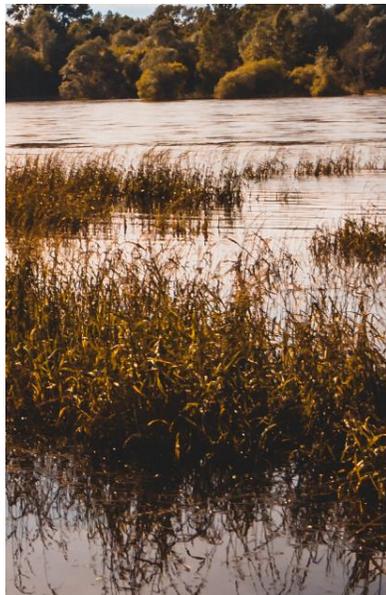


# 2020-2022 COMMUNITY HEALTH IMPROVEMENT PLAN



Adopted 11/21/2019

Peoria, Tazewell, and Woodford Counties

January 1, 2020 – December 31, 2022

# 2020-2022 Community Health Improvement Plan

PEORIA, TAZEWELL, AND WOODFORD COUNTIES

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## INTRODUCTION: THE PARTNERSHIP FOR A HEALTHY COMMUNITY

The Partnership for a Healthy Community (PFHC) is a multi-sector community initiative working to improve population health in the tri-county region. The overall vision of the 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 PFHC focuses on strengthening and aligning community efforts, leverage funding and supporting collaborative opportunities to drive health outcomes. In an effort to improve health in the tri-county region, the PFHC was created in 2016 to develop a collaborative approach to the Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP). The collaborative includes the regional health systems, local health departments, and community agencies. Since 2016, the Partnership for a Healthy Community has increased development and capacity to assist in creating a sustainable collaborative initiative to improve health. The PFHC has a board which has a reporting structure, bylaws, elections and appointments of officers. The organizational structure of the board 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).

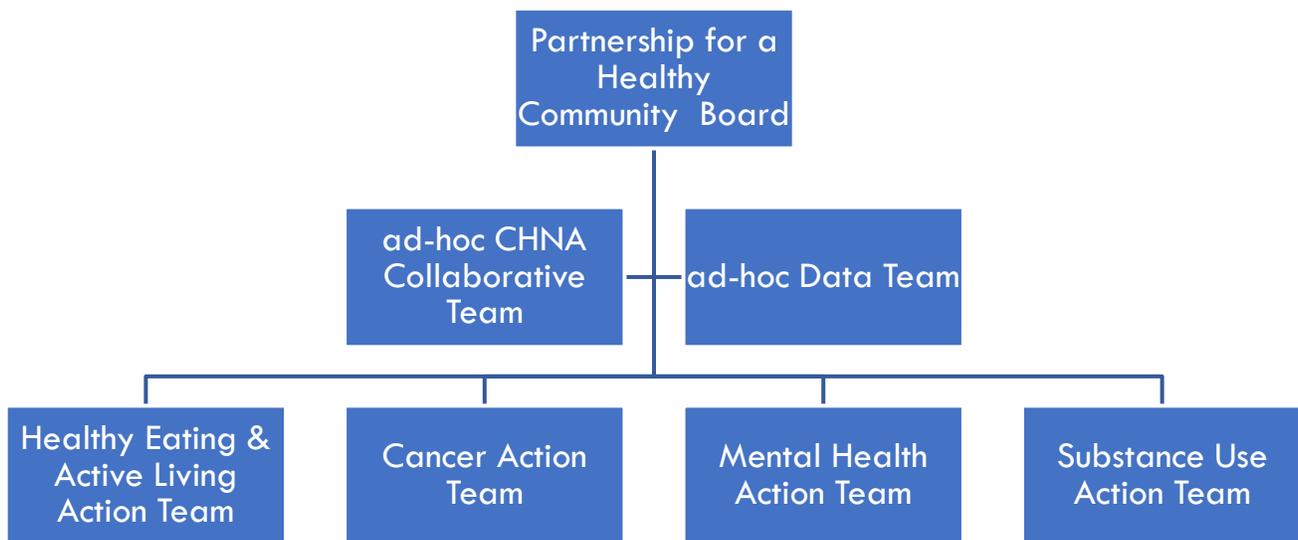


Figure 1: Partnership for a Healthy Community organizational chart

The PFHC acts as the conduit for planning, coordination, and facilitation. Each priority health action team reports their work to the PFHC Board to promote coordinated health improvement strategies. This approach, which includes accountability and leveraging of resources, has identified PFHC as the community-driven partnership of public and private stakeholders working to address priority health issues in Peoria, Tazewell and Woodford Counties. The Partnership for a Healthy Community has emerged as the recognized leader in community health improvement.

## Partnership for a Healthy Community Board

The Partnership for a Healthy Community Board is charged with leading and supporting the collaborative process. With their adopted bylaws, the PFHC Board membership includes representation of various sectors and jurisdictions that represent the community at large. At minimum, there are seven agencies who are directly charged with community health needs assessment and improvement planning; OSF Saint Francis Medical Center, UnityPoint Health, Advocate Eureka Hospital, Hopedale Medical Complex, Peoria City/County Health Department, Tazewell County Health Department and Woodford County Health Department. The PFHC Board is responsible for supporting the mission and implementing the process. Along with actively participating in priority areas, the PHFC Board implements evidence-based strategies that align with the local health improvement plan. The following is a list of current PFHC Board members with the adoption of the 2020-2022 CHIP.

<b>Hillary Aggertt</b>	Woodford County Health Department
<b>Brent Baker</b>	Greater Peoria Economic Development Council
<b>Holly Bill</b>	Hult Center for Healthy Living
<b>Ann Campen</b>	Tazwood Center for Wellness
<b>Beth Crider</b>	Peoria Regional Office of Education
<b>Len Ealey</b>	Pekin Public School District
<b>Greg Eberle</b>	Hopedale Medical Complex
<b>Amy Fox</b>	Tazewell County Health Department
<b>Lisa Fuller</b>	OSF Healthcare Saint Francis Medical Center
<b>Sally Gambacorta</b>	Advocate Eureka Hospital
<b>Monica Hendrickson</b>	Peoria City/County Health Department
<b>Tim Heth</b>	UnityPoint Health
<b>Mike Hinrichsen</b>	Village of Germantown Hills
<b>Tricia Larson</b>	Tazewell County Board of Health
<b>Adam Sturdavant</b>	OSF Medical Group - Pediatrics
<b>Larry Weinzimmer</b>	Bradley University
<b>Jennifer Zammuto</b>	Heart of Illinois United Way

## CHIP 2017-2019 HIGHLIGHTS

Beginning in 2016, the Partnership for a Healthy Community has worked collectively to establish and coordinate evidence-based intervention strategies for the tri-county region. The first cycle of the Community Health Improvement Plan (CHIP) included participants representing multiple organizations both the public and private sector interests in population health planning. This planning was used to identify and prioritize health needs 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.

The Mobilizing for Action through Planning and Partnerships (MAPP) process was utilized to facilitate the 2017-2019 CHIP. MAPP assisted in applying strategic thinking to prioritize public health issues and identify common theme and resources to address them. Using actionable data to identify health needs and priorities, including those related to health disparities, health inequities, and the social determinants of health, the Partnership for a Healthy Community developed the 2017-2019 Community Health Improvement Plan (CHIP). The CHIP plan identified four health priorities; Behavioral Health, Healthy Eating & Active Living, Cancer (Breast & Lung), and Reproductive Health. Action Teams were established for each priority to implement intervention strategies, develop policies, share data, and identify funding opportunities (Figure 2).



### Partnership for a Healthy Community Structure

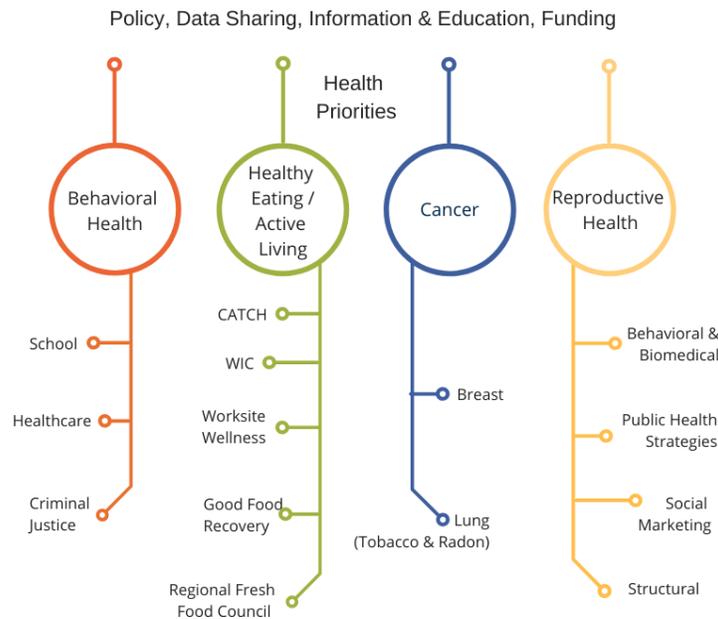


Figure 2: 2017-2019 CHIP health priorities and structure.

