Community Health Improvement Plan

Carle Health Greater Peoria

2023-2025

Contents

A Collaborative Approach to Community Health

Carle Health Greater Peoria is a nonprofit hospital system serving the Central Illinois community. As our mission states, we are your trusted partner in all healthcare decisions. Our vision is to improve health by providing highly accessible, world-class care and services. Our dedicated teams across Central Illinois understand that to improve the quality of life for individuals in our communities we must deeply understand the greatest health needs of our communities and the people we serve. We must understand our patients' needs beyond the clinical environment so that we better understand patients' barriers to achieving optimal health. We also know that we must work together as a community to address the unique social determinants of health and health related social needs that continue to have a significant impact on health outcomes.

To accomplish this, Carle Health Greater Peoria partners with Partnership for a Healthy Community (PFHC) and trusted community partner agencies to complete a Tri-County Community Health Needs Assessment (CHNA) every three years. PFHC is a community-driven partnership that includes members from Bradley University, Carle Health, Heartland Health Services, OSF St. Francis Medical Center, Peoria City/County Health Department, Tazewell County Health Department, and Woodford County Health Department, in addition to many community partner agencies.

The 2022 CHNA provided detailed data about our community, defined as Peoria, Tazewell, and Woodford counties, and the health of our community members using primary and secondary sources. It is important to note that primary data was received from persons who represent broad interests of the community including residents from each of the three counties and its 13 identified regions. Respondents included residents from diverse backgrounds including at-risk populations (people living in shelters, utilizing food pantries and soup kitchens) and residents with expertise in health and public health.

Prioritization of the most concerning health issues was completed in a collaborative approach with PFHC and community partners on May 24, 2022. Over 50 individuals from various community sectors attended the prioritization meeting and ranked each of the six most concerning health issues. Ranking scores considered 1) the magnitude of the health issues (i.e. how many people are impacted by the health issue); 2) the severity of the health issue in terms of morbidity and mortality, and 3) the potential impact that can be made through strategic interventions and mobilizing community partnerships. Six health areas were presented and scored during this collaborative meeting. Those were Access to Care, Cancer, Healthy Eating Active Living (HEAL), Mental Health, Obesity, and Substance Use.

Approval of Priority Health Issues

Three priority health issues emerged from the 2022 Tri-County Community Health Needs Assessment and prioritization efforts:

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

The remaining three priorities (Access to Care, Cancer, and Substance Use) were not selected as top health priorities at the community prioritization meeting. It is important to note that while these were not chosen as priority concerns for the 2023-2025 cycle these three health areas will be incorporated within the 2023-2025 CHIP strategies and/or through Performance Management as a continuation from the 2020-2022 cycle. Access to Care is included as a key strategy within the Mental Health priority.

Our teams will continue efforts from the previous Community Health Improvement Plan (CHIP) to improve Cancer through Performance Management efforts. Refer to the Appendix for Cancer strategies listed under Performance Management.

Carle Health Greater Peoria chose to align the 2023-2025 Community Health Improvement Plan (CHIP) directly with Partnership for a Healthy Community's CHIP and adopt the three same prioritized health issues. We will also continue to support improved cancer outcomes through performance management efforts. Our team strongly believes that this choice will lead to a greater community impact.

The Board of Trustees, formerly Methodist Health Services Corporation (MHSC), reviewed and approved the three priority health issues on August 25, 2022. The 2023-2025 Community Health Improvement Plan (CHIP) outlines the adopted implementation strategy to address the three priority health issues and was adopted/approved by the Carle Health West Region Board on April 27, 2023.

Carle Health's Mission, Vision, & Values

Mission

Carle Health's mission is to be your trusted partner in all healthcare decisions.

Vision

Our vision is to improve health by providing highly accessible, world-class care and service.

Values

As an organization we all work together to practice and uphold the organizational values:

- Excellence: We're committed to being the very best in all we do.
- Integrity: We're grateful for the trust placed in us by those we serve, and we always strive to do the right thing.
- Inclusivity: We welcome, respect and value every individual.
- Compassion: We seek to understand and empathize with others.
- Accountability: We take ownership of everything we do in a way people can count on.

Community Benefit

Implementation Plan Summary

Healthy Eating Active Living (HEAL)

Carle Health Greater Peoria Lead Departments: Wellness Center // Employee & Corporate Wellness

Other Departments/Resources Involved: Family Medical Center (FMC), Methodist College, Hult Center for Healthy Living, Optimum Health Solutions, Pediatric Providers, School-Based Health Centers, WellMobile

Identified Need: Healthy Eating Active Living, or HEAL, is defined in the CHNA as having healthy eating and active living and access to food and food insecurity. HEAL was identified as a priority health issue for the Tri-County communities. Nearly 70% of survey respondents from the CHNA reported eating less than 3 servings of fruits and vegetables in a day and this same source notes that more than half of tri-county residents reported that they do not engage in physical activity for at least 30 minutes at least 3 times per week. Males and those who were younger reported eating less fruits and vegetables per day as with those who were Black/African American, has lower education, and lower household income; specifically, Peoria and West Peoria regions. Exercise was rated lower for residents in the Eastern Woodford County region. 2.4% of survey respondents reported they or their family were hungry in the past week. Hunger, or food insecurity, tended to be higher among homeless individuals or those with unstable housing. Hunger was less common among those who were White, had higher educational attainment, and higher household income.

HEAL Implementation Plan Highlights: For the complete CHIP please refer to the Appendix.

> **Goal:** Improve overall healthy eating and physical activity in the Tri-County Region.
>
> **Objective 1:** By December 31, 2025, increase accessibility of healthy food in the Tri-County Region through the support of community gardens by 10%. *(Baseline: TBD)*
>
> **Objective 2:** By December 31, 2025, increase adults reporting exercising 1-5 days a week among the Tri-County Region by 1*%. (Baseline: 28% of adults reported no exercise at all; 2022 CHNA)*
>
> > **HEAL Strategy 1:** Support Tri-County Partnership for a Healthy Community's (PFHC) CHIP efforts: Gardening Interventions and Social Support Interventions.
> >
> > **HEAL Strategy 2:** Increase HEAL education and fitness opportunities for youth.
> >
> > **HEAL Strategy 3:** Increase physical activity among adult residents and staff.

Target Populations: Males and those who were younger reported eating less fruits and vegetables per day as with those who were Black/African American, lower education, and lower household income; specifically Peoria and West Peoria regions. Exercise was rated lower for residents in the Eastern Woodford County region. Hunger was higher among homeless individuals or those with unstable housing. Hunger was less common among those who were White, had higher educational attainment, and higher household income.

Mental Health

Carle Health Greater Peoria Lead Departments: Trillium Place

Other Departments/Resources Involved: Family Medical Center (FMC), Compliance Department, Human Resources, Hult Center for Healthy Living, Optimum Health Solutions, Nutrition and Dietetics

Identified Need: The 2022 Community Health Needs Assessment (CHNA) noted that "good" mental health fell over 73% among respondents from 2016 to 2022. This same source notes that reports of anxiety and depression doubled since the last assessment, and challenges to staying mentally healthy 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 of resources, lack of providers and diverse providers (people of color, multiple languages, LGBTQ+ friendly), lack of inpatient beds, lack of money, and lack of transportation.

Mental Health Implementation Plan Highlights: For the complete CHIP please refer to the Appendix.

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

Objective 1: 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 Tri-County 2015-2018 HCI Conduent)*

Objective 2: 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%. *(Baselines: 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 HCI Conduent; and % of respondents that indicated they spoke to someone about their mental health in the last 30 days- 40% 2022 CHNA)*

MH Strategy 1: Support Tri-County Partnership for a Healthy Community's (PFHC) CHIP efforts: Culturally Adaptive Health Care and Telemedicine.

MH Strategy 2: Increase access to comprehensive behavioral health services, care coordination, and resources and supports.

MH Strategy 3: Increase mental health prevention education and awareness to improve mental health.

Target Populations: According to the Community Health Needs Assessment, those who reported having a mental health condition were more often younger, LGBTQ+, with lower household income and had unstable or no housing. Those with lower educational attainment more often reported below average mental health. Peoria respondents more often reported a mental health condition. Woodford residents had the lowest proportion of residents reporting a mental health condition. 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.

Obesity

Carle Health Greater Peoria Lead Departments: Clinic Operations

Other Departments/Resources Involved: Family Medical Center (FMC), Hult Center for Healthy Living, Optimum Health Solutions, Pediatric Providers, School-Based Health Centers, Weight Loss Clinic, Wellness Center

Identified Need: Obesity has been identified as a priority health issue in the Tri-County area. The effects of obesity include health conditions, lower quality of life, and reduced lifespan and is one of the leading causes of preventable death in the United States. According to the 2022 Community Health Needs Assessment, Peoria County has seen an increase in the number of people diagnosed with overweight and obesity from 64.4% in 2010-2014 to 64.6% in 2015-2019. Tazewell and Woodford counties have seen a decrease in these time frames. All three counties are slightly below the state average of 65.7% (2015-2019). In the 2022 CHNA Survey, respondents indicated that being overweight was their most prevalently diagnosed health condition.

Obesity Implementation Plan Highlights: For the complete CHIP please refer to the Appendix.

> **Goal:** Reduce the proportion of residents with obesity (defined as overweight and obese) in the Tri-County Region.
>
> **Objective 1:** By December 31, 2025, reduce the proportion of adolescents with obesity in the Tri-County Region by 1%. *(Baseline: High school students who had obesity- PC 14%, TC 13%, WC 9%, IL 15%, US 16% CDC 2019 YRBS)*
>
> **Objective 2:** By December 31, 2025, reduce the proportion of adults (women) with obesity in the Tri-County Region by 2%. *(Baseline: PC 64.6%, TC 64.8%, WC 64.8%, IL 65.7% IBRFSS 2015-2019)*
>
> > **OB Strategy 1:** Support Tri-County Partnership for a Healthy Community's (PFHC) CHIP efforts: Digital Health Interventions and Strong People - Healthy Weight.
> >
> > **OB Strategy 2:** Reduce the proportion of adolescents with obesity through individualized health coaching for adolescents with overweight and obesity.
> >
> > **OB Strategy 3:** Reduce the proportion of adults with obesity through individualized support for weight loss.

Target Populations: There are significant differences in gender, age, housing, and county of residence by weight status. 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.

Appendix

PRIORITY 1: HEALTHY EATING ACTIVE LIVING (HEAL) IMPLEMENTATION PLAN

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

Objective 1: By December 31, 2025, increase accessibility of healthy food in the Tri-County Region through the support of community gardens by 10%.
(Baseline: TBD)

Objective 2: By December 31, 2025, increase adults reporting exercising 1-5 days a week among the Tri-County Region by 1%.
(Baseline: 28% of adults reported no exercise at all; 2022 CHNA)

Alignment with Community Health Improvement Goals

Partnership for a Healthy Community 2023-2025 CHIP- Objectives 1 & 2 to improve HEAL in the Tri-County Region

Healthy People 2030- NWS-07 Increase vegetable consumption by people aged 2 and older; NWS-06 Increase fruit consumption by people aged 2 years and over; PA-01 through PA-05 Increasing the proportion of adults who increase physical activity

Illinois State Health Improvement Plan (SHIP) 2021- Goals to increase opportunities for healthy eating and increase opportunities for active living (SHIP, 2021, pp. 51-54)

INTERVENTION STRATEGIES*	TASKS/TACTICS	EVALUATION PLAN
HEAL Strategy 1: Support Tri-County Partnership for a Healthy Community's (PFHC) CHIP efforts: Gardening Interventions and Social Support Interventions	**HEAL Strategy 1, Task 1:** Identify key staff to participate in PFHC HEAL Action Team **HEAL Strategy 1, Task 2:** Disseminate PFHC campaign and recruitment messages to promote Gardening Interventions and Social Support Interventions **HEAL Strategy 1, Task 3:** Partner with PFHC and community resources to promote intervention strategies **HEAL Strategy 1, Task 4:** Support community garden in region of concern at Family Medical Center (FMC)	• # of PFHC HEAL Action Team meetings/hours attended • # of campaigns distributed • # of WellMobile activities used to promote interventions • # of social media impressions • # of participants engaged/enrolled in interventions • # fresh pounds of food produced and distributed • # of community members utilizing community garden • # of partners engaged • # of priority zip codes impacted

HEAL Strategy 2: Increase HEAL education and fitness opportunities for youth	**HEAL Strategy 2, Task 1:** Identify internal regional HEAL education resources and collect baseline data – Hult Center, Methodist College, Nursing Education, Family Medical Center, Optimum Health, Wellness Center, etc. **HEAL Strategy 2, Task 2:** Identify external regional HEAL partners/resources **HEAL Strategy 2, Task 3:** Provide HEAL community health education to target populations **HEAL Strategy 2, Task 4:** Utilize American Academy of Pediatrics (AAP) Bright Futures Guidelines to screen for HEAL and connect families with resources to address food insecurity and other SDOH **HEAL Strategy 2, Task 5:** Share success stories of the HEAL efforts within the tri-county area	• # of campaigns distributed • # of partners engaged • # of priority zip codes impacted • # of WellMobile stops • # of participants reached through community health education and activities • # providers utilizing Bright Futures guidelines at well visits • Pre/post changes in knowledge/behavior • # success stories shared • # of priority zip codes impacted
HEAL Strategy 3: Increase physical activity among adult residents and staff	**HEAL Strategy 3, Task 1:** Establish internal regional HEAL team to collect baseline data and create action plan for community and worksite wellness activities **HEAL Strategy 3, Task 2:** Provide physical activity programming through WellMobile service line to promote increase in physical activity in leisure time **HEAL Strategy 3, Task 3:** Provide worksite wellness to increase physical activity and HEAL for all employees	• # of WellMobile stops • # of participants reached through, Optimum Health, Wellness Center, WellMobile and community education and outreach • Pre/post changes in knowledge/behavior • Pre/Post changes in biometrics • # success stories shared • # of priority zip codes impacted

TARGET POPULATIONS:	Males and those who were younger reported eating less fruits and vegetables per day; those who were Black/African American, have lower education, and lower household income; specifically Peoria and West Peoria regions. Exercise was rated lower for residents in the Eastern Woodford County region. Hunger was higher among homeless individuals or those with unstable housing. Hunger was less common among those who were White, had higher educational attainment, and higher household income.

RESOURCES:	Hult Center FTEs to participate in PFHC HEAL Committee and PFHC Board; Family Medical Center Residency Program FTE for community garden coordination; Health Insurance Incentives for Wellness Participation; Hult Center and Wellness Center FTE for implementing health education programs; School-Based Health Centers for well visits and Bright Futures, WellMobile FTE and resources, Methodist College; Optimum Health Solutions

**Note: Plans to address selected CHNA priorities are dependent upon resources and may be adjusted on an annual basis to best address the health needs of our community.*

PRIORITY 2: MENTAL HEALTH IMPLEMENTATION PLAN

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

Objective 1: 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 Tri-County 2015-2018 HCI Conduent)

Objective 2: 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%.
(Baselines: 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 HCI Conduent; and % of respondents that indicated they spoke to someone about their mental health in the last 30 days- 40% 2022 CHNA)

Alignment with Community Health Improvement Goals

Partnership for a Healthy Community 2023-2025 CHIP- Objectives 1 & 2 to improve mental health in the Tri-County Region

Healthy People 2030- MHMD-01-02- Reduce the suicide rate and MHMD-04 Increase the proportion of adults with SMI who get treatment; MHMD-05 Increase the proportion of adults with depression who get treatment; MHMD-03 Increase the proportion of children with mental health problems who get treatment; MHMD-06 Increase the proportion of adolescents with depression who get treatment

Illinois State Health Improvement Plan (SHIP) 2021- Objectives to reduce the age-adjusted suicide rate and reduce emergency department visits, hospitalizations due to behavioral health issues; Death reduction strategies to expand access to mental health treatment
(SHIP, 2021, pp. 43-44)

INTERVENTION STRATEGIES*	TASKS/TACTICS	EVALUATION PLAN
MH Strategy 1: Support Tri-County Partnership for a Healthy Community's (PFHC) CHIP efforts: Culturally Adaptive Health Care and Telemedicine	**MH Strategy 1, Task 1:** Identify key staff to participate in PFHC Mental Health Action Team **MH Strategy 1, Task 2:** Partner with PFHC and community resources to promote intervention strategies **MH Strategy, Task 3:** Identify trauma-informed care trainings for providers and mental health employees and create training implementation plan **MH Strategy 1, Task 4:** Identify and coordinate regular meetings with supervisors for trauma-informed care and system-wide sustainability **MH Strategy 1, Task 5:** Share success stories of the program within the tri-county area and with senior leadership/board	• # of engaged staff • # of meetings/hours attended • # of campaigns distributed • # of providers completing training • Pre/Post changes in knowledge/behavior among participants • # policies implemented • # of priority zip codes impacted • Reduced hospital readmissions • Improved patient experience surveys

MH Strategy 2: Increase access to comprehensive behavioral health services, care coordination, and resources and supports.	**MH Strategy 2, Task 1:** Identify regional mental health access points and collect baseline data – Access Center Call Line, Systems of Care, Young Minds Institute, High ED Utilizers, etc. **MH Strategy 2, Task 2:** Distribute patient experience surveys to patients utilizing mental health services and create an action plan for continuous improvement **MH Strategy 2, Task 3:** Launch Young Minds Institute to increase access to care & provide more resources for children, adolescents, & families; Continue providing and increasing services for Telemedicine, Access Center Call Line, Systems of Care, and High ED Utilizers management **MH Strategy 2, Task 4:** Disseminate marketing and recruitment messages to promote mental health resources for youth and adults in Tri-County Region **MH Strategy 2, Task 5:** Share success stories of the mental health efforts within the tri-county area	• Increase # calls utilizing the Access Center Call Line • Improved patient experience surveys • # of partners engaged in mental health Systems of Care • Young Minds Institute launched to increase access for child and adolescent mental health care • Reduced admissions between ED and inpatient • Increased service integration among mental health service providers • Reduced referral time from prescribing to mental health service • Priority areas/zip codes provided services to reach target population
MH Strategy 3: Increase mental health prevention education and awareness to improve mental health.	**MH Strategy 3, Task 1:** Identify regional mental health prevention community education resources and collect baseline data – Hult Center, Methodist College, Nursing Education, Family Medical Center, etc. **MH Strategy 3, Task 2:** Establish partners to provide suicide prevention education and training opportunities to providers, medical students, medical staff, and community members **MH Strategy 3, Task 3:** Disseminate marketing and recruitment messages to promote mental health prevention education for youth and adults in Tri-County Region **MH Strategy 3, Task 4:** Support Regional DEI efforts that include LGBTQ+ supports for community and staff **MH Strategy 3, Task 5:** Share success stories of the mental health prevention education efforts within the tri-county area	• # of participants reached through education and outreach • # of established partnerships for sustained suicide prevention trainings • Pre/post changes for knowledge/behavior gained • DEI Committee established • DEI/LGBTQ+ community efforts launched/supported • Increase in DEI/LGBTQ+ engagement • # participants & staff engaged • # of campaigns/marketing distributed • Priority areas/zip codes provided services to reach target population

TARGET POPULATIONS:	According to the Community Health Needs Assessment, those who reported having a mental health condition were more often younger, LGBTQ+, have lower household income, and had unstable or no housing. Those with lower educational attainment more often reported below average mental health. Peoria respondents more often reported a mental health condition. Woodford residents had the lowest proportion of residents reporting a mental health condition. 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.

RESOURCES:	Trillium Place FTEs for leading PFHC Mental Health Action Team and lead for Strategy 2; Trillium Place FTEs and lead for Systems of Care (SOC) efforts; Hult Center for Healthy Living FTE for PFHC Mental Health Action Team and Lead for Strategy 3; Family Medical Center (FMC) FTE; HR, Compliance, and Nutrition FTE for DEI and LGBTQ+ Efforts

**Note: Plans to address selected CHNA priorities are dependent upon resources and may be adjusted on an annual basis to best address the health needs of our community.*

PRIORITY 3: OBESITY IMPLEMENTATION PLAN

GOAL: Reduce the proportion of residents with obesity (defined as overweight and obese) in the Tri-County Region.

Objective 1: By December 31, 2025, reduce the proportion of adolescents with obesity in the Tri-County Region by 1%.
(Baseline: High school students who had obesity- PC 14%, TC 13%, WC 9%, IL 15%, US 16% CDC 2019 YRBS)

Objective 2: By December 31, 2025, reduce the proportion of adults (women) with obesity in the Tri-County Region by 2%.
(Baseline: PC 64.6%, TC 64.8%, WC 64.8%, IL 65.7% IBRFSS 2015-2019)

Alignment with Community Health Improvement Goals

Partnership for a Healthy Community 2023-2025 CHIP- Objectives 1 & 2 to reduce proportion of adolescent and adult obesity

Healthy People 2030- NWS-03, NWS-04- Objectives to reduce proportion of children, adolescents, and adults with obesity

Illinois State Health Improvement Plan (SHIP) 2021- Objectives to reduce the percentage of obesity among children and adults

INTERVENTION STRATEGIES*	TASKS/TACTICS	EVALUATION PLAN
Obesity Strategy 1: Support Tri-County Partnership for a Healthy Community's (PFHC) CHIP efforts: Digital Health Interventions and Strong People - Healthy Weight.	**OB Strategy 1, Task 1:** Identify key staff to participate in PFHC Obesity Action Team **OB Strategy 1, Task 2:** Disseminate PFHC campaign and recruitment messages to promote Digital Health Interventions & Strong People Healthy Weight **OB Strategy 1, Task 3:** Partner with PFHC and community resources to promote intervention strategies	• # of engaged staff • # of PFHC Obesity Action Team meetings/hours attended • # of campaigns distributed • # of social media impressions • # of participants enrolled in programs • # of partners engaged • # of priority zip codes impacted

Obesity Strategy 2: Reduce the proportion of adolescents with obesity through individualized health coaching for adolescents with overweight and obesity.	**OB Strategy 2, Task 1:** Collect baseline data **OB Strategy 2, Task 2:** Develop recruitment campaign in tri-county area **OB Strategy 2, Task 3:** Establish provider referral protocol **OB Strategy 2, Task 4:** Partner with community resources to educate about Hult Center's WELL (Wellness Education and Lifestyle Learning) adolescent health coaching program to increase referrals and establish coaching locations **OB Strategy 2, Task 5:** Provide individualized health coaching to adolescents at-risk for developing type 2 diabetes **OB Strategy 2, Task 6:** Share success stories of the program within the tri-county area	• # promotional campaigns • # patients enrolled in health coaching • Referral protocol established and approved by pediatric providers • Pre/Post changes in knowledge/behavior among participants • 5-7% improvement in BMI • Pre/Post changes in behavior • Pre/Post changes in biometrics • # success stories shared • # of priority zip codes impacted
Obesity Strategy 3: Reduce the proportion of adults with obesity through individualized support for weight loss.	**OB Strategy 3, Task 1:** Collect baseline data **OB Strategy 3, Task 2:** Launch weight loss clinic for adults **OB Strategy 3, Task 3:** Launch outreach body composition scanning program to tri-county **OB Strategy 3, Task 4:** Develop recruitment campaign in tri-county area **OB Strategy 3, Task 5:** Share success stories of the programs within the tri-county area	• # promotional campaigns • # patients enrolled in health coaching • Pre/Post changes in knowledge/behavior among participants • 5-7% improvement in BMI • Pre/Post changes in behavior • Pre/Post changes in biometrics • # success stories shared • # patients enrolled • # promotional WellMobile stops to target regions • # hours obesity education • # individual and community education sessions • # of priority zip codes impacted

TARGET POPULATIONS:	Peoria County has seen an increase in the number of people diagnosed with overweight and obesity from 64.5% in 2010-2014 to 64.6% in 2015-2019. Tazewell and Woodford counties have seen a decrease in these time frames. There are significant differences in gender, age, housing, and county of residence by weight status. Those who are female, older in age, live in Tazewell County, or reported unstable housing more often report being overweight. Moreover, those who were homeless more often reported they were not overweight.

RESOURCES:	Clinic staff FTE for leading Obesity Strategies; Hult Center for Healthy Living FTE for PFHC Obesity Action Team membership and Lead for Strategy 2; Weight Loss Clinic FTE for leading Strategy 3 efforts; In-School Health, Pediatric Providers, and FMC FTE for referrals to weight loss programs and screening for obesity among pediatrics; Optimum Health and Wellness Center FTE for Strategy 3

**Note: Plans to address selected CHNA priorities are dependent upon resources and may be adjusted on an annual basis to best address the health needs of our community.*

PERFORMANCE MANAGEMENT: CANCER

GOAL: Reduce the illness, disability, and death caused by lung, breast, and colorectal cancer in the Tri-County Region.

Objective 1: By December 31, 2025, reduce the female breast cancer death rate in the Tri-County Region by 1%.
(Baseline: 19.7 per 100,000 in 2018; PC 20.6, TC 20.6, WC 22.9)

Objective 2: By December 31, 2025, reduce colorectal cancer death rate in the Tri-County Region by 1%.
(Baseline: 13.4 per 100,000 in 2018; PC 11.6, TC 13.8, WC 12.1)

Objective 3: By December 31, 2025, reduce lung cancer death rate in the Tri-County Region by 1%.
(Baseline: TBD)

Objective 4: By December 31, 2025, increase genetic screenings to identify high risk patients (all cancers) in Tri-County Region by 1%.
(Baseline: 34.8 per 100,000 in 2018; PC 39.2, TC 41.8, WC 36.9)

Alignment with Community Health Improvement Goals

Partnership for a Healthy Community 2023-2025 CHIP- Objectives 1 - 3 to reduce cancer death rates

Healthy People 2030- C-01, C-02, C-03, C-04, C-05, C-06, C-07, C-D01- Objectives to decrease death rates and increase cancer screening rates

INTERVENTION STRATEGIES*	TASKS/TACTICS	EVALUATION PLAN
Cancer Strategy 1: Support Tri-County Partnership for a Healthy Community's (PFHC) Cancer Performance Management efforts.	**C Strategy 1, Task 1:** Identify key staff to participate in/lead PFHC Cancer Action Team **C Strategy 1, Task 2:** Disseminate PFHC campaign and recruitment messages to promote intervention strategies **C Strategy 1, Task 3:** Partner with PFHC and community resources to promote intervention strategies	• # screenings offered • types of screenings offered • # screenings completed

Cancer Strategy 2: Increase the number of cancer screenings (breast, colorectal, and lung) to decrease cancer deaths.	**C Strategy 2, Task 1:** Collect baseline data **C Strategy 2, Task 2:** Develop recruitment campaign in tri-county area **C Strategy 2, Task 3:** Track screening data internally and externally and monitor progress **C Strategy 2, Task 4:** Share success stories of the program within the tri-county area	• # screenings offered • types of screenings offered • # screenings completed
Cancer Strategy 3: Collaborate with community partner agencies to offer community-wide cancer screening events and education.	**C Strategy 3, Task 1:** Create planning committee to plan annual screening and education events **C Strategy 3, Task 2:** Develop recruitment campaign for tri-county area **C Strategy 3, Task 3:** Complete annual events **C Strategy 3, Task 4:** Share success stories of the programs within the tri-county area	• # promotional campaigns • # patients screened at screening events • # success stories shared • # individual and community education sessions • # of priority zip codes impacted

TARGET POPULATIONS:	Cancer rates in Peoria County are higher than the State of Illinois and Tazewell County reports significantly higher rates of lung and breast cancer compared to the State of Illinois. Breast cancer screenings tended to be lower for women in unstable housing (homeless) and those who live in the Peoria/West Peoria region. Colorectal cancer screening tended to be less for those in an unstable housing environment, for residents who live the Peoria/West Peoria region, and residents who live the Western Tazewell County region. Smoking (lung cancer risk) was rated higher for residents with less education and those with lower income, as well as those who live in the Peoria/West Peoria region and residents who live in the Bartonville/Limestone region.

RESOURCES:	Oncology Department staff FTE for leading Cancer Strategies at Carle Health and PFHC; FTE for PFHC Cancer Action Team membership and Lead for Performance Management Cancer Strategies

**Note: Plans to address selected CHNA priorities are dependent upon resources and may be adjusted on an annual basis to best address the health needs of our community.*

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