Partnership for a Healthy Community
Board Meeting

February 23, 2023
1:00pm-2:30pm
Teams

AGENDA

1. **Approve 1/26/23 meeting minutes** (Action) **(Pages 2-4)**

2. **Committee Updates**
    a. HEAL
    b. Mental Health **(Pages 5-6)**
    c. Obesity
    d. Data Team **(Pages 7-10)**
    e. Website & Social Media
    f. Performance Management
        i. Cancer: 2023 Community Wide Screening Days

3. **Board Business**
    a. CHIP Update and Plan Approval (Action) **(Pages 11-102)**
    b. Grants for the Benefit of Homeless Individuals: SAMSHA – *Kate Green* (Discussion)
    c. Annual Meeting (Discussion)
    d. Annual Report Draft and Report Approval (Action) **(Pages 103-116)**

4. **Miscellaneous/Announcements**
    a. Support Role

Next Meeting:
Thursday, March 23, 2023
1:00pm-2:30pm
Teams

Partnership for a Healthy Community Board
Meeting Minutes
January 26, 2023

Members Present via Microsoft Teams:	Amy Fox	Holly Bill
	Hillary Aggertt	Sally Gambacorta
	Beth Crider	Larry Weinzimmer
	Monica Hendrickson	Ann Campen
	Nicole Robertson	Craig Maynard
	Kate Green	Adam Sturdavant
	Tricia Larson	Chris Setti
	Phil Baer	
Others Present:	Amy Roberts	Amanda Sutphen

Approval of 12/08/22 Meeting Minutes

Mr. Weinzimmer made a motion to approve the minutes from the December 8, 2022 meeting. Motion was seconded by Mr. Setti. Motion carried (11,0).

Committee Updates

HEAL

Ms. Fox noted that the HEAL team met in mid-December with Dr. Donohue. She stated that they did not make it as far as the Mental Health team for deciding their impact for the next cycle. There is an event they are working with the Regional Food Council on, on February 21st in the morning. They are hoping to impact legislators around the farm bill. That afternoon, they will do a listening session with the state on some of the money moving in from farm to school in the area and what they can do with local farmers to impact that. They will receive 5th year funding from the community foundation as well.

Mental Health

Ms. Bill did not have a dashboard this month, they are working to solidify their goals and objectives. Dawn Lochbaum from OSF will be Chairing the Mental Health Action Team. They are still looking for another Co-Chair, potentially from UnityPoint Health.

Obesity

Mr. Baer stated that the Obesity had their kickoff meeting on January 17th, mostly discussion around the two interventions to focus on. The majority of the discussion was around the current state of what is happening already. They talked about risks and barriers as well. They are working on drafting out the objectives and evaluation plan, getting feedback from the team to finalize that plan. The minutes were attached in the agenda packet.

Data Committee

Amanda stated they are working on finalizing collecting 2022's data. She thanked everyone that has helped to supply the data. She has updated as far as she can from her end and is just waiting for the data to come in. There are a few pieces of outstanding data but will circle back to get those and will

have that information wrapped up for the previous cycle.

Performance Management

Substance Use

Ms. Bill reviewed the Substance Use slides in the agenda packet. This included their goals and objectives. The team has been meeting often and is led by Megan Hanley, Epidemiologist at TCHD. They are working on some of the same initiatives, but with deeper conversations with other community partners. They are working on distribution of Narcan and MAPP activities. All three counties are attending, and Jolt has been able to attend. They are looking at how can they can boost the efforts of the events that have been going on over the last few years. Denise Backes will also be joining as the Co-Chair and potentially Ms. Bill as the Board liaison, but unsure if that position will be needed.

Board Business

New Member

Ms. Fox noted that Mr. Baer has been attending Board meetings for quite a while and Tazewell County has an opening. Ms Fox would like to put forward Mr. Baer as a Board member representing Tazewell. Mr. Setti made a motion to approve Mr. Baer as a Partnership Board member. Motion was seconded by Ms. Hendrickson. Motion carried (12,0). Ms. Fox noted that this will be filling Mr. Eberle's position as he could no longer attend.

Board Bylaws

Ms. Fox wanted to review the bylaws, specifically looking at the election for a new co-chair. Health Departments rotate, this is Ms. Fox's year two. Ms. Fuller has been filling the Co-Chair for the last three years. The bylaws state the nominations can be made electronically and they need to be a Partnership member (not Board member) for at least a year. This will be by a ballot at the annual meeting voted on by everyone at the Annual Meeting. Ms. Fox stated that the nomination they have received so far is for Mr. Baer, who has not been on the Board for a year. Ms. Fox wanted to be clear that the language is correct in the bylaws and that it does not need to be changed. Board members voiced their opinion, that since this is a young board and the language could stay the same.

Annual Meeting

Ms. Fox noted that the Annual Meeting has been scheduled for Tuesday, March 7th from 9-11am at the Spalding Center, which has already been reserved. They will be bringing in a continental type of breakfast, no caterer has been obtained yet. Current plan Co-chairs will do their final year 3 wrap up and then a preview of the new CHIP and goals and moving forward. An email has gone out to the current Chairs to get their reports and to start working on their slides. They will also contact the new Chairs to get their slides for the new CHIP.

CHIP Update

Ms. Hendrickson stated the CHIP as it stands is in the packet, still things to be added. The biggest things missing are the dashboards for HEAL and Obesity. The other portion missing is Dr. Donohue's forces of change assessment, which will be compiled as a single report as an appendix. She would like the Board to read through it and give feedback.

Ms. Hendrickson noted that Dr. Donohue has a couple more hours left to complete her practicum. The last part of her project will be to evaluate the Partnership on the process, what worked and

what didn't work, etc. She might be reaching out to members to get feedback. Dr. Kelly has been contracted by the PCCHD and they pay $3,000 a month. Her contract will be ending this summer. To end her contract, for the new cycle she will be creating an evaluation plan and starting that process earlier. HEAL and Obesity can rely on Dr. Kelly to help finish up the dashboards.

Miscellaneous/Member Announcements

Ms. Hendrickson stated the Healthcare Collaborative is working through an MOU between the two hospitals systems, FQHC, UICOMP, and the local health departments. This will outline and formalize their role and how they interact with the public. The NIH grant is planning dollars in relation to social determinants of health, PCCHD applied for it and their letter intent was accepted and now can apply fully for the grant. This will bring money for a 2-year period to formalized how the Healthcare Collaborative and the Partnership interact and navigate systems. This grant is due at the beginning of February.

Ms. Fox stated that Ms. Aggertt is working with Joy to update the website, getting old plans achieved and putting on new plans. Each priority group will be able to go on there and update their own information, after some sort of training roll out. They would like to keep a calendar active, so as the groups grow they can see when all the meetings are. Spaces could be created for the Performance Management groups and RJE Commission.

Ms. Hendrickson noted that the Board still needs to discuss how the Board support the action teams in this new cycle. Ms. Hendrickson stated that herself and her team are stretched thin and interventions now require a different lens and Chair. Ms. Bill stated it would be nice to have Board members present at the action team meetings, the Board could give updates and ask if there is anything the group needs from a higher level, they would be the contact. This shows that the Board the invested and cares about the work of the action teams. Ms. Fox included that these interventions are mostly primary care focused and the community organizations would need different involvement, the same with the health departments. Ms. Robertson added the communication piece, regarding the website. She stated a decision or direction from the Board would be helpful. Ms. Aggertt said they are going to revamp the website, but they need to know what each of the priority teams want from the website and make sure everything gets updated and how it gets updated. The meeting function hasn't been utilized a lot, but you can note on there if it's virtual or in person's location, etc. They are waiting to see where the CHIP lies and then can talk with all the groups and designate one person from each action team for updates. Ms. Fox suggested a virtual meeting with Joy and others to talk about their experience with the website.

Ms. Hendrickson noted that the next meeting is February 23rd. She stated CHIP and dashboard feedback would be needed prior to that meeting. Please have all feedback to Ms. Hendrickson by February 17th, especially those involved in the process. Ms. Fox stated that the heavier lift would be for the Obesity and HEAL teams to get their information squared away with their dashboards.

OBJECTIVE #1: (HP2030) By December 31, 2025, decrease the number of suicides in the tri-county area by 10%. Baseline: Suicide deaths (per 100,000) – *Tri-County 2015-2018- Source: HCI Conduent; PC 16.2; TC 14.7; WC 17.7; IL 11.1*

OBJECTIVE #2: (HP2030) 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%. *– Source: HCI Conduent; Age-adjusted ER rate due to pediatric mental health per 10,000; PC 312.5; TC 275.5; WC 139.9; IL 192.3 and Age-adjusted hospitalization rate due to adult mental health per 10,000; PC 286.8; TC 173.1; WC 113.4; IL 158.9; and % of respondents that indicated they spoke to someone about their mental health in the last 30 days (41% in 2022 CHNA)*

Intervention Strategies:

- **Culturally-Adapted Health Care**
    - Tactics:
        - Promote awareness and education trainings quarterly that are focused on improving cultural competence related to mental health care.
        - Provide tailored educational trainings by-annually to healthcare professionals in the Tri-County region.
        - Create policies to support matching patient race/ethnicity/cultural/sexual orientation backgrounds to provider
        - Make culturally- and linguistically-adapted materials and marketing available
    - Evaluation Plan:
        - Establish baseline, increase # providers completing cultural competence trainings by 10%
        - Increase # providers/systems that have policies to support cultural competence by 10%
        - Improve patient experience ratings (likelihood to recommend) by 1%
        - 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)
- **Telemedicine**
    - Tactics:
        - Establish baseline, inventory available telemedicine among tri-county
        - Disseminate information through 10 promotional campaigns on how to access (mental health) telemedicine
        - Support the development of structured partnerships for community healthcare organizations to provide telemedicine
        - Expand number of locations for community members to access telemedicine mental health care (community settings, OSF Strive, libraries, Wraparound Center, etc.)

        - Provide more than 100 residents access to mental health telemedicine appointments who are either medically underserved or live in rural areas
    - Evaluation Plan:
        - Reduce # hospital readmissions among individuals who engage in telemedicine by 30%
        - Increase # patients engaged in mental health telemedicine by 10%
        - Increase # new patients enrolled in telemedicine by 10%
        - Increase # telemedicine community access points by 10%

Mental Health

Goal: Improve mental health among tri-county residents through preventive strategies and increased access to services

Objectives	Source	Frequency	Baseline	2020	2021	2022
By December 31, 2022, decrease the number of suicides in the tri-county area by 10%.	IDPH Suicide Deaths Iquery	Annual	27 Peoria 22 Tazewell (2018) 26 Peoria 14 Tazewell (2019)	22 Peoria 16 Tazewell 4 Woodford	NA	NA
By December 31, 2022, decrease the number of residents in the tri-county areas who reported feeling depressed in the past 30 days by 10%.	CHNA survey	3 years	54% 0 28% 1-2 9% 3-5 9% 5+			42% 0 34% 1-2 13% 3-5 11% 5+
By December 31, 2022, decrease the number of residents in the tri-county areas who reported feeling anxious or stressed in the past 30 days by 10%.	CHNA survey	3 years	60% 0 25% 1-2 8% 3-5 7% 5+			48% 0 25% 1-2 8% 3-5 7% 5+
By December 31, 2022, decrease the number of residents in the tri-county areas who reported considering suicide in the past 12 months by 10%.	CHNA survey	3 years	17.17 Tri-County 18 Peoria 19.5 Tazewell 14 Woodford			NA
Strategies	**Source**		**Baseline**	**2020**	**2021**	**2022**
Increase knowledge of mental health and reduce stigma by providing Mental Health First Aid (MHFA) and Youth Mental Health First Aid (YMHA): *Establish baseline and increase certifications in the Tri-county by 10% (2,176)*	Mental Health First Aid Quarterly Report	Quarterly	1,227 MHFA 751 YMHFA 1,978 Total	1,264 MHFA 861 YMHFA 2,125 Total	1,326 MHFA 774 YMHFA 2,100 Total (as of 12/31/21)	1,393 MHFA 861 YMHFA 2,254 Total (as of 9/30/22)
Universal school-based suicide awareness & education programs: *Establish baseline and increase number of students in the Tri-county receiving suicide prevention education by 10% (4,386)*	Hult Center for Healthy Living & Community Partners	Annual	3,988	968	982	298

School based social emotional instructions: *Establish baseline and increase number of trauma-informed schools in the Tri-county by 10%*	Regional Offices of Education & Community Partners	Annual	0	3	3	17
Behavioral health primary care integration *(Increase number of providers in primary care settings by 10%, increase number of providers in specialized care settings by 10%, and increase number of providers in prompt care settings by 10%)*	Community Partners-OSF and UPH	Annual	19 Primary 1 Specialty 0 Prompt	19 Primary 1 Specialty 0 Prompt	20 Primary 1 Specialty 0 Prompt	20 Primary 1 Specialty 0 Prompt
Poor Mental Health Days: *Decrease the average number of mentally unhealthy days reported in past 30 days (age-adjusted) in the tri-county.*	County Health Rankings	Annual	4.0 Peoria 3.5 Tazewell 3.3 Woodford (2019)	3.9 Peoria 3.8 Tazewell 3.7 Woodford	4.3 Peoria 4.4 Tazewell 4.1 Woodford	4.6 Peoria 4.3 Tazewell 4.1 Woodford
Mental Health Provider Rate: *Increase the mental health provider rate in providers per 100,000 population.*	County Health Rankings	Annual	450:1 Peoria 570:1 Tazewell 3,870:1 Woodford (2019)	420:1 Peoria 550:1 Tazewell 3,500:1 Woodford	400:1 Peoria 530:1 Tazewell 3,500:1 Woodford	370:1 Peoria 490:1 Tazewell 2,930:1 Woodford

Last Updated: 2/13/23

Substance Use

Goal: Reduce substance use to protect the health, safety, and quality of life for tri-county residents.

Objectives	Source	Frequency	Baseline	2020	2021	2022
By December 31, 2022, reduce the rate of drug-induced deaths within the tri-county region by 10% from 22.2 per 100,000 tri-county residents to 20.0 per 100,000.	Vital Records Overdose Data	Annual	Rate: 26.81 Peoria 14.00 Tazewell 5.17 Woodford Count: 49 Peoria 19 Tazewell 2 Woodford (2019)	Rate: 22.09 Peoria 19.62 Tazewell 12.99 Woodford Count: 40 Peoria 26 Tazewell 5 Woodford	Rate: 22.29 Peoria 27.60 Tazewell 13.08 Woodford Count: 40 Peoria 36 Tazewell 5 Woodford	NA
By December 31, 2022, increase the proportion of adolescents reporting never using substance (alcohol, any tobacco/vaping, cigarettes, inhalants, marijuana) in the last year in the tri-county area by 5%	Illinois Youth Survey 8th grade	Bi-Annual	33% Peoria 29% Tazewell 20% Woodford (2018)	25% Peoria 33% Tazewell 30% Woodford		27% Peoria 26% Tazewell 11% Woodford
Strategies	**Source**		**Baseline**	**2020**	**2021**	**2022**
Criminal Justice and Harm Reduction Efforts: *Reduce overdoses by 10% through use of Narcan and stable housing for frequent utilizers*	IDPH, Fatal and Non-Fatal	Annual	162 Peoria 66 Tazewell >10 Woodford (2019)	239 Peoria 88 Tazewell >10 Woodford	139 Peoria 73 Tazewell >10 Woodford	NA
Criminal Justice and Harm Reduction Efforts: *Increase Narcan distribution in the Tri-county by 10%.*	Jessica Kinsel- UnityPoint Place	Annual	1325 Peoria 347 Tazewell 73 Woodford	3616 Peoria 563 Tazewell 0 Woodford	4204 Peoria 200 Tazewell 56 Woodford	6087 Peoria 430 Tazewell 122 Woodford
Criminal Justice and Harm Reduction Efforts: *Increase Narcan administrations in the Tri-county by 10%.*	Narcan Advisory Groups Opioid Data Summary	Annual	755 (2019)	971	942	492 (Q1 &Q2)
Technology-Enhanced Classroom Instructions: *Enroll nine Tri-County schools in Drugs Safety programs to increase knowledge*	UnityPoint Health & Everfi	Annual	0	11	NA	NA

Mass Media Campaign: *Implement mass media campaign against chemically impaired driving and underage drinking and binge drinking*	Tazewell County Health Department	Annual	0	1	1	0
Youth Leadership Programs: *Increase number of students certified as peer educators by 10%*	Hult Center for Healthy Living	Annual	0	0	0	15

Last Updated: 2/13/23

CHIP Report

Community Health Improvement Plan

Partnership for a Healthy Community

healthyhoi.org

I. INTRODUCTION

Partnership for a Healthy Community (hereafter referred to as PFHC) is a multi-sector community partnership working to improve population health in the Tri-County Region. Created in 2016, the PFHC uses a collaborative approach to improve health in development and oversight of the Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP). The collaborative includes the regional health systems, health departments, and community agencies. PFHC is a community-driven partnership of public and private stakeholders working to address priority health issues in Peoria, Tazewell, and Woodford counties. Partnership for a Healthy Community is recognized as leaders in community health improvement.

Since 2016, Partnership for a Healthy Community has increased development and structure to assist in creating a sustainable collaborative initiative. PFHC currently has a reporting structure, adoption of bylaws, and elections and appointments of officers. The organization structure includes an ad-hoc CHNA collaborative team, ad-hoc data team, and health priority action teams to identify and implement health priority goals and strategies.

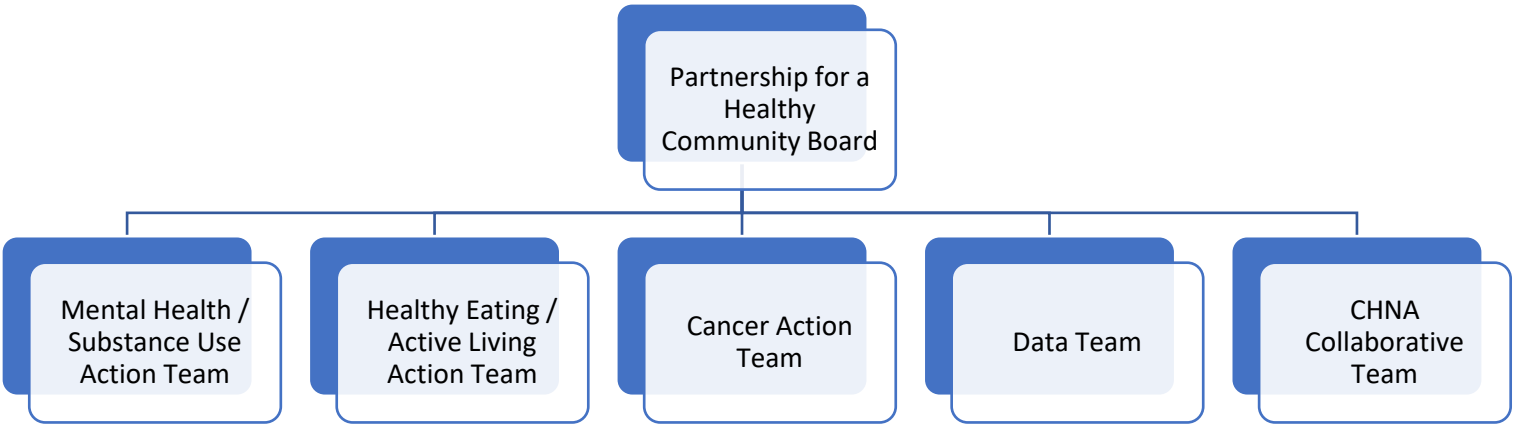

Figure 1: PFHC Action Team Committees 2020-2022

PFHC provides backbone support from multi-sectors to plan, coordinate, and support community health initiatives. Priority health action teams report their work to PFHC Board to promote a coordinated health improvement strategy.

The overall vision of PFHC is for the Tri-County Region to be a thriving community that is inclusive, diverse, and sustainable to ensure health equity and opportunity for all. The 2023-2025 CHIP is the third plan developed using this collaborative approach. As PFHC continues to align community efforts in addressing health outcomes, this cycle maximized efforts to increase data collection and gap analysis to drive interventions.

2022 PARTNERSHIP FOR A HEALTHY COMMUNITY BOARD MEMBERS

Lisa Fuller, Co-Chair	**OSF Healthcare Saint Francis Medical Center**
Amy Fox, Co-Chair	**Tazewell County Health Department**
Hillary Aggertt	**Woodford County Health Department**
Amelia Boyd	**UnityPoint Health**
Holly Bill	**Hult Center for Healthy Living**
Ann Campen	**UnityPlace**
Beth Crider	**Peoria Regional Office of Education**
Sally Gambacorta	**Carle Eureka Hospital**
Kate Green	**Home for All – Continuum of Care**
Monica Hendrickson	**Peoria City/County Health Department**
Tricia Larson	**Tazewell County Board of Health**
Craig Maynard	**Eureka College**
Nicole Robertson	**American Cancer Society**
Chris Setti	**Greater Peoria Economic Development Council**
Adam Sturdavant	**OSF Medical Group - Pediatrics**
Larry Weinzimmer	**Bradley University**
Jennifer Zammuto	**Heart of Illinois United Way**

II. CHIP 2020-2022 HIGHLIGHTS

Since 2016, PFHC has worked collectively to establish and coordinate evidence-based intervention strategies for the Tri-County Region. The first cycle of the CHIP plan included the gathering of multiple organizations, sectors, and the public to participate in population health planning. Experts and community members worked together to identify and prioritize local health concerns and quality of life issues, map, and leverage community resources, and form effective partnerships to implement health improvement strategies in Peoria, Tazewell, and Woodford Counties.

In 2019, the Partnership for a Healthy Community began their second cycle in needs assessment and improvement planning, building from the previous lessons learned and increased community commitment. The focus of 2020-2023 CHNA/CHIP was to leverage additional community partners in leadership and expand the interventions through focused social determinants of health (SDOH) impacts. However, beginning

in February 2020, the COVID-19 pandemic would greatly impact this cycle's capacity to implement and engage various interventions.

Throughout the 2020-2022 CHNA/CHIP cycle, PFHC was able to pivot interventions and programming to address novel challenges and to highlight programming that met increased demand. The Partnership for a Healthy Community Action Teams pivoted in response to the COVID-19 pandemic and worked creatively to address barriers. Examples of this flexibility included increased food distribution, opioid overdose response, and launch telehealth to increase access to mental health providers.

Healthy Eating/Active Living (HEAL)

HEAL was prioritized by Peoria, Tazewell & Woodford Counties to focus on youth and adult nutrition and physical activity, food insecurity, and built environment. HEAL formed workgroups to develop objectives and strategies to reduce the proportions of adults considered obese, youth who self-reported as overweight and obese, and reduce food insecurity within the Tri-Counties. HEAL continues to receive the Community Foundation of Central Illinois' *Ending Hunger Together* Grant to increase healthy food access, advance community education, and create economic and agricultural development opportunities. Additionally, the Illinois State Physical Activity and Nutrition (ISPAN) grant continues to focus on Food Service Guidelines, Breastfeeding, Active Living, and Early Childhood Education programming. *HEAL Team News* was created and distributed to promote HEAL activities among community partners. HEAL has offered support to the development of many campaigns: Move It Mondays, Hunger Action Month & Tri-County Hunger Walk, WIC Farmers Market, and 12 Days of Giving.

Breast, Lung, and Colorectal Cancers

The Cancer Community Action Team worked to reduce the illness, disability, and death caused by breast, lung, and colorectal cancer. The objective was to reduce age-adjusted death rate by 1% for all three cancers. The team focused on increasing the number of breast, lung, and colon cancer screenings performed in the tri-county area. Additionally, there were a number of projects aimed at increasing smoking cessation participation, creating tobacco free policies in the tri-county area, and increasing the proportion of homes with an operating Radon mitigation system.

The past three years had some unique challenges for this team due to the COVID pandemic and the subsequent disengagement from elective healthcare that accompanied efforts to slow the spread of the virus. With this in mind a large percentage of our efforts were devoted to educating our community members on the need to continue screening for cancer during this unique time. The team utilized print, radio, television, and social media to educate the public that cancer does not stop during a pandemic. The Cancer Action Team designed a press release from the Partnership for a Healthy Community to educate the community on the need to get back to screening. All partners shared ideas and held screening events to prioritize a return to screening. The data demonstrated screenings return to pre-COVID levels by the end of this three-year cycle. Lung screenings in particular far exceeded previous levels. Edwards Settlement Grant dollars were obtained and used to increase lung screening awareness along with increasing applications for home Radon mitigation systems. These efforts contributed to a significant increase throughout the area in lung screenings and Radon mitigation. Efforts were made to educate the community on the various methods for colon screenings. Colon cancer screening kits were made available at community outreach events by both UnityPoint and OSF Healthcare. Illinois Tobacco-Free Communities Grant was successful

throughout the pandemic in increasing tobacco-free policies. Genetic screening activities were also emphasized by local healthcare provider partners to identify high risk individuals and adjust screening regimens accordingly. Barriers to care was also a focus as the American Cancer Society provided grants to both UnityPoint and OSF Healthcare to assist patients living with cancer with transportation and lodging.

Substance Use and Mental Health

Substance Use, defined as abuse of illegal and legal drugs, alcohol, and tobacco/vaping use, and Mental Health, defined as anxiety, depression, and suicide, were identified as a priority concerns for the Tri-County in the 2019 Community Health Needs Assessment. These two priority concerns were addressed under one working group during the 2020-2022 CHIP cycle, as many of the key agencies involved in the selected interventions worked together to address these concerns. The group selected goals, objectives, and strategies to address mental health and substance use issues across all three counties.

Substance Use efforts were largely focused on reducing overdoses and drug-induced deaths through increased Narcan distribution efforts, expanding access to stable housing for frequent utilizers, and providing education and awareness through social media and technology-enhanced classroom instruction. Mental Health efforts led to an increased number of community members certified in the evidence-based training, Mental Health First Aid, additional suicide prevention efforts throughout schools and communities, and an increased number of behavioral health providers throughout primary care settings.

III. EXECUTIVE SUMMARY

a. Statement of Purpose

In 2022, PFHC embarked on the planning of the 2023-2025 CHIP. It was important to Partnership for a Healthy Community that the board and action committees continue to take a collaborative approach to accomplishing the goals identified in the CHIP. To facilitate this process, the CHIP Transition Team, an ad-hoc committee, was formed to review the process and intentionally plan community feedback. The committee consisted of members from the three local health departments (Peoria, Tazewell, and Woodford) and three hospital systems (Carle Eureka, OSF Saint Francis Medical Center and UnityPoint Health). To assist in the transition between the two cycles, the committee focused on reviewing the CHNA, identifying gaps, supporting evidence-based interventions, and creating a structure to gain feedback and voice to the process.

b. Development Process for the 2023-2025 CHIP

Community Health Needs Assessment and Prioritization

The 2022 Community Health Needs Assessment (CHNA) provides and assists with data determination for strategic planning. As with the previous CHNA, the 2022 CHNA included community engagement and statistical analysis both county and regionally. A quality improvement project the PFHC Board discussed was to conduct regional analyses, specifically identifying thirteen (13) geographic sub-areas within the tri-county. The data was used to make health priority determinations. The completed 2022 CHNA can be found at www.healthyhoi.org.