## Behavioral Health

Behavioral Health was prioritized by all three counties. The Behavioral Health Action Team’s purpose was to create goals, objectives and strategies regarding access to services, mental health, substance use and suicides. The action team focused on three systems that could effect change; Criminal Justice, Education, and Healthcare.

## Frequent Utilizer Matrix

Community Health Needs Assessment & Improvement Plan

2017 Data Sharing Project



The Healthcare and Criminal Justice sub-action team examined how data coordination could assist in improving outcomes from drug overdoses and understand the impact on costs frequent utilizers had on the system of community and health services overall. The Narcan Advisory Group mapped how first responders and service providers were purchasing and utilizing overdose reversal medications. The Narcan Advisory group collected data on overdose reversals occurring in Peoria and Tazewell Counties (Figure 3). The group expanded to share overdose data to help understand the growing epidemic of opioids.

Figure 3: Narcan Advisory Group Frequent Utilizer Matrix

The Education sub-action team strategically focused on increasing support and resources to understand, prevent, and address Adverse Childhood Experiences (ACEs). Throughout the CHIP this action team looked at multiple ways of approaching comprehensive social emotional learning (SEL) for children, specifically in building capacity for trained professionals to be able to work with teachers in public schools (Figure 4).

The Education sub-action team with additional partner agencies, worked on coordinating numerous resources within the tri-county communities to create a library of resources, protocols for teacher observations and professional development, as well as distribution of an online learning course.

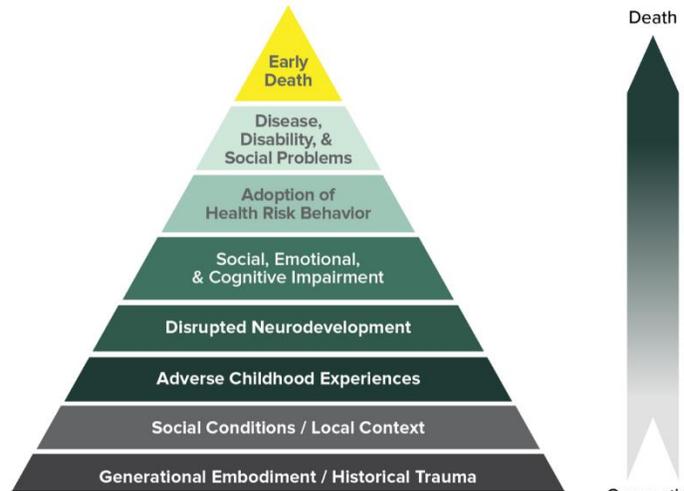


Figure 4: Centers for Disease Control and Prevention ACES model

## Healthy Eating/Active Living

Healthy Eating/Active Living (HEAL) was prioritized by all three counties to focus on youth and adult nutrition and physical activity. The HEAL action team formulated goals, objectives and strategies that focused on improving the local and emergency food systems in the tri-county area by utilizing evidence-based programs, sustaining ongoing efforts, and by being proactive in addressing needs and coordinating efforts within the region. Members received the inaugural Ending Hunger Together Grant through the Community Foundation of Central Illinois to develop collaborative food access strategies with community partners. As a tri-county, the PFHC successfully received funding for the Illinois State Physical Activity and Nutrition (ISPAN) Grant. This grant focuses on Food Service Guidelines, Breastfeeding, Active Living and Early Childhood Education programming.



## Breast and Lung Cancers

Breast and Lung Cancers were selected as top priorities for Tazewell and Woodford Counties to reduce illness, disability and death caused by breast and lung cancer in the tri-county area.

The Lung Cancer Action Team worked on policy creation, awareness, education and testing to the tri-county community to decrease the risk factors associated with lung cancer. Through a tri-county collaboration of agencies, initiatives have been streamlined and funding increased for Illinois Tobacco Free Communities and Illinois Emergency Management Agency Radon Grant.

A major legislative agenda was the passage of a Tobacco 21 ordinance for several cities before the state law passed that would increase the legal age of purchasing from 18 years to 21 years for tobacco products; directly impacts the access and initiation by youth to use tobacco products. As a Health in All Policy approach, Tobacco 21 not only improves the health of the individual but also the overall community.

In addition to addressing tobacco, the team focused on the effects that

environmental exposure to radon that causes lung cancer. Through a grant from the Illinois Emergency Management Agency (IEMA), the tri-county has been able to provide testing kits for residents to determine radon levels in their homes. Awareness and education have also been streamlined to reach a broader audience regarding radon and lung cancer.

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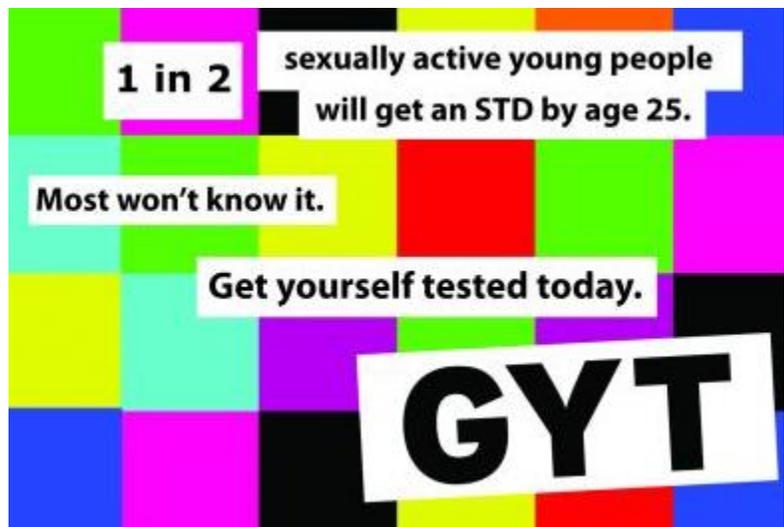


1 in 8 women will receive a breast cancer diagnosis during their life.

The Breast Cancer Action Team continues to collaborate in collecting mammogram screenings and numerous outreach data from OSF St. Francis, UnityPoint Health, Hopedale, Advocate Eureka hospital systems and the Tazewell, Peoria and Woodford County Health Departments. The action team has worked to provide breast health outreach services to women in the tri-county area. The action team has documented over 35 educational events with community partners in the past cycle. In 2018, 439 women under the age of 40 received breast cancer screenings, over 2 times more than 2017. In efforts to increase awareness and education promoting mammogram screenings, the Breast Cancer Action Team developed a Breast Cancer Screening Position Statement. The statement included support of the American College of Radiology, Society of Breast Imaging and the National Comprehensive Cancer Network's recommendation of breast cancer screenings starting at the age of 40. In addition, the committee supports the CDC's recommendations of women having breast cancer risk assessments beginning at the age of 30.

## Reproductive Health

Reproductive Health was prioritized by Peoria County to focus on teen birth, sexually transmitted infections (STI) and low birth rates. The Reproductive Health Action Team was formed to create goals, objectives and strategies around reproductive health issues. The Behavioral and Biomedical sub-action team focused on increasing awareness, defining best practices, and sharing resources. Activities included organizing GYT events at all Peoria Public High Schools, facilitating a PrEP provider education event, and championing the adoption by the Peoria County Board of Health of the U=U consensus statement.



In Peoria County, the preterm birth rate among black women is 86% higher than the rate among all other women. The new program, Centering Pregnancy, is used to address lack of prenatal care, a key risk factor in preterm birth and poor birth outcomes. The program uses a cohort approach in which a group of women due to give birth near the same time receive healthcare advice and wraparound support as a group with the providers. The results are improved health outcomes for both mother and infant.

## EXECUTIVE SUMMARY

### Statement of Purpose

In 2019, the PFHC embarked on the planning of the 2020-2022 CHIP. It was important to the Partnership for a Healthy Community that the board and action teams continue to take a collaborative approach to accomplishing the goals identified in the CHIP. The PFHC Board adopted the collaborative spectrum (Figure 5) to assess the teams progress in identifying collaboration, leveraging resources, and strengthen existing partnerships. With this approach, the PFHC proceeded with the planning process of the 2020-2022 CHIP.

