated with accidents was still higher in Peoria County compared to Woodford County.

Years of Potential Life Lost & Life expectancy

	Peoria	Tazewell	Woodford	Illinois
Years of potential life lost [1]	9,002	6,821	6,640	7,066
Life expectancy [1]				
Overall	76.8	78.3	79.1	78.6
Black	70.2	75.7	SUPP	72.2
Hispanic	86.9	97.3	SUPP	83.6
White	78.0	78.0	SUPP	79.1

Data sources:
1. 2018-2020 NCHS

Years of Potential Life Lost (YPLL) depicts the number of years of life that were lost to deaths of people under the age of 75, per 100,000 people. For instance, in Peoria County, 9,002 years of life were lost to deaths of people under the age of 75, per 100,000 people.

Life Expectancy measures the average number of years from birth a person can expect to live, according to the current mortality experience (age-specific death rates) of the population.

Age-adjusted death rate by race/ethnicity

	Peoria	Tazewell	Woodford	Illinois
Age-adjusted death rate [1]				
Overall	424.0	354.5	305.3	351.9
Black	723.0	SUPP	SUPP	640.2
Hispanic	224.0	SUPP	SUPP	258.8
White	379.8	SUPP	SUPP	325.5

Data sources:
1. 2018-2020 NCHS

Injury death rate by race/ethnicity

	Peoria	Tazewell	Woodford	Illinois
Injury death rate [1]				
Overall	88.8	65.2	59.6	69.8
Black	119.1	SUPP	SUPP	119.9
Hispanic	29.0	SUPP	SUPP	38.8
White	88.6	SUPP	SUPP	70.7

Data sources:
1. 2018-2021 NCHS

SUPP: Data are suppressed when there is not sufficient data and/or do not meet the criteria for confidentiality constraints.

Mental health and injury related mortality for the Tri-County region

	Peoria	Tazewell	Woodford	Illinois	United States
Firearm fatalities rate [1]	13.1	7.5	7.8	11.8	12.0
Homicide mortality rate[1]	9.1	1.8	SUPP	8.0	6.0
Deaths of despair[2]	48.4	45.9	26.1	44.3	50.7

Data sources:
1. 2014-2020 NCHS
2. 2018-2021 CDC WONDER multiple cause of death. Age-adjusted rates are not available for the county level locations.

Deaths of despair: A drop in life expectancy occurred for the first time in the United States over the past decade, largely attributed to behavior-related medical conditions that were related to social and economic disparities. There are three main contributors or causes of death that are classified together as "deaths of despair": overdoses, alcohol-related deaths, and suicides.

Mental health related deaths by race for the Tri-County region

	Peoria	Tazewell	Woodford	Illinois
Suicide death rate [1]				
Overall	15.1	13.4	15.2	10.9
White	14.6	14.1	SUPP	12.7
Non-white	SUPP	SUPP	SUPP	6.8
Alcohol-related death rate [1]				
Overall	12.1	11.8	SUPP	10.7
White	12.7	12.3	SUPP	11.8
Non-white	10.5	SUPP	SUPP	7.0
Drug-related death rate [1]				
Overall	26.1	21.3	SUPP	25.8
White	25.7	21.5	SUPP	22.2
Non-white	27.2	SUPP	SUPP	37.9
Overdose death rate [1]				
Overall	25.1	20.4	SUPP	25.3
White	24.9	20.7	SUPP	21.7
Non-white	20.4	SUPP	SUPP	37.0

Data sources:
1. 2018-2021 CDC WONDER multiple cause of death

SUPP: Data are suppressed when there is not sufficient data and/or do not meet the criteria for confidentiality constraints.

Due to small numbers, minority racial groups were categorized together rather than separately in order to identify potential differences.

Additional mortality data for the Tri-County region

	Peoria	Tazewell	Woodford	Illinois	United States
Infant mortality rate	8.6	5.3	6.8	6.1	6.0
Child mortality rate	67.4	43.6	67.6	49.2	50.0
Motor vehicle mortality rate	10.6	9.3	14.7	8.8	12.0

Data sources:
1. 2014-2020 NCHS

SUPP: Data are suppressed when there is not sufficient data and/or do not meet the criteria for confidentiality constraints.

All Intents Fatal Injury Rate and Social Determinant of Health (SDOH) Measure

	SDOH Measure Value	SDOH Measure Quartile	Age-adjusted Mortality Rate	Age-Adjusted Mortality Quartile
Peoria	0.92	High	91.48	Mid-High
Tazewell	0.21	Low	68.52	Mid-Low
Woodford	0.07	Low	54.63	Low

Data sources:
1. 2014-2020 NCHS

County-level age-adjusted fatal injury rates per 100,000 population are ranked by quartile (low, mid-low, mid-high and high). The Social Vulnerability Index (SVI) percentile ranking values are ranked from 0 to 1 in quartiles as low (0.00-0.25), mid-low (0.25-0.50), mid-high (0.50-0.75), and high (0.75-1.00). Higher SVI ranking values correspond to higher vulnerability. The SVI ranking for a county will differ depending on whether national or state-specific data are selected. Social vulnerability refers to the potential negative effects on communities caused by external stresses on health outcomes. Such stresses include natural or human-caused disasters, or disease outbreaks and can be further described by the CDC.

NEXT STEPS

Please note that mortality data collected by the CDC and state level are expected to be released in January 2024. When these are released, the data team will update the next quarterly report to update the mortality data for the Tri-County region. These updates are anticipated Q1/Q2 for 2024. The annual report will provide updated mortality rates, trend analyses on health priorities, and annual updates on performance measures (e.g., substance use, cancer).

Note that starting with mortality records in 2018, single-race categories can be examined in CDC WONDER. Prior to that year, bridged race categories were predominately used with public health surveillance systems. Once additional years of data are available to aggregate by county additional information on health disparities will be assessed by the team. Such information could help improve understanding of health inequity that exists in the region, especially if certain populations are disproportionally impacted by a certain disease.

Substance Use Objectives 2023-2025

Objectives	**Target**	**Baseline Data**	**Year 1**
By December 31, 2025, reduce drug overdose deaths by 5% resulting in a Tri-County overdose death rate of 22.12 per 100,000.	Overdose Death Rate for Tri-County: 22.12 per 100,000	Peoria: 16.4 per 100,000 Tazewell: 20.6 per 100,000 Woodford: 13.1 per 100,000 Tri-County: 23.27 per 100,000 *Source: IDPH Opioid Data Dashboard, 2021*	Peoria: 33 per 100,000 Tazewell: 18.2 per 100,000 Woodford: 5.2 per 100,000 *Source: IDPH Opioid Data Dashboard, 2022*
By December 31, 2025, reduce the proportion of adolescents reporting using substances in the Tri-County area by 5%.	Peoria: 25% Tazewell: 35% Woodford: 7%	Peoria: 30% Tazewell: 40% Woodford: 11% *Source: 2022 Illinois Youth Survey*	Survey is conducted every other year.
By December 31, 2025, increase the proportion of people with a substance use disorder (SUD) in the Tri-County region who received treatment in the past year by 3%.	Peoria: 283.25 per 100,000 Tazewell: 279.6 per 100,000 Woodford: 135.5 per 100,000	Total Buprenorphine Patients per County (per 100,000 population): Peoria: 275.0 per 100,000 Tazewell: 271.5 per 100,000 Woodford: 131.6 per 100,000 *Source: Illinois Prescription Monitoring Program, 2020*	Data has not been updated since 2020.
Units of Naloxone Distributed by County (Source: Sue Tisdale at Trillium Place)		2022 Peoria: 6087 Tazewell: 430 Woodford: 122	2023 (through September 2023) Peoria: 3818 Tazewell: 846 Woodford: 4
Fentanyl Test Strips Distributed		2022 Peoria: 2300 Tazewell: 225	2023 Peoria: 3140 Tazewell:
Xylazine Test Strips Distributed			

Substance Use Meeting Minutes
July 20, 2023
3:00 pm – 4:30 pm
Location: Hult Center for Healthy Living Training Room

Contact Information: Denise Backes (denise.backes@banyancenters.com), Megan Hanley (mhanley@tchd.net)

Useful Resources:

- Partnership for a Healthy Community Website: https://healthyhoi.wildapricot.org
- Meeting Information and Data Tracking:
  - Substance Use: https://healthyhoi.wildapricot.org/2020-22-Substance-Use
- Discussion Boards: https://healthyhoi.wildapricot.org/discussions

Attendees: Diane Reynolds, Tracy Terlinde, Dustin Schulz, Elizabeth Hensold, Ellie Keyes, Ella Dancey, Anthony Montalvo, Kelli Kennedy, Jennifer Wenger, Katy Endress, Megan Hanley, Denise Backes, Michele Carmichael, Alex Strong, Erika Hahn

I. Introductions – Brief introductions were conducted.

II. Objectives for 2023-2025 Cycle

Objectives	Target	Baseline Data
By December 31, 2025, reduce drug overdose deaths by 5% resulting in a Tri-County overdose death rate of 22.12 per 100,000.	Overdose Death Rate for Tri-County: 22.12 per 100,000	Peoria: 16.4 per 100,000 Tazewell: 20.6 per 100,000 Woodford: 13.1 per 100,000 *Source: IDPH Opioid Data Dashboard, 2021*
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III. Presentation by Denise Backes on Banyan Treatment Centers

Denise offered an overview of Banyan Treatment Centers and their two locations in the state of Illinois. They have 2 residential sites in Gilman and Naperville. One of the benefits of their organization is that they are equipped to handle co-occurring mental health and substance use conditions. They are private pay only but will accept active duty military, first responders, and veterans with any payor source. Reach out to Denise if you have any further questions or would like to refer someone.

IV. Work Group Report Out – Sharing Completed Workplans

a. Healthcare Provider/First Responder Education
    i. First Responder Education Update from Brooks:
        - Reached out to IDEOA about securing a spot for next April. The email was forwarded to the Director. I have not heard anything back. I followed up and still have not heard anything.
        - The person that did reply stated they usually have all the spots secured by October timeframe, so at least we still have some time
        - I plan on using my Counterdrug Task Force contacts at HQ to see if they can help out with at least getting a response
        - In the event I do hear anything back I have secured all of the analyst around IL who work for narcotics units. I will use them to send out a survey to all of these narcotics agents to see what courses they are most interested in.
    ii. Healthcare Provider Education
        - The survey received 13 responses – all from Primary Care Providers.
        - Obvious gaps were identified in knowledge surrounding MAT.
        - Some facilities expressed the need for assistance building policies and procedures on MAT prescribing.
        - Jennifer W. from OSF reported that OSF is almost complete with building out education materials for providers on MAT in EPIC. MAT was approved to be prescribed in OSF's hospital system for patients ages 18 and up.
b. Naloxone Distribution/Outreach
    i. PCCHD continues to work on placing vending machines with naloxone, fentanyl, and xylazine test strips in areas of highest need.
    ii. TCHD just released an awareness campaign emphasizing that opioids can impact anyone. Their naloxone outreach efforts continue.
c. School-based Education
    i. Discussed the integration of the Illinois Youth Survey into Peoria Public Schools. Michele C. shared the following information to add to that discussion:
    ii. CDC is in charge of IL-YRBS: https://www.cdc.gov/healthyyouth/data/yrbs/participation.htm#data-download
    iii. U of I handles IL Youth Survey: https://iys.cprd.illinois.edu/
    iv. https://iys.cprd.illinois.edu/results/county/
    v. School districts who participate do these in opposing years. Some Peoria County districts complete the IYS, so there is more data there which may be helpful to the workgroup.

V. Member Announcements

a. Brightside Clinic is hosting an Overdose Awareness Night event on August 31 from 5-8 at the 3300 Event Center in Peoria. See attached flyer for further information.

VI. Next Meeting

a. August 17, 2023, from 3:00-4:30 at Hult Center for Healthy Living (Work group meeting)

Substance Use Meeting
September 21, 2023
3:00 pm – 4:30 pm
Location: Hult Center for Healthy Living Training Room

In-Person Attendees: Tracy Terlinde, Megan Hanley, and Ella Dancey
Virtual Attendees: Kim Litwiller, Erika Hahn, Armando Mirando, Denise Backes, Alex Strong, & Sarah Williams.
Contact Information: Denise Backes (denise.backes@banyancenters.com), Megan Hanley (mhanley@tchd.net)

Useful Resources:

- Partnership for a Healthy Community Website: https://healthyhoi.wildapricot.org
- Meeting Information and Data Tracking:
  - Substance Use: https://healthyhoi.wildapricot.org/2020-22-Substance-Use
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Agenda

I. Introductions

II. Objectives for 2023-2025 Cycle

Objectives	Target	Baseline Data
By December 31, 2025, reduce drug overdose deaths by 5% resulting in a Tri-County overdose death rate of 22.12 per 100,000.	Overdose Death Rate for Tri-County: 22.12 per 100,000	Peoria: 16.4 per 100,000 Tazewell: 20.6 per 100,000 Woodford: 13.1 per 100,000 *Source: IDPH Opioid Data Dashboard, 2021*
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III. Presentation on the use of Overdose Surveillance & Response Grant in Peoria & Tazewell Counties. Group discussion on how to continue and sustain momentum from this work.

a. Peoria County Update: Tracy gave a report on the work that PCCHD has done with their Overdose Surveillance grant from IDPH. They are placing 3 vending machines that will have naloxone, fentanyl and xylazine test strips, and safe sex supplies in areas of need. These locations include the 3300 Event Center, Phoenix CDS in downtown Peoria, and eventually at a location in the South Side of Peoria. PCCHD is working with Sue Tisdale to keep the vending machines stocked with Narcan. PCCHD's application for the CDC

Overdose 2 Action grant was accepted; however, they have not received funding yet. If funding was awarded, they would be able to sustain the purchasing of fentanyl test strips and other supplies for their vending machines, purchase drug checking machines, and fund additional peer support efforts.

b. Tazewell County: Megan provided an overview of the work TCHD has accomplished in their 3 years of having funding from IDPH. TCHD has naloxone available in most communities of the county, by partnering with local businesses and first responders. Since March 2023, 106 Narcan kits have been distributed throughout Tazewell County from these locations. Additionally, TCHD has purchased a residential sharps disposal kiosk that is available 24/7 at our Tremont campus. TCHD also conducted a digital awareness campaign highlighting that addiction can impact anyone. The digital advertisement had over 160,000 adults ages 30-59.

IV. Work Group Report Out – Sharing Completed Workplans

a. Healthcare Provider/First Responder Education – Katy Endress has directed this group to each work on reaching out to another provider to discuss their responses further and how we can help facilitate implementation in their practice, address concerns, and answer questions based on our experience. During work group meetings, the group will be discussing challenges and successes related to this.

b. Naloxone Distribution/Outreach – Group discussed splitting into separate groups. Discussed who else needs to be at the table for the outreach group.

c. School-based Education – Only thing to report is this group is looking to increase engagement of Peoria Public Schools in the 2024 Illinois Youth Survey.

V. Member Announcements

a. A reminder was shared about Hunger Action Month being in September and that health was hosting a walk on September 30th at 9am at OSF Center for Health on Route 91.

VI. Action Steps

a. Join Substance Use discussion board at https://healthyhoi.org/discussions . Request access/a login if you haven't already and choose Substance Use.

VII. Next Meeting

a. October 19, 2023, from 3:00-4:30 at Hult Center for Healthy Living (Work group meeting)

Substance Use Meeting
January 18, 2024
3:00 pm – 4:30 pm
Location: Hult Center for Healthy Living Training Room

Contact Information: Denise Backes (denise.backes@banyancenters.com), Megan Hanley (mhanley@tchd.net)

Useful Resources:

- Partnership for a Healthy Community Website: https://healthyhoi.wildapricot.org
- Meeting Information and Data Tracking:
  - Substance Use: https://healthyhoi.wildapricot.org/2020-22-Substance-Use
- Discussion Boards: https://healthyhoi.wildapricot.org/discussions

Agenda

I. Attendees – Megan Hanley, Katy Endress, Tracy Terlinde, Conor Mahoney, Ella Dancey

II. Objectives for 2023-2025 Cycle – An overview of the group's objectives were given.

Objectives	Target	Baseline Data
By December 31, 2025, reduce drug overdose deaths by 5% resulting in a Tri-County overdose death rate of 22.12 per 100,000.	Overdose Death Rate for Tri-County: 22.12 per 100,000	Peoria: 16.4 per 100,000 Tazewell: 20.6 per 100,000 Woodford: 13.1 per 100,000 *Source: IDPH Opioid Data Dashboard, 2021*
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III. Presentation on Overdose trends in 2023 & overdose deaths in the Tri-County Region

IV. Review of objectives, discuss the work going towards each objective, and data from 2023 as we have moved through the first year of this CHIP cycle. (See attached data sheet for updates)

a. A discussion was had around the increase in the overdose death rate for Peoria County in 2022; the group is curious to compare that to the number of overdose deaths in 2023 once the data is finalized.

b. Objective 2 – Hult Center is seeing an increase in requests from schools surrounding vaping education. The Illinois Youth Survey data that is used to measure Objective 2 will not be available until summer 2024 and includes all substance use (including tobacco).

c. Objective 3 – Data on buprenorphine patients has not been updated.

V. Work Group Report Out – Sharing Progress

a. Healthcare Provider/First Responder Education
    i. A survey was sent out to healthcare providers in the Tri-County asking about prescribing MAT and any barriers or questions they might have regarding it. Each member of this workgroup has been assigned a provider to have a conversation with about their survey responses and help them move forward with prescribing MAT.

b. Naloxone Distribution/Outreach
    i. PCCHD has placed their 3 naloxone vending machines and are waiting to place a 4th one at the Wrap Around Center in Peoria. These machines are needing restocked regularly and include naloxone, fentanyl test strips, xylazine test strips, and safe sex supplies.
        - Narcan Administration data for Peoria County (through 11/30/2023) included 896 narcan administrations and 29 overdose deaths.
    ii. TCHD has continued to increase access to naloxone. In 2023, TCHD gave out 324 naloxone kits to community members or agencies.
        - Tazewell County had 17 overdose deaths (through November 2023). 5 of which involved the substance Kratom.
        - The group had a discussion about Kratom; to date Peoria County has seen no deaths with Kratom in toxicology. The group discussed putting public messaging together surrounding the dangers of Kratom and discussed advocating for policy change surrounding it.

c. School-based Education
    i. Ella shared that Hult is receiving increased request for substance use education in elementary schools and middle schools, particularly surrounding vaping. They have also heard of increased reports of students bringing gummies with THC in them to school.
        - The group discussed the potential for social media awareness messaging surrounding the "look-a-likes" of a candy or gummy that has THC in it compared to a regular brand of Sour Patch Kids, etc.

VI. Member Announcements

VII. Action Steps

a. Join Substance Use discussion board at https://healthyhoi.org/discussions . Request access/a login if you haven't already and choose Substance Use.

VIII. Next Meeting

a. February 15th at 3pm – this meeting will be virtual only and we will break into our three sub-groups (school-based, narcan/outreach, and healthcare provider education)

Promoting Tobacco and Vape-Free Schools in Greater Peoria

Recommendations and resources to help Greater Peoria schools respond to the youth tobacco/vaping epidemic.

Developed by Hult Center for Healthy Living
Updated 12/2023

WWW.HULTHEALTHY.ORG

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Contents

Recommendations for Schools

1-School leaders should review the American Heart Association's Tobacco-Free Schools Toolkit

Key takeaways to note from the American Heart Association's Tobacco-Free Schools Toolkit:

- **Schools are the "front lines" of the youth vaping epidemic** and can structure education and disciplinary practices to help prevent and reduce the use of tobacco and vaping (American Heart Association (AHA), p. 2).
- The most effective approaches to help students quit are through **education** and **counseling**. Best practice is to **avoid punitive discipline** and offer "alternative-to-suspension" programs and cessation strategies (p. 2); Suspension for tobacco and vaping increases the likelihood of negative educational outcomes (p. 2).
- Schools should:
    - Review school policies to ensure your school is using best practices.
    - Educate all students (universal strategies) and parents.
    - Support students who are using tobacco. More than half (60%) of students who are using tobacco/vapes want to quit.
- **Review your discipline policy to include supportive and restorative responses** to at least the first two violations of tobacco use or possession (p. 11).
    - For at least the first two offenses, schools should:
        - Inform parents/guardians of the violations.
        - Engage students in a conversation to identify reasons for tobacco use.
        - Help students establish healthier coping strategies.
    - **Schools should not include exclusionary discipline** for at least the first two violations. Suspension, expulsion, and loss of extracurricular opportunities are NOT the most effective strategies to help youth quit using tobacco and are known to have negative impacts (p. 12).
    - **Schools should not use law enforcement in disciplinary actions** related to student tobacco possession and should avoid any efforts to criminalize youth who have been victims of an industry that has marketed the sale of these addictive substances specifically to youth (p. 12).

2-Choose universal approaches to prevent/reduce tobacco/vaping

Note that early elementary and elementary students should be provided with Social Emotional Learning curriculum to equip students with coping strategies, relationship building, and resilience.

- A full list of universal interventions can be found in Appendix A. Our team reviewed the list and is recommending the following:
    - School-Wide Campaign Efforts and Policy Review
    - Consider Providing Classroom-Based Health Education for Middle & High School Students

        - **CATCH My Breath (CMB)** - Available at no cost; Classroom-based weekly educational lessons for grades 5-12; each grade includes four sessions that are 35-40 minutes each; these lessons can be provided by a staff member at your school or by an outside provider such as Hult Center for Healthy Living.
        - **Tazewell County Health Department – Project Alert - Available at no cost to Tazewell County Schools only;** Classroom-based educational lessons for grades 7 & 8 provided by TCHD.
    - Consider Self-Paced Online Health Education for Middle & High School Students
        - **ASPIRE | MD Anderson Cancer Center and University of Texas** – Available at no cost; an online, self-paced smoking prevention program for middle & high school students; includes 5 modules that takes approximately 3.5-5 hours to complete.
        - **Vaping: Know the Truth** - Available at no cost; an online, self-paced program for 8th-12th grade students 4 self-paced lessons approx. 10 minutes each; 30-40 minutes total

3-Develop an action plan and interventions for "At-Risk" students (At least the first two offenses)

- A full list of interventions can be found in Appendix B.
- For at least the first two offenses, consider:
    - Informing parents/guardians.
    - Requiring students to complete an online course such as **SmokeSCREEN** - Available for $5 per student; Online, self-paced learning modules for middle and high school students; takes 2-3 hours to complete.
    - Require one-on-one counseling/conversations with appropriate staff members (school nurse, counselor, leaders, security being mindful of best practices to not include law enforcement) to discuss harmful effects of tobacco/nicotine, reasons for use, and healthy coping strategies.
    - If the school has the capacity, consider providing an in-person intervention such as **INDEPTH** which can be provided in a small group or one-on-one setting; this could be provided by a school staff member, school nurse, or counselor, for example.
    - Provide students with information for quitting (Appendix C).

4-Develop an action plan and interventions for "High Risk" students (At least three or more offenses)

- A full list of *voluntary* cessation interventions can be found in Appendix C.
- For at least three or more offenses, consider:

- Informing parents/guardians.
- Offering an in-person voluntary cessation program such as **NOT on Tobacco (N-O-T);** facilitated in person by a staff member or community partner who has completed the facilitator training ($400); Ten 50-minute sessions.
- Offering an online, self-paced voluntary cessation program such as **N-O-T for Me.**
- Offering **Your Call, Your Quit | Illinois Tobacco Quitline (quityes.org)** which includes up to 9 one-on-one counseling sessions; Offers free training for staff on services.

APPENDICES

APPENDIX A: UNIVERSAL STRATEGIES

Prevention Efforts for All Students

School-Wide Campaign Efforts & School-Wide Policies

Level:	Universal (all students)
Description:	School-wide campaign; CDC launched the Empower Vape-Free YouthTM campaign in 2023 to encourage middle and high school educators to speak with students about the risks of e-cigarettes and nicotine addiction. The campaign also provides resources for educators to help students avoid or quit vaping; there is also The Real Cost Cigarette Prevention Campaign | FDA
Audience:	Middle & High Schools
Lessons:	N/A
Research:	N/A
Other:	While there are no official training modules, this site has videos for students to watch and fact sheets for educators Free Posters are available to order: FDA Tobacco Education & Prevention Resources: Posters, Flyers, & More (hhs.gov)
Costs:	No cost
Recommendation:	Highly recommended; Great resources, no official training.

American Heart Association's (AHA) Tobacco-Free Schools Toolkit

Level:	Universal (all students)
Description:	School-wide policies and practices to support tobacco-free environments
Audience:	Middle & High Schools
Lessons:	N/A
Research:	N/A
Other:	This packet includes best practices for alternatives to suspensions, discipline, sample letters for parents/caregivers, announcements, and recommendation for disciplinary approaches (pages 11-12)
Costs:	No cost
Recommendation:	Highly recommended that all school leaders review for best practices

Classroom-Based Health Education

CATCH My Breath (CMB)

Level:	Universal (all students)
Description:	Classroom-based education programs for teen vaping prevention can be taught during science, health, advisory, or PE/health; peer-led discussion groups are used in every session with a teacher leading.
Audience:	Grades 5-12
Lessons:	Each has four (4) sessions that take approximately 35-40 minutes each; recommendation to implement one session per week.
Research:	Only evidence-based vaping prevention program. Peer-reviewed: 45% of 7th grade students tried vaping the following year.
Other:	Includes parent toolkits, optional video add-ons for a cost, presentation slides with scripting available, and teacher education guides. It aligns with CHES, CC, and CASEL and uses the social cognitive theory.
Costs:	There is no cost, but you can purchase teacher training and add-ons if you want, but it is unnecessary. Training is free and self-paced online. Training takes approximately one hour.
Recommendation:	Recommended: This is nicely packaged, making it easy to implement and is free.

Tazewell County Health Department – Project Alert

Level:	Universal (all students)
Description:	Classroom-based education programs where TCHD health educator comes as a presenter to teach life skills and decision making
Audience:	Grades 7 & 8
Lessons:	12 core lessons for 7th graders and 3 review lessons for 8th graders
Research:	Evidence-based
Other:	Includes parent toolkits, optional video add-ons for a cost, presentation slides with scripting available, and teacher education guides. It aligns with CHES, CC, and CASEL and uses the social cognitive theory.
Costs:	There is no cost, but you can purchase teacher training and add-ons if you want, but it is unnecessary. Training is free and self-paced online. Training takes approximately one hour.
Recommendation:	Recommended: This is nicely packaged, making it easy to implement and no cost

Standford Toolkit- You and Me, Together Vape-Free

Level:	Universal (all students)
Description:	Classroom-based education programs; also includes cannabis in middle and high school
Audience:	Elementary, Middle, and High School
Lessons:	2 lessons for elementary, 6 lessons for Middle & High School approximately 50 minutes each
Research:	Evidence-based

Other:	Includes PowerPoints on Canva, online quizzes, Kahoot! Interactive quizzes, and worksheets
Costs:	No cost
Recommendation:	Recommended; quick access, easy to implement, and no cost

Self-Paced Online Health Education

ASPIRE | MD Anderson Cancer Center and University of Texas

Level:	Universal (all students) prevention education for all students
Description:	An online, self-paced smoking prevention interactive experience. Online educational resource for educators that delivers tobacco prevention education to teens and adolescents.
Audience:	Middle & High School; 11-18 Year Olds
Lessons:	5 interactive modules that take 3.5-5 hours to complete in total
Research:	Testimonials from former smokers, health care professionals, students, and cancer survivors. Learn more about impact here.
Other:	90 percent of students who have used this toolkit have reported an increase in knowledge of tobacco harms, a desire for a tobacco-free lifestyle. This is not an alternative to suspension or cessation program.
Costs:	No cost
Recommendation:	Recommended for general students; not recommended for students who have been caught smoking

Vaping: Know the Truth

Level:	Universal (all students) prevention curriculum focused; also linked with texting service called "This is Quitting" for those who are at-risk/high risk
Description:	An online, self-paced called *Vaping: Know the Truth* is a free digital learning experience
Audience:	Grades 8-12th
Lessons:	4 self-paced lessons approx. 10 minutes each; 30-40 minutes total
Research:	Research-based
Other:	Used by 3 out of 5 U.S School districts; Schools do need to sign up to join, which may take time; each student will need their own login; provided by Everfi
Costs:	No Cost
Recommendation:	Recommended for general students

APPENDIX B: STRATEGIES FOR AT-RISK

For Students with At MINIMUM 1-2 Offenses

Self-Paced Online Health Education

SmokeSCREEN – Online self-paced game

Level:	At-Risk (1-2 Offenses)
Description:	An online, self-paced alternative to suspension skill-building platform.
Audience:	Middle & High School (10-16 years)
Lessons:	2-3 hours to complete; a guide for teachers is also available
Research:	Promising effects on risk perception, beliefs about e-cigs
Other:	Upon login, the game prompts with, "smokeSCREEN is about building your personal network of friends while dealing with risks from people who don't always do the right thing, such as using tobacco products. Choose your friends wisely! Some people will help you move forward with your goals, but others may tempt you with unhealthy choices."; note that this website also includes other online modules for STI/HIV prevention and mental health that may be helpful for schools
Costs:	~$5 per student
Recommendation:	Recommend since it's online and self-paced which will allow for alternative to suspension activity; A little difficult to access; not an instant log on- you have to email the team, wait for a response (within 24 hours), and then pay for access; students will need to save their login/password info to gain access to the game again later

Group-Based Health Education

INDEPTH: Intervention for Nicotine Dependence: Education, Prevention, Tobacco, and Health

Level:	At-risk (1-2 Offenses) This is an alternative to suspension or citation program. This can be a MANDATORY program for those caught vaping.
Description:	Small group setting OR 1-on-1; trained facilitator needed; A trained adult educates students with group and one-on-one training sessions.
Audience:	High School; Ages 14-19
Lessons:	Four 50-minute sessions
Research:	60% of student participants reported that they were willing to quit using tobacco products after completing the program. This is not a smoking cessation program, but it does help connect students to resources for quitting.
Other:	The online facilitator training takes about one hour to complete and the certification is good for 3 years
Costs:	No cost facilitator training and content
Recommendation:	Recommend; the online facilitator training is free and easy-to-navigate

Safety First – Drug Curriculum (Stanford)

Level:	At-Risk (1-2 Offenses; or at-risk for using)
Description:	Safety First is meant for high school students. This curriculum is particularly relevant for students already using, for students at-risk for using, and/or for students living in communities in which there are any level of exposure to drugs. The curriculum is designed to be used in classrooms or group settings.
Audience:	High School Students
Lessons:	Contains 13 lessons – one lesson is on vaping.
Research:	Evidence-informed; theory-based
Other:	Site provides a cannabis toolkit prevention site that allows you to print lessons and provides additional materials on cannabis prevention.
Costs:	Free Training for Facilitators
Recommendation:	This would be a good curriculum to use for general Substance Use classes. ***Not recommended for vaping.***

MY Healthy Futures (Alternative to Suspension Nicotine Curriculum)-Stanford

Level:	At-Risk (1-2 Offenses)
Description:	Small group setting; facilitator needed; This is an Alternative-to-Suspension curriculum geared for students who have been caught using nicotine products, e-cigarettes, or any tobacco products and/or for any student who is interested in trying to reduce or quit nicotine use.
Audience:	This does not specifically state what age groups but would be recommended for Junior High and HS students.
Lessons:	5 lessons; The hyperlink gives you access to the teaching guide and recommendations
Research:	Evidence-based
Other:	There are five vaping modules with and one alternative model with a cannabis curriculum. The modules are set up in group settings. The following is an example of the first module. 1. (5 min) Check-Ins 2. (15 min) Teach **1st Course Module** 3. (10 min) Breakout Rooms for Students to Discuss **Review & Reflect Questions** 4. (10 min) Small Groups Report Out to Class 5. (10 min) Wrap Up Module and Do **Quiz** as a Class
Costs:	No cost
Recommendation:	DO NOT Recommend; When researching this resource, the links were broken when trying to access the modules. Resources may be updated at a later date. This curriculum is in a group setting with a facilitator (training materials provided) and a positive alternative to ISS. The curriculum contains a plethora of resources including course guide, facilitator guides, reflection worksheets, final knowledge quiz and/or Kahoot quiz. There are also add-on features as well.

APPENDIX C: STRATEGIES FOR HIGH RISK

For Students with At MINIMUM 3+ Offenses and Those Who Want to Quit

Group-Based Cessation

NOT on Tobacco (N-O-T)

Level:	High risk (3+ Offenses)
Description:	Voluntary youth-centered group CESSATION program for all tobacco products, including vaping. This is a VOLUNTARY program.
Audience:	High School; Ages 14-19
Lessons:	Ten 50-minute lessons
Research:	N-O-T is an evidence-based program with an impressive success rate, with approximately 90 percent of teens who participate in the program cutting back or quitting tobacco all together. Post program, Not On Tobacco® program youth also have been shown to have better grades, higher motivation, fewer absences, better relationships with teachers and fewer school tobacco use policy violations.
Other:	There is an online self-paced module
Costs:	$400 facilitator training.
Recommendation:	Recommend if there are funds for the facilitator training. This program is offered through the American Lung Association.

Self-Paced Online/Call/Text Cessation

N-O-T for Me

Level:	High risk (3+ Offenses)
Description:	An online, self-paced VOLUNTARY CESSATION program to help teens who want to quit tobacco, including vaping.
Audience:	High School; Ages 14-19
Lessons:	8 self-paced sessions that should be completed weekly
Research:	Evidence-based
Other:	
Costs:	No cost
Recommendation:	Recommend since it's the only online cessation program and no cost

This is Quitting

Level:	High risk (3+ Offenses)
Description:	Free and anonymous text messaging program to help young people quit vaping; VOLUNTARY CESSATION program to help teens who want to quit tobacco, including vaping.
Audience:	Middle & High School
Lessons:	8 self-paced sessions that should be completed weekly
Research:	Evidence-based
Other:	To enroll in This is Quitting, teens and young adults can text **DITCHVAPE** to **88709**

Costs:	No cost
Recommendation:	Recommend as an option for those who want to quit

Your Call, Your Quit | Illinois Tobacco Quitline (quityes.org)

Level:	High Risk – actively using
Description:	Illinois tobacco Quitline provides free tobacco and vaping cessation services to all Illinois residents. Can be referred by a provider or self-sign-up on web, by texting, or calling the Quitline number
Audience:	13 yrs and +
Lessons:	One-on-one coaching, counselor services up to 9 sessions over a 6-week period, and texting services
Research:	Quitting with the support of a Quitline counselor is proven to be more effective than on your own. Some of the counselors were former smokers. Every Counselor is a Certified Tobacco Treatment Specialist trained in methods proven to help people quit addictive nicotine and tobacco products.
Other:	To enroll to or call 1-866-QUIT-YES (1-866-784-8937).
Costs:	No cost
Recommendation:	Recommend as an option for people who want to quit

SmokefreeTXT for Teens | Smokefree Teen

Level:	High Risk – actively using and designed specifically for QUITTING
Description:	Self-paced texting challenges. The smoke free text messaging program is a texting based only program that offers support up to 14 days (about 2 weeks) before your quit date. Will start up to two weeks before quit date and will last for 6 weeks (about 1 and a half months) following your quit date
Audience:	13yrs –17 yrs.
Lessons:	Texting services for up to 8 weeks (about 2 months) (two weeks before quit date and 6 weeks following your quit date. Will provide daily and weekly challenges for clients to complete.
Research:	Offered through National Cancer institute's smokefree.gov
Other:	To enroll text QUIT to 47848
Costs:	No cost
Recommendation:	Recommend as an option for people who want to quit

MLMQ (IL) - Start My Quit (mylifemyquit.org)

Level:	High Risk – actively using and designed specifically for QUITTING
Description:	My Life, My Quit program is a free and confidential service developed by National Jewish Health, the nation's number 1 respiratory hospital, for teens who want help quitting all forms of tobacco including vaping.
Audience:	13 yrs –19 yrs; Teen focused
Lessons:	1:1 support with a health coach up to 5 one-on-one coaching sessions scheduled every 7-10 days. Self-paced educational material. Additional support is made available through texting and online chat.
Research:	Evidence-based

Other:	To enroll call 1-800-QUIT.NOW or text Start my quit to 36072
Costs:	No cost
Recommendation:	Recommended as an option for people who want to quit