A variety of data sources were used as part of the assessment which included demographic composition of the Tri-County Region, the predictors for and prevalence of diseases, the leading causes of mortality, the accessibility to health services and healthy behaviors. Primary data is a key component of the CHNA, specifically to engage the community in determining trends and perceptions. To perform these analyses, information was collected from publicly available sources as well as private sources of data. Additionally, surveys were completed by 1,649 respondents in the community. The residents were assessed with a special focus on the at-risk or economically disadvantaged population.

On May 24, 2022, Partnership for a Healthy Community hosted a prioritization meeting with over 50 community members representing a variety of sectors. During this event the data was shared (Appendix A) to review the key health priorities and voting was conducted to determine the top three areas of concern.

The 2023-2025 Health Priorities are:

- **Healthy Eating / Active Living (HEAL)** includes a healthy eating plan, physical activity throughout the day, access to foods, and food security
- **Obesity** includes individuals who are overweight or obese
- **Mental Health** includes depression, anxiety, and suicide

Gap Analysis

Upon completion of the CHNA Prioritization, the ad-Hoc Transition Team began to focus on the selection of goals, objectives, and interventions. Discussion regarding areas of opportunity from the previous cycle included focused gap analysis regarding sub-populations that are disproportionately impacted in regards to the three health priorities. Utilizing staff from the University of Illinois College of Medicine Peoria, a gap analysis was completed to assist in development of the interventions (Appendix B). The report included analysis of the community survey, along with local and national data to further examine the gaps and barriers as they pertain to HEAL, obesity, and mental health.

Intervention Assessment

PFHC's work is rooted in using evidence-based practices to improve health outcomes. Using validated resources, the ad-Hoc committee established an extensive list of interventions that specifically impacted the three health priorities. The committee then conducted a crosswalk to establish if the interventions aligned with the gap analysis and/or are currently being conducted within the 2020-2022 CHNA/CHIP. (Appendix C).

CHIP Development Feedback

The Partnership for a Healthy Community hosted three CHIP Development meetings in October 2022, each focused on one key health priority. Prior to the meetings, attendees were provided the gap analysis, intervention crosswalk, and a training video explaining the importance of choosing evidence-based practices.

The development days included multisector partners and individuals with lived-experience to review the interventions in determining the next cycle's scope of work. The day included a walk-through of evidence-based practices, discussion of intervention assessment, and lastly a dot-voting process to determine rankings of activities. No more than three interventions were selected in an effort to allow action teams to focus on specific gaps and have meaningful outcomes through a highly coordinated approach.

IV. 2023-2025 Health Priority Goals, Objectives, and Interventions

For the 2023-2025 Community Health Improvement Plan, community stakeholders and partners assembled within Action Teams to begin development of the goals, objectives, and interventions. Embedded in the process was a review of the data used in priority selection along with the interventions selected during the CHIP Development meetings. Facilitated discussion begin with walking through the Forces of Change which examines trends that would impact the ability to conduct work (i.e. legislation, economic shifts). The Forces of Change Assessment can be found in Appendix D. The Action Team members provided feedback on tactics and evaluation of milestones to demonstrate success for the evidence-based interventions. All of the information has been consolidated into the three following dashboards:

1. Healthy Eating / Active Living
2. Obesity
3. Mental Health

HEALTHY EATING/ACTIVE LIVING

Goal:	**Improve overall healthy eating and physical activity in the Tri-County area.**
Objective HEAL1	By December 2025, increase accessibility of healthy food in the Tri-County region through the support of community gardens by 10%.
Objective HEAL2	By December 31, 2025, increase adults reporting exercising 1-5 days a week among the tri-county region by 1%. *Baseline: 28% of adults report no exercise at all (CHNA)*

Intervention Strategies

<u>Gardening- Increase vegetable consumption among children. (HE)</u>

	Tasks/Tactics	**Evaluation Plan**
	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
	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 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 area.

<u>Physical Activity- Increase physical activity through social supports to improve fitness of adults in the tri-county area. (PA)</u>

	Tasks/Tactics	**Evaluation Plan**
	PA 1: Increase data collection focusing on adult physical activity in the tri-county area.	• # of establishments collecting adult physical activity data in the tri-county area.
	PA 2: Recruit additional tri-county partner participation in the HEAL action team.	• Increase # of partners recruited by 6.

	PA 3: Create promotional campaigns to promote physical activity in the tri-county area.	• Increase the number of physical activity campaigns in the tri-county area.
	PA4: Create social support events focused on increasing physical activity in the tri-county area.	• Increase the number of adults attending each event by 50%.

OBESITY

Goal:	**Reduce the proportion of residents with obesity in the tri-county area.**
Objective OB1	By December 31, 2025, reduce the proportion of adolescents with obesity in the tri-county area by 1%.
Objective OB2	By December 31, 2025, reduce the proportion of adults (women) with obesity in the tri-county area by 2%.

Intervention Strategies

Digital Health Interventions for Adolescents with Obesity (DHIAO)

	Tasks/Tactics	**Evaluation Plan**
	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.
	DHIAO 2: Promote through education and awareness utilizing social media communication.	• # of promotional campaigns performed through the tri-county area. •
	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.
	DHIAO 4: Promote behavioral change through use of technology devices.	• Pre / Post changes is behavior
	DHIAO 5: Personalize program with Text Messaging, Health coaching calls, or Tele Visits	• Pre/ Post changes in Biometrics

Strong People Healthy Weight (SPHW)

	Tasks/Tactics	**Evaluation Plan**
	SPHW 1: Collect Baseline data	• # of data points collected.
	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.

MENTAL HEALTH

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%. *Baseline: Suicide deaths per 100,000–PC 16.2; TC 14.7; WC 17.7; IL 11.1 (Source: Tri-County 2015-2018 HCI Conduent)*
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%. *Baseline: Age-adjusted ER rate due to pediatric mental health per 10,000; PC 312.5; TC 275.5; WC 139.9; IL 192.3 and Age-adjusted hospitalization rate due to adult mental health per 10,000; PC 286.8; TC 173.1; WC 113.4; IL 158.9 (Source: HCI Conduent); and % of respondents that indicated they spoke to someone about their mental health in the last 30 days (Source: 41% in 2022 CHNA)*

Intervention Strategies

<u>Culturally-Adapted Health Care (CAHC)</u>

	Tasks/Tactics	**Evaluation Plan**
	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)
	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%
	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%
	CAHC 4: Make culturally- and linguistically adapted materials and marketing available	• Improve patient experience ratings (likelihood to recommend) by 1%

<u>Telemedicine (TELMED)</u>

	Tasks/Tactics	**Evaluation Plan**

	TELMED 1: Establish baseline, inventory available telemedicine among tri-county	• Complete inventory list of all telemedicine access.
	TELMED 2: Disseminate information through 10 promotional campaigns on how to access (mental health) telemedicine	• Increase # patients engaged in mental health telemedicine by 10%
	TELMED 3: Support the development of structured partnerships for community healthcare organizations to provide telemedicine	• Increase # new patients enrolled in telemedicine by 10%
	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%
	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%

V. Evaluation and Monitoring

Within Partnership for a Healthy Community's Improvement Plan, there is an "Evaluation Plan" that contains both process indicators and outcome indicators. These indicators will be tracked throughout the three-year cycle, with a specific focus on capturing gap analysis data measures. PFHC Board will be responsible for assuring that data is monitored and reported to the community.

Partnership for a Healthy Community Board reserves the right to amend this 2023-2025 Community Health Improvement Plan as needed to reflect changes with organizational capacity as well as changes in community focus. In addition, throughout the cycle, the acuity of health needs may become more significant and require amendments to the strategies developed to address the health need. Finally, in compliance with Internal Revenue Code Section 501(r), requirements for hospitals may refocus the limited resources the organization committed to the Plan to best serve the community.

VI. Acknowledgements

The work required to support development of the Community Health Improvement Plan can not be done in a silo. There were over 50 community agencies and stakeholders involved in bringing the improvement plan forward. In addition, PFHC Board would like to specifically identify the following individuals:

Sarah Donohue, PhD, Director of Research Services, University of Illinois College of Medicine Peoria

Sarah Warfield Kelly, PhD, MPH, Research Epidemiologist / Assistant Professor, University of Illinois College of Medicine Peoria

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CHIP Transition Team:

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Holly Bill, MPH, CHES, CNP, Assistant Manager, Hult Center for Healthy Living, UnityPoint Health

Amy Fox, Public Health Administrator, Tazewell County Health Department

Lisa Fuller, MS, MA, Vice President Outpatient and Ancillary Services, OSF HealthCare Saint Francis Medical Center

Sally Gambacorta, MA, MS, Community Health Director, Carle BroMenn Medical Center | Eureka Hospital

Monica Hendrickson, MPH, Public Health Administrator, Peoria City/County Health Department

Nicole Robertson, MPH, Senior Manager, American Cancer Society

Amanda Sutphen, MS, Ambulatory HOD Coordinator, OSF HealthCare Saint Francis Medical Center

Spalding Pastoral Center – Catholic Diocese of Peoria Staff

APPENDIX A: PRIORITIZATION DATA

ACCESS TO CARE

National Target Data

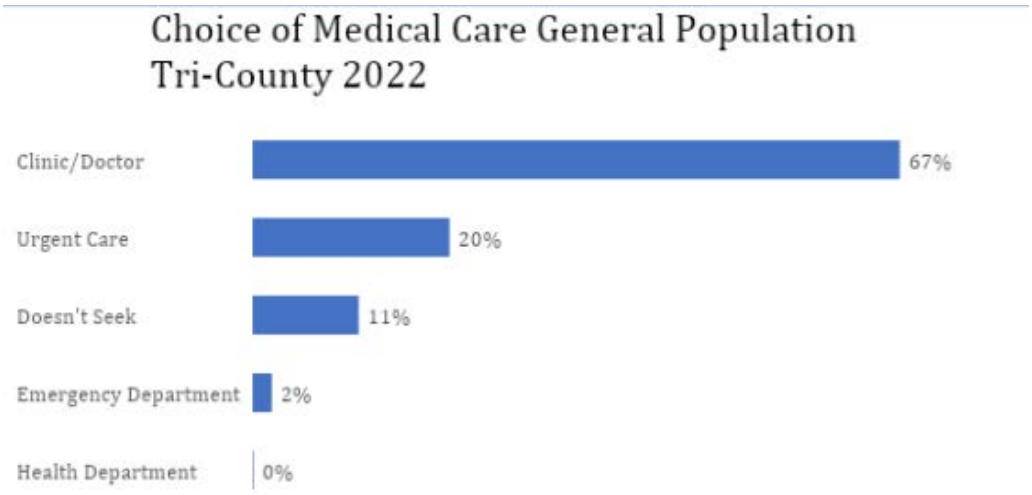
Healthy People 2030 aims to reduce the portion of individuals who cannot get medical care when needed to 3.3%.

Healthy People 2030 aims to increase the proportion of people using a primary care provider to 84%.

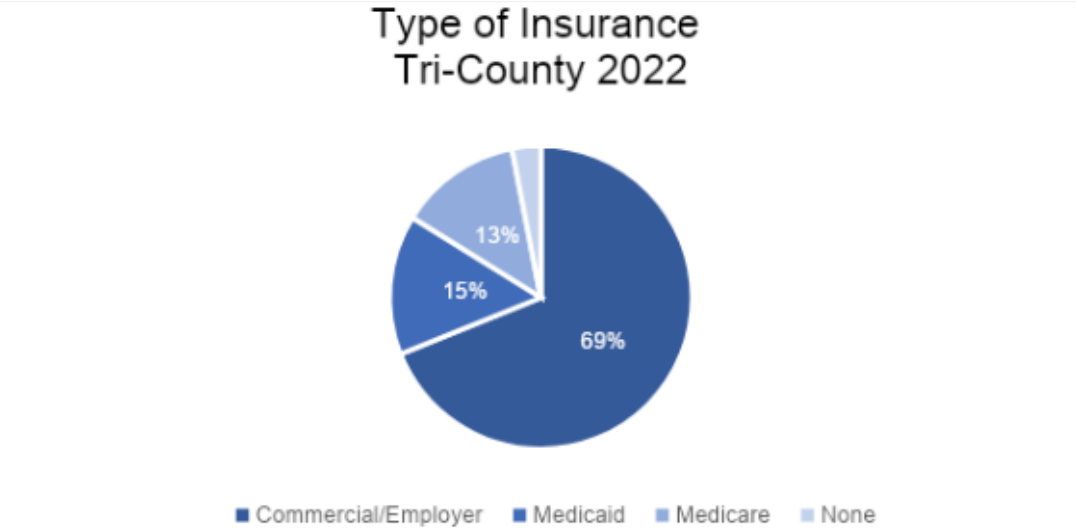
Healthy People 2030 aims to increase the proportion of individuals under age 65 with health insurance to 92.1%.

Community Status Assessment Data

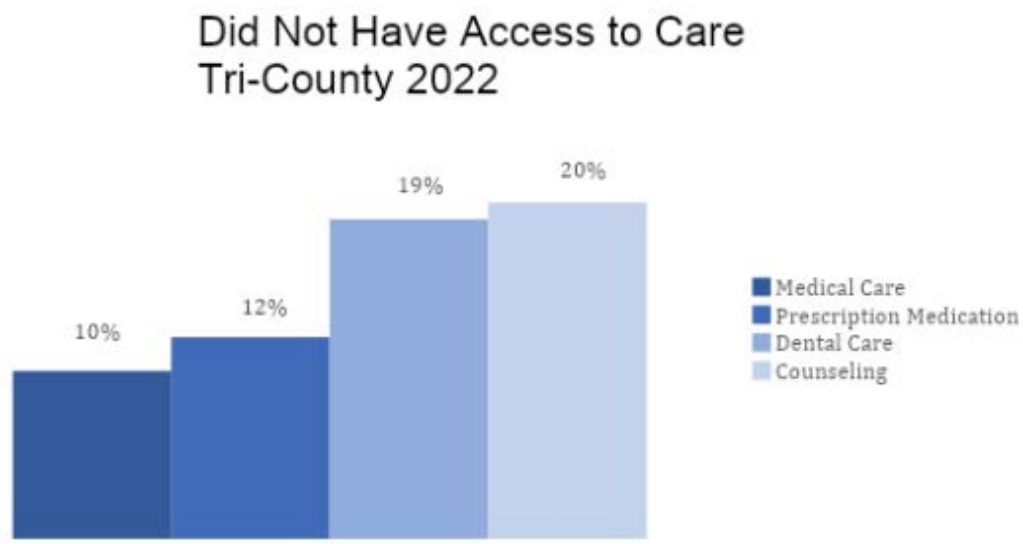
Survey respondents were asked to select the type of health-care facility used when sick. The most common response for source of medical care was clinic/doctor's office, chosen by 67% of survey respondents. This was followed by urgent care (20%), not seeking medical attention (11%), the emergency department (2%) and the health department (0%).



CHNA survey data show 69% of the residents are covered by commercial/employer insurance, followed by Medicare (15%) and Medicaid (13%). Only 3% of respondents indicated they did not have any health insurance. Data from the survey show that for the 3% individuals who do not have insurance, the most prevalent reason was cost.



Access to four types of care were assessed: medical care, prescription medication, dental care, and counseling. Survey results show that 10% of the population did not have access to medical care when needed; 12% of the population did not have access to prescription medication when needed; 19% of the population did not have access to dental care when needed; and 20% of the population did not have access to counseling when needed.



Supplemental Conduent's Healthy Communities Institute (HCI) Data

Peoria County: scored above for adults having a routine medical check-up and adults having medical insurance compared to other counties in Illinois.

Region 1, 3, 4, 5, 6 scored **below** the county for adults having a routine medical check-up.

Region 1, 2, 3, 5, 6 scored **below** the county as whole for without medical insurance.

Tazewell County: was comparable for adults for having a routine medical check-up and above for adults having medical insurance compared to other counties in Illinois.

Region North, South, West scored **below** the county for adults having a routine medical check-up.

Region East, North, West, South scored **below** the county for adults without medical insurance.

Woodford County: scored above for adults having a routine medical check-up and adults having medical insurance compared to other counties in Illinois.

Region Central, East, West scored **below** the county for adults having a routine medical check-up.

Region Central, East, West scored **below** the county for adults without medical insurance.

Focus Group Data

Challenges to staying health across all counties included:

- Unhealthy eating/lack of health literacy around eating/lack of access to healthy food
- Lack of providers for preventative care
- Other challenges included: Lack of healthcare for women with a particular emphasis on having more female providers (Woodford), lack of dental providers (Tazewell), lack of exercise (Peoria) or safe spaces to ride bikes (Tazewell).

Challenges to accessing healthcare included:

- Lack of transportation
- Lack of insurance/fear of cost
- Long wait times to see PCP and longer wait times for specialist care
- Other challenges included a lack of diverse providers and providers who listen (Peoria), a lack of interpreters and who speak the same dialect (Peoria and Tazewell), and prejudice in the healthcare systems (Peoria and Tazewell).

Social Determinants of Health Data

Health Care Assess and Quality

69% of the Tri-County population used a clinic or doctor office for care. (CHNA Survey Data)

13.3% of the Tri-County population reported no access to medical care. (CHNA Survey Data)

11.6% of the Tri-County population receive Medicaid Insurance, with 20% of that population being Peoria County. (CHNA Survey Data)

2.7% of the Tri-County population reported have no insurance. (CHNA Survey Data)

Survey respondents reported too long of wait for inability to access medical care and counseling services and could not afford co-pay regarding access to dental care and prescriptions. (CHNA Survey Data)

Health literacy For the Tri-County region, 16% of the population is at elevated risk for health literacy. This is lower than the State of Illinois average of 34% (SocialScape® powered by SociallyDetermined®, 2022).

Education Access and Quality

Students who entered 9th grade in 2021 in Peoria County school districts, except Peoria HS, Manual Academy, Limestone Community HS, Il Valley Central HS, Illini Bluffs HS and Farmington HS reported high school graduation rates that were comparable to the State average of 86%. (CHNA Survey Data)

Students who entered 9th grade in 2021 in Tazewell County school districts, except East Peoria HS and Delavan HS reported high school graduation rates that were comparable to the State average of 86%. (CHNA Survey Data)

Students who entered 9th grade in 2021 in Woodford County school districts, except Eureka HS, Low Point-Washburn JR SR HS and Roanoke-Benson HS reported high school graduation rates that were comparable to the State average of 86%. (CHNA Survey Data)

Healthy People 2030 aims to decrease the proportion of adolescents and young people who are not in school or working to 10.1% from 11.2%.

Social and Community Context

62.3% of the Tri-County population reported have 5 or more social interactions weekly. (CHNA Survey Data)

5.3% of the Tr-County population reported having 1 or less social interactions weekly. (CHNA Survey Data)

Social support is when someone can talk to friends and family about their concerns and get help coping. Research shows that when people don't have social support, they're at increased risk for physical and mental health problems. People who have social support are more likely to make healthier choices and have better health outcomes, like reduced stress. (CHNA Survey Data)

Healthy People 2030 has a target to increase adults who talk to friends or family about their health to 92.3% from 86.9 (2017).

Economic Stability (Healthy People 2030)

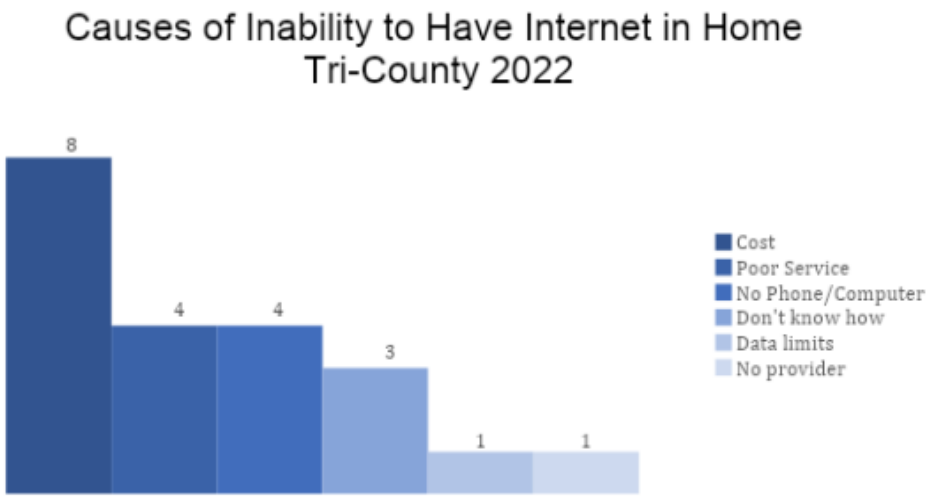
An estimated $8.3 billion is spent each year on emergency department (ED) care that could be provided in another location. (Healthcare Financial Management Association)

Neighborhood and Built Environment (CHNA Survey Data)

For Tri-County, 9% of the population is at elevated risk for digital landscape. This is the same as the State of Illinois average of 9% (SocialScape® powered by SociallyDetermined®, 2022).

Survey respondents were asked if they had Internet access. Of respondents, 95% indicated they had Internet in their homes. For those who did not have Internet in their home, cost was the most

frequently cited reason. Note that these data are displayed in frequencies rather than percentages given the low number of responses. (CHNA Survey Data)



Tri-County Regions of Concern

- Access to healthcare provider:
  - Having a personal physician tends to be higher for women, older people, and those with a higher income.
  - Having a personal physician tends to be rated lower for residents who live in the Peoria/West Peoria region. Clinic/Doctor's Office tends to be rated lower for residents who live in the Peoria/West Peoria region. Emergency Department tends to be rated higher for residents who live in the Peoria/West Peoria region. Do Not Seek Medical Care tend to be rated higher for residents who live in the Peoria/West Peoria region and the South/West Peoria County region
- Insurance
  - Medicare tends to be used more frequently by men, older people, White people, those with lower education, those with lower income, Peoria County residents and people in Woodford County. Medicare tends to be used less often by Black people and people from Tazewell County.
  - Medicaid tends to be used more frequently by younger people, Black people, those with lower education, those with lower income, Peoria County residents, and people with an unstable (e.g., homeless) housing environment. Medicaid is used less by White people and Tazewell County residents.
  - Commercial/employer insurance is used more often by younger people, women, White people, and those with higher education, Tazewell County resident, those with higher education and those with higher income. Private insurance is used less by Woodford County residents.
  - No Insurance tends to report more often by those with lower income.
- Access to prescription medications
  - Tends to be higher for White people, those with higher education, those with higher income and those with a stable housing environment.
  - Access to prescription medications tends to be lower for Black people and Peoria County residents. Additionally, tends to be rated lower for residents who live in the Peoria/West Peoria region.
- Access to dental care
  - Tends to be higher for White people, those with higher education, those with higher income and those with a stable housing environment.

    - Access to dental care tends to be lower for Black people, Latino people, Peoria County residents, who live in the Bartonville/Limestone region and the North Tazewell County region.
- Access to counseling
    - Tends to be higher for White people, those with higher education, those with higher income and those with a stable housing environment.
    - Access to counseling tends to be lower for Black people, and for residents who live in South Tazewell County region.
- Access to Internet
    - Tends to be rated higher for women, younger people, those with higher education, those with higher income and those in Tazewell County.
    - Access to Internet tends to be rated lower for those living in an unstable (e.g., homeless) housing environment and those in Woodford County.

CANCER

Malignant Neoplasms were the 1st or 2nd top leading causes of death in the tri- county in 2020 as well as the 2nd leading in Illinois. It was also the number 1 underlying cause of death in individuals aged 45-84 in Illinois.

National Target Data

Healthy People 2030 has a target of 77.1% for women being screened for breast cancer with a baseline of 72.8% (2018).

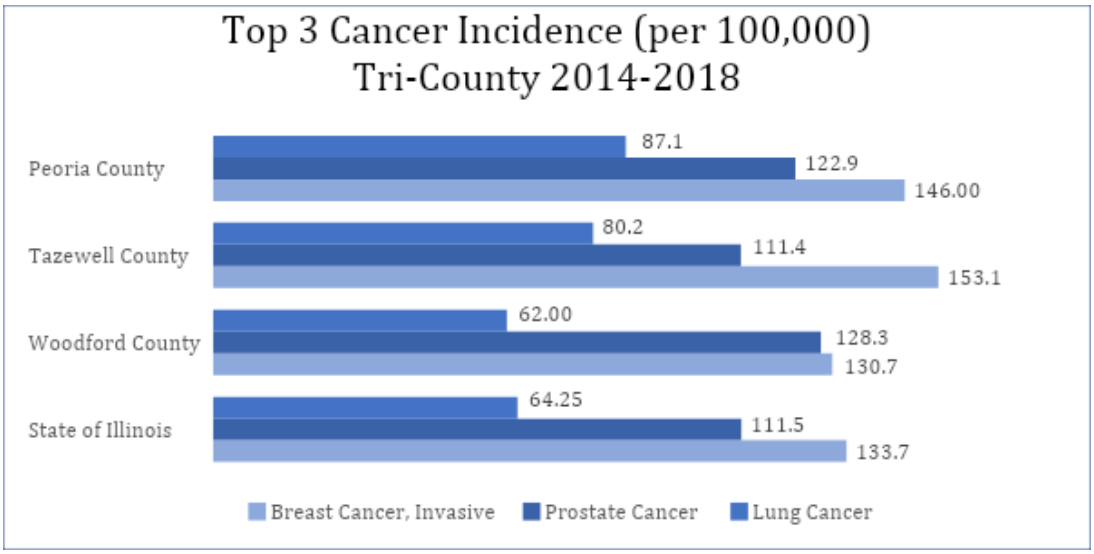
Healthy People 2030 has a target of 74.4% of adults being screened for colorectal cancer with a baseline of 65.2% (2018).

Healthy People 2030 has a target of 16.9 per 100,000 deaths for prostate cancer with a baseline 18.3 per 100,000 (2019).

Healthy People 2030 has a target for lung cancer screening is 7.5% with a baseline of 4.5% (2015) for adults aged 55-80.

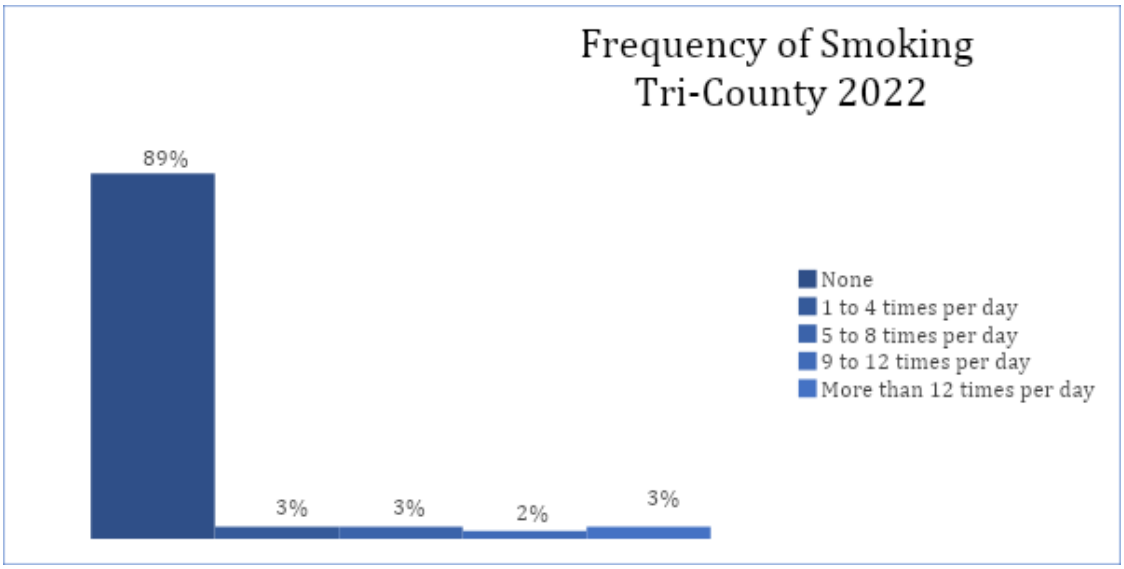
Community Status Assessment Data

The top three prevalent cancers in Tri-County, comparisons are illustrated in figure. Specifically, all cancer rates in Peoria County are higher than the State of Illinois. Tazewell County reports significantly higher rates of lung and breast cancer compared to the State of Illinois. Woodford County reports significantly higher rates of prostate cancer than the State of Illinois.



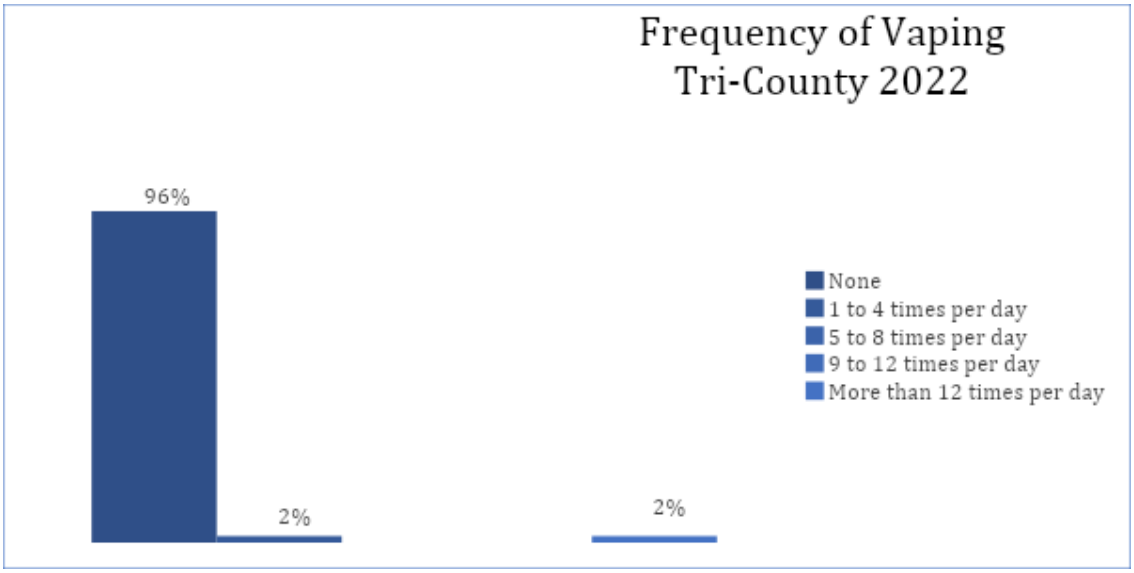
Source: Illinois Department of Public Health – Cancer in Illinois

CHNA survey data show 89% of respondents do not smoke and 96% of respondents do not vape.



Source: CHNA Survey

Community Health Rankings reports the percentage of the population who smoke is 18% for both Peoria and Tazewell Counties and 16% for Woodford County. This is above both the state and national levels at 15% and 12.5%, respectively.



Source: CHNA Survey

In 2019, 19.9% of high school students in Illinois used electronic vaping products on at least one day in the past 30 days. Nationally the rate is 32.7%, according to truth initiative.

Results from the CHNA survey show that 70% of women had a breast screening in the past five years and 72% of women had a cervical screening. For men, 35% had a prostate screening in the past five years. For women and men over the age of 50, 63% had a colorectal screening in the last five years.

Supplemental Conduent's Healthy Communities Institute (HCI) Data

Peoria County: scored above for adults having cancer compared to other counties in Illinois but had a higher incidence rate than the state. Breast, cervical, and colorectal cancer incidence rates were worse compared to other counties and the state. Lung cancer had a higher incidence rate than the state and prostate cancer incidence was worse than other counties in Illinois and the state.

Region 2, 3, 4, 5 scored **below** the county for adults with cancer.

Region 1, 3 scored **below** the county for colon screenings.

Region 1 scored **below** the county for cervical screenings.

Tazewell County: scored above for adults having cancer compared to other counties in Illinois but had a higher incidence rate than the state. Breast and cervical cancer incidence rates were worse compared to other counties and the state. Lung cancer had a higher incidence rate than the state. Mammogram screenings for women aged 50-74 were lower compared to the state.

Region East, West, North scored **below** the county for colon screenings.

Region West scored **below** the county for cervical screenings.

Woodford County: scored above for adults having cancer compared to other counties in Illinois but had a higher incidence rate than the state. Prostate cancer incidence rates were worse than other counties in Illinois and the state.

Region Central, East, West scored **below** the county for colon screenings

Regions Central scored **below** the county for cervical screenings.

Focus Group Data

Challenges to staying health across all counties included:

- Unhealthy eating/lack of health literacy around eating/lack of access to healthy food
- Lack of providers for preventative care
- Other challenges included: Lack of healthcare for women with a particular emphasis on having more female providers (Woodford), lack of dental providers (Tazewell), lack of exercise (Peoria) or safe spaces to ride bikes (Tazewell).

Challenges to accessing healthcare included:

- Lack of transportation
- Lack of insurance/fear of cost
- Long wait times to see PCP and longer wait times for specialist care
- Other challenges included a lack of diverse providers and providers who listen (Peoria), a lack of interpreters and who speak the same dialect (Peoria and Tazewell), and prejudice in the healthcare systems (Peoria and Tazewell).

Social Determinants of Health Data

Health Care Assess and Quality

70% of the women in the Tri-County have been screened for breast cancer in the past 5 years. (CHNA Survey Data)

35% of men in the Tri-County have been screened for prostate cancer in the past 5 years. (CHNA Survey Data)

63% of adults in the Tri-County have been screened for colorectal cancer in the past years. (CHNA Survey Data)

72% of female were screened for cervical cancer in the past 5 years. (CHNA Survey Data)

69% of the Tri-County population used a clinic or doctor office for care. (CHNA Survey Data)

13.3% of the Tri-County population reported no access to medical care. (CHNA Survey Data)

11.6% of the Tri-County population receive Medicaid Insurance, with 20% of that population being Peoria County. (CHNA Survey Data)

2.7% of the Tri-County population reported have no insurance**.** (CHNA Survey Data)

Education Access and Quality

31.3% of the Tri-county population have a bachelor's degree. (CHNA Survey Data)

13.3% of the Tri-County population have a high school diploma or less. (CHNA Survey Data)

Social and Community Context

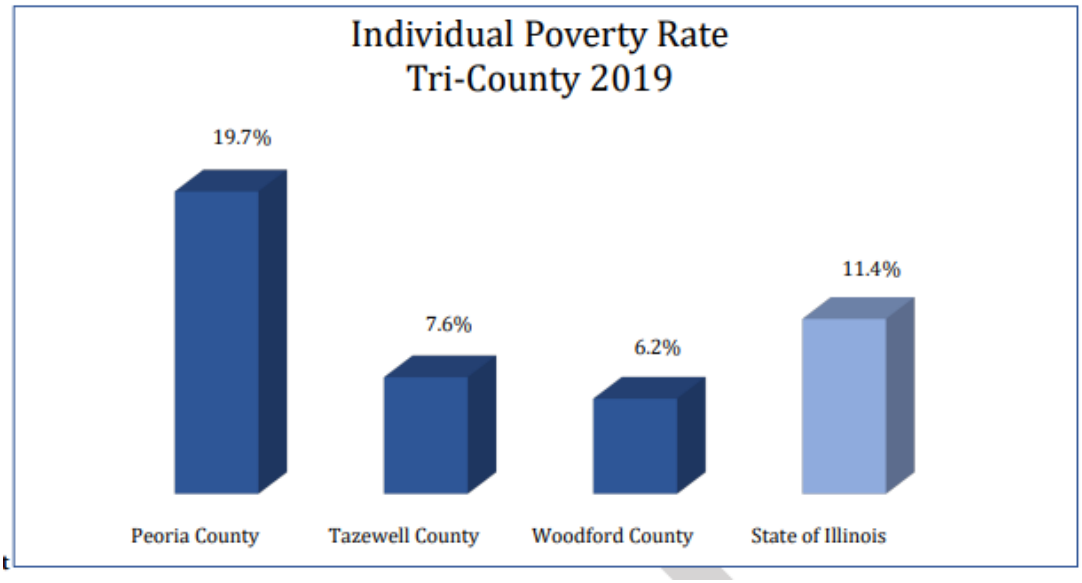
62.3% of the Tri-County population reported have 5 or more social interactions weekly. (CHNA Survey Data)

5.3% of the Tr-County population reported having 1 or less social interactions weekly. (CHNA Survey Data)

Economic Stability

Poverty has a significant impact on the development of children and youth. Below is the poverty rate for all individuals across the Tri-County area for 2019. (CHNA Survey Data)

In Peoria County, the percentage of individuals living in poverty was 19.7%, which is higher than the State of Illinois individual poverty rate of 11.4%. In Tazewell County, the percentage of individuals living in poverty 7.6%, which is significantly lower than the State of Illinois poverty rate of 11.4%. In Woodford County, the percentage of individuals living in poverty is 6.2%, which is also significantly lower than the State of Illinois poverty rate of 11.4% (Figure)

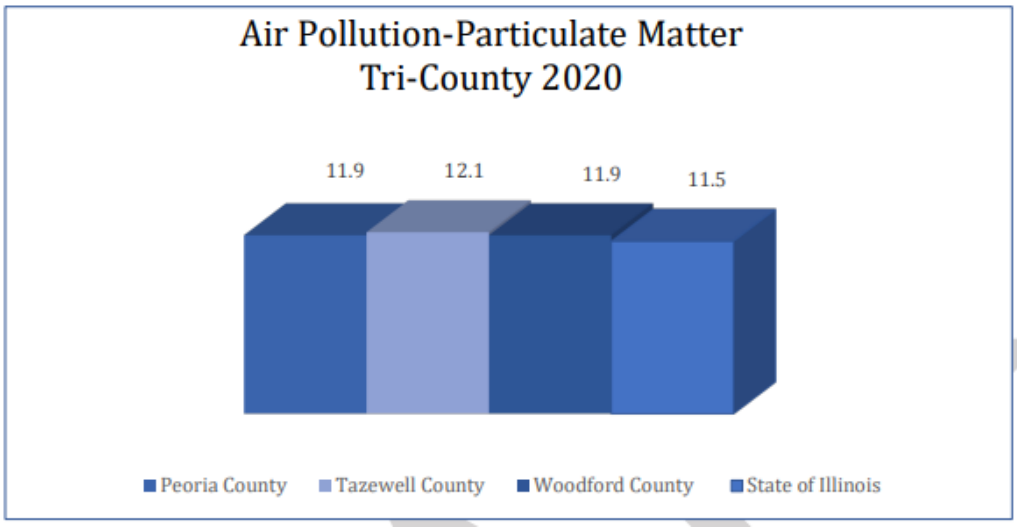


Source: US Census

In 2019, the national patient economic burden associated with cancer care was $21.09 billion, made up of patient out-of-pocket costs of $16.22 billion and patient time costs of $4.87 billion. (National Cancer Institute)

Neighborhood and Built Environment

According to the County Health Rankings, Air Pollution - Particulate Matter (APPM) is the average daily density of fine particulate matter in micrograms per cubic meter (PM2.5) in a county. Fine particulate matter is defined as particles of air pollutants with an aerodynamic diameter less than 2.5 micrometers. These particles can be directly emitted from sources such as forest fires, or they can form when gases are emitted from power plants, manufacturing facilities and automobiles. The relationship between elevated air pollution, particularly fine particulate matter and ozone, and compromised health has been well documented. Negative consequences of ambient air pollution include decreased lung function, chronic bronchitis, asthma, and other adverse pulmonary effects. The APPM for the Tri-County region (11.5) is slightly higher than the State average of 11.5 (Figure)



Source: County Health Rankings 2021

Tri-County Regions of Concern

Access to medical care

- Tends to be rated lower for residents who live in the Peoria/West Peoria region and the Bartonville/Limestone region.

Breast screening

- Tends to be more likely for older women, White women, those with a higher level of education, those with higher income and those from Tazewell County.
- Breast cancer screening tends to be lower for those in an unstable (e.g., homeless) housing environment and those from Peoria County residents who live in the Peoria/West Peoria region.

Cervical screening

- Tends to be more likely for younger women, White women, those with a higher level of education, and those with higher income.
- Cervical cancer screening tends to be lower for those in an unstable (e.g., homeless) housing environment, those from Woodford County, and for residents who live in the Peoria/West Peoria region.

Prostate screening

- Tends to be more likely for older men, those with higher income and men from Woodford County.

Colorectal screening

- Tends to be more likely for older people, those with higher income and those from Woodford County.
- Colorectal screening tends to be less likely for those in an unstable (e.g., homeless) housing environment, for residents who live in the Peoria/West Peoria region, residents who live in the North-West Peoria County region and residents who live in the Western Tazewell County region

Smoking

- Tends to be rated higher for residents with less education and those with lower income. In addition, it is higher for residents who live in the Peoria/West Peoria region and residents who live in the Bartonville/Limestone region.

Vaping

- Tends to be rated higher by younger people, those with less education and those with lower income, as well as for residents who live in the Bartonville/Limestone region.

HEALTHY EATING & ACTIVE LIVING

National Target Data

Healthy People 2030 Nutrition and Healthy Eating

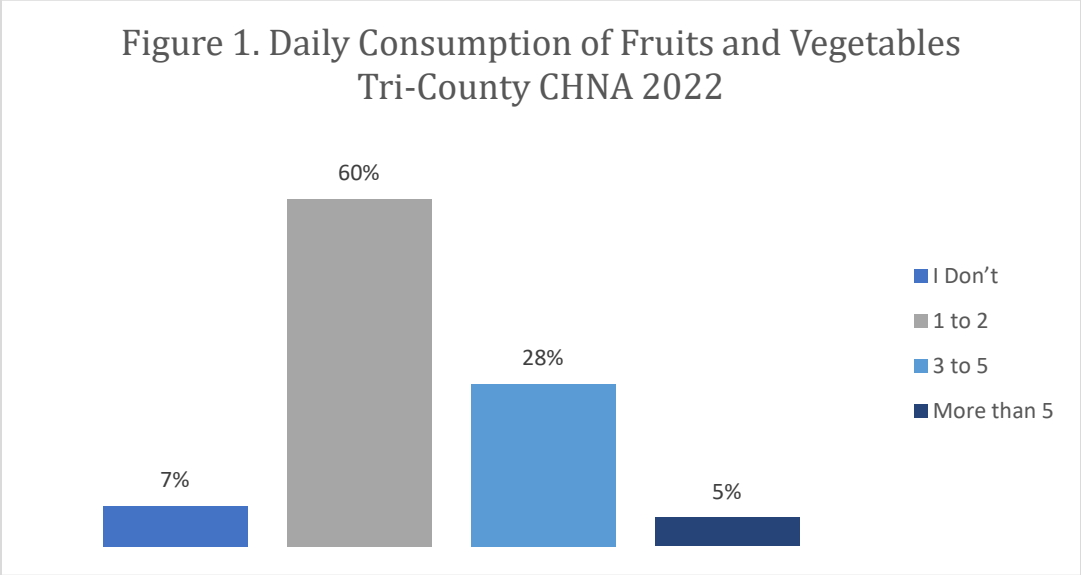
- Reduce household food insecurity and hunger from 11.1% (2018) to 6.0%
- Eliminate very low food security in children from .59% in 2018 to 0.0%

Healthy People 2030 Physical Activity

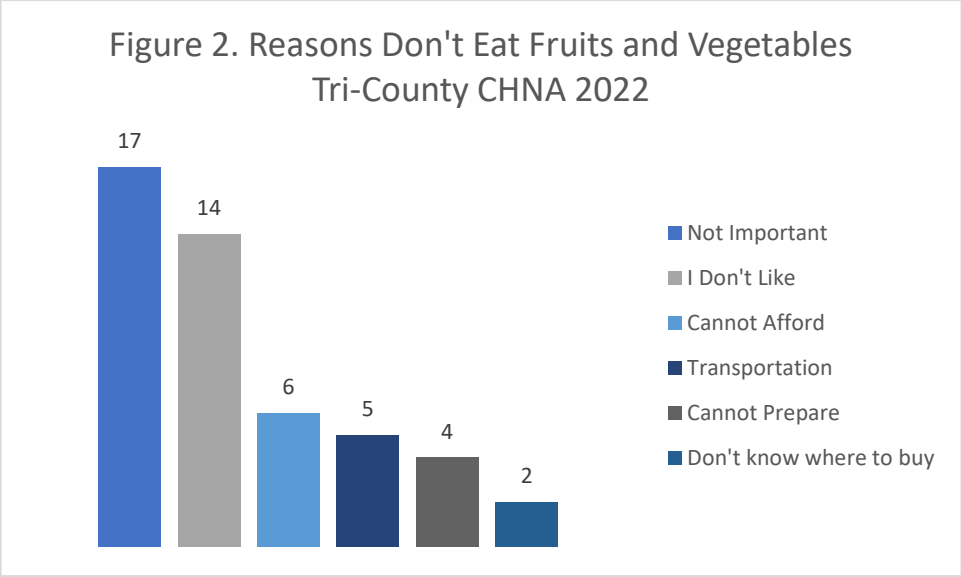
- Reduce the proportion of adults who do no physical activity in their free time from 25.4 % (2018) to 21.2% (NHIS)
- Increase the proportion of adults who do enough physical activity substantial health benefits from 54.2 % in 2018 to 59.2% (NHIS)

Community Status Assessment Data

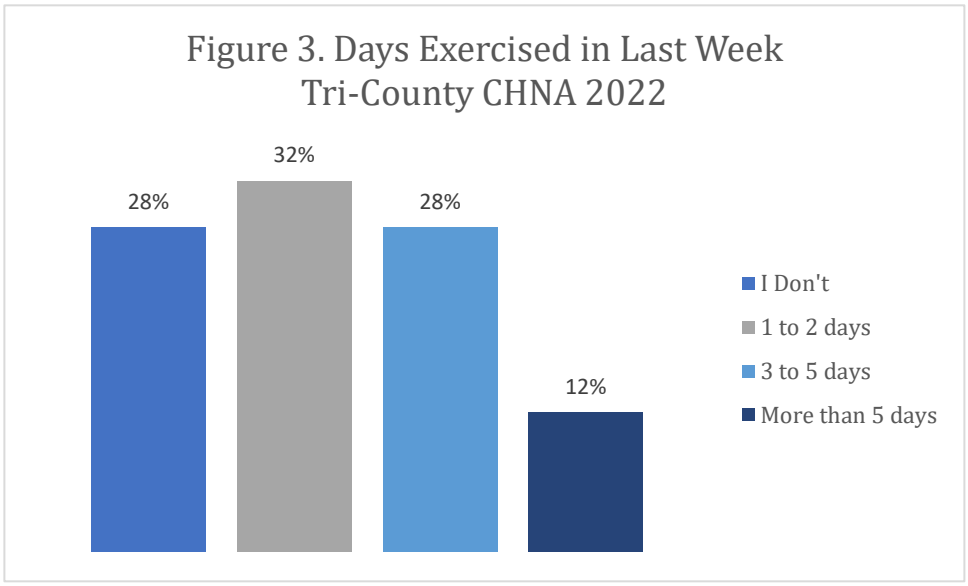
The CHNA survey asked respondents to report how many servings of fruits and vegetables they consumed each day. Over two-thirds (67%) of residents reported that they consumed little or no fruits and vegetables each day as shown in Figure 1.



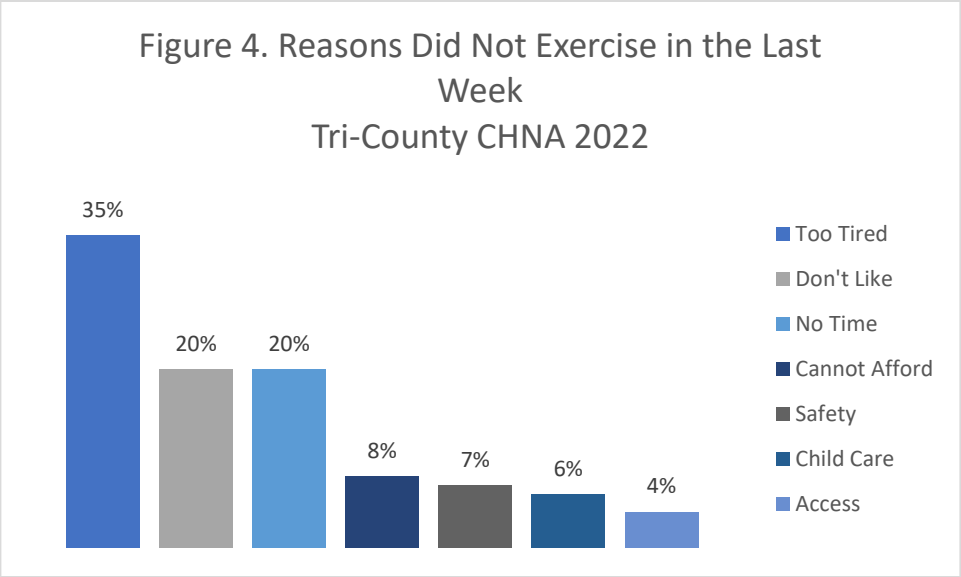
Individuals that indicated that they do not eat fruits or vegetables were asked to follow-up with their reasons for not eating them which are displayed in Figure 2. The most cited reasons for not eating fruits and vegetables were "not important" and "I don't like". Note that this only represents a small sample of the survey population and is displayed in frequencies rather than percentages.



A healthy lifestyle, comprised of regular physical activity, has been shown to increase physical, mental, and emotional well-being. Specifically, 28% of respondents indicated that they do not exercise at all, while the majority (60%) of resident's exercise 1-5 times per week (Figure 3).



To find out why some residents do not exercise at all, a follow up question was asked. The most common reasons for not exercising are too tired (35%), dislike of exercise (20%) and not having enough time (20%) (Figure 4).



Supplemental Conduent's Healthy Communities Institute (HCI) Data

Peoria County has a higher average amount spent on fast food than most counties in Illinois, but it is lower than the average for Illinois and the U.S. Peoria County has a lower average amount spent on fruits and vegetables than most counties in Illinois, but it is higher than the average for Illinois.

Region 1 scored **below** the tri-county area for healthy eating

Tazewell County has a higher average amount spent on fast food than most counties in Illinois, but it is lower than the average for Illinois and the U.S. Tazewell County has a lower average amount spent on fruits and vegetables than most counties in Illinois, but it is higher than the average for Illinois. No regional disparities identified through CHNA Survey Data

Woodford County has a higher average amount spent on fast food than most counties in Illinois, but it is lower than the average for Illinois and the U.S. Woodford County has a lower average amount spent on fruits and vegetables than most counties in Illinois, but it is higher than the average for Illinois.

East Region scored **below** the tri-county area for exercise

Focus Group Data

Challenges to staying health across all counties included:

- Unhealthy eating/lack of health literacy around eating/lack of access to healthy food
- Lack of providers for preventative care
- Other challenges included: Lack of healthcare for women with a particular emphasis on having more female providers (Woodford), lack of dental providers (Tazewell), lack of exercise (Peoria) or safe spaces to ride bikes (Tazewell).

Challenges to accessing healthcare included:

- Lack of transportation

- Lack of insurance/fear of cost
- Long wait times to see PCP and longer wait times for specialist care
- Other challenges included a lack of diverse providers and providers who listen (Peoria), a lack of interpreters and who speak the same dialect (Peoria and Tazewell), and prejudice in the healthcare systems (Peoria and Tazewell).

Social Determinants of Health Data

Education Access and Quality

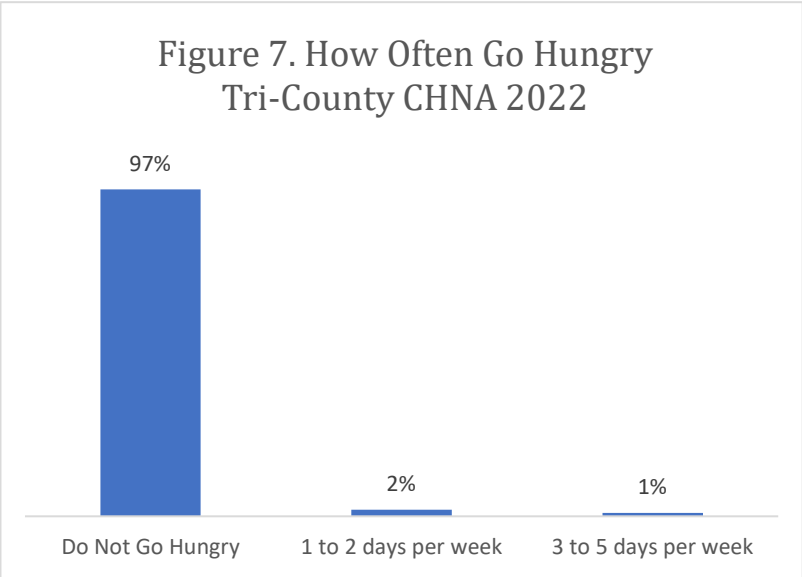
Students who entered 9th grade in 2021 in Peoria County school districts, except Peoria HS, Manual Academy, Limestone Community HS, Il Valley Central HS, Illini Bluffs HS and Farmington HS reported high school graduation rates that were comparable to the State average of 86%.

Students who entered 9th grade in 2021 in Tazewell County school districts, except East Peoria and Delavan HS reported high school graduation rates that were comparable to the State average of 86%.

Students who entered 9th grade in 2021 in Woodford County school districts, except Eureka HS, Low Point-Washburn JR SR HS and Roanoke-Benson HS reported high school graduation rates that were comparable to the State average of 86%.

Economic Stability

Assessing food insecurity is an essential measure to ensure that everyone has access to food and drink necessary for living healthy lives. Food insecurity exists when people don't have physical and economic access to sufficient, safe, and nutritious food that meets their dietary needs for a healthy life.



Respondents were asked, “How many days a week do you or your family members go hungry?” Most respondents indicated they do not go hungry (97%); however, 3% indicate they go hungry between 1 and 5 days per week.

Neighborhood and Built Environment

Food landscape is a measure of the conditions that affect the ability of residents to access health, affordable nutrition. Key risk influencers include accessibility, affordability, and literacy. For the TriCounty region, 22% of the population is at elevated risk for food landscape. This is lower than the State of Illinois average of 25%. (SocialScape® powered by SociallyDetermined®, 2022)

Tri-County Regions of Concern

Frequency of exercise

- Tends to be rated higher for men, those with higher education, those with higher income and people from an unstable (e.g., homeless) housing environment.
- Rated lower for residents who live in the Eastern Woodford County region.

Consumption of fruits and vegetables

- Tends to be more likely for older people, those with a higher level of education and those with higher income.
- Consumption of fruits and vegetables tends to be less likely for Black people, and lower for residents who live in the Peoria/West Peoria region.

MENTAL HEALTH

National Target Data

Healthy People 2030 aims to increase the proportion of adults with serious mental illness get the treatment they need from 64.1% to 68.8% (2018).

Healthy People 2030 aims to increase the proportion of children with mental health problems who get treatment from 73.3% to 82.4% (2018).

Healthy People 2030 aims to reduce the suicide rate from 13.9 to 12.8 suicide per 100,000 population (2019).

Community Status Assessment Data

The CHNA survey asked respondents to self-assess their overall mental health status which is displayed in Figure 1. “Good” mental health status fell over 73% between 2016 and 2022 from 72% down to 19%. In 2019, only 8% of respondents answered “Poor”, and in 2022 that number doubled to 16%.

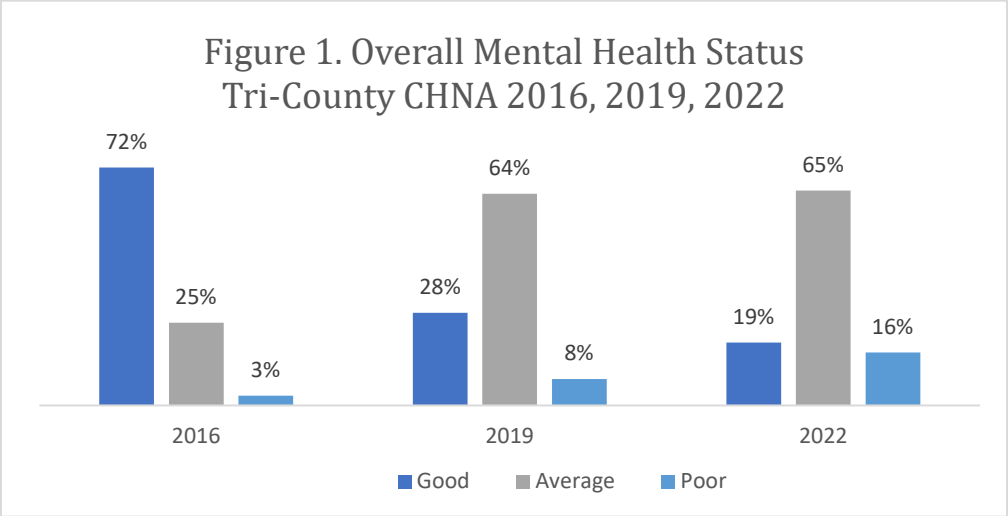


Figure 2 examines how often respondents have felt depressed in the past 30 days. 58% stated that they felt depressed at least 1 to 2 days in the past 30 days, and 11% of respondents feeling depressed more than 5 days in the past 30 days.

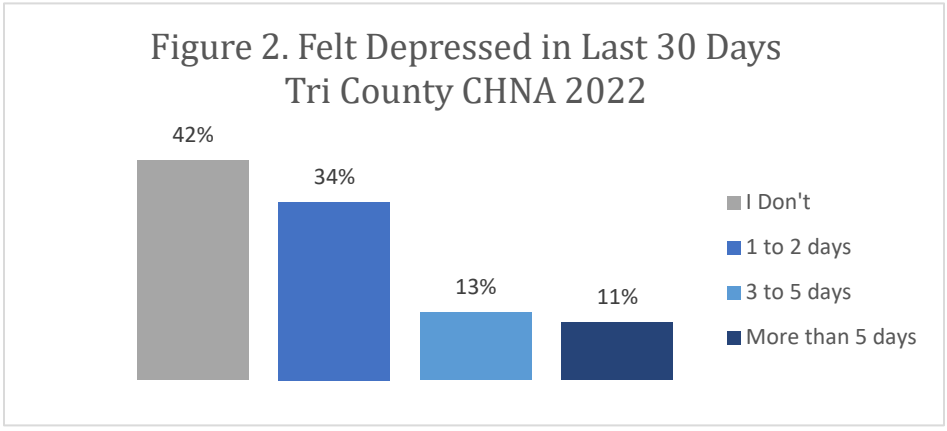
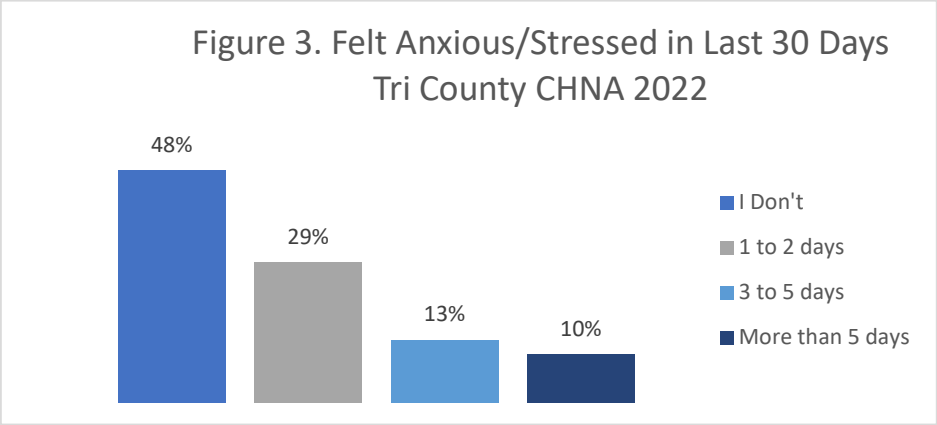


Figure 3 examines the prevalence of anxiety and stress among respondents in the previous 30 days. 52% stated that they felt anxious or stressed at least 1 to 2 days in the past 30 days. 10% of individuals experienced anxiety or stress more than 5 days in the past 30 days.



Results of the 2022 CHNA show a 12% increase in the number of people experiencing depression, compared to 2019. Similarly, results of the 2022 CHNA show a 12% increase in the number of people experiencing stress / anxiety, compared to 2019.

Supplemental Conduent's Healthy Communities Institute (HCI) Data

Peoria County:

Region 1 scored **below** the tri-county area for adults with depression

Region 2 scored **below** the tri-county area for adults with anxiety

Region 3 scored **below** the tri-county area adults with lower overall mental health

Tazewell County:

North, South and East regions scored **below** the tri-county area for adults having depression

Woodford County:

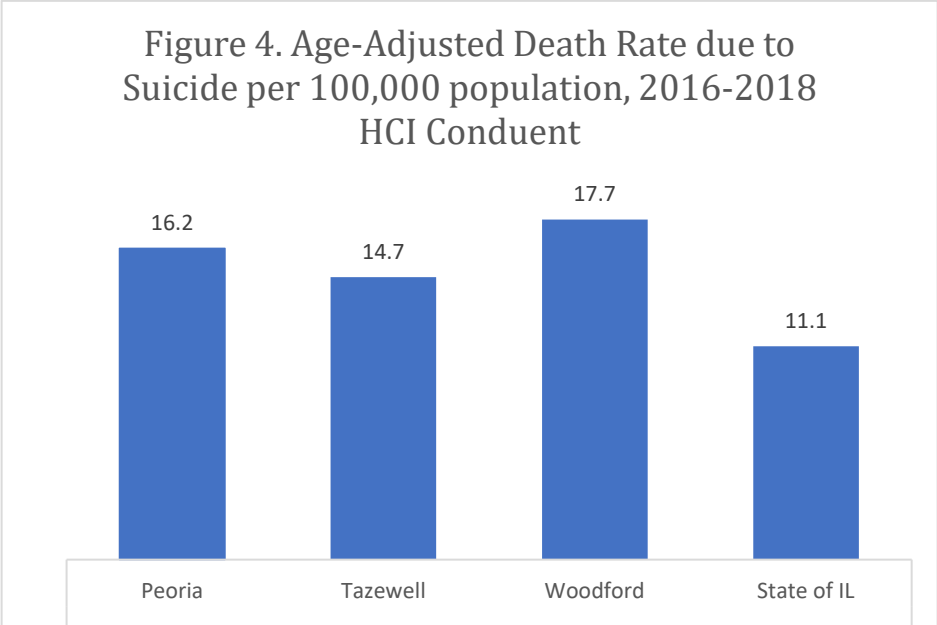
No regional disparities identified through CHNA Survey Data

Suicide:

Peoria County has a lower age-adjusted suicide rate than most counties in Illinois, but it is higher than the Illinois rate and is trending upward.

Tazewell County has a lower age-adjusted suicide rate than most counties in Illinois, but it is higher than the Illinois rate and is trending upward.

Woodford County is in the middle of Illinois counties when comparing age-adjusted suicide rates and is trending downward, but it is higher than the Illinois rate.

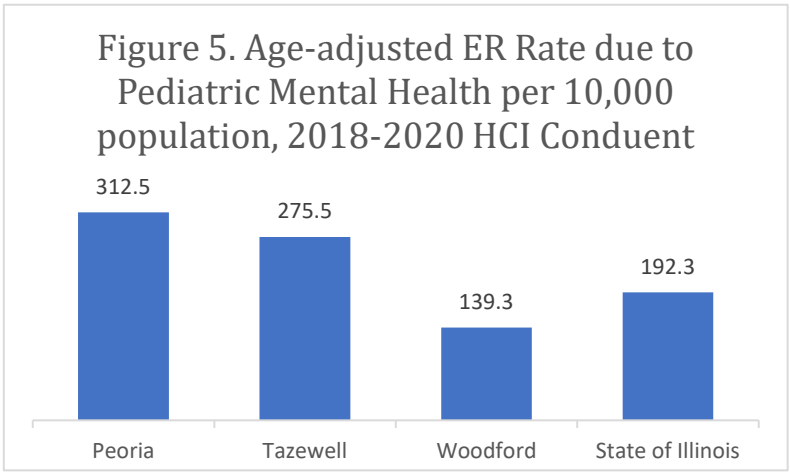


Pediatric Hospitalization:

Peoria County has a higher age-adjusted ER rate due to pediatric mental health than most counties in Illinois and is higher than the Illinois rate.

Tazewell County has a higher age-adjusted ER rate due to pediatric mental health than most counties in Illinois and is higher than the Illinois rate.

Woodford County has a lower age-adjusted ER rate due to pediatric mental health than most counties in Illinois and is lower than the Illinois rate.

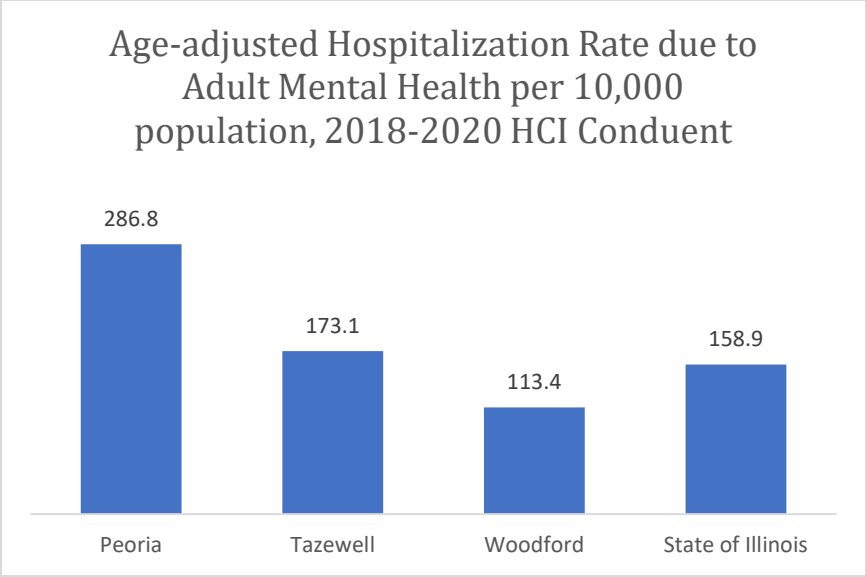


Adult Hospitalization:

Peoria County has a higher age-adjusted hospitalization rate due to adult mental health than most counties in Illinois and is higher than the Illinois rate.

Tazewell County has a higher age-adjusted hospitalization rate due to adult mental health than most counties in Illinois and is higher than the Illinois rate.

Woodford County has a higher age-adjusted hospitalization rate due to adult mental health than most counties in Illinois but is lower than the Illinois rate.



Focus Group Data

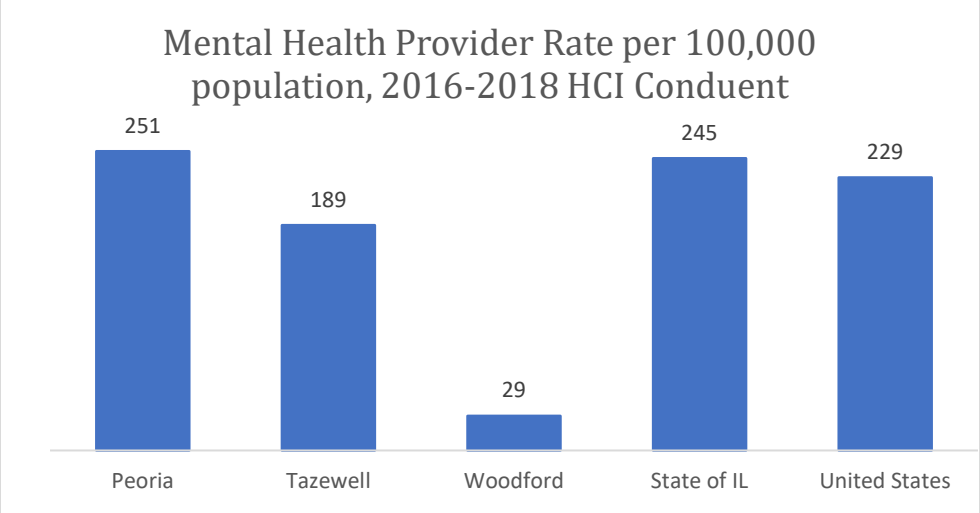
Challenges to staying mentally healthy among the tri-county area included: stigma, unstable home environment, and lack of teacher training to recognize symptoms.

Challenges associated with accessing mental health services among the tri-county area included: lack of knowledge or resources, lack of providers and diverse providers (people of color, multiple languages, LGBTQ+ friendly), lack of inpatient beds, lack of money, lack of insurance, and lack of transportation.

Social Determinants of Health Data

Health Care Assess and Quality (CHNA Survey Data)

Peoria County has a higher rate of mental health providers per 100,000 population than the State of Illinois. Tazewell and Woodford both have lower rates than the state and national level.



Education Access and Quality

Students who entered 9th grade in 2021 in Peoria County school districts, except Peoria HS, Manual Academy, Limestone Community HS, Il Valley Central HS, Illini Bluffs HS and Farmington HS reported high school graduation rates that were comparable to the State average of 86%.

Students who entered 9th grade in 2021 in Tazewell County school districts, except East Peoria HS and Delavan HS reported high school graduation rates that were comparable to the State average of 86%.

Students who entered 9th grade in 2021 in Woodford County school districts, except Eureka HS, Low Point-Washburn JR SR HS and Roanoke-Benson HS reported high school graduation rates that were comparable to the State average of 86%.

Healthy People 2030 has a goal to increase the proportion of public schools with a counselor or social worker which is still in the research phase

Health Literacy

Health literacy is a measure of factors in the community that impact healthcare access, navigation and adherence. Key risk influencers include culture, demographics and education. For the Tri-County region, 16% of the population is at elevated risk for health literacy. This is lower than the State of Illinois average of 34% (SocialScape® powered by SociallyDetermined®, 2022)

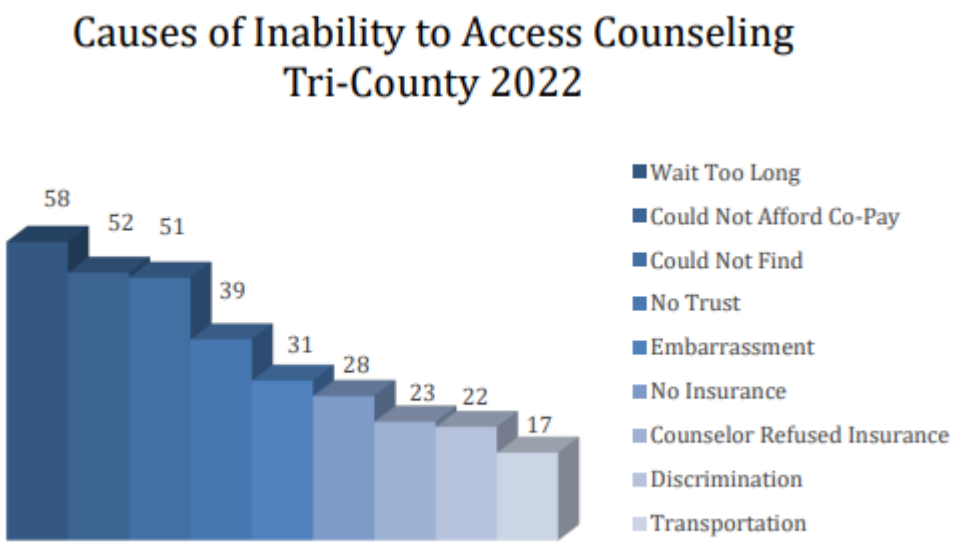
Social and Community Context

59% of the Tri-county population identified that they have been able to talk with someone about their mental health, while 41% did not.

Of those that spoke to someone about their mental health, 43% spoke to a counselor, 34% spoke to family or friends, and 23% spoke to a doctor or nurse.

Economic Stability

Survey respondents who reported they were not able to get counseling when needed were asked a follow-up question. The leading causes of the inability to gain access to counseling were the wait was too long (58), inability for afford co-pay (52) and could not find counselor (51)



Neighborhood and Built Environment

Another factor in accessing mental health care is transportation. Transportation network is a measure of the adequacy of the transportation network to facilitate access to care. Key risk influencers include access and proximity to resources. While survey data indicate transportation was not a leading cause of inaccessibility, for the Tri-County region, 14% of the population is at elevated risk for transportation network. This is higher to the State of Illinois average of 6% (SocialScape® powered by SociallyDetermined®, 2022)

Tri-County Regions of Concern

- **Depression** tends to be rated higher for residents who live in the Peoria/West Peoria region and Northern, Southern and Eastern Tazewell County.
- **Anxiety** tends to be rated higher for residents who live in the Northern Peoria/Peoria Heights region.
- **Perceptions of mental health** tends to be rated lower for residents who live in the Bartonville/Limestone region.
- **Access to counseling** tends to be rated lower for residents who live in South Tazewell County region

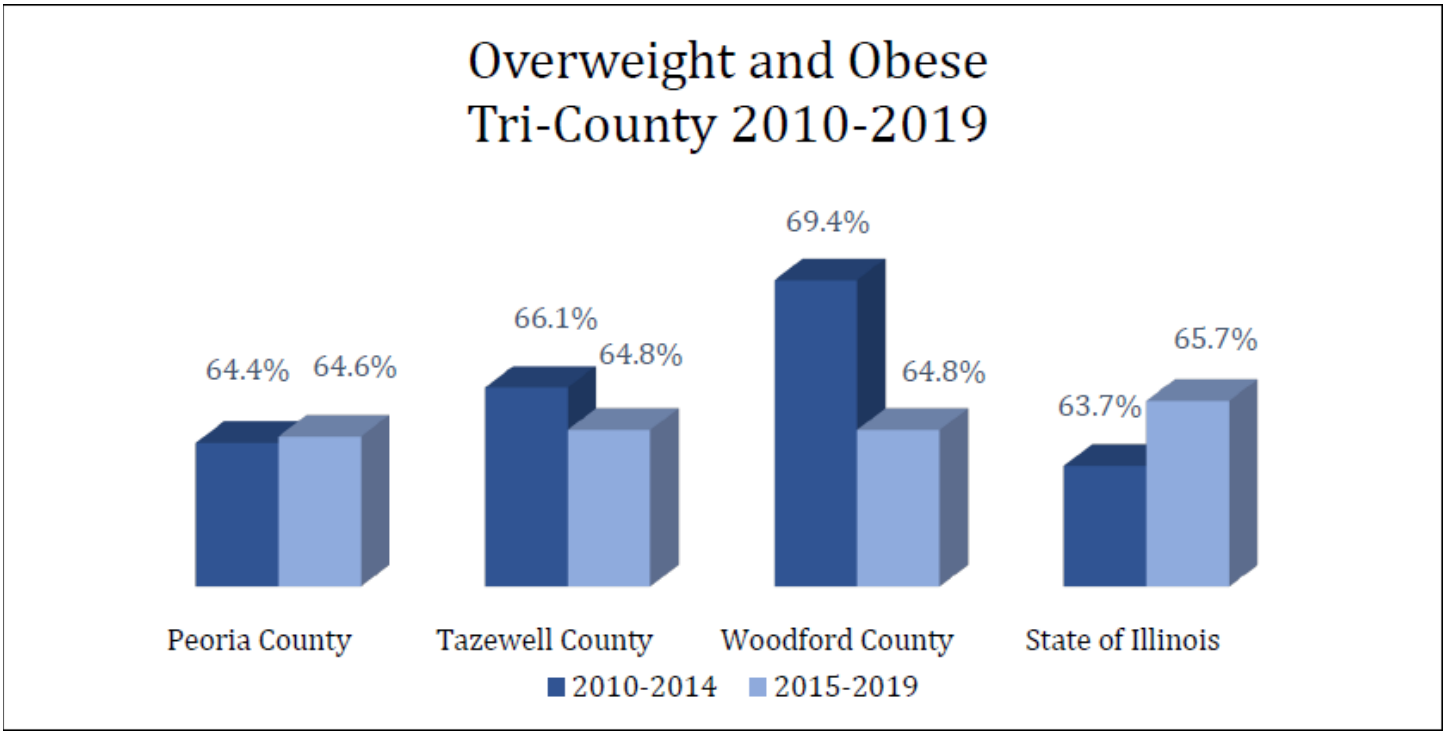
OBESITY

National Target Data

- **Healthy People 2030 (HP 2030)** Reduce the proportion of children and adolescents with obesity to 15.5%.
- **HP 2030** Reduce the proportion of adults with obesity to 36.0%.
- **HP 2030** Increase the proportion of health care visits by adults with obesity that include counseling on weight loss, nutrition, or physical activity to 32.6%.
- **HP 2030** Increase the proportion of women who had a healthy weight before pregnancy to 47.1%

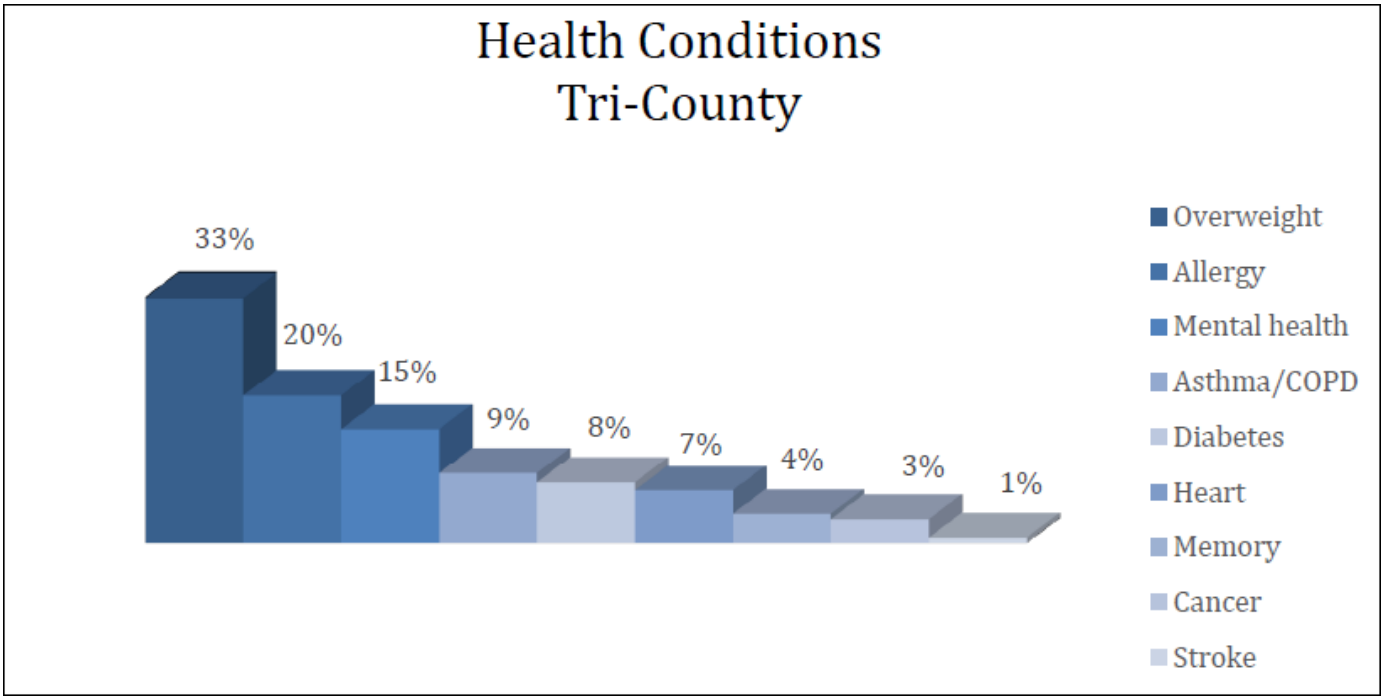
Community Status Assessment Data

Peoria County has seen an increase in the number of people diagnosed as overweight or obese from 2010-2014 to 2015-2019 from 64.4% to 64.6%. Tazewell County has seen a decrease in the number of people diagnosed with being overweight and obese from 2010-2014 to 2015-2019 from 66.1% to 64.8%. Woodford County has also seen a decrease from 2010-2014 to 2015-2019 from 69.4% to 64.8%. For the State of Illinois, the percentage of obese and overweight people has increased from 63.7% to 65.7% with all three counties being slightly below the State of Illinois.



Source: Illinois Behavioral Risk Factor Surveillance System

In the 2022 CHNA Survey, respondents indicated that being overweight was their most prevalently diagnosed health condition.



Source: CHNA Survey

Supplemental Conduent's Healthy Communities Institute (HCI) Data

Peoria County: scored below other counties in Illinois for adults 20+ who are obese.

Region 2, 3, 4 & 5 scored below the county for adults who are obese.

Region 6 scored above the county for adults who are obese.

Tazewell County: has an obese population of 29.9%.

Region East, North, South & West scored above the county for adults who are obese

Woodford County: scored below other counties in Illinois for adults 20+ who are obese.

Region Central, East, & West scored above the county for adults who are obese.

Social Determinants of Health (SDoH) Data

Health Care Access and Quality according to a 2016 paper, various studies indicate that weight bias and discrimination in the healthcare setting can lead to negative outcomes for patients. This paper found that around 79% of people who are overweight or obese report eating more to cope with weight discrimination and around 52% of women report their weight as a barrier to receiving healthcare. Weight bias can lead to disordered eating, avoiding preventative care, gaining weight and having negative healthcare experiences.

Education Access and Quality According to Centers for Disease Control and Prevention (CDC) for children aged 2-19 years the prevalence of obesity decreased as household education level increased.

Adults with college degrees have a lower prevalence of obesity, but this can differ by sex and race/ethnicity (CDC).

Social and Community Context involves relationships, specifically positive ones. Positive relationships at home, work, and in the community can help reduce negative health impacts on individuals.

Economic Stability According to Harvard T.H. Chan School of Public Health there are direct and indirect costs associated with the treatment of obesity and obesity-related conditions. Direct costs involve outpatient and inpatient health services, lab and radiological tests and drug therapy. Indirect costs are harder to measure, but include the categories of value of lost work, insurance, and wages.

The CDC estimates the annual cost of obesity in the United States (U.S.) was $147 billion in 2008. Medical costs were $1,429 higher for obese individuals compared to those with a healthy weight.

The prevalence of obesity decreases in adolescents aged 2-19 years as income level increases (CDC).

Neighborhood and Built Environment National data provides evidence that greater walkability in residential neighborhoods may lead to lower child BMI and obesity. According to a study by Kaiser Permanente, barriers to walkability include lack of sidewalks, vehicles not obeying speed limits, distracted drivers, crime and lack of places to walk to.

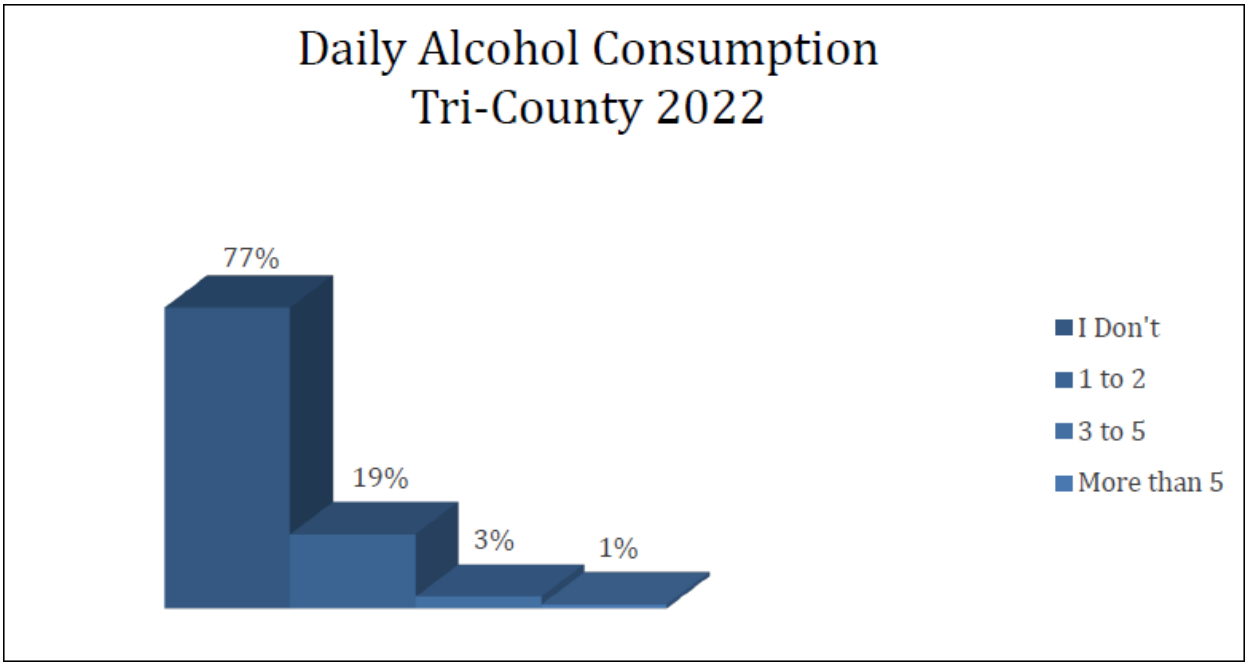
SUBSTANCE USE

National Target Data (Healthy People 2030):

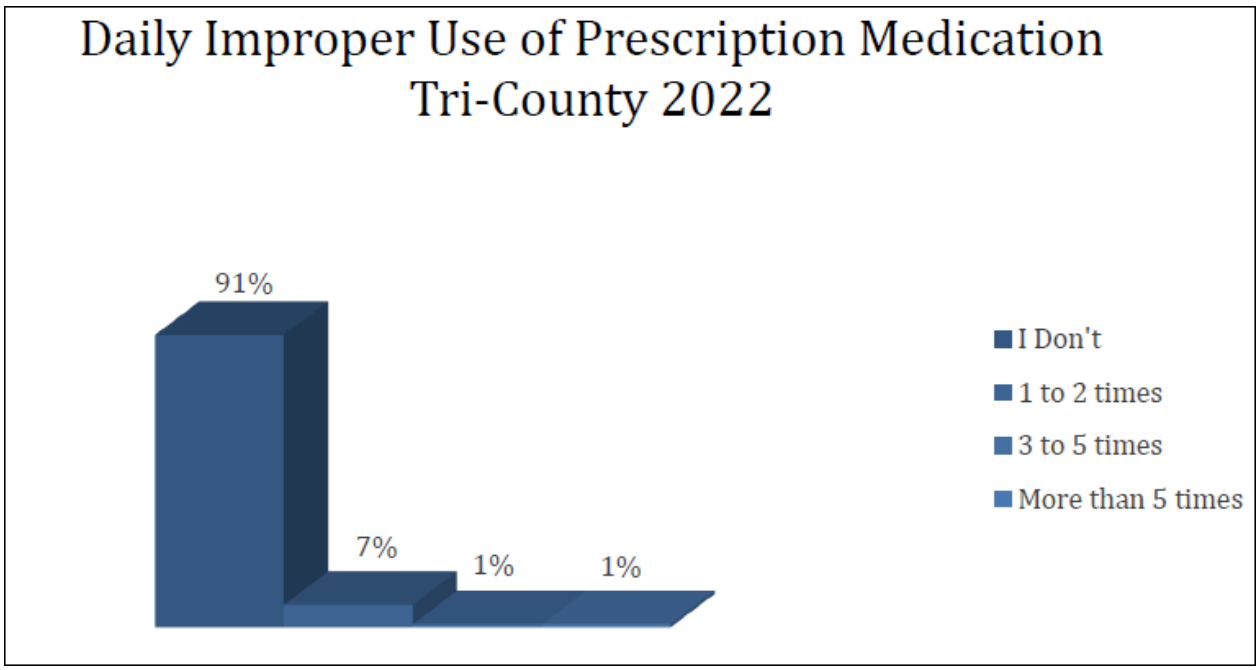
- Reduce the portion of adults who used drugs in the past month to 12%.
- Reduce the proportion of adults who use marijuana daily or almost daily to 3.4%.
- Reduce the proportion of people aged 21 years and over engaged in binge drinking in the past month to 25.4%.
- Reduce the proportion of motor vehicle crash deaths that involve a drunk driver in the past year to 28.3%.
- Reduce the proportion of people who misused prescription drugs in the past year 3.6%.
- Reduce drug overdose deaths to 20.7 per 100,000.
- Reduce the proportion of adolescents who drank alcohol in the past month to 6.3%.
- Reduce the proportion of adolescents who used drugs in the past month to 5.5%.
- Reduce the proportion of adolescents who used marijuana in the past month to 5.8%.
- Reduce the proportion of people under 21 years who engaged in binge drinking in the past month to 8.4%.

Community Status Assessment Data

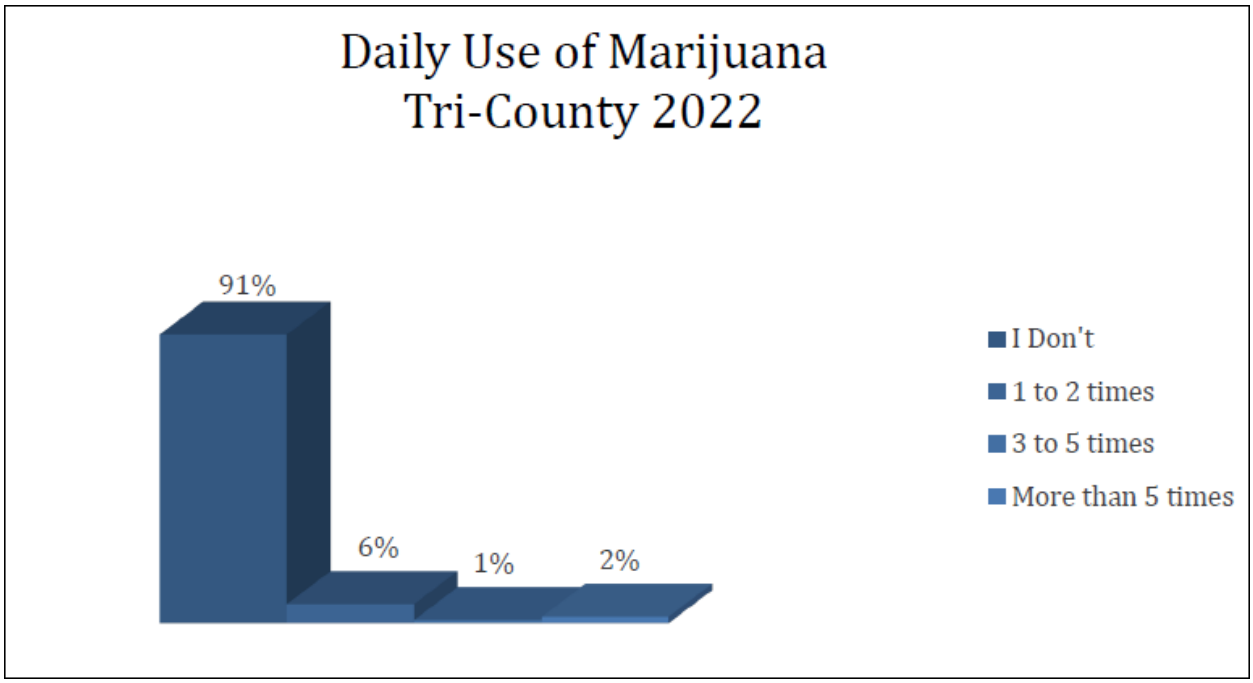
The CHNA helped to identify the typical daily usage of several substances in the Tri-County area including alcohol, prescription medication, marijuana and illegal substances. Alcohol is consumed by 23% of respondents on a typical day, while all other substances (prescription medication, marijuana, and illegal substances) had 8% or less usage on a typical day. In the CHNA, drug abuse (illegal) at 30% and drug abuse (legal) at 15% were the two top perceived unhealthy behaviors. For this same measure, alcohol abuse was the 5th out of 10 at 10%.



Source: CHNA Survey



Source: CHNA Survey



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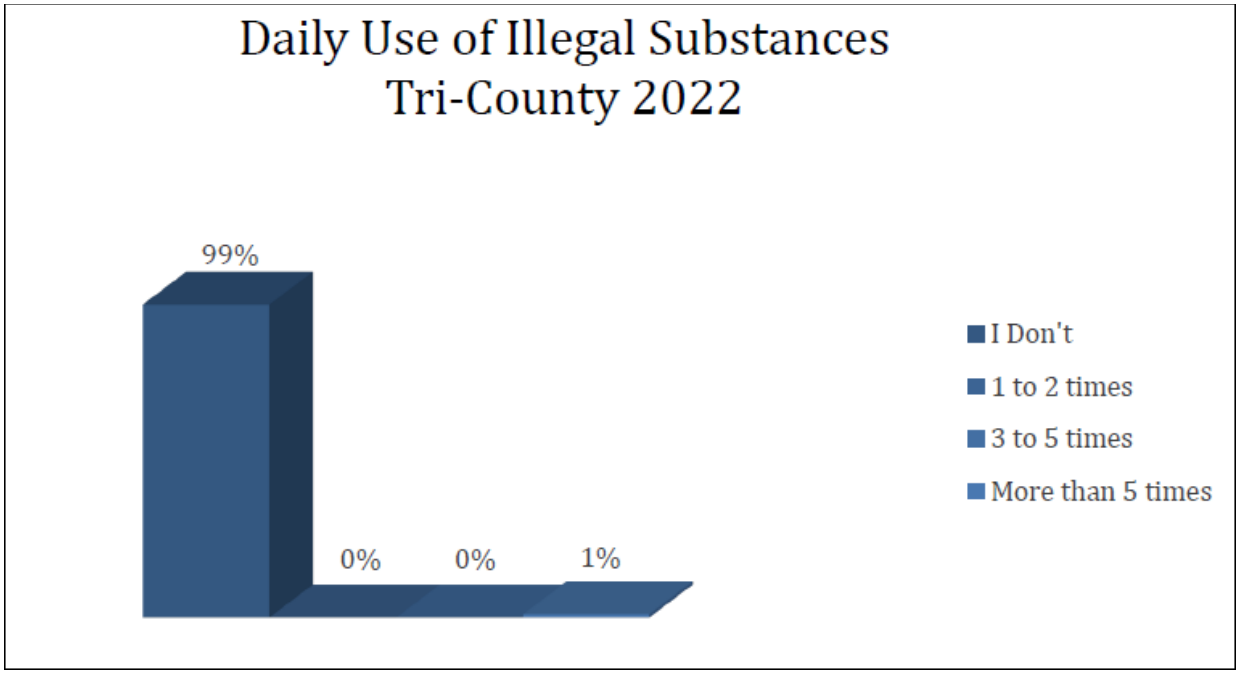
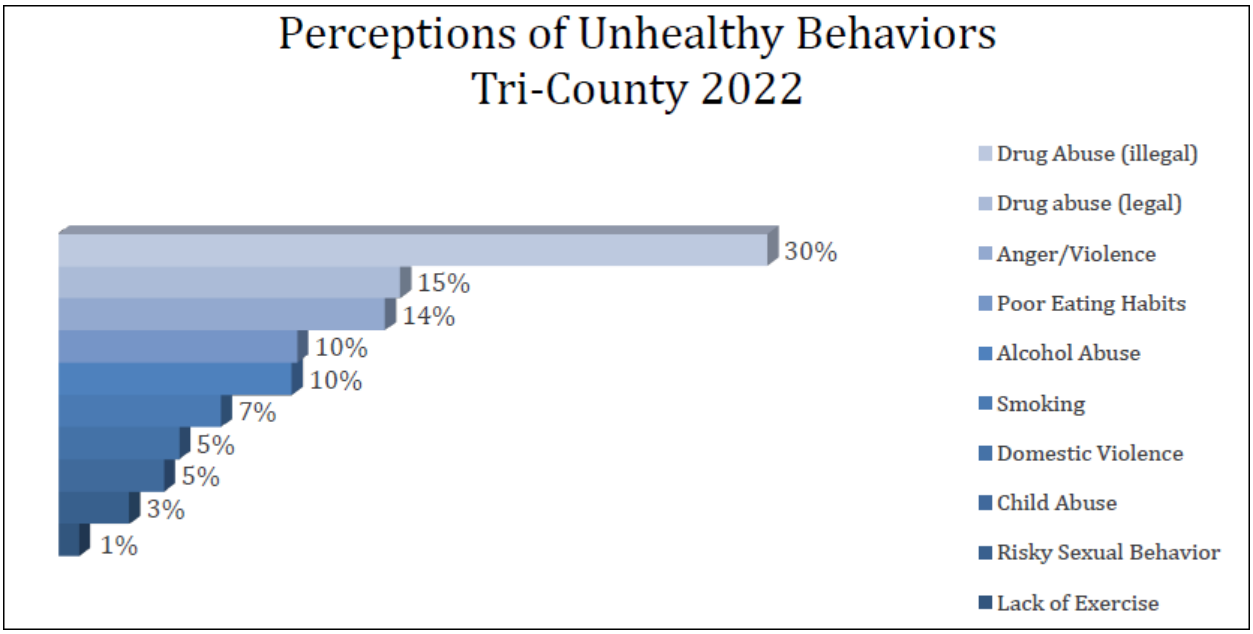


Source: CHNA Survey



Source: CHNA Survey

Supplemental Conduent's Healthy Communities Institute (HCI) Data

Peoria County: scored above other counties in Illinois for adults who binge drink, adults who drink excessively, and teens who use alcohol.

Region 2, 3, 4, 5 & 6 scored above the county for adults who binge drink.

Peoria County scored above the State of Illinois for fatal opioid overdoses, age-adjusted drug and opioid-involved overdose death rate, and death rate due to drug poisoning.

Tazewell County: scored above other counties in Illinois for teens who use alcohol and the percent of driving deaths with alcohol involvement.

Region East, North, South & West scored above the county for adults who binge drink.

Tazewell County scored above other counties in Illinois teens who use marijuana and hospitalization rate due to opioid use.

Woodford County:

Woodford County scored below other counties in Illinois for adults who binge drink and adults who drink excessively. Additionally, scored above other counties in Illinois for teens who use alcohol and the ER rate due to adult alcohol use.

Region Central & East scored above the county for adults who binge drink.

Woodford County scored above the State of Illinois for the age-adjusted drug and opioid-involved overdose death rate and fatal opioid overdoses.

Woodford County scored above other counties in Illinois for death rate due to drug poisoning, non-fatal opioid overdose, ER rate due to opioid use. ER rate due to substance use, hospitalization rate due to opioid use, hospitalization rate due to substance use and teens who use marijuana.

Social Determinants of Health (SDoH) Data

Health Care Access and Quality

69% of the Tri-County population used a clinic or doctor office for care. (CHNA Survey Data)

13.3% of the Tri-County population reported no access to medical care. (CHNA Survey Data)

11.6% of the Tri-County population receive Medicaid Insurance, with 20% of that population being Peoria County. (CHNA Survey Data)

2.7% of the Tri-County population reported have no insurance. (CHNA Survey Data)

Survey respondents reported too long of wait for inability to access medical care and counseling services and could not afford co-pay regarding access to dental care and prescriptions. (CHNA Survey Data)

Health literacy For the Tri-County region, 16% of the population is at elevated risk for health literacy. This is lower than the State of Illinois average of 34% (SocialScape® powered by SociallyDetermined®, 2022).

Education Access and Quality

Students who entered 9th grade in 2021 in Peoria County school districts, except Peoria HS, Manual Academy, Limestone Community HS, Il Valley Central HS, Illini Bluffs HS and Farmington HS reported high school graduation rates that were comparable to the State average of 86%. (CHNA Survey Data)

Students who entered 9th grade in 2021 in Tazewell County school districts, except East Peoria HS and Delavan HS reported high school graduation rates that were comparable to the State average of 86%. (CHNA Survey Data)

Students who entered 9th grade in 2021 in Woodford County school districts, except Eureka HS, Low Point-Washburn JR SR HS and Roanoke-Benson HS reported high school graduation rates that were comparable to the State average of 86%. (CHNA Survey Data)

Healthy People 2030 aims to decrease the proportion of adolescents and young people who are not in school or working to 10.1% from 11.2%.

Social and Community Context

62.3% of the Tri-County population reported have 5 or more social interactions weekly. (CHNA Survey Data)

5.3% of the Tr-County population reported having 1 or less social interactions weekly. (CHNA Survey Data)

Social support is when someone can talk to friends and family about their concerns and get help coping. Research shows that when people don't have social support, they're at increased risk for physical and mental health problems. People who have social support are more likely to make healthier choices and have better health outcomes, like reduced stress. (CHNA Survey Data)

Healthy People 2030 has a target to increase adults who talk to friends or family about their health to 92.3% from 86.9 (2017).

Economic Stability

According to the National Institute on Drug Abuse, substance use costs the U.S. over $600 billion annually. Drug addiction treatment can help to reduce associated health and social costs. Elements that should be looked at includes economic wellbeing and housing stability.

Neighborhood and Built Environment

For Tri-County, 9% of the population is at elevated risk for digital landscape. This is the same as the State of Illinois average of 9% (SocialScape® powered by SociallyDetermined®, 2022).

Survey respondents were asked if they had Internet access. Of respondents, 95% indicated they had Internet in their homes. For those who did not have Internet in their home, cost was the most frequently cited reason. Note that these data are displayed in frequencies rather than percentages given the low number of responses. (CHNA Survey Data)

Tri-County Regions of Concern

Misuse of prescription medication tends to be rated higher for residents who live in the Peoria/West Peoria region.

Use of Marijuana tends to be rated higher for residents who live in the Peoria/West Peoria region and residents who live in the Bartonville/Limestone region.

Use of illegal substances tends to be rated higher for residents who live in the Peoria/West Peoria region and for residents who live in the South-West Peoria region.

Priority Data Sources

National Target Data

Healthy People 2030 (HP2030) is a national framework setting the goals and objectives towards attaining healthy and thriving communities. Created by the Office of US Surgeon General, the initiative is to create targets and support data-driven processes in improving the health of individuals.

Community Status Assessment Data

The Community Status Assessment (CSA) includes data regarding the demographic composition of the Tri-County region, the predictors for and prevalence of diseases, leading causes of mortality, accessibility to health services and healthy behaviors. Included is a detailed analysis of secondary data to assess information regarding the health status of the community. The secondary data sources include publicly available sources as well as private sources of data.

Additionally, primary data were collected for the general population and the at-risk or economically disadvantaged population. Areas of investigation included perceptions of the community health issues, unhealthy behaviors, issues with quality of life, healthy behaviors and access to medical care, dental care, prescription medications and mental-health counseling.

Supplemental Conduent's Healthy Communities Institute (HCI) Data

Conduent Healthy Communities Institute platform (HCI) is the technology foundation for a customizable, publicly accessible website. It is a powerful data management tool that provides hundreds of indicators related to community health with comparisons to local, state and national benchmarks. The platform includes data on social determinants of health and valuable analyses on preventable hospitalization and ER admissions.

Focus Group Data

Between June 2021 and April 2022, nine focus groups on mental health were conducted in Peoria (four, including one in Spanish), Tazewell (three) and Woodford (two) counties. The work was in partnership between the University of Illinois College of Medicine Peoria and the Partnership for a Healthy Community. The population in these groups consisted of adults, and they were asked questions related to the challenges they have experienced or witnessed in their community when it comes to healthcare and specific health priorities.

Social Determinants of Health Data (HP2030)

Health Care Assess and Quality

Many people in the United States don't get the health care services they need. Healthy People 2030 focuses on improving health by helping people get timely, high-quality health care services.

About 1 in 10 people in the United States don't have health insurance.[1] People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

Education Access and Quality

People with higher levels of education are more likely to be healthier and live longer. Healthy People 2030 focuses on providing high-quality educational opportunities for children and adolescents — and on helping them do well in school.

Children from low-income families, children with disabilities, and children who routinely experience forms of social discrimination — like bullying — are more likely to struggle with math and reading. They're also less likely to graduate from high school or go to college. This means they're less likely to get safe, high-paying jobs and more likely to have health problems like heart disease, diabetes, and depression.

In addition, some children live in places with poorly performing schools, and many families can't afford to send their children to college. The stress of living in poverty can also affect children's brain development, making it harder for them to do well in school. Interventions to help children and adolescents do well in school and help families pay for college can have long-term health benefits.

Social and Community Context

People's relationships and interactions with family, friends, co-workers, and community members can have a major impact on their health and well-being. Healthy People 2030 focuses on helping people get the social support they need in the places where they live, work, learn, and play.

Many people face challenges and dangers they can't control — like unsafe neighborhoods, discrimination, or trouble affording the things they need. This can have a negative impact on health and safety throughout life.

Positive relationships at home, at work, and in the community can help reduce these negative impacts. But some people — like children whose parents are in jail and adolescents who are bullied — often don't get support from loved ones or others. Interventions to help people get the social and community support they need are critical for improving health and well-being.

Economic Stability

In the United States, 1 in 10 people live in poverty,[1] and many people can't afford things like healthy foods, health care, and housing. Healthy People 2030 focuses on helping more people achieve economic stability.

People with steady employment are less likely to live in poverty and more likely to be healthy, but many people have trouble finding and keeping a job. People with disabilities, injuries, or conditions like arthritis may be especially limited in their ability to work. In addition, many people with steady work still don't earn enough to afford the things they need to stay healthy.

Employment programs, career counseling, and high-quality child care opportunities can help more people find and keep jobs. In addition, policies to help people pay for food, housing, health care, and education can reduce poverty and improve health and well-being.

Neighborhood and Built Environment (CHNA Survey Data)

The neighborhoods people live in have a major impact on their health and well-being.[1] Healthy People 2030 focuses on improving health and safety in the places where people live, work, learn, and play.

Many people in the United States live in neighborhoods with high rates of violence, unsafe air or water, and other health and safety risks. Racial/ethnic minorities and people with low incomes are more likely to live in places with these risks. In addition, some people are exposed to things at work that can harm their health, like secondhand smoke or loud noises.

Interventions and policy changes at the local, state, and federal level can help reduce these health and safety risks and promote health. For example, providing opportunities for people to walk and bike in their communities — like by adding sidewalks and bike lanes — can increase safety and help improve health and quality of life.

Tri-County Regions of Concern

Given the size and diversity of the Tri-County area, thirteen (13) regions were identified to provide more detailed analyses. Based on zip codes, there were six (6) regions identified in Peoria County, four (4) regions identified in Tazewell County and three (3) regions identified in Woodford County. Specific regional descriptions and complete results of regional analyses were completed to address geographic inequity.

Peoria
Region 1: Peoria/West Peoria (61602, 61603, 61604, 61605, 61606, 61625)
Region 2: North Peoria/Peoria Heights (61612, 61614, 61615, 61616)
Region 3: Bartonville/Limestone (61607, 61547)
Region 4: South West Peoria County (61569,61533, 61536)
Region 5: North West Peoria County (61529, 61517, 61559)
Region 6: North East Peoria County (61528, 61525, 61626, 61523, 61552)
Tazewell
North (61611, 61571, 61610)
South (61534, 61734, 61747, 61759, 61721)
East (61550, 61755, 61568)
West (61564, 61554)
Woodford
East (61738, 61760, 61771, 61561, 61516)
Central (61570, 61545, 61530, 61729, 61742)
West (61548, 61611)

APPENDIX B: GAP ANALYSIS

HEAL

2022

Community needs to improve HEAL in Peoria, Tazewell, and Woodford Counties

SEPTEMBER 2022

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Healthy Eating, Active Living

Healthy eating, active living (HEAL): Defined as having healthy eating and active living, access to food and food insecurity. A healthy lifestyle, comprised of a proper diet, has been shown to increase physical, mental, and emotional well-being. In addition, HEAL has been shown to reduce morbidity and mortality. Some factors that contribute to HEAL include access to healthy foods, lack of fitness opportunities, lack of time, work demands, and personal health problems such as chronic diseases.

The U.S. Department of Agriculture (USDA) recommends that adults eat at least 1.5 to 2 cups of fruit and 2 to 3 cups per day of vegetables as part of a healthy eating pattern. Yet only 1 in 10 adults meet these fruit or vegetable recommendations [1-2]. Based on these recommendations, data from the CHNA survey were collapsed into two categories based on the amount of fruits and vegetables they reported to eat per day. Those who reported eating at least 3 servings of fruits and vegetables and those that did not eat that many servings a day were categorized for further analyses to identify potential gaps and barriers to healthy eating.

Community perspectives

Healthy eating: Among survey respondents, nearly 70% reported eating less than 3 servings of fruits and vegetables in a day (n=799). Males (p=0.02) and those who were younger less often ate at least 3 servings of fruits and vegetables in a day (p <0.01). Moreover, those who were Black/African American (p=0.02) or those with lower education attainment (p <0.01), or lower household income (p<0.01) more often reported eating less than 3 servings of fruits and vegetables.

- Among those who did not eat at least 3 servings of fruits and vegetables a day, the most common reasons were they did not think it was important to them (1.7%) and that they did not like fruits/vegetables (2.6%).
- Moreover, those who did not eat the recommended amount of fruits and vegetables most often accessed their foods from a grocery store (92.3%). Other sources for food were a gas station (3.0%), fast food (1.14%), or convenience store (1.23%).
- Among all survey respondents, 2.4% (n=20) reported they or their family were hungry in the past week. Hunger tends to be less likely for those who were White, higher educational attainment, and higher household income. In addition, hunger tends to be more likely for people in unstable (e.g., homeless) housing.

According to the Physical Activity Guidelines for Americans, adults need 150 minutes of moderate-intensity physical activity [3]. In the CHNA individuals were asked, "In the last WEEK how many times did you participate in exercise, (such as jogging, walking, weight-lifting, fitness classes) that lasted for at least 30 minutes?" Responses to this question could have been: none, 1-2 times, 3-5 times, more than 5 times. Based on the Physical Activity Guidelines for Americans, respondents were collapsed into two categories based on the number of days they exercised for at least 30 minutes. Those who reported exercising for at least 3 days and those that exercised less than 3 days. Additional analyses were used to identify potential gaps and barriers to an active lifestyle.

Active living: More than half of residents in the Tri-County area do not engage in physical activity for at least 30 minutes, for at least 3 times a week (61.0%, n=745). In particular, females ($p < 0.01$), reported lower educational attainment ($p < 0.01$), and those with lower household incomes ($p = 0.03$) more often do not engage in the recommended amount of physical activity.

- Among those who did not engage in the recommended amount of physical activity, the most common reasons were they were too tired (26.0%), lack of time (16.7%), do not like to exercise (16.8%), and cannot afford the fees to exercise (7.3%).

Of note, no county or regional differences were found in the Tri-County area in regard to healthy eating, active living questions assessed in the CHNA.

Related health metrics using external data sources

In addition to the community perspective of health behaviors related to healthy eating and active living, supplementary measures were used to compare between counties and to the state. Table 3 provides these metrics and further information on how these metrics are collected is provided below.

Table 3. County-level HEAL Metrics

Metric	Peoria	Tazewell	Woodford	Illinois	US
Healthy Eating					
Food Environment Index	7.3	8.1	8.9	8.6	7.8
Food insecurity	11%	9%	8%	10%	12%
Limited access to healthy foods	13%	9%	5%	5%	4%
Active Living					
Physical inactivity	27%	24%	23%	25%	26%
Access to exercise opportunities	75%	80%	58%	87%	80%

The *Food Environment Index (FEI)* ranges from a scale of 0 (worst) to 10 (best) and equally weights two indicators of the food environment: limited access to healthy foods and 2) food insecurity. The FEI is based on 2019 data used form the USDA Food Environment Atlas.

Physical Inactivity is based on responses to the 2019 Behavioral Risk Factor Surveillance Survey (BRFSS) conducted by the Centers for Disease Control and Prevention (CDC). This denotes the percentage of adults ages 18 and over reporting no leisure-time physical activity in the past month (age-adjusted).

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. Data from 2020 and 2021were used from Business Analyst, ESRI, YMCA, & US Census Tigerline Files to calculate this metric.

Food insecurity is measured by the percentage of population who lack adequate access to food. Data collected in 2019 was used from Map the Meal Gap to estimate this metric.

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. This measure is developed by using 2019 data from the USDA Food Environment Atlas.

National Goals

Table 4 provides a description of healthy eating and active living measures for Healthy People 2030 being used to the target goals.

Table 4. Healthy People 2030 Goals Related to Healthy Eating, Active Living

Description	Baseline	Target
Healthy Eating [1]		
Household food insecurity and hunger	11.1	6
Low food security among children	0.59	0
Fruit consumption by people aged 2 years and over (Defined as cup equivalents of fruit per 1,000 calories)	0.51	0.56
Vegetable consumption by people aged 2 years and over (Defined as cup equivalents of vegetable per 1,000 calories)	0.76	0.84
Consumption of dark green leafy vegetables, red and orange vegetables, and beans and peas by people aged 2 years and over (Defined as cup equivalents of dark green vegetables, red and orange vegetables, and beans and peas per 1,000 calories)	0.31	0.33
Whole grain consumption by people aged 2 years and over (Defined as ounce equivalents of whole grants per 1,000 calories)	0.46	0.62
Consumption of added sugars by people aged 2 years and over (Defined as percent of calories form added sugars)	13.5	11.5
Consumption of saturated fat by people aged 2 years and over (Defined as percent of calories from saturated fat)	11.4	8.4
Active Living (adults) [2]		
Proportion of adults who do no physical activity in their free time (Defined as the proportion of adults who engage in no leisure-time physical activity)	26.1	21.8
Proportion of adults who do enough aerobic physical activity for substantial health benefits (Defined as aerobic physical activity of at least moderate intensity for at least 150 minutes/week, or at least 75 minutes/week of vigorous intensity, or an equivalent combination)	47.9	52.9
Proportion of adults who do enough aerobic physical activity for extensive health benefits (Defined as aerobic physical activity of at least moderate intensity for more than 300 minutes/week, or more than 150 minutes/week of vigorous intensity, or an equivalent combination)	29.3	33.9
Proportion of adults who do enough muscle-strengthening activities (Defined as muscle-strengthening activities on 2 or more days of the week)	31.9	36.6
Proportion of adults who do enough aerobic and muscle strengthening activities (Defined as at least 150 minutes a week of moderate-intensity aerobic activity and muscle-strengthening activity at least 2 days a week)	25.2	29.7
Proportion of older adults with physical or cognitive health problems who get physical activity (Defined as engagement in light, moderate, or vigorous leisure-time physical activities in 2018)	41.3	51.0
Active Living (children and adolescents) [3]		
Proportion of children who do enough aerobic physical activity	25.9	30.4
Proportion of children and adolescents who play sports	58.4	63.3
Proportion of adolescents who do enough muscle-strengthening activities	51.1	56.1
Proportion of adolescents who do enough aerobic physical activity	26.1	30.6
Proportion of adolescents who do enough aerobic and muscle strengthening activities	20.0	24.1

[1] Household food insecurity and hunger along with low food security among children obtained from the 2020 Current Population Survey Food Security Supplement (CPS-FSS). Consumption of other foods was collected from the 2013-2016 National Health And Nutrition Examination Survey (NHANES).
[2] Data source: 2020 National Health Interview Survey (NHIS)
[3] Data source: National Survey on Children's Health (NSCH) and Youth Risk Behavior Surveillance System (YRBSS)

Gaps and barriers

The following gaps and barriers have been identified in the Tri-County region around HEAL.

Awareness/Education

Primary prevention strategies, such as improving awareness and knowledge on healthy eating, active living could provide substantial benefits for community members. Providing education to community members, in particular those who are: Black/African American, younger, and have lower educational attainment could help improve this health priority. Conducting a social media campaign that encourages increased activity and healthy food choices is another way to improve awareness and knowledge [4-5]. Such programs that improve the understanding on the benefits of healthy eating, active living would be beneficial to the community based on CHNA data. In addition, providing cooking classes on how to make healthier meals could be helpful when encouraging community members on behavior change when it comes to increasing the number of fruits and vegetables consumed by community members.

For children and adolescents, school-based programs are promising programs that provide education on nutrition and physical activity [6-7]. Additional resources could also provide a school linked health center so that all children and adolescents receive a BMI measurement [8].

Access

Increasing access to healthy foods would be of great importance when encouraging community members to maintain a healthy diet [9]. Based on data from the CHNA and external sources, reducing food insecurity is especially important in Peoria and Tazewell Counties. Promoting the use of school and/or community gardens can be helpful, especially in communities where access to healthy foods is limited [6-8, 10-11].

In addition, improving access to exercise opportunities would also encourage healthier behaviors among community members [12]. Programs developed that promote physical activity, especially among females and those with a lower household income should be a priority. Based on findings from national data sources, only 58% of residents in Woodford County have access to exercise opportunities compared to the other counties which range between 75-80% of residents. Developing community-based exercise opportunities such as sponsoring a 5k walk, could be beneficial. In addition, identifying ways to reduce other barriers such as cost and time could be helpful. In particular, providing off hours and weekends to host events could be helpful to engage community members in such activities.

Metrics to assess healthy eating, active living

Measuring the **reach** of the programs provided and the associated **outcomes** would be valuable to understand changes occurring in the community. The following things can be used to measure the improvement of health behaviors related to nutrition and physical activity.

Reach

- Number of individuals attending meetings or trainings
    - When each meeting/class is offered including time of day and day of the week
- Number of individuals engaged with social media posts or other media releases
- Number of individuals screened for dietary counseling and surveillance
- Number of nutrition classes or cooking classes offered in the community
    - Number of individuals who attended the class
- Number of community gardens
    - Proportion of residents accessing community gardens
- Number of physical activity classes offered in the community
    - Number of individuals who attended fitness classes in the community

If healthcare data is available, the following CPT and ICD-10 codes can be used to assess changes in these numbers in the community.

- Screening and Nutrition (CPT) codes: 97802-97804, 99401-9904
- Nutrition/dietary counseling (ICD-10) codes: Z71.3, S9470
- Nutrition class (CPT) code: S9452
- Self-care management training (CPT) code: 97535

Outcomes

- Changes in annual survey data (public health department or national surveillance systems)
    - Number of fruits and vegetables eaten in a day
        - Increase the proportion of residents who eat the recommended amount of fruits and/or vegetables
    - Number of days/week residents engage in physical activity
        - Increase in the proportion of residents who engage in more physical activity
        - Identify the type of physical activity the residents engage in (e.g., strength training, aerobic, etc.)

- Pre- and post-evaluations for any meetings, trainings, and educational programs provided in the community

APPENDICES

PHYSICAL ACTIVITY AMONG SURVEY RESPONDENTS

	Does not exercise at least 3 times a week (n=745)		Exercise at least 3 times a week for 30 minutes (n=476)		
	n	**%**	**n**	**%**	**p-value**
Gender					**<0.01**
Male	143	19.70	133	28.66	
Female	398	54.82	227	48.92	
Non-binary, transgender	185	25.48	104	22.41	
Age					0.24
Under 20 years old	9	1.23	10	2.12	
Between 21-35 years old	141	19.34	85	18.05	
Between 36-50 years old	241	33.06	147	31.21	
Between 51-65 years old	234	32.10	137	29.09	
Over 65 years old	104	14.27	92	19.53	
Sexual Preferences					0.47
Heterosexual	622	83.49	409	85.92	
Lesbian, Gay, Queer, or Bisexual	48	6.44	24	5.04	
Prefer not to answer or missing	75	10.07	43	9.03	
Race/ethnicity					0.20
White/Caucasian	650	89.04	432	92.11	
Black/African American	44	6.03	22	4.69	
Other	36	4.93	15	3.20	
Education status					**<0.01**
Some high school, GED, or High School Diploma	107	14.64	50	10.57	
Some college	244	33.38	145	30.66	
Bachelors or Graduate Degree	380	51.98	278	58.77	
Household income					**<0.01**
Less than $20,000	58	8.18	24	5.37	
Between $20,001-$40,000	122	17.21	58	12.98	
Between $40,001- $60,000	115	16.22	71	15.88	
Between $60,001-$80,000	120	16.93	72	16.11	
Over $80,001	294	41.47	222	49.66	
Housing Stability					**0.02**
Homeless	14	1.93	18	3.84	
Unstable Housing	58	7.99	23	4.90	
Stable Housing	654	90.08	428	91.26	

County					0.31
Peoria	280	37.58	184	38.66	
Tazewell	247	33.15	139	29.20	
Woodford	218	29.29	153	32.14	

Other for race/ethnicity includes: Hispanic/LatinX, Pacific Islander, Native American, Asian/South Asian, Multiracial

For nominal variables, chi-square tests were performed. The null hypothesis for that is there is no difference between the distributions in the categorical variable by physical activity. Since the alpha level was set to 0.05, we would reject the null hypothesis and conclude that there is a statistically significant difference between the demographic variable of interest and physical activity when the p-value was less than 0.05.
For ordinal variables, Cochran Armitage test for trend was conducted. The null hypothesis is of no trend, which means that the proportion in each level by physical activity is the same for all levels of the demographic variables tested. Using the same alpha level of 0.05, a two-sided p-value of less than 0.05 would indicate rejecting the null, indicating that there is a statistically significant difference (either increasing or decreasing) in the proportion for the demographic ordinal variable on physical activity.

Summary:

There are significant differences in gender, educational attainment, household income, and housing stability by physical activity ($p<0.05$). In particular, those who are female, report lower educational attainment, lower household income, or unstable housing more often report less than 90 minutes of physical activity in a week.

HEALTHY EATING AMONG SURVEY RESPONDENTS

	Eats less than 3 servings of fruits and vegetables (n=799)		Eats at least 3 Servings of Fruits and vegetables (n=418)		
	n	**%**	**n**	**%**	**p-value**
Gender					**0.02**
Male	194	24.97	80	19.56	
Female	411	52.90	212	51.83	
Non-binary, transgender	172	22.14	117	28.61	
Age					**<0.01**
Under 20 years old	16	2.05	3	0.72	
Between 21-35 years old	153	19.62	74	17.79	
Between 36-50 years old	258	33.08	128	30.77	
Between 51-65 years old	248	31.79	120	28.85	
Over 65 years old	105	13.46	91	21.88	
Sexual Preferences					0.05
Heterosexual	667	83.48	361	86.36	
Lesbian, Gay, Queer, or Bisexual	56	7.01	15	3.59	
Prefer not to answer or missing	76	9.51	42	10.05	
Race/ethnicity					**0.01**
White/Caucasian	699	89.50	383	92.51	
Black/African American	51	6.53	11	2.66	
Other	31	3.97	20	4.83	
Education status					**<0.01**
Some high school, GED, or High School Diploma	114	14.56	41	9.83	
Some college	281	35.89	106	25.42	
Bachelors or Graduate Degree	388	49.55	270	64.75	
Household income					**<0.01**
Less than $20,000	57	7.52	23	5.84	
Between $20,001-$40,000	134	17.68	46	11.68	
Between $40,001- $60,000	132	17.41	54	13.71	
Between $60,001-$80,000	125	16.49	66	16.75	
Over $80,001	310	40.90	205	52.03	
Housing Stability					**<0.01**
Homeless	23	2.96	9	2.17	
Unstable Housing	65	8.38	16	3.86	
Stable Housing	688	88.66	390	93.98	

County					0.28
Peoria	311	38.92	150	35.89	
Tazewell	257	32.17	129	30.86	
Woodford	231	28.91	139	33.25	

Other for race/ethnicity includes: Hispanic/LatinX, Pacific Islander, Native American, Asian/South Asian, Multiracial

For nominal variables, chi-square tests were performed. The null hypothesis for that is there is no difference between the distributions in the categorical variable by eating the recommended amount of healthy food. Since the alpha level was set to 0.05, we would reject the null hypothesis and conclude that there is a statistically significant difference between the demographic variable of interest and reported healthy eating habits when the p-value was less than 0.05.
For ordinal variables, Cochran Armitage test for trend was conducted. The null hypothesis is of no trend, which means that the proportion in each level by healthy eating habits is the same for all levels of the demographic variables tested. Using the same alpha level of 0.05, a two-sided p-value of less than 0.05 would indicate rejecting the null, indicating that there is a statistically significant difference (either increasing or decreasing) in the proportion for the demographic ordinal variable on physical activity.

Summary:

There are significant differences in gender, educational attainment, household income, and housing stability by health eating habits ($p<0.05$). In particular, those who are female, report lower educational attainment, lower household income, or unstable housing more often report eating less than 3 fruits and vegetables in a week.

PHYSICAL ACTIVITY BY REGION

	Does not exercise at least 3 times a week (n=504)		Exercise at least 3 times a week for 30 minutes (n=318)		
Location	**n**	**%**	**n**	**%**	**p-value**
Peoria					0.82
Peoria/West Peoria	87	32.58	63	35.59	
North Peoria/Peoria Heights	90	33.71	58	32.77	
Bartonville/Limestone	26	9.74	16	9.04	
South West Peoria County	14	5.24	13	7.34	
North West Peoria County	24	8.99	11	6.21	
North East Peoria County	26	9.74	16	9.04	
Tazewell					0.17
North Tazewell County	93	39.24	71	50.35	
South Tazewell County	31	13.08	12	8.51	
East Tazewell County	42	17.72	20	14.18	
West Tazewell County	71	29.96	38	26.95	
Woodford					0.10
East Woodford County	93	56.02	71	68.93	
Central Woodford County	31	18.67	12	11.65	
West Woodford County	42	25.30	20	19.42	

Chi-square tests were performed, exact chi-square when indicated by small numbers. The null hypothesis for that is there is no difference between the distributions in the region by physical activity status. Since the alpha level was set to 0.05, we would reject the null hypothesis and conclude that there is a statistically significant difference between the region and reported physical activity when the p-value was less than 0.05.

Summary:

No regional differences were detected in the Tri-County region for self-reported physical activity among residents.

HEALTHY EATING BY REGION

	Eats less than 3 servings of fruits and vegetables (n=552)		Eats at least 3 Servings of Fruits and vegetables (n=267)		
Location	**n**	**%**	**n**	**%**	**p-value**
Peoria					0.06
Peoria/West Peoria	109	36.33	39	27.86	
North Peoria/Peoria Heights	94	31.33	51	36.43	
Bartonville/Limestone	31	10.33	11	7.86	
South West Peoria County	19	6.33	9	6.43	
North West Peoria County	26	8.67	9	6.43	
North East Peoria County	21	7.00	21	15.00	
Tazewell					0.40
North Tazewell County	87	36.86	51	43.97	
South Tazewell County	27	11.44	16	13.79	
East Tazewell County	43	18.22	19	16.38	
West Tazewell County	79	33.47	30	25.86	
Woodford					0.61
East Woodford County	102	59.30	62	63.92	
Central Woodford County	27	15.70	16	16.49	
West Woodford County	43	25.00	19	19.59	

Chi-square tests were performed, exact chi-square when indicated by small numbers. The null hypothesis for that is there is no difference between the distributions in the region by reported healthy eating behaviors. Since the alpha level was set to 0.05, we would reject the null hypothesis and conclude that there is a statistically significant difference between the region and healthy eating behavior when the p-value was less than 0.05.

Summary:

No regional differences were detected in the Tri-County region for self-reported healthy eating habits among residents.

2022

Community needs to improve mental health in Peoria, Tazewell, and Woodford Counties

SEPTEMBER 2022

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Mental Health

Mental health: defined as depression, anxiety, and suicide for this Tri-County report.

The CDC defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses in life, can work productively and fruitfully, and is able to make a contribution to his or her community."

A myriad of factors can influence mental health outcomes, including suicide. Some of the direct factors that contribute to mental health include: other chronic health conditions, culture, genetics, and lack of coping skills. Examples of some indirect factors include: lack of appropriate medical services, lack of education about recognizing mental health issues, and stigma surrounding mental health.

Community Perspective

Approximately 24.1% of respondents reported feeling depressed, down, or hopeless more than 3 days in the past month. Similarly, 20.9% of respondents reported that stress and/or anxiety has stopped them from their normal daily activities more than 3 days in the past month. Moreover, among survey respondents, 19.8% reported a mental health condition (n=243). Those who reported having a mental health condition were more often younger ($p<0.01$), LGBTQ+ ($p<0.01$), with lower household income ($p<0.01$) and had unstable or no housing ($p< 0.01$). In addition, 14.8% of respondents reported that their mental health was below average (n=178). Along with the factors previously mentioned for those who reported a mental health condition, those with lower educational attainment more often reported below average mental health ($p<0.01$).

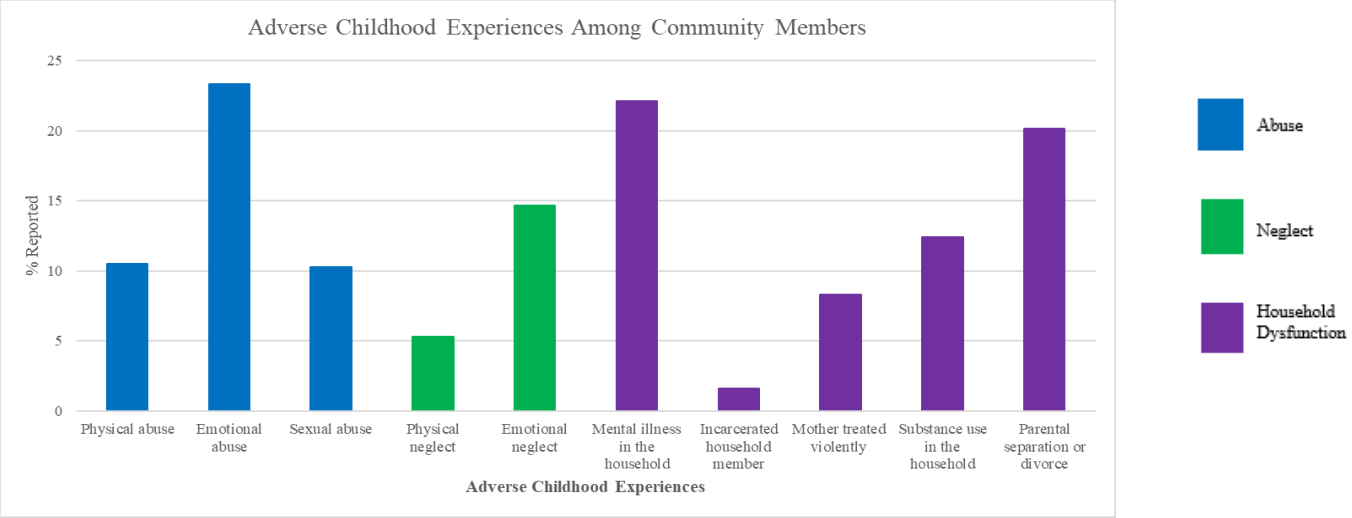
Of note, there were significant differences between the three counties among those who reported to have a mental health condition. Peoria respondents more often reported a mental health condition ($p<0.01$). In fact, roughly 25% of the respondents who reported a mental health condition in Peoria whereas Woodford residents had the lowest proportion of residents (12.1%) report a mental health condition.

When examining regional differences, significant differences were identified within Peoria County. Residents in Peoria/West Peoria more often reported below average mental health compared to other areas in the county. The South West Peoria, North West Peoria, and North East Peoria less often reported below average mental health ($p=0.02$).

Additional indicators of mental health

Adverse childhood experiences (ACE) such as abuse, neglect, or household dysfunction are associated with severe problems later in life, especially mental health outcomes. ACE scores were calculated from CHNA respondents using the sum of the ten questions. Those with 4 or more ACEs were collapsed into one category. Previous research suggests that an ACE score of 4 or more are at increased risk for several mental health outcomes including: suicide, depression, and anxiety [29-32]. ACEs were highly prevalent, nearly half of respondents reported at least one ACE. In fact, approximately 13.8% (n=169) of survey respondents reported more than 4 ACEs. The proportion of survey respondents who reported at least one of the ACEs assessed in the CHNA are shown in Figure 3, categorized by type of ACE: abuse, neglect, or household dysfunction.

Figure 3. Adverse Childhood Experiences (ACEs) among Community Members in the Tri-County region



Related health metrics using external data sources

Table 7 provides county-level metrics assessing mental health among the Tri-County region. Additional information on how these are measured is provided below.

Table 7. County-level Mental Health Metrics

Metric	Peoria	Tazewell	Woodford	Illinois	US
Poor mental health days	4.6	4.6	4.3	4.2	4.5
Frequent mental distress	15%	15%	14%	13%	13%
Depressive disorder	22%	27%	20%	22%	20%
Mental health providers	370:1	490:1	2,930:1	370:1	350:1
Suicide mortality rate	15.0	13.0	15.0	11.0	13.9

Poor mental health days measures the average number of mentally unhealthy days reported in past 30 days (age-adjusted) using data from the 2019 BRFSS.

Frequent mental distress is the percentage of adults (age-adjusted) who have reported 14 or more days of poor mental health per month using data from the 2019 BRFSS.

Depressive disorder is measured by the percentage of adults (age-adjusted) who have ever been told they had a depressive disorder (i.e., lifetime measure) using data from the 2019 BRFSS.

Mental health providers denote the ratio of the population to mental health providers in the county. The ratio represents the number of individuals served by one mental health provider in a county, if the population was equally distributed across providers. This data is collected from Centers for Medicare & Medicaid Services (CMS), National Provider Identification (NPI).

Suicide mortality rate is the number of deaths due to suicide per 100,000 population and is age-adjusted. Data from 2016-2020 CDC WONDER is used for this metric, to identify accurate measures for counties with smaller populations.

National Goals

Table 8 provides a description of mental health goals for Healthy People 2030.

Table 8. Healthy People 2030 Goals Related to Mental Health

Description	**Baseline**	**Target**
Depression & anxiety		
Proportion of adolescents with depression who get treatment [1]	41.4	46.4
Proportion of adults with depression who get treatment [1]	64.8	69.5
Proportion of primary care visits where adolescents and adults are screened for depression [2]	8.5	13.5
Suicide		
Suicide mortality rate [3]	14.2	12.8
Suicide attempts among adolescents [4]	2.4	1.8
Suicidal thoughts among lesbian, gay, or bisexual high school students [5]	58.5	52.1

[1] Data source: 2019 National Survey on Drug Use and Health (NSDUH)
[2] Data source: 2016 National Ambulatory Medical Care Survey (NAMCS)
[3] Data source: 2010 National Vital Statistics System- Mortality (NVSS-M)
[4] Data source: 2019 Youth Risk Behavior Surveillance System (YRBSS)
[5] Data source: 2017 Youth Risk Behavior Surveillance System (YRBSS)

Gaps and barriers

Awareness/Education

Primary prevention strategies, such as increasing awareness and education around mental health, including information on community resources and where to obtain support is one preventative way to improve mental health. Examples include developing a social media campaign to spread awareness on identifying the signs of mental health conditions [33-36]. Programs such as the Mental Health First Aid (MHFA) is one evidence-based program for the community that educates individuals on identifying someone experiencing a mental health crisis [37]. These types of programs could not only increase awareness and education surrounding mental health, but it could also reduce stigma surrounding mental health.

Working collaboratively with community entities to implement health programs to improve mental health throughout the region could be an efficient way to disseminate information [38-39]. In fact, leveraging local, state, and national resources when disseminating mental health resources in the community could be an example of streamlining ongoing mental health efforts [40-44].

Given that younger individuals and those in the LGBTQ+ community more often reported worse mental health outcomes in the survey, implementing school-based programs or community-based programs that are tailored for these population is essential [45-47]. There are several evidence-based programs and some promising practices as well that could be used throughout the region to help curtail this growing problem. One example is the use of Trauma Informed Awareness in school systems using program management provided by SAMHSA [48-49].

Screening

In regards to improving secondary prevention measures, amplifying resources for healthcare providers in the Tri-County region in order to increase number of prevention programs, screenings, and interventions conducted in the community could also improve mental health status by connecting people to appropriate care. There is a need to expand access to screening services to assess for depression, emotional, and mental health conditions using validated instruments that are low cost and low burden for healthcare professionals (e.g., PHQ-9).

Access to care

In order to address gaps in all prevention strategies, supporting the expansion of mental health care available in the Tri-County area is essential in improving mental health for the community. While Peoria respondents more often reported poor mental health, Woodford County is well below the average number

of residents to mental health providers. Enhancing access to appropriate mental health care is essential in improving mental health outcomes such as depression, anxiety, and suicide. In particular, identifying and improving the number of individuals who seek mental health care after an incident diagnosis is one way to ensure access to care is improving in the community.

Metrics to assess mental health

Measuring the **reach** of the programs provided and the associated **outcomes** would be valuable to understand changes occurring in the community. The following things can be used to measure the improvement of mental health.

Reach

- Number of individuals attending meetings or trainings related to mental health
    - When each meeting/training is offered including time of day and day of the week
    - Number of at-risk individuals who have attended the events
- Number of individuals engaged with social media posts or other media releases

Outcomes

- Changes in annual survey data (public health department or national surveillance systems)
    - Number of adults in the region who have been diagnosed with a mental health condition (incident diagnosis)
    - Number of individuals reporting poor mental health status
- Number of individuals screened for mental health conditions
- Proportion of adults who are receiving care for mental health disorders
- Proportion of children and adolescents who are receiving care for mental health disorders
- Number of individuals who are diagnosed with a mental health condition and seen by a mental health professional in a timely manner
    - Time to follow-up appointment after incident diagnosis
    - Assessing the suicide-related morbidity and mortality
        - Reduction in suicide mortality
        - Increase in the number of individuals obtaining follow-up care following a non-fatal suicide attempt or documented suicide ideation

- Pre- and post-evaluations for any meetings, trainings, and educational programs provided in the community

If healthcare data is available, the following CPT and ICD-10 codes can be used to assess changes in these numbers in the community.

  - Mental health screening (ICD-10 code): Z13.3, Z00.121
  - Mental health treatment (CPT code): H0002, H0004, H0017, H0018, H0019, H0023, H0024, H0025, H0030, H2012, H2037, 96127, 96160, 96161, 99214, 99215
  - Depression disorders (ICD-10 code): F32, F33
  - Anxiety disorders (ICD-10 code): F41
  - Suicidal ideation/self-harm (ICD-10 code): R45.851, E950-E958.9, T14.91
  - Other diagnostic measures related to negative health outcomes:
    - Bullying or psychological abuse (ICD-10: T74.3)
    - Target of (perceived) adverse discrimination and persecution (ICD-10: Z60.5)

APPENDICES

MENTAL HEALTH CONDITION AMONG SURVEY RESPONDENTS

	No mental health conditions (n=983)		Mental health condition (n=243)		
	n	**%**	**n**	**%**	**p-value**
Gender					**<0.01**
Male	250	26.23	27	11.25	
Female	463	48.58	164	68.33	
Non-binary, transgender	240	25.18	49	20.42	
Age					**<0.01**
Under 20 years old	6	0.62	13	5.37	
Between 21-35 years old	143	14.88	85	35.12	
Between 36-50 years old	301	31.32	87	35.95	
Between 51-65 years old	325	33.82	46	19.01	
Over 65 years old	186	19.35	11	4.55	
Sexual Preferences					**<0.01**
Heterosexual	845	85.96	189	77.78	
Lesbian, Gay, Queer, or Bisexual	36	3.66	36	14.81	
Prefer not to answer or missing	102	10.38	18	7.41	
Race/ethnicity					0.80
White/Caucasian	867	90.22	217	90.04	
Black/African American	54	5.62	12	4.98	
Other	40	4.16	12	4.98	
Education status					0.31
Some high school, GED, or High School Diploma	127	13.15	30	12.45	
Some college	321	33.23	71	29.46	
Bachelors or Graduate Degree	518	53.62	140	58.09	
Household income					**<0.01**
Less than $20,000	55	5.96	29	12.29	
Between $20,001-$40,000	124	13.43	56	23.73	
Between $40,001- $60,000	148	16.03	38	16.10	
Between $60,001-$80,000	157	17.01	36	15.25	
Over $80,001	439	47.56	77	32.63	
Housing Stability					**<0.01**
Homeless	25	2.62	8	3.32	
Unstable Housing	47	4.92	34	14.11	
Stable Housing	884	92.47	199	82.57	

County					**<0.01**
Peoria	350	35.61	115	47.33	
Tazewell	306	31.13	83	34.16	
Woodford	327	33.27	45	18.52	

Notes:
Other for race/ethnicity includes: Hispanic/LatinX, Pacific Islander, Native American, Asian/South Asian, Multiracial

For nominal variables, chi-square tests were performed. The null hypothesis for that is there is no difference between the distributions in the categorical variable by mental health status. Since the alpha level was set to 0.05, we would reject the null hypothesis and conclude that there is a statistically significant difference between the demographic variable of interest and mental health status when the p-value was less than 0.05.
For ordinal variables, Cochran Armitage test for trend was conducted. The null hypothesis is of no trend, which means that the proportion in each level by mental health status is the same for all levels of the demographic variables tested. Using the same alpha level of 0.05, a two-sided p-value of less than 0.05 would indicate rejecting the null, indicating that there is a statistically significant difference (either increasing or decreasing) in the proportion for the demographic ordinal variable on mental health.

Summary:

There are significant differences in gender, age, sexual preference, household income, county of residence, and housing stability by mental health status ($p<0.05$). In particular, those who are female, younger in age, identify as LGBTQ+, lower household income, live in Peoria County, or reported unstable housing more often report having a mental health condition.

SELF-REPORTED MENTAL HEALTH STATUS AMONG SURVEY RESPONDENTS

	Average or above average mental health (n=938)		Below average mental health (n=166)		
	n	**%**	**n**	**%**	**p-value**
Gender					0.10
Male	236	23.51	29	16.76	
Female	522	51.99	103	59.54	
Non-binary, transgender	246	24.50	41	23.70	
Age					**<0.01**
Under 20 years old	9	0.89	10	5.71	
Between 21-35 years old	170	16.83	57	32.57	
Between 36-50 years old	318	31.49	68	38.86	
Between 51-65 years old	331	32.77	33	18.86	
Over 65 years old	182	18.02	7	4.00	
Sexual Preferences					**<0.01**
Heterosexual	883	85.81	137	76.97	
Lesbian, Gay, Queer, or Bisexual	46	4.47	26	14.61	
Prefer not to answer or missing	100	9.72	15	8.43	
Race/ethnicity					0.16
White/Caucasian	907	89.71	164	94.25	
Black/African American	56	5.54	6	3.45	
Other	48	4.75	4	2.30	
Education status					**<0.01**
Some high school, GED, or High School Diploma	115	11.32	36	20.69	
Some college	332	32.68	58	33.33	
Bachelors or Graduate Degree	569	56.00	80	45.98	
Household income					**<0.01**
Less than $20,000	47	4.84	33	19.30	
Between $20,001-$40,000	125	12.87	51	29.82	
Between $40,001- $60,000	156	16.07	28	16.37	
Between $60,001-$80,000	174	17.92	18	10.53	
Over $80,001	469	48.30	41	23.98	
Housing Stability					**<0.01**
Homeless	27	2.68	6	3.43	
Unstable Housing	47	4.66	33	18.86	
Stable Housing	934	92.66	136	77.71	

County					0.16
Peoria	385	37.41	72	40.45	
Tazewell	323	31.39	63	35.39	
Woodford	321	31.20	43	24.16	

Other for race/ethnicity includes: Hispanic/LatinX, Pacific Islander, Native American, Asian/South Asian, Multiracial

For nominal variables, chi-square tests were performed. The null hypothesis for that is there is no difference between the distributions in the categorical variable by self-reported mental health status. Since the alpha level was set to 0.05, we would reject the null hypothesis and conclude that there is a statistically significant difference between the demographic variable of interest and self-reported health status when the p-value was less than 0.05.
For ordinal variables, Cochran Armitage test for trend was conducted. The null hypothesis is of no trend, which means that the proportion in each level by self-reported mental health status is the same for all levels of the demographic variables tested. Using the same alpha level of 0.05, a two-sided p-value of less than 0.05 would indicate rejecting the null, indicating that there is a statistically significant difference (either increasing or decreasing) in the proportion for the demographic ordinal variable on self-reported mental health status.

Summary:

There are significant differences in age, sexual preference, education status, household income, and housing status by self-reported mental health status ($p<0.05$). In particular, those who are younger, identify as LGBTQ+, report lower educational attainment, lower household income, and unstable housing more often report below average mental health.

MENTAL HEALTH CONDITION BY REGION

	No mental health conditions (n=623)		Mental health condition (n=201)		
Location	**n**	**%**	**n**	**%**	**p-value**
Peoria					0.09
Peoria/West Peoria	101	30.61	49	42.61	
North Peoria/Peoria Heights	109	33.03	39	33.91	
Bartonville/Limestone	33	10.00	9	7.83	
South West Peoria County	25	7.58	3	2.61	
North West Peoria County	27	8.18	8	6.96	
North East Peoria County	35	10.61	7	6.09	
Tazewell					0.65
North Tazewell County	128	43.69	37	43.02	
South Tazewell County	30	10.24	13	15.12	
East Tazewell County	49	16.72	13	15.12	
West Tazewell County	86	29.35	23	26.74	
Woodford					0.50
East Woodford County	128	61.84	37	58.73	
Central Woodford County	30	14.49	13	20.63	
West Woodford County	49	23.67	13	20.63	

Chi-square tests were performed, exact chi-square when indicated by small numbers. The null hypothesis for that is there is no difference between the distributions in the region by mental health status. Since the alpha level was set to 0.05, we would reject the null hypothesis and conclude that there is a statistically significant difference between the region and mental health status when the p-value was less than 0.05.

Summary:

No regional differences were detected in the Tri-County region for self-reported mental health status among residents.

SELF-REPORTED MENTAL HEALTH STATUS BY REGION

	Average or above average mental health (n=680)		Below average mental health (n=135)		
Location	**n**	**%**	**n**	**%**	**p-value**
Peoria					**0.02**
Peoria/West Peoria	112	30.60	32	45.07	
North Peoria/Peoria Heights	123	33.61	24	33.80	
Bartonville/Limestone	33	9.02	9	12.68	
South West Peoria County	27	7.38	1	1.41	
North West Peoria County	32	8.74	2	2.82	
North East Peoria County	39	10.66	3	4.23	
Tazewell					0.98
North Tazewell County	138	43.95	27	42.19	
South Tazewell County	35	11.15	8	12.50	
East Tazewell County	51	16.24	11	17.19	
West Tazewell County	90	28.66	18	28.13	
Woodford					0.92
East Woodford County	138	61.61	27	58.70	
Central Woodford County	35	15.63	8	17.39	
West Woodford County	51	22.77	11	23.91	

Chi-square tests were performed, exact chi-square when indicated by small numbers. The null hypothesis for that is there is no difference between the distributions in the region by self-reported mental health status. Since the alpha level was set to 0.05, we would reject the null hypothesis and conclude that there is a statistically significant difference between the region and self-reported mental health status when the p-value was less than 0.05.

Summary:

There are significant regional differences in Peoria County. In particular, there are more residents who reported lower mental health status who lived in Peoria/West Peoria compared to other regions. No significant regional differences were detected in Tazewell or Woodford County.

2022

Community needs to improve obesity in Peoria, Tazewell, and Woodford Counties

SEPTEMBER 2022

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Obesity

Obesity: defined as being overweight and obese.

According to the CDC, obesity is defined as a body mass index (BMI) of 30 kg/m^2 or higher in adults [13]. In the past decade, obesity has been recognized by the World Health Organization (WHO) and American Medical Association (AMA) as a chronic disease, similar to diabetes or heart disease [14]. Obesity is a complex disease in which abnormal or excess body fat impairs health. Effects from obesity include health conditions, lower quality of life, and a reduced lifespan. In fact, obesity is one of the leading causes of preventable death in the United States. In order to identify those who are at risk for complications related to obesity, body mass index (BMI) is often collected. Although BMI is not always an accurate tool for identifying obesity-related complications, it can be easily collected in routine physical examinations. BMI measurements can help healthcare providers identify individuals who may benefit from additional medical management.

Some direct factors that contribute to obesity include: nutrition, physical activity, sleep, genetics, and certain medical conditions. Indirect factors that contribute to obesity include: lack of resources to obtain healthy foods, lack of education on nutrition and medical services (i.e. medication, weight management), limited access to healthcare, and lack of understanding of medical needs.

Community perspectives

Approximately half of survey respondents in the Tri-County region stated that obesity/overweight status was one of the top health issues in the community (n=612). Among survey respondents, 45.8% reported they were overweight (n=561). Those who reported being overweight more often were female ($p < 0.01$) and older in age ($p<0.01$). In addition, those who reported uncertainty about their housing situation more often reported being overweight whereas those who were homeless more often reported they were not overweight ($p < 0.01$).

There were significant differences between the three counties for residents who reported to be overweight ($p < 0.01$). In particular, Tazewell County residents more often reported being overweight compared to the other two counties. In fact, 52.7% of those who completed the CHNA survey for Tazewell County reported they were overweight whereas Peoria had the lowest proportion of individuals who reported being overweight (42.8%). No regional differences were found in the Tri-County area.

Related health metrics using external data sources

Data from the Behavioral Risk Factor Surveillance System (BRFSS) estimates that roughly two-thirds of adults in Illinois are overweight or obese, which has risen by 20% over the past decade [15]. Researchers have estimated that obesity is projected to increase across the nation, resulting in nearly half the population being obese by 2030. In fact, they projected 50% of the adult population in Illinois to have obesity, and 25.5% of them will have severe obesity (BMI, ≥35) by 2030 [16]. The prevalence of adults in Illinois who are overweight and obese from 2011-2020 can be found in Figure 2 below.

Figure 2. Weight classification among adults in Illinois, 2011-2020

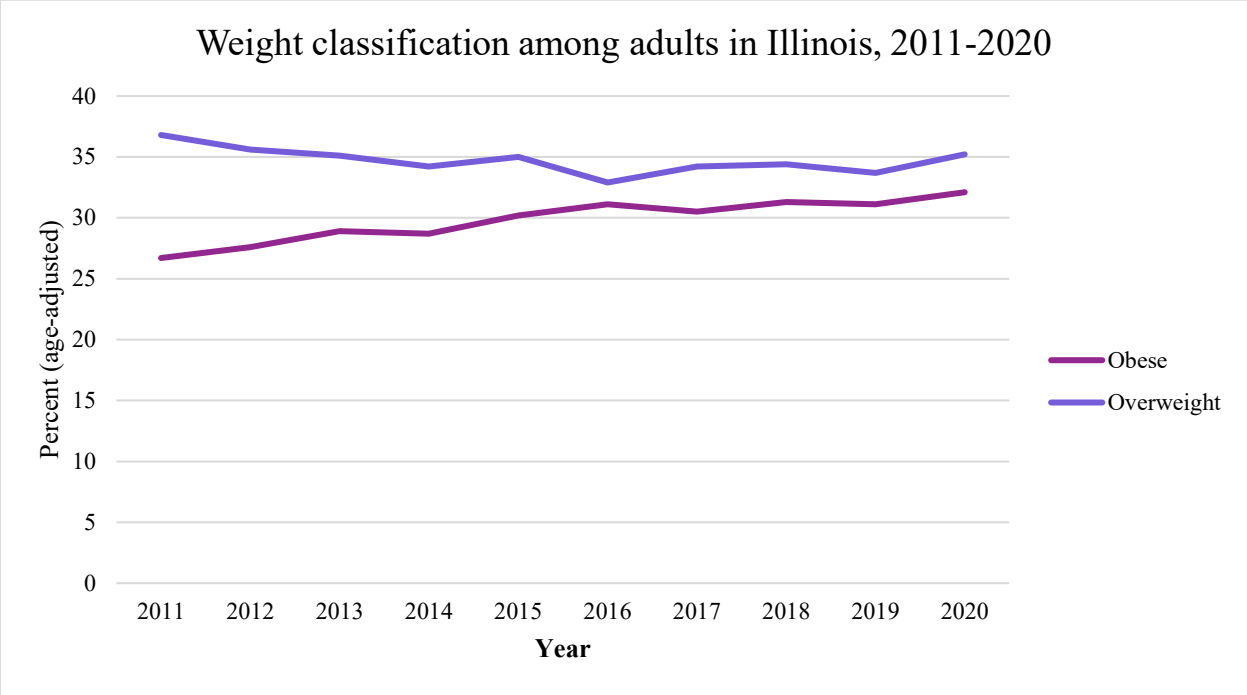


Table 5 provides county-level metrics assessing obesity among the Tri-County region. Additional information on how these are measured is provided below.

Table 5. County-level Obesity Metrics

Metric	Peoria	Tazewell	Woodford	Illinois	US
Adults obese	39%	33%	32%	32%	32%
High school students who had obesity	14%	13%	9%	15%	16%

Adults obese is measured by the percentage of the adult population (age 18 years and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m^2 (age-adjusted) using data from 2019 Behavioral Risk Factor Surveillance System (BRFSS).

High school students who had obesity is measured by the average proportion of students (8th-12th grade) who were overweight or obese based on BMI categories using data from the 2019 Youth Risk Behavior Survey (YRBS). Woodford County only had responses for 8th graders, which could impact results reported.

National Goals

Table 6 provides a description of obesity-related goals for Healthy People 2030.

Table 6. Healthy People 2030 Goals Related to Obesity

Description	**Baseline**	**Target**
Obesity		
Proportion of children and adolescents with obesity [1]	17.8	15.5
Proportion of adults with obesity [1]	38.6	36.0
Proportion of health care visits by adults with obesity that include counseling on weight loss, nutrition, or physical activity [2]	24.8	32.6
Proportion of women who had a healthy weight before pregnancy [3]	42.1	47.1

[1] Data source: 2013-2016 National Health And Nutritional Examination Survey (NHANES)
[2] Data source: 2016 National Ambulatory Medical Care Survey (NAMCS)
[3] Data source: 2018 National Vital Statistics System (NVSS-N)

Gaps and barriers

Awareness/Education

Improving the overall knowledge of obesity would be helpful in reducing the prevalence of obesity in the Tri-County region. In addition to providing education on factors that are related to obesity, increasing awareness to reduce stigma related to obesity would be beneficial. Ensuring that media campaigns and other materials distributed use language that is non-stigmatizing has been shown to benefit health outcomes [17-18]. Primary prevention strategies, such as developing educational campaigns on obesity including a variety of communication modes such as social media and written materials disseminated throughout the community could help reduce the prevalence of obesity over time in the community [19].

Screening programs

In regards to improving secondary prevention measures, promoting screening programs in the community to identify those who may be at risk for obesity-related complications would be an effective way to improve weight status in the community. In fact, the U.S. Preventive Services Task Force (USPSTF) recommends that healthcare providers screen all individuals over 6 years of age for obesity.

Offering self-management programs that encourage healthy nutrition and/or physical activity would also help reduce obesity in the community [20-21]. One additional way to do this is the use of Community Resource Specialists, who can provide referrals to local resources to help individuals achieve sustainable lifestyle changes. These referrals may include programs such as support groups or appropriate medical resources in the community.

Access to care

In order to address gaps in all prevention strategies, improving tertiary prevention such as access to care is essential in reducing morbidity and mortality related to obesity. In particular, enhancing access to appropriate medical care is essential in improving weight status among community members. Adults with obesity and other co-occurring chronic conditions often need weight management support in order to improve weight status. Therefore, increasing the number of individuals engaged in weight management services is important to address this health priority. Bariatric surgery, commonly referred to as weight loss surgery has been found to significantly reduce morbidity and mortality among individuals with high BMI [22-25]. Moreover, bariatric surgery results in greater improvement in weight loss outcomes and weight associated comorbidities compared with non-surgical interventions, regardless of the type of procedure performed [26-28].

Metrics to assess obesity

Measuring the **reach** of the programs provided and the associated **outcomes** would be valuable to understand changes occurring in the community. The following things can be used to measure the improvement of weight status.

Reach

- Number of individuals attending meetings or trainings related to obesity
    - When each meeting/class is offered including time of day and day of the week
- Number of individuals engaged with social media posts or other media releases
- Number of individuals screened for obesity/overweight
- Number of people who are obese/overweight and seen by weight management specialists
    - Proportion of individuals who are provided pharmacotherapy, psychological and behavioral interventions
    - Proportion of individuals who qualify and undergo bariatric surgery

If healthcare data is available, the following CPT and ICD-10 codes can be used to assess changes in these numbers in the community.

- Office or outpatient evaluation (E/M): 99201-99215
- Preventive medicine counseling: 99401-99404, 99411, 99412
- Obesity counseling: G0447
- Obesity (CPT) code: E66.9, E66.01 (often in conjunction with Z71.3, Z00.00)
- Bariatric surgery (CPT code): 43770-43775

Outcomes

- Changes in annual survey data (public health department or national surveillance systems)
    - Number of adults in the region who are obese/overweight
    - Number of children and adolescents in the region who are obese/overweight
- Pre- and post-evaluations for any meetings, trainings, and educational programs provided in the community

APPENDICES

WEIGHT STATUS AMONG SURVEY RESPONDENTS

	Not overweight (n=665)		Overweight (n=561)		
	n	**%**	**n**	**%**	**p-value**
Gender					**<0.01**
Male	178	27.68	99	18.00	
Female	310	48.21	317	57.64	
Non-binary, transgender	155	24.11	134	24.36	
Age					**<0.01**
Under 20 years old	12	1.85	7	1.26	
Between 21-35 years old	143	22.10	85	15.29	
Between 36-50 years old	207	31.99	181	32.55	
Between 51-65 years old	184	28.44	187	33.63	
Over 65 years old	101	15.61	96	17.27	
Sexual Preferences					0.47
Heterosexual	566	85.11	468	83.42	
Lesbian, Gay, Queer, or Bisexual	34	5.11	38	6.77	
Prefer not to answer or missing	65	9.77	55	9.80	
Race/ethnicity					0.96
White/Caucasian	584	89.98	500	90.42	
Black/African American	36	5.55	30	5.42	
Other	29	4.47	23	4.16	
Education status					0.72
Some high school, GED, or High School Diploma	91	13.96	66	11.89	
Some college	195	29.91	197	35.50	
Bachelors or Graduate Degree	366	56.13	292	52.61	
Household income					0.57
Less than $20,000	56	9.03	28	5.19	
Between $20,001-$40,000	79	12.74	101	18.74	
Between $40,001- $60,000	101	16.29	85	15.77	
Between $60,001-$80,000	95	15.32	98	18.18	
Over $80,001	289	46.61	227	42.12	
Housing Stability					**<0.01**
Homeless	26	4.04	7	1.25	
Unstable Housing	38	5.91	43	7.76	
Stable Housing	579	90.05	504	90.97	

County					**<0.01**
	Peoria	266	40.00	199	35.47
	Tazewell	184	27.67	205	36.51
	Woodford	215	32.23	157	27.99

Other for race/ethnicity includes: Hispanic/LatinX, Pacific Islander, Native American, Asian/South Asian, Multiracial

For nominal variables, chi-square tests were performed. The null hypothesis for that is there is no difference between the distributions in the categorical variable by weight status. Since the alpha level was set to 0.05, we would reject the null hypothesis and conclude that there is a statistically significant difference between the demographic variable of interest and weight status when the p-value was less than 0.05.
For ordinal variables, Cochran Armitage test for trend was conducted. The null hypothesis is of no trend, which means that the proportion in each level by weight status is the same for all levels of the demographic variables tested. Using the same alpha level of 0.05, a two-sided p-value of less than 0.05 would indicate rejecting the null, indicating that there is a statistically significant difference (either increasing or decreasing) in the proportion for the demographic ordinal variable on weight status.

Summary:

There are significant differences in gender, age, housing stability, and county of residence by weight status ($p<0.05$). In particular, those who are female, older in age, lived in Tazewell County, or reported unstable housing more often report being overweight. Moreover, those who were homeless more often reported they were not overweight.

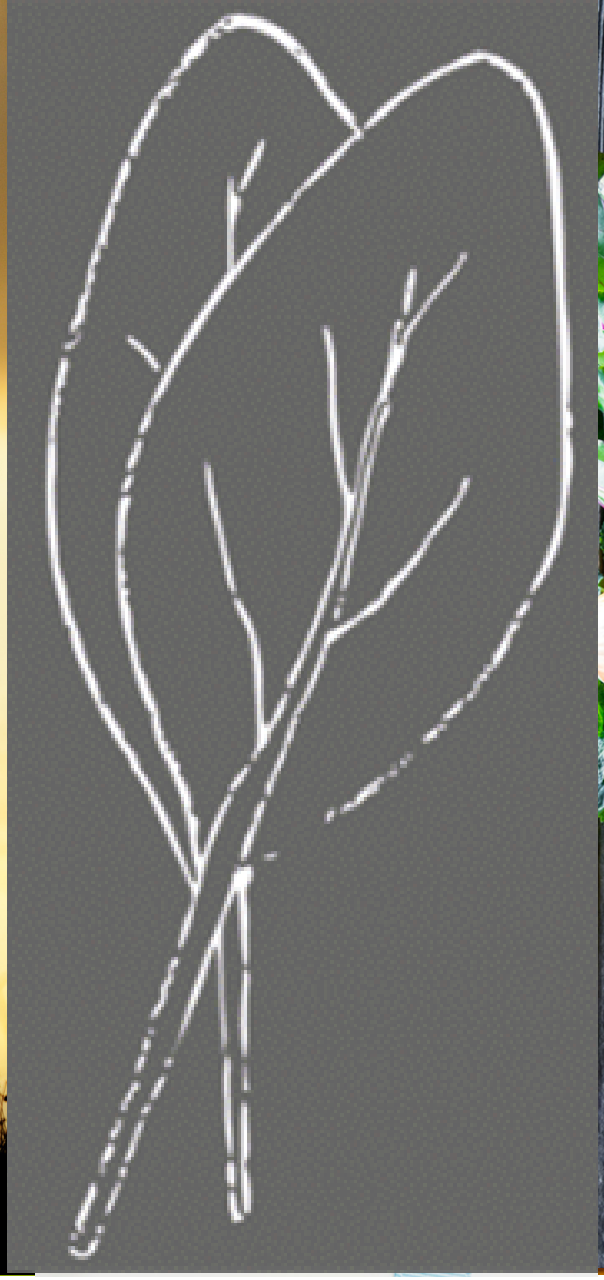
WEIGHT STATUS BY REGION

	Not overweight (n=439)		Overweight (n=385)		
Location	**n**	**%**	**n**	**%**	**p-value**
Peoria					0.65
Peoria/West Peoria	88	33.98	62	33.33	
North Peoria/Peoria Heights	86	33.20	62	33.33	
Bartonville/Limestone	20	7.72	22	11.83	
South West Peoria County	19	7.34	9	4.84	
North West Peoria County	22	8.49	13	6.99	
North East Peoria County	24	9.27	18	9.68	
Tazewell					0.88
North Tazewell County	75	41.67	90	45.23	
South Tazewell County	22	12.22	21	10.55	
East Tazewell County	31	17.22	31	15.58	
West Tazewell County	52	28.89	57	28.64	
Woodford					0.72
East Woodford County	75	58.59	90	63.38	
Central Woodford County	22	17.19	21	14.79	
West Woodford County	31	24.22	31	21.83	

Chi-square tests were performed, exact chi-square when indicated by small numbers. The null hypothesis for that is there is no difference between the distributions in the region by weight status. Since the alpha level was set to 0.05, we would reject the null hypothesis and conclude that there is a statistically significant difference between the region and weight status when the p-value was less than 0.05.

Summary:

No regional differences were detected in the Tri-County region for weight status among residents.



PARTNERSHIP FOR A HEALTHY COMMUNITY

2022 ANNUAL REPORT

Partnership for a Healthy Community

healthyhoi.org

WWW.HEALTHYHOI.ORG

2022 Board Members

Amy Fox, Chair
Tazewell County Health Department

Sally Gambacorta, Vice-Chair
Carle Eureka Hospital

Hillary Aggertt
Woodford County Health Department

Phil Baer
OSF Healthcare, Saint Francis Medical Center

Holly Bill
Hult Center for Healthy Living

Amelia Boyd
UnityPoint Health

Ann Campen
Tazwood Center for Wellness

Beth Crider
Peoria Regional Office of Education

Lisa Fuller
OSF Healthcare, Saint Francis Medical Center

Kate Green
Home for All Continuum of Care

Monica Hendrickson
Peoria City/County Health Department

Tricia Larson
Tazewell County Board of Health

Craig Maynard
Eureka College

Nicole Robertson
American Cancer Society

Chris Setti
Greater Peoria Economic Development

Adam Sturdavant
OSF Medical Group - Pediatrics

Larry Weinzimmer
Bradley University

Jennifer Zammuto
Heart of IL United Way

Partnership for a Healthy Community

On behalf of the Partnership for a Healthy Community, I am pleased to present the 2022 Annual Report.

In 2022, the Partnership for a Healthy Community (PFHC) completed our third year of the three-year cycle. I thank board members who completed their 3 year cycle and welcome new team members for the upcoming cycle.

The PFHC saw continued challenges in 2022 as many meetings continued virtually, as in person opportunities were irregular due to the rates of COVID transmissions within our counties. Initiatives continued within our partnership to address the health priorities of Peoria, Tazewell, and Woodford counties, even with these ongoing challenges.

I would like to especially thank our Priority Team Leaders for their commitment and enthusiasm for creating a healthier Tri-County.

The PFHC Board is proud of the work of our Action Teams and looks forward to tackling the challenges ahead of us as a partnership.

Amy Fox

Amy Fox, Chair

Partnership for a Healthy Community
healthyhoi.org

Executive Summary

The successful adoption of the 2020-2022 Community Health Improvement Plan (CHIP) demonstrated the capacity and sustainability of the Partnership's multi-sector approach in addressing health within the Tri-County. In 2021 & 2022, the Partnership for a Healthy Community continued to address priority health concerns, while beginning to collect data and assess health priorities in a new Community Health Planning cycle.

Priority Teams for the 2020 - 2022 cycle worked with many challenges due to the pandemic. Their outstanding cooperation and collaborative efforts are highlighted in this report.

Highlight: *2020-2022 CHNA/CHIP*

The Partnership for a Healthy Community (PFHC) continued to monitor and implement strategies identified in the 2020-2022 Community Health Improvement Plan (CHIP).

Several highlights of the past year include the formalization of a performance management system for priorities that are not moving forward as a top 3 issue. The areas of Cancer and Substance Use are acknowledged as vital to follow into the new CHIP and will now be in the performance management system.

Mental Health

Improve mental health among tri-county residents through preventative strategies and increased access to services.

The Mental Health Action Team strived to improve mental health through a variety of evidence based strategies outlined in the Implementation Plan. During 2022, the Action Team continued to hold bi-monthly meetings with the Substance Use Action Team. Priority Action Teams were formed in an effort to make further progress towards meeting objectives. Priority Action Teams met monthly, and as needed, reported progress on a regular basis to the Board.

The Mental Health Action Team worked to improve the following mental health objectives:

Objective #1: (HP2020) By December 31, 2022, decrease the number of suicides in the Tri-County area by 10%.
Objective #2: (HP2020) By December 31, 2022, decrease the number of residents in the Tri-County area who reported feeling depressed or anxious in the past 30 days by 10%.

In 2022, four Priority Action Teams continued to meet in an effort to further progress towards meeting objectives:

*This list continues to change

* **Active Organizations:**
AMT
Bob Michel Community-Based Clinic
Carle Health
Gateway Foundation
Heart of Illinois United Way
Heartland Health Services
Home for All Continuum of Care
Hult Center for Healthy Living
Methodist College
NAMI Tri-County Illinois
Peoria City/County Health Department
Peoria County Sheriff's Office
Peoria Police Department
Prairie State Legal
Tazewell County Health Department
Woodford County Health Department
Peoria Public Schools
Peoria Regional Office of Education
OSF Resource Link
OSF Healthcare, St Francis Medical Center
UnityPlace
UnityPoint Health - Central Illinois

Priority Action Team: Mental Health First Aid

Mental Health First Aid is a skills-based training course that teaches participants about mental health and substance use disorders. The Tri-County Mental Health First Aid Cadre remains strong. The 10 cadre MHFA trainers have continued to provide mental health trainings throughout the central Illinois area.

In 2022, the cadre has added several new members and increased services to include Marshall and Stark counties. The cadre is continuing to form new partnerships and strengthen existing partnerships.

Funding to continue MHFA trainings is a concern, as partners rely heavily on grants and local sources to be able to provide the training at a free or reduced cost. The Tazewell County Health Department received a grant to help with funding for teen MHFA instructor certification. Carle Eureka Hospital received a grant to assist in providing free classes to our service area with inclusion of surrounding rural areas.

Several of our members have added additional training certifications that were identified as a need for our community, including public safety, rural, and military/veterans. The goals for the next year are to continue providing trainings with the addition of specialized courses for the specific populations (EMTs, fire/police, etc.). The cadre is also working to offer a teen certification program and provide continuing education credits for licensure.

To inquire about a Mental Health First Aid Training for yourself or your team, please visit www.healthyhoi.org.

The Mental Health Action Team was highly successful in 2022 through the efforts of the newly-formed **Mental Health First Aid (MHFA) Cadre**.

The cadre was established in October 2020 in an effort to:

- Increase the number of community members who are certified in Mental Health and Youth Mental Health First Aid
- Increase the number of MHFA trainers in our tri-county area
- Increase the number of free and low-cost trainings available Provide a pool of MHFA trainers to learn and assist each other

Mental Health FIRST AID

from NATIONAL COUNCIL FOR MENTAL WELLBEING

2,314

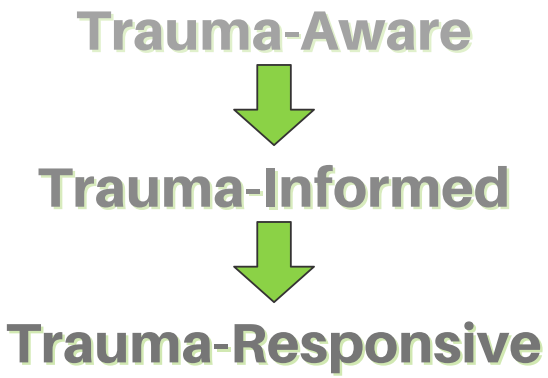
Tri-county residents certified in Mental Health First Aid

1/1/22-12/31/22 data

Priority Action Team: Trauma-Informed Schools

The Peoria Regional Office of Education (ROE) SEL Hub Coach has supported around 70 schools in Area 3 for the school year 2022-23. Area 3 encompasses the Tri-County area and beyond. Currently within Peoria County, there are 17 partner schools with an additional four schools beginning their full coaching partnership with the ROE within the next month bringing the total of schools accessing trauma-related coaching support to 21.

Charter Oak, Elmwood High School, and Pleasant Hill Elementary were recognized as trauma-responsive and continue to implement strategies designed after their pre-assessment and the coaching support provided by the ROE SEL Hub Coach to create healthier school environments for their students and staff. The sub-committee will continue to monitor all the schools' efforts and provide recognition once post assessment data has been shared.



Priority Action Team: Mental Health Provider Rate

Increase the mental health provider rate in providers per 100,000 population.

2019 Baseline	2022 Rate
450: 1 Peoria	370: 1 Peoria
570: 1 Tazewell	490: 1 Tazewell
3,870: 1 Woodford	2,930: 1 Woodford

Priority Action Team: Suicide Prevention

The Suicide Prevention Priority Action team met monthly throughout 2022 to look through data and make recommendations for the larger committee.

Suicide Prevention

The Suicide Prevention Workgroup included members from the VA Bob Michel Community Based Outpatient Clinic, Hult Center for Healthy Living, OSF Healthcare Saint Francis Medical Center, UnityPoint Health and our local health departments. The team is in the process of designing suicide prevention toolkits to upload to the website that provides resources for schools, clinicians, and veterans, to name a few. This will drive more traffic to the website and utilize social media platforms to educate the community on the Partnership and the toolkits. Our team receives updated local data from Tazewell County Health Department to keep us informed.

Suicide Prevention Education

In addition to providing school-based suicide prevention education in the classroom setting, an effort was made to increase knowledge and skills among medical student, medical residents, and medical providers throughout our communities. In 2022, a total of 158 medical residents and providers participated in the QPR Suicide Prevention Gatekeeper Training. This 2-hour evidence-based training provide three simple steps to navigate the conversation of suicide and refer someone to get help.

Substance Use

Reduce substance use to protect the health, safety, and quality of life for Tri-County residents.

The Substance Use Action Team strived to reduce substance use through a variety of evidence-based strategies outlined in the Implementation Plan. During 2022, the Action Team continued to hold bi-monthly meetings with the Mental Health Action Team. Priority Action Teams were formed in an effort to make further progress towards meeting the objectives. Priority Action Teams met monthly, and as needed, and reported progress on a regular basis.

The Substance Use Action Team worked to improve the following objectives:

Objective #1: (HP2020) By December 31, 2022, reduce the rate of drug-induced deaths within the Tri-County region by 10%.
Objective #2: (HP2020) By December 31, 2022, increase the proportion of adolescents reporting never using substances in the Tri-County area by 5%.

In 2022, four Priority Action Teams continued to meet in an effort to further progress towards meeting objectives:

Priority Action Team: Peer Educator Trainings

A plan is in place to increase the number of high school students who become

Certified Peer Educators

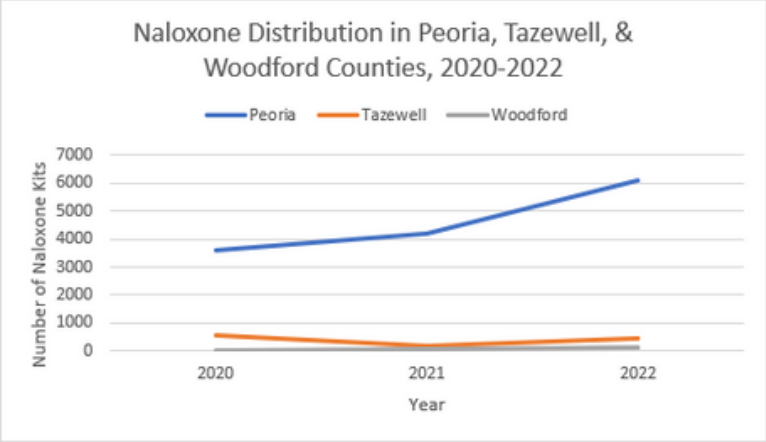
A new approach to health promotion to empower peers to live heathier lives

In 2022, 15 high school students were trained to become Certified Peer Educators, or CPEs. Certified Peer Educators are trained to implement health education and school-wide health events for their school campuses. Students have helped to implement health fairs, promote health services, and distribute health messaging throughout their schools. CPE training is offered by Hult Center for Healthy Living. Students become certified by completing 8 in-person training modules followed by a certification exam. Learn more about this certification training at www.hulthealthy.org or by emailing info@hulthealthy.org.

Priority Action Team: Stable Housing & Narcan Distribution

Stable Housing

Madison II was brought online by Phoenix Community Development Center (CDS). It includes 24 new units of housing. Work continued on the development at the old Methodist College of Nursing site. Several capital commitments have been made and Phoenix CDS is working to secure the remaining funding for a 2024 rehab. They are also working to close on Madison III which will focus on youth experiencing homelessness and will include an additional 16 units.



Narcan Distribution

In 2022, Naloxone (Narcan) distribution and harm reduction efforts continued to increase in the Tri-County region. At the end of the 2020-2022 CHIP cycle, naloxone distribution trends in the positive direction in all three counties. As harm reduction efforts continue in 2023-2025, this upward trend should continue. UnityPlace and JOLT Harm Reduction regularly train Tri-County residents in the administration of Narcan, how to recognize the signs of overdose, and educate to reduce stigma around persons who use drugs. 230 Tri-County residents were trained on how to save a life using Naloxone in 2022. The Partnership Substance Use group hopes to continue collaboration with our community partners through outreach events to reduce the harm of substance use and increase access to recovery resources. Learn more about administering Naloxone to save a life at https://www.unitypoint.org/peoria/overdose-education.aspx

Healthy Eating Active Living

Foster and promote healthy eating and active living to reduce chronic disease and food insecurity in the tri-county area.

Funding for the HEAL Food System Partners is provided, in part, by Community Foundation of Central Illinois.

4,847 Facebook reaches
201 Facebook engagements
19 Facebook posts

Integrated Referral and Intake System (IRIS)

65 One Time Food Deliveries ~serving 106 adults & 64 children
175 Food Resource Referrals

Food Pantry Network - HOI

Food Pantry Network (FPN) – HOI recognized as having taken an innovative approach to reach limited resource audiences and create programs with the goal of improving health and serving their communities.

FPN-HOI meets bi-monthly meetings to address trends, challenges, and network with organizations similar in nature. Additionally, their advisory board selects topics and plans training opportunities to enhance the knowledge and skills of those within the emergency food system. This year, they hosted a trauma and food conference, food safety conference, connecting to local produce meeting with Community Garden Network, client dignity and nutrition education.

Mobile Pantry

Six monthly mobile pantry events were held from May to October featuring Latin inspired products and recipes with nutrition education. 277 cars drove through, each representing multiple households with over 650 children served.

Over 75% of participants identified as Hispanic and almost half had someone in the household with a cardiometabolic condition like diabetes or hypertension. Latin inspired staple items included masa, rice, beans, and dried chiles. Featured produce for different recipes included zucchini, tomatoes, fresh corn, cilantro, avocado, and limes.

Healthy Eating Active Living

Hunger Action Month - Hunger Walks

Our inaugural 2022 Tri-County Hunger Walks also corresponded with Hunger Action Month, as the Walks and Wear Orange Day taking place on Hunger Action Day: Friday September 23 @ 6:00pm.

Three walk locations across the Tri-County took place on the same day/time. Educational yard signs were developed and placed along the walk at each site to raise awareness about hunger locally. A Hunger Walk Logo was developed, and T-shirts made for volunteers. Proclamations were coordinated with local cities and counties and read at each event, as well as at the perspective counties 1st board meeting of September. The entry fee for each Walk was one healthy, shelf-stable food item per walker and all food was donated to the local pantries. A Shopping List for donations was developed by HEAL-FSP around Healthy Eating Research guidelines and input from our local pantries. Donations were collected from area businesses/organizations and Hunger Walk Swag Bags were handed out to all walk participants containing various items and resources available throughout the Tri-County.

Community Garden Network - GIS Mapping

The GIS mapping allows users to see where a garden is located and if it is open to the public or not. Currently, we have 19 garden locations and working on 4 others to be added soon. The way the gardens operate varies - half are used by an organization to educate and provide for clients/members. The other half are to be used by anyone who needs food. We hope to add more each year. Tri-County Gardens Interactive Map is available at arcgis.com

Helpful and encouraging tips for integrating healthy habits into our daily lives by adding 10- minute movement breaks for 12 weeks

#MOVEIT MONDAYS

Social media graphics and messages were shared by HEAL partners

Eatable Alphabet

3 Head Start sites participated in 4 weeks of the Eatable Alphabet Curriculum October to November. PCCCEO donated the food supplies for teaching sessions and Bradley Dietetic Interns and UICOMP medical students taught lessons. The alphabet activity cards feature foods that start with each letter. They guide a preschool aged child through activities in order to taste, prepare and experience foods. 97 to 121 children and 5 to 15 caregivers participated in 4 lessons.

5-2-1-0 Pilot

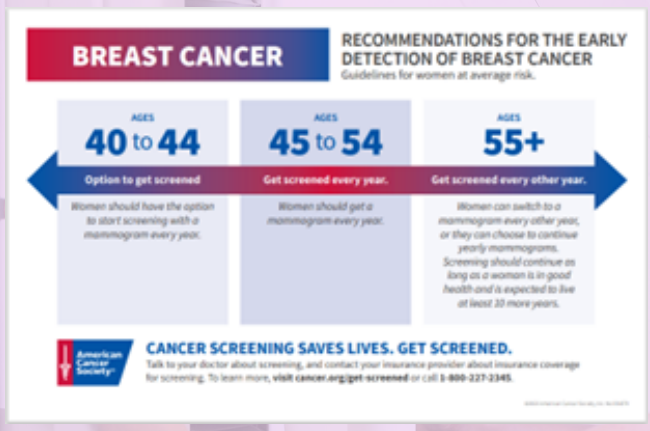
5 servings of fruits & vegetables * **2** or less hours of recreational screen time and healthy sleep habits * **1** hour or more of physical activity * **0** sugary drinks, more water and low-fat milk

A collaborative team comprised of OSF Healthcare, University of Illinois College of Medicine Staff and Medical Students, University of Illinois Extension SNAP-Ed & Tazewell County Health Department spearheaded this effort. The developed curriculum was implemented as a one-hour activity station format at St Ann's Garden of Hope in Peoria and as a 5 lesson (1 hour each) format with 2 groups at the YMCA in Peoria, 1 group at Marquette Heights School in Marquette Heights and 1 group at Wilson Intermediate in Pekin. ***Watch for more details: go.illinois.edu/5210video***

Cancer

Reduce the illness, disability and death caused by lung, breast, and colorectal cancer in the tri-county area.

The objectives included reducing age-adjusted death rate by 1% for all three cancers. The past three years had some unique challenges for this team due to the COVID pandemic and the subsequent disengagement from elective healthcare that accompanied efforts to slow the spread of the virus. With this in mind, a large percentage of our efforts were devoted to educating our community on the need to continue screening for cancer during this unique time. Screenings did return to pre-COVID levels by the end on this three-year cycle and in the case of lung screening far exceed previous levels due to the funding from the Edwards Settlement Grant.



Breast Cancer

UnityPoint Health and OSF Healthcare, Saint Francis Medical Center have seen an increase in patients at high-risk breast clinic.

UnityPoint Health

14,980 screening mammograms
16 screening events

OSF Healthcare

22,672 screening mammograms
36 screening events

American Cancer Society:

Patient Support Grants-
Transportation (UPH + OSF)
- 6,220 one-way rides provided
- 105 patients served

Lodging (OSF)
- 375 nights provided
- 119 patients served

Lung Cancer

The Edwards Settlement Grant targets Peoria and Tazewell County to provide equity in 61554, 61610, 61611, 61605, and 61607 zip codes.

- 4,111 students were educated
- 298 health kits were provided to students with breathing issues
- 20,326 adults educated on lung health
- 1,434 LDCT screenings for lung issues
- 238 breathing tests completed
- 37 home radon mitigation systems installed
- 59 Healthy Homes interventions for air quality

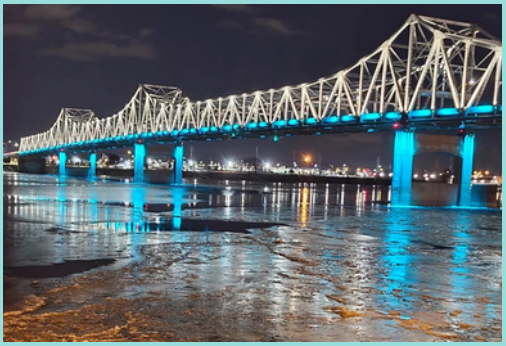
Cancer

Colorectal Cancer

UnityPoint screened 77.1% of the eligible population (45-75 yo)
TOTAL - 25,811
OSF Healthcare screened *(waiting for figures)*

Cervical Cancer

·UnityPoint Health screened 50.1% of patients (21-64 yo women)
TOTAL 8,749



Murray Baker Bridge lit teal for awareness of Cervical Cancer Month in January.
Total Facebook Impressions = 25,085

January is Cervical Cancer Awareness Month

- Multiple organizations/businesses lit up in teal
- Murray Baker Bridge illuminated teal for 5 days

Tobacco

The Illinois Tobacco Free Communities (ITFC) grant continues to promote new or updated polices in the Tri-County area. An addition to the grant this past year was reaching out to businesses and restaurants covered under the 2008 Smoke Free Illinois Act, encouraging owners to add e-cigarettes, and vaping to their policies. A rack card was designed and distributed to promote this new grant deliverable.

Events, outdoor spaces, campuses, and multi-unit housing continue to be the focus of the ITFC grant with 6 new polices since July 2021. In total 58 tobacco-free policies have been created for the Tri-County ITFC grant.

Funds for Illinois Tobacco-Free Communities is funded, in part, by Illinois Department of Public Health.

2023-2025

Community Health Needs Assessment & Improvement Plan

The Partnership for a Healthy Community spearheaded a collaborative approach in conducting a Community Health Needs Assessment for the Tri-County region. The Partnership for a Health Community is a multi-sector community partnership working to improve population health. The Partnership for a Healthy Community formed an ad hoc committee creating a collaborative team to facilitate the community health needs assessment.

The Community Health Needs Assessment (CHNA) was used to assist in identification of health concerns and included primary and secondary data from a variety of sectors and community survey on perception. Multiple organizations, sectors, and the public participated in population health planning to identify and prioritize health needs and quality of life issues, map and leverage community resources, and form effective partnerships to implement health improvements stategies in Peoria, Tazewell and Woodford Counties.

Mental Health

Improve mental health among tri-county residents through preventative strategies and increased access to services.

Healthy Eating & Active Living

Foster and promote healthy eating and active living to reduce chronic disease and food insecurity in the tri-county area.

Obesity

Reduce the illness, disability and death caused by obesity.

The Partnership for a Healthy Community (PFHC) recognizes that to impact true change, the work of those involved needs to be open and available to the communities we serve. Our goal of transparency and accountability is to create an informed public, support collaborations, and provide a platform for engaging a variety of stakeholders.

The WWW.HEALTHYHOI.ORG website offers updated information on meetings, projects, and supports innovation and partnerships. Features include discussion boards, centralized Action Team areas, and routine reporting.

The PFHC continues to seek additional partners, agencies, and those with lived experiences to join the initiative to continue our vision for a thriving community that is inclusive, diverse, and sustainable to ensure health equity and opportunity for well-being for all.


Partnership for a
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