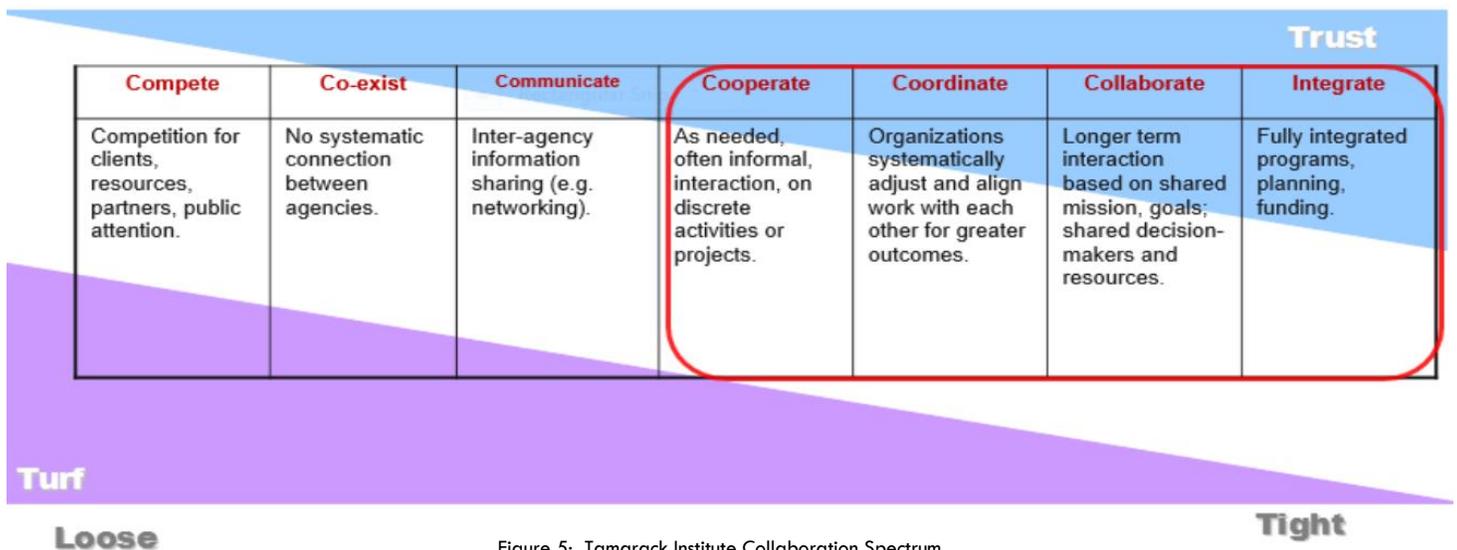
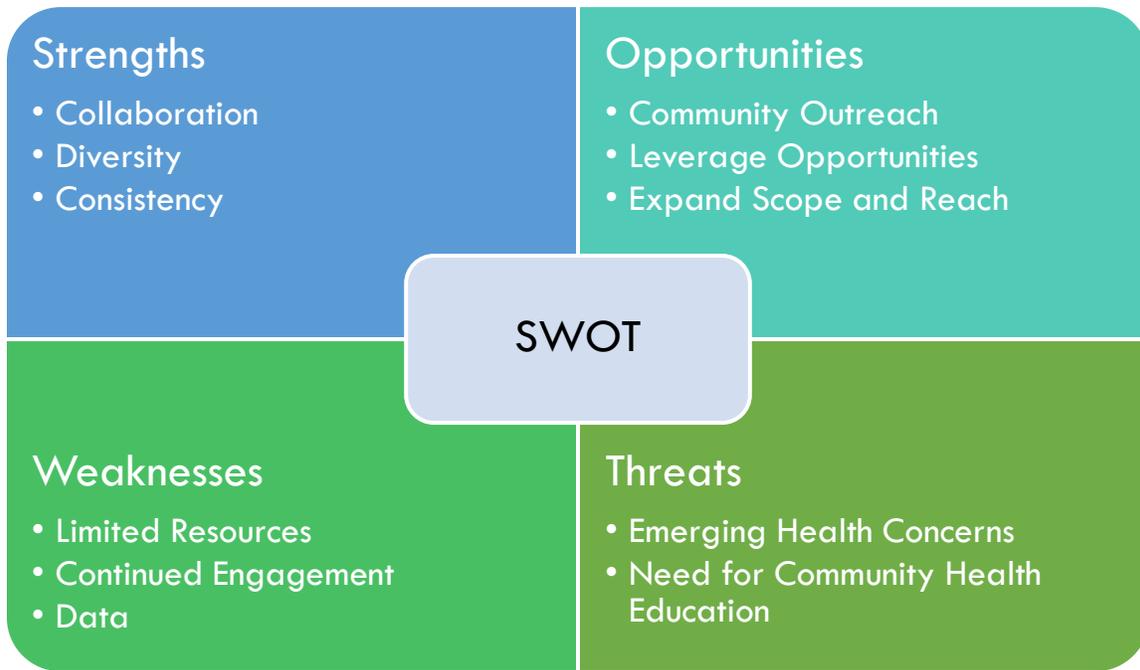


Figure 5: Tamarack Institute Collaboration Spectrum.

### Strengths, Weaknesses, Opportunities and Threats (SWOT) Themes

The Partnership for a Healthy Community worked with the current action teams to develop a SWOT analysis of the 2017-2019 CHIP and the effectiveness of the action teams (Figure 6). This data was used to provide strategic direction to develop the 2020-2022 CHIP plan priorities. Appendix 1 includes the SWOT reports for each action team. Common themes for the four priority areas include:



### Data Team

While reviewing the SWOT analysis results and receiving feedback from the action teams for the 2020-2022 CHIP, the PFHC realized a need for a designated data team. The ad-hoc data team would examine what primary and secondary data sources are available and how the data can be assembled to inform evidence-based decisions on health priorities and implementation strategies across all action teams. In addition, the data would assist in monitoring progress of the action teams' efforts.

#### Data Team Goals:

1. Analyze primary and secondary data goals collectively for the CHNA
2. Identify and share data sources to support evidence-based interventions
3. Provide data support to action teams for new and emerging strategies
4. Measure outcomes of evidence-based strategy implementation throughout the three-year cycle

### Website Team

In addition to a data team, the PFHC also established a website team. The website team worked to develop an improved website with the ability to highlight the progress and research of the PFHC Board and action teams. The website also features the ability to host discussion forums on health issues and activities, and act as a repository of documents and reports.

## Social Determinants and Health Equity

The Partnership for a Healthy Community has a commitment to equity and values intervention strategies for disadvantaged and marginalized populations. The goal is to achieve the highest level of health and access to care for all people. This entails focused efforts to identify and remove barriers to healthy outcomes and increase opportunities for health care education, access and a healthy built environment.

The 2020-2022 CHIP specifically identifies the social determinants of health related to each identified health priority. The CHNA revealed that mental health and substance use, absence or limitation of health care, and the prevalence of hunger are more likely for those with less education, lower income, and those in an unstable (e.g. homeless) housing environment. The PFHC action teams purposefully included health equity strategies into their implementation plans; to address barriers and improve community health.

### *Why is Health Equity Important?*



Health equity means that everyone has a fair and just opportunity to be as healthy as possible. Improving community health and longevity starts with ensuring all communities have equitable access to health care, healthy food, good schools, affordable housing, and jobs to establish and maintain a healthy lifestyle. Data shows that nearby zip codes and even adjacent neighborhoods can often have striking differences in life expectancy and health outcomes. Research has documented that rural and low-income urban communities continue to experience increased health risks related to geographic, socioeconomic and environmental factors. As an example, rural communities often must travel greater distances to reach health care delivery sites. Low-income urban neighborhoods may lack health care centers in their neighborhoods or lack access to health care due to transportation barriers. Racial/ethnic populations in particular, face various social determinants to health due to concentrated poverty, discrimination, lack of access to quality education, livable housing, safe environments, and health care. These inequities exist in both urban and rural populations resulting in a higher prevalence and mortality rates of chronic diseases. Higher rates of suicide, injury, and substance use can also be found in these communities. The PFHC realizes that it is important to acknowledge and understand health inequities and their root causes in order to effectively leverage community resources and give every individual and family a fair chance of attaining good health, regardless of where they live.

## Development Process for the 2020-2022 CHIP

### CHNA

The Community Health Needs Assessment provides and assists with data determination for strategic planning. Statistical analysis and community engagement were used to make health priority determinations. Primary and secondary data was used from various sources in which several themes became prevalent. The 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. Results from the CHNA were used for strategic decision-making purposes as they directly relate to the health needs of the community.

The CHNA was designed to assess issues and trends impacting the communities served by PFHC stakeholders, as well as perceptions of targeted stakeholder groups. In order to perform these analyses, information was collected from publicly available sources, as well as private sources of data. Additionally, surveys were completed by 1,376 respondents in the community. The residents were assessed with a special focus on the at-risk or economically disadvantaged population. The CHNA survey questions included perceptions of the community health issues, unhealthy behaviors, issues with quality of life, healthy behaviors, access to medical care, dental care, prescription medications and mental health counseling. Additionally, social determinants of health were analyzed to provide insights into why certain segments of the population may have responded differently.

### Prioritization

The Partnership for a Healthy Community held two major community meetings to determine the CHNA priorities and to develop the CHIP strategies. The PFHC worked with community partners to develop objectives and strategies for the 2020-2022 CHIP.

On March 12, 2019, the PFHC Board and current action teams met with community partners to present the CHNA data and identified the following health areas for prioritization.

#### Phase 1 of the Prioritization identified 15 health areas from the CHNA:

Access to Care	Aging Issues	Anxiety
Asthma	Cancer	Depression
Gun Violence	Low Birth Weight	Nutrition
Obesity	Physical Activity	Sexually Transmitted Infections
Substance Use	Suicide	Teen Birth Rate

#### Phase 2 of the Prioritization narrowed the focus to 7 health areas from the CHNA:

Access to Care	Aging Issues	Cancer
Healthy Eating Active Living	Mental Health	Reproductive Health
Substance Use		

Ultimately, prioritization of the most significant health-related issues in the tri-county region were identified. Health needs were evaluated and ranked based on:

- (1) magnitude of the issue (i.e., what percentage of the population was impacted by the issue);
- (2) severity of the issue in terms of its relationship with morbidities and mortalities;
- (3) potential impact through collaboration.

Using a modified version of the Hanlon Method, four significant health needs were prioritized based on the highest rank and ratings:

- Healthy Eating/Active Living – defined as active living and healthy eating, and their subsequent impact on obesity, access to food, and food insecurity
- Cancer - defined as incidence of breast, lung, and colorectal cancer and cancer screenings
- Mental Health - defined as depression, anxiety, and suicide
- Substance Use - defined as abuse of illegal and legal drugs, alcohol, and tobacco/vaping use

On August 22, 2019 the Partnership for Healthy Community held a community implementation meeting with community partners and current action team members to begin the selection of key objectives for the 2020-2022 CHIP.

Attendees participated in two breakout sessions per health priority to determine objectives based on CHNA data and evidence-based sources such as Healthy People 2020 (A list of sources of public health evidence made available can be found in Appendix 2). The participants determined objectives based on:

- Data sheets (Mental Health, Substance Use, Cancer, HEAL/Obesity)
- SWOT Analysis for each priority
- Collaboration Spectrum
- Links for evidence/scientifically supported strategies

In total, over 100 community members from various sectors participated in the CHNA and CHIP planning process.

After the CHIP community planning meeting, the action teams subsequently held three working meetings to establish the CHIP goals, objectives, strategies, measures, and resources.

## Goals for Each Health Priority

From January 1, 2020 to December 31, 2022, the Partnership for a Healthy Community Board and action teams will be working together to implement the following Community Health Improvement Plan health priorities and goals:

### 1. Healthy Eating & Active Living

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

### 2. Cancer (breast, lung, colorectal)

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

### **3. Mental Health**

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

### **4. Substance Use**

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

The following pages of this document outline additional information on each health priority in the Community Health Improvement Plan by reviewing factors in the following categories:

- CHNA Data Summary
- Illinois Youth Survey
- County Health Rankings
- Illinois Department of Public Health Data
- Community Commons
- Social Determinants of Health
- Health Priority Goal, Objectives, and Strategies

The 2020-2022 CHIP Implementation charts can be found in Appendix 2. The charts are a detailed compilation of each priority action team's implementation strategy to achieve the goals of the 2020-2022 CHIP Plan. The charts include health priority goals, objectives, strategies, tasks, evaluation plans, and implementation resources and partners. The action teams will continue to meet over the three-year CHIP cycle and partner with the data team to identify measurable interventions and collaborative opportunities in each health category.

The PFHC Board will continually monitor the progress of each action team and require measurements for process outcomes and objectives.

## 2020-2022 CHIP PRIORITY: HEALTHY LIVING AND ACTIVE LIVING (HEAL)

### CHNA Data

#### **Overweight and Obese**

Being Overweight was the number one health condition that people reported having on the 2019 CHNA with 39% of individuals.

#### **BRFSS:**

Between 2007-2009 and 2010-2014 the number of individuals diagnosed as obese or overweight in the tri-county increased. Between the years of 2010-2014 all three counties in the tri-county had higher percentages of obesity and being overweight compared to the state of Illinois.

#### **Illinois Youth Survey:**

Between 11-17% of 8<sup>th</sup> to 12<sup>th</sup> graders who participated in the 2018 Illinois Youth Survey reported a BMI in the category of “Overweight” while 6-13% of 8<sup>th</sup> to 12<sup>th</sup> graders reported a BMI in the category of “Obese”. The prevalence of obesity in Illinois students in 2016 was 11%.

#### **County Health Rankings:**

In 2019, 28% of adults in Illinois have adult obesity (report a BMI of 30 or more) compared to 30-32% of people in Peoria, Tazewell, and Woodford counties according to County Health Rankings.

#### **Community Commons:**

In 2015 31.8% of tri-county adults were obese (BMI>30). This is higher than state and national obesity percentages. Woodford County is the only county within the tri-county region that was below the state and national percentages.

#### **Physical Activity:**

##### **CHNA:**

When asked “How Many Days Did You Exercise in the Last Week” 23% of CHNA survey respondents answered that they did not exercise at all. In contrast, only 12% indicated that they exercised more than 5 days a week.

##### **Illinois Youth Survey:**

In 2016, the percentage of students in the tri-county reporting that they exercised at least 60 minutes daily in the past week ranged from 22-37% depending on county and grade compared to overall State of Illinois students that ranged between 22-29%.

##### **County Health Rankings:**

In 2019, physical inactivity or the percentage of adults 20 and over reporting no leisure-time physical activity is 22% in Illinois compared to 24-26% of adults in Peoria, Tazewell, and Woodford Counties.

## CHIP Plan Goals, Objectives, and Strategies

### Goal

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

### Objectives

- By 2022, reduce the proportion of adults considered obese by 2%.
- By 2022, reduce the proportion of youth (Grade 8-12), who self-reported overweight and obese by 2%.
- By 2022, decrease food insecurity in populations residing in Peoria, Tazewell, and Woodford Counties by 1%.

### Strategies

- Community based social support for physical activity and nutrition.
- Breastfeeding promotion programs.
- Family based physical activity interventions.
- Screen time interventions for children
- Multi-component obesity prevention interventions.
- Food insecurity screening.
- Create multi-sector partnerships and networks

## 2020-2022 CHIP PRIORITY: CANCER (BREAST, LUNG, COLORECTAL)

### **CHNA Data**

Malignant Neoplasms were the 1<sup>st</sup> or 2<sup>nd</sup> top leading causes of death in the tri-county in 2017 as well as the 2<sup>nd</sup> leading in Illinois.

In the past five years 72% of women had a breast screening and 61% women and men over the age of 50 had a colorectal screening. The data was stratified based on recommended ages by the American Cancer Society; women should receive breast cancer screenings by age 45 and everyone over the age of 45 should receive colorectal screenings.

### **Breast Cancer:**

#### ***IDPH:***

Breast cancer is the most common cancer in women in Illinois. Woodford County is below the state rate.

#### ***Partnership-Cancer Priority:***

The Partnership for a Healthy Community Breast Cancer Action Team has increased screenings by 1.98% from 2017-2018 with a total of 41,113 screenings in 2018. The highest number of screenings occurred between the ages of 50-69 years. Of the 41,113 screenings in 2018, 574 of these individuals received a cancer diagnosis and were referred to providers.

#### ***National Cancer Institute:***

From 2011-2015, both Peoria and Woodford Counties are above the state and national breast cancer mortality rates.

### **Lung Cancer:**

#### ***IDPH:***

Lung cancer is the number two most common cancer among men and women in Illinois. While Woodford County's rate is below Illinois's rate, both Peoria and Tazewell counties are above it.

#### ***Community Commons:***

As of 2014, the tri-county was above the state and national levels of cigarette expenditures as a percentage of total household expenditures. While state and national levels are between 1.5-1.56%, the tri-county was 1.88%. Peoria, Tazewell, and Woodford Counties are above the national age-adjusted percentage while only Woodford County is below the state percentage.

## Colorectal Cancer:

### **IDPH:**

Colorectal cancer is the third most common cancer among men and women in Illinois. While Woodford County's incidence rate is below Illinois's rate, both Peoria and Tazewell counties are above it.

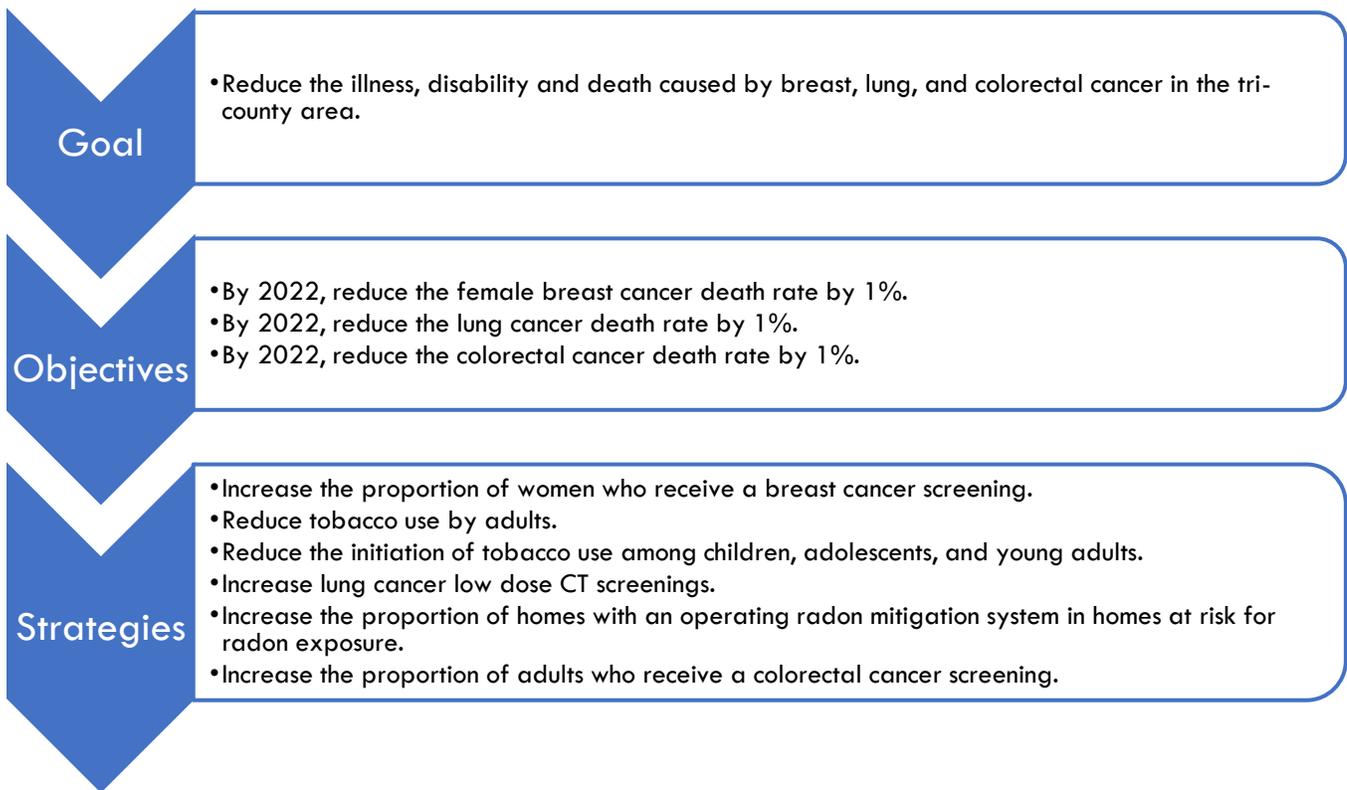
### **National Cancer Institute:**

All three counties are above the state, national, and HP2020 age-adjusted colorectal cancer death rates.

### **Economic Impact:**

The direct medical costs (total of all health care costs) for cancer in the United States for 2015 was \$80.2 billion (Agency for Healthcare Research and Quality).

## CHIP Plan Goals, Objectives, and Strategies



## 2020-2022 CHIP PRIORITY: MENTAL HEALTH

### **CHNA Data**

The CHNA survey asked respondents to rate the three most important health issues in the community out of 10 options. An overwhelming 69% rated mental health as an important health issue in the community.

In 2016, 72% of survey respondents answered “Good” compared to only 28% of 2019 respondents.

### **Depression and Anxiety:**

#### ***Illinois Youth Survey:***

In 2019, the survey asked 8<sup>th</sup>-12<sup>th</sup> grade students during the past 12 months if they ever felt so sad or hopeless almost every day for two weeks or more in a row that they stopped some usual activities. Data showed that between 18-37% of students answered yes.

### **CHNA**

When asked how often they have felt depressed in the past 30 days, 46% of respondents said that they felt depressed at least 1 to 2 days in the past 30 days with 9% of these respondents experiencing depression more than 5 days in the past 30 days.

When asked how often they have felt anxious or stressed in the past 30 days, 40% of respondents said that they felt anxious or stressed at least 1 to 2 days in the past 30 days with 7% of these respondents experiencing anxiety or stress more than 5 days in the past 30 days.

### **Suicide:**

There was a higher incidence of suicide in the tri-county compared to State of Illinois averages in 2015.

### **County Health Rankings**

While the Illinois suicide rate was 11.7 per 100,000 population, from 2012-2016, each county had higher rates. Rates within this period were 12.4 in Peoria, 13.5 in Tazewell, and 23.5 in Woodford County.

### ***Illinois Violent Death Reporting System (IVDRS):***

During 2015-2016 over 80% of the suicides that occurred in the tri-county were over the age of 20. 100% in Tazewell and 77% in Peoria during 2016 were white males. Firearm related suicides were the number one cause of suicide in 2016 with 36% Peoria, 37.4% Tazewell, and 45% Woodford county.

### ***Illinois Youth Survey:***

In the 2018 Illinois Youth Survey students were asked if they seriously considered attempting suicide in the past 12 months. Results show between 14-20% of students had considered suicide.

### **Community Commons:**

From 2012-2016 Peoria, Tazewell and Woodford Counties all had higher age-adjusted suicide rates than the State of Illinois. Tazewell and Woodford Counties both had a higher rate than the national rate.

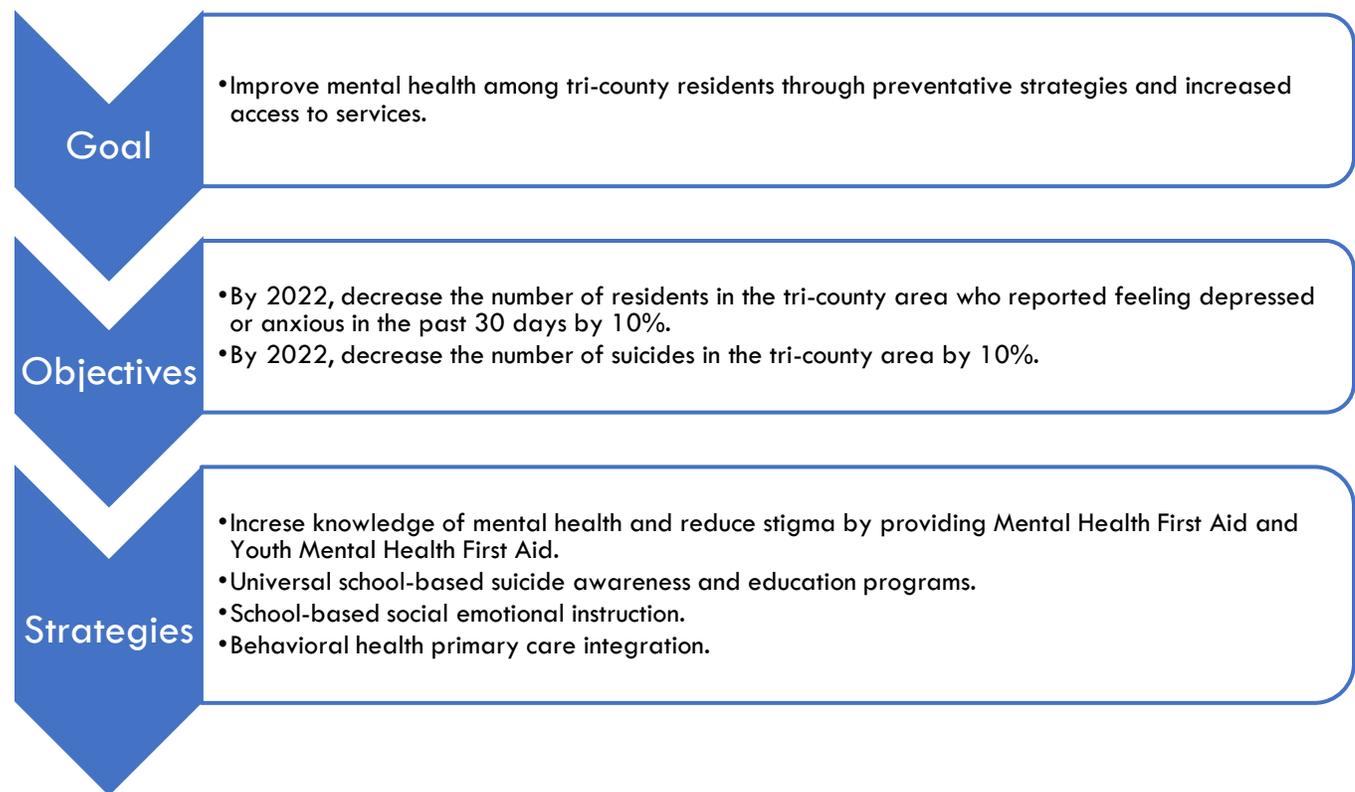
**Economic Impact:**

Each year, serious mental illness costs Americans \$193 billion in lost earnings (American Journal of Psychiatry). Much of the economic burden of mental illness is the loss of income due to unemployment, expenses for social supports, and a range of indirect costs due to a chronic disability. The average cost of one suicide was \$1,329,553 with 97% being due to lost productivity. Total cost of suicides and suicide attempts costs \$93.5 billion annually. (National Institutes of Health)

**Social Determinants:**

In the CHNA, depression was more likely for respondents living in Peoria County. Also, those respondents had less education, lower income, and lived in an unstable (e.g. homeless) housing environment. Stress and anxiety tend to be rated higher for younger individuals, those with less education, those with less income and those in an unstable (e.g. homeless) housing environment. In the tri-county, suicide rates tend to be higher for white males over the age of 20.

**CHIP Plan Goals, Objectives, and Strategies**



## 2020-2022 CHIP PRIORITY: SUBSTANCE USE

### **CHNA Data**

When asked to select the three most important unhealthy behaviors in the community 60% of CHNA survey respondents answered drug abuse (illegal). In addition, alcohol abuse, drug abuse (legal), and smoking/vaping were amongst the top ten as well.

#### ***Illinois Youth Survey:***

In 2016, reports of prescription drug abuse among area youth was above the Illinois average in Peoria 8<sup>th</sup> graders (5% vs. IL 4%). All other groups reported rates that were at or below state averages.

#### ***IDPH Data:***

From 2012-2016 the tri-county area has experienced an elevated overdose mortality rate compared to state and national trends.

There seems to be an increasing trend in drug overdose deaths for “any drug” in the system as well as “any opioid” for Tazewell and Peoria counties from 2013-2017 with a decrease in 2018. Woodford has persistently been well below the other counties’ rates. (Provisional data from 2018 as of 2/6/2019)

#### ***County Health Rankings:***

According to County Health Rankings the drug overdose mortality rate per 100,000 population from 2014-2016 ranges in Illinois from 8-34 with the Illinois’s average being 15. The tri-county ranges from 15-18. The percentage of adults reporting binge or heavy drinking as of 2016 is between 20-22% in the tri-county with the Illinois county range between 14-24% and the Illinois average 21%.

#### ***Economic Impact:***

Alcohol abuse costs the U.S. \$191.6 billion and drug abuse costs \$151.4 billion (Substance Abuse and Mental Health Services Administration - SAMSHA). Excessive alcohol consumption cost the U.S. \$223.5 billion in 2006, or about \$1.90 per drink. Binge drinking is 76% of the costs (Centers for Disease Control and Prevention).

#### ***Social Determinants:***

In the CHNA use of substances tends to be rated higher by Latino people, those with less education, those with lower income, and those in an unstable (e.g. homeless) housing environment.

#### ***Healthy People 2020 Interventions:***

There are 22 evidence-based interventions listed that would pertain to substance use that will be reviewed to determine community involvement, cost, and feasibility prior to implementation.

## CHIP Plan Goals, Objectives and Strategies

### Goal

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

### Objectives

- By 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.
- By 2022, increase the proportion of adolescents reporting never using substances in the tri-county area by 5%.

### Strategies

- Criminal Justice
- Harm reduction efforts
- Technology enhanced classroom instruction.
- Mass Media campaigns against alcohol-impaired driving/underage and binge drinking.
- Youth leadership programs.
- Proper drug disposal program.

## EVALUATION AND MONITORING

Within the Partnership for a Healthy Community Health Improvement Plan charts, there is an “Evaluation Plan” column that contains both process indicators and outcome indicators. These indicators will be tracked throughout the three-year cycle ending in 2022, with the assistance of the action teams. The PFHC Board, along with the data action team will be responsible for assuring that the indicator data is being tracked and that it is shared with community partners. Through evaluation, accountability will be increased, modifications to the plan considered, and a stronger commitment to improving the health of tri-county citizens will be communicated to its residents and stakeholders.

The Partnership for a Healthy Community Board reserves the right to amend this 2020-2022 Community Health Improvement Plan (CHIP) as needed to reflect each organization’s role and responsibilities in executing the CHIP as well as the resources each organization is committing. In addition, certain significant health needs increase and require amendments to the strategies. Other entities or organizations in the community may develop programs to address the same health needs or joint programs may be adopted. Finally, in compliance with Internal Revenue Code Section 501(r) requirements for hospitals may refocus the limited resources the organization committed to the CHIP to best serve the community.

## ACKNOWLEDGEMENTS

### **Action Team Chairs**

#### **Healthy Eating Active Living**

Greg Eberle, Hopedale Medical Center  
Kaitlyn Streitmatter, University of Illinois Extension  
Shanita Wallace, Tazewell County Health Department  
Hillary Aggertt, Woodford County Health Department

#### **Cancer**

Tom Cox, OSF Healthcare St. Francis Medical Center  
Diane Hahn, CRC Life  
Wendy Lewis, CRC Life  
Andrea Ingwersen, Woodford County Health Department

#### **Mental Health and Substance Use**

Holly Bill, Hult Center for Healthy Living  
Tim Bromley, OSF Healthcare St. Francis Medical Center  
Monica Hendrickson, Peoria City/County Health Department

### **Data Team Chairs**

Tim Heth, UnityPoint Health  
Monica Hendrickson, Peoria City/County Health Department

### **Healthcare Systems**

Advocate Eureka Hospital  
Hopedale Medical Complex  
OSF Healthcare Saint Francis Medical Center  
UnityPoint Health

### **Health Departments**

Peoria City/County Health Department  
Tazewell County Health Department  
Woodford County Health Department

Thank you  
Leslie McKnight, PhD – Peoria City/County Health Department  
*For coordinating the information presented within the CHIP*

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# APPENDIX 1: STRENGTHS, WEAKNESSES, OPPORTUNITIES, AND THREATS (SWOT) ASSESSMENTS

## Behavioral Health (14 participants)

### I. Strengths:

- The varied experiences/backgrounds of the members. Everyone having one common goal- helping our communities find/educate on behavioral health
- Working together as a Tri-County effort
- Passionate membership, buy-in from schools
- Networking, collaboration, education
- The team cooperation to get things done
- Initially identifying the problems that existed in the number of people providing mental health services.
- Collaboration recognition of issues, working towards solutions
- Evaluation of Narcan
- Discussion of community systems of behavioral health care that are working and not working. Focus on behavioral health and criminal justice system.
- Great representation from agencies, those who work in behavioral health; strong goals
- The collaboration of ideas and numerous agencies to provide an impact on the community.
- Representation from multiple diverse community partners both public and private
- Concerted effort in schools for ACEs/trauma training data on Narcan and overdose reversals

### II. Weakness/Barriers

- The weakness has been lack of communication to be involved. The geographic tri-county area has not been well represented.
- Finding ways to fill the high demand of what is going on in the tri-county area. I.E. High need for mental health/substance abuse issues. Not enough resources (beds for emergency situations, funds, counselors, etc.)
- Resources for staff, stigma
- Uncertain, but I would say impacting access for underserved populations- youth and young adults
- There hasn't been a lot of meeting to attend
- Seems that there are Peoria working groups already going on and Tazewell/Woodford hasn't been as involved
- Means to implement solutions (financial, man-power)
- Keeping the work tri-county focused
- Group seems to struggle with direction and roles. Not always clear what part PCCHD has in the discussion. Provider may share that lack of clarity.
- Lack of resources to make referrals; hard to collect outcomes on behavioral health (health education perspective)
- Lack of consistent meetings/attendance. Some members worked on their own projects that have an impact on the goals, but it didn't feel like the committee was working on goals at times, just individuals
- Lack of communication with full BH Action Team, lack of meeting schedule, uncertainty of BH actions and accomplishments throughout the 3 years
- I am not an instrumental part of the team, but I think that it will be helpful to have the efforts of the hospitals incorporated into the plan

**III. Opportunities**

- Place some focus on Woodford for Behavioral Health. We are seeing more substance abuse through the ER
- Building a stronger system and finding unique ways to care for more people in the tri-county areas.
- Systematic collaboration between entities providing “SEL” or other youth services in our schools
- Decreased stigma towards MI treatment; increase awareness on the breadth of issues; increased interest of more collaboration to assist/help address the needs.
- Leadership of the committee
- Meeting regularly and have defined goals to achieve
- Data is continually improving. Many opportunities to improve social, wellness and behavioral health
- Continued community education and awareness as better assessment of what is really going on. Possibility for future grant funding
- Come to agreement about committee role as facilitator of creative thinking, explore grant opportunities and/or assisting with data collection demonstrating change or lack thereof.
- UnityPlace will provide a stronger, united approach to behavioral healthcare; stigma is reducing; data collection is becoming stronger.
- Improving the connection of member’s efforts to the committee goals. Clear ideas of who is working on what and the impact it has towards the committee goals.
- Collaboration of public health and behavioral health services leveraging existing capacity (HD, Hospitals, & community). New legislation focused on trauma-informed training for police officers, suicide prevention, and awareness education for colleges and universities (HB51; HB 2152; HB2766)
- Breaking silos to work together regardless of agency requirements.

**IV. Threats/Barriers**

- Resources. We have great ideas but how do you help them come to fruition?
- Resources in Central Illinois- including our hard-working providers for mental illness and substance abuse prevention.
- Lack of funding
- Siloes work
- Lack of health care providers; funding for social agencies, private insurance vs Medicaid accessible facilities especially for youth.
- Recruitment
- Politics, Poverty, indifference to recognizing the problems and possible solutions
- Continued changes on the substances being used.
- To many agendas from committee members
- Lack of funding; violence, trauma, racism, health equity, access to services, and more continue to impact behavioral/mental health
- Individual agency goals that may be priority over the committee goals. Which may have an impact on attendance/participation in meetings.
- Marijuana legalization, vaping health concerns (lack of knowledge of dangers and increase of availability).
- Behavioral Health is a big area and will require excellent communication and synergy amongst partners
- Resources, funding, insurance coverage, substance use, stigma
- Siloes work related to the organization rather than breaking the silo to assist as an overall.

## Healthy Eating/Active Living (17 participants)

### I. Strengths:

- Variety of organizations involved
- Consistent core group of individuals working together.
- Bringing a variety of groups together to share ideas and resources.
- Developing relationships
- Fresh food access planning and increasing collaboration strategies.
- Collaboration in a way that has brought about new initiatives and work in our community that would not have existed before.
- Collaborating agencies working together to make resources more readily available throughout multiple communities. Shows leadership among cross-county jurisdictions. Shows a willingness to better the community through support and making new changes that are critical for sustaining growth and public health outcomes.
- Collaboration, EHT grant, participation and attendance.
- Strong commitment and focus to food insecurities
- Great community connections/networking. Having break out groups during big meeting and sharing progress at the end of the meetings is helpful.
- Build strong partnerships, create a website and communication platforms and move into actionable work.
- Organization, partners at the table and communicating relevant information.
- Commitment to the goals created in the CHNA, and the ability to create a plan to improve outcomes.
- Great collaboration, working together to benefit all, sharing of resources, dedicated team, knowledgeable team and passionate.
- The group is built with such a diverse group of professionals with each bringing their knowledge and personal strengths to the group to go towards a common goal. Everyone listens well and is open to new ideas and opportunities.
- Consistent meetings, minutes, good cooperation among members.
- Great communication among members, networking to assist others and understand the needs of the tri-county area.

### II. Weakness/Barriers

- I feel I get more out of it when I reach out to the group members individually than the whole group meetings.
- Inconsistent attendance
- I find it difficult to determine just where I fit in with this group. There is interesting work discussed but I find it confusing and overlapping with other initiatives.
- There are quite a few meetings between HEAL and grant work.
- Collaboration for fresh food access is strong, however, I feel like physical activity and work place wellness are operating on their own and have minimal or no progress at all because the focus has been fresh food access (for a good reason). There needs to be a work statement for physical activity and implementation goals that included individual organizations initiative and at least one collaborative project that includes all interested HEAL team members for physical activity.
- Trying to work through the data process without having a great way to find what we need to prove our good work. Trying to find the best way to affect change.
- Some barriers are trying to find a time to meet that works with everyone's schedules.
- Platform for documents.
- The team was focused and acted upon primarily on one aspect of the HEAL team priority. This is a good thing but there are other objectives that need to be met as well.

- For me personally being on 2 committees (HEAL & Lung Cancer) when HEAL and lung cancer started meeting on the same day & time is made me step away from most of the HEAL meetings because I was a co-chair for lung cancer.
- Identifying collective work opportunities as a HEAL action, but much has been done in the last 6 months with Ending Hunger Together
- Keeping partners engaged
- Consistent engagement of all team members
- Funding losses; members falling off and not being able to support efforts once able to support for various reasons; difficult to track progress on overall goals.
- Not being able to reply on current timely data on these indicators to base changes on. I believe in a lot of the meetings we might be missing helpful or important partners or leaders in this area.
- Time on task, need more inclusive objectives and strategies
- It is confusing to know what all falls under HEAL and what is part of a grant and how they work together.

### III. Opportunities

- Hopefully the grant will allow us to get bigger, more impactful projects done.
- The opportunities are to expand the existing programming and to take a deeper look into chronic disease.
- It seems to me there needs to be a streamlining of the work that is occurring. I'm not sure if this comes from communication difficulties or if I am just not integrating effectively but I feel like the meetings are more talk than action. Help me understand where I can play an active role.
- Improve the flow of data and building intra-agency support
- Designated champions or team captains for the break out teams of HEAL that will assist with a designated amount of communication per month and present on goals moving forward to provide clarity to other members.
- Utilizing different data sets, documented what is used and make sure it is a data set that will affect our audience we are reaching through our work. Continued collaboration to bring about sustainable, replicable changes throughout our tri-county.
- Allowing access to the meetings by phone conference if the location of the meeting doesn't work out for one's schedule. I believe this method is already being done.
- Wild Apricot website, future grant applications.
- HEAL has established a good grasp on food insecurities. This will allow our new team to embrace the other focus areas in HEAL along with supporting the existing programs
- Be sure to check all groups meeting days and not have overlap. Find more people to be involved in CATCH team if that continues to be a subgroup of HEAL.
- Continue to seek opportunities to connect in HEAL initiatives as a whole partnership. Build capacity with new HEAL partners.
- Tri county WIC Coordinators collaborating on projects, utilizing additional funding opportunities like Ending Hunger Together, partnering with Regional Fresh Food Council to avoid overlap
- As a leader I it would be helpful for me to understand team engagement, gaps in who is attending and if that negatively impacts outcomes. I would like to be able to ensure you have the resources you need to execute. Creating take-aways for team members so that they can speak to the work, next steps, seek assistance as needed.
- Increased quality data to really see the needle move.
- Bring in more partners without losing the ones we have such as the fresh food council.
- Several projects have momentum and concentration can be given to new areas such as physical activity
- Understanding all the different groups working on the same goals and how to work together to make a bigger impact throughout the tri-county area.
- Wild Apricot will be helpful to communicate more, share information and not have an email but a place on the website to see everything.

#### **IV. Threats/Barriers**

- Lack of funding
- Engagement
- I think we are all working with fewer resources- time, staffing, and money are being pinched everywhere. IT is difficult for me to justify an entire afternoon out of my office to travel to Peoria for a meeting.
- Funding and finding additional resources
- Creating projects that are too large scale that are not sustainable for time or resources present.
- Not putting our communities in the forefront of our discussion. - I think involving more community members in some of our conversations could be beneficial.
- Time and being able to attend the meetings without interfering with other daily commitments.
- Lack of attendance, participation, stakeholder buy in
- Engagement and recruitment of new team members
- Making sure everyone who has an interest in HEAL has a place or group to work in, sometimes people who came to the meetings were not sure what group they fit into.
- Lack of full participation in the HEAL strategies unless buy in on the organizational level is identified.
- Time commitment required may deter people from actively participating.
- It is a heavy lift, changing a culture. Would be great to have better buy in from city leadership, support, engagement. I think this exists in some areas but not all-how do we get these folks at the table to support the work.
- Changes in people leaving or joining the group. Getting the necessary data regarding indicators on a variety of HEAL topics to be able to see change or work towards objectives more easily.
- Time on task and having entities see their work represented
- Potentially to many meetings relating to breakouts and grants; funding; resource sharing

### **Cancer (9 participants)**

#### **I. Strengths**

- Quarterly meetings have been great ways to keep up with what every person is up too in their fields of work.
- Cancer Health is being addressed, Healthy People is easy to understand, nay community Evidence Based models have proven to be effective
- I think we have pulled together existing projects and learned from each other so that we can support programs that all have similar effects on the health of the population as far as lung health and reducing lung cancer risk. I think we've done a good job at documenting activities that are proven strategies that work.
- Dedicated, knowledgeable, open to suggestions, able to follow-up
- Having the cancers broken out into 2 subgroups
- Being able to pull data together to find actionable items to work on.
- It has been great to learn all the community resources available.
- Cross agency collaboration & coordination IBCCP, Komen, and hospital engagement Improved data collection (i.e. mammograms) Radon mitigation provider involvement Regional tobacco prevention grant - pooling resources for collective & increased impact.
- Radon-gained mitigator -collaboration Tobacco-collaboration, group work/projects -tri-county educational messages mirror those of nation campaigns

**II. Weaknesses/Barriers**

- Not enough group time in terms of nicotine, breast, and radon. For a while the hour and half long meetings were used for each of the 3 areas to break up in their own groups to meet and discuss. Sometimes when all areas get together to meet, not a whole of time is spent on 1 area.
- Retain members on a task force, low public awareness/value of Partnership, need purpose statement
- I think we've struggled to retain people and bring new people to the table. Attendance has been low recently. I also think we might be a bit too detached in the radon versus tobacco with lung cancer and even more-so with breast cancer
- Not all members able to attend, need cross sector members, need to focus on the identified evidence-based strategies or add an agenda item for other updates, need to focus on some joint activities, rather than each member reporting on their own activity
- It is hard for me to attend the meetings in the middle of the day, especially with travel time at times being 20-30 minutes to the meeting and back.
- Combined meetings take up a lot of time to accomplish tasks.
- As a healthcare provider, it has been very difficult for me to attend these meetings especially with traveling to outside locations
- Lack of engagement of new members – American Cancer Society, cancer prevention providers, insurance providers. Quarterly meetings with combined groups are long and difficult to review material from both lung & breast cancers. Traveling to the various HD's is time consuming.
- Conference call are difficult to follow and/or hear all information. Decrease in engagement outside of local health department staff.

III. Radon-lacking representation across varied sectors – lacking engagement beyond H.D. – lack of funding for mitigation (we promote people testing but lack resources if they cannot afford mitigation of it is needed) – lack of guidance and support from PFHC board Tobacco – lack participation outside if ITFC grantees – lack of guidance and support from PFHC board – engagement beyond H.D.s

**IV. Opportunities**

- Tobacco 21 and efforts to control vaping and E- Cigs are next areas of focus.
- Have the Partnership act/form a Central Illinois Cancer Coalition. <https://nc crt.org/resource/can-ccc-coalitions-advance-80-by-2018/> Replicate successful projects! Create simple mission statement, easily repeated. Expand partnership with non-healthcare (teach teens about cancer, include BU) Simplify dashboards.
- I think we could have opportunities to spread our messages at health fairs and when we talk to stakeholders in the community and include multiple messages for strategies in marketing materials. I also think there could be more initiative from people stepping up to take tasks on that can make us more collaborative.
- Identify additional cross sector members, focus the agenda on the strategies, identify joint activities
- Keep cancers broken out into teams. Do these feed up to a main cancer action team? Some people really could be involved in all 3, but cannot make that kind of time commitment
- ADDING VIRTUAL MEETINGS WHERE INFORMATION COULD BE COLLECTED OR SURVEY MONKEY FOR DECISIONS TO TALK ABOUT AT THE NEXT MEETING.
- It would be great to get this information out to the public; not sure it's advertised well. Ladies need to know how to decrease their risk for breast cancer.
- Use of an online meeting format (i.e. Join me, meeting request, etc.) – less traveling & easier to follow for all Tri-County Tobacco Prevention Grant – collaborative Substance abuse priority Recruit and engage IL Cancer Care, American Cancer Society, Insurance companies. Strengthened partnership with local HD & hospitals – more accurate data & power to move priorities.
- Radon-expand membership (realtors, building contractors, inspectors) -flexibility in funding Tobacco-diversify funding to include more education and funding for schools to combat e-cig/vaping -expand membership, more participation from current

## V. Threats/Barriers

- Nicotine use among the youth are on the rise, so we must come up with a plan to try to minimize that in our counties of interest.
- Limited funding, coalition/community have alternate goals/priorities, obtain data across entities, no coordinated screening guideline
- I think one threat/barrier is that certain employees may only be allowed to be laser-focused on certain aspects of their job that many not be inclusive of other strategies we are trying to work together towards as a committee.
- Lack of resources in funding, members spread thin for activities, budget for the strategies, lack of time for grant writing, data collection, state resources (radon website and up to date data), possible regulation or law changes, too many focus areas for cancer and not enough membership for additional activities in each area as well as some members are not able to cross over to other subject area (tobacco, radon, breast, colon)
- Need a champion on each group - someone who can see the vision for these and will hold others accountable.
- Timing- How to get all of us together to get information out. With working full time and having 3 active children, it's hard to find extra time.
- Challenges of managing 3 cancer prevention groups. Marijuana legalization increased vaping accessibility
- Radon-many people still do not believe radon is a dangerous health threat or that it is even real Tobacco-funding (ITFC) -public perception, changing mindset about tobacco free public places -educating younger generation about dangers of e-cigs/vaping and chewing tobacco -chewing tobacco still acceptable in farming/rural communities

## APPENDIX 2: COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) DASHBOARDS

### Healthy Eating / Active Living

January 1, 2020 – December 31, 2022

HEALTH PRIORITY: HEALTHY EATING/ACTIVE LIVING (HEAL)			
GOAL: TO FOSTER AND PROMOTE HEALTHY EATING AND ACTIVE LIVING TO REDUCE CHRONIC DISEASE AND FOOD INSECURITY IN THE TRI-COUNTY AREA.			
	INTERVENTION STRATEGIES (Evidence-based)	EVALUATION PLAN	POTENTIAL RESOURCES/PARTNERS
<p>OBJECTIVE #1 (HP2020): By 2022, reduce the proportion of adults considered obese by 2%</p> <p>Baseline: The percentage of adults considered obese (<i>Data from County Health Rankings</i>):</p> <ul style="list-style-type: none"> <li>• Peoria-33%</li> <li>• Tazewell- 33%</li> <li>• Woodford- 28%</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Community-based social support for physical activity and nutrition</u></li> </ul>	<ul style="list-style-type: none"> <li>• BMI</li> <li>• Exercise days of at least 30 minutes in the last week (CHNA)</li> <li>• Servings/separate portions of fruit and/or vegetables on a typical day (CHNA)</li> </ul>	Advocate Eureka Hospital Ending Hunger Together Partners Hopedale Medical Complex OSF Healthcare / Saint Francis Medical Center Park District(s) serving the tri-county Peoria City/County Health Department Tazewell County Health Department Tri-County Regional Planning UnityPoint Health University of Illinois Extension Woodford County Health Department
<p>OBJECTIVE #2 (HP2020): By 2022, reduce the proportion of youth (Grade 8-12), who self-reported overweight and obese by 2%</p> <p>Baseline: 11% to 17% of youth report being overweight and 13% of youth report being obese (<i>Data from IYS</i>)</p>	<ul style="list-style-type: none"> <li>• <u>Breastfeeding promotion programs</u></li> <li>• <u>Family-based physical activity interventions</u></li> <li>• <u>Screen time interventions for children</u></li> <li>• <u>Multi-component obesity prevention interventions</u></li> </ul>	<ul style="list-style-type: none"> <li>• Breast feeding rates (WIC)</li> <li>• Fruit/Vegetable consumption in the last 7 days (IYS)</li> <li>• Hours per day spent on non-school related screen time (IYS)</li> <li>• Days physically active for a total of at least 60 minutes in the last 7 days (IYS)</li> </ul>	Advocate Eureka Hospital Colleges and universities within the tri-county Ending Hunger Together Partners Hopedale Medical Complex OSF Healthcare / Saint Francis Medical Center Park District(s) serving the tri-county Peoria City/County Health Department Regional Fresh Food Council School districts within the tri-County Tazewell County Health Department Tri-County Regional Planning UnityPoint Health University of Illinois Extension Woodford County Health Department WIC YMCA YWCA

<p>OBJECTIVE #3 (HP2020): By 2022, decrease food insecurity in populations residing in Peoria, Tazewell and Woodford Counties by 1%</p> <p>Baseline: The percentage of households reporting food insecurity (<i>Data from County Health Rankings</i>):</p> <ul style="list-style-type: none"> <li>• Peoria- 16%</li> <li>• Tazewell- 10%</li> <li>• Woodford- 9%</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Food insecurity screening</u></li> <li>• <u>Create multisector partnerships and networks</u></li> </ul>	<ul style="list-style-type: none"> <li>• Food insecurity data (WIC)</li> <li>• Healthcare food insecurity screening data</li> <li>• Days per week hungry (CHNA)</li> <li>• Hungry because there was not enough food at home in the last 30 days (IYS)</li> </ul>	<p>Advocate Eureka Hospital Ending Hunger Together Partners Hopedale Medical Complex OSF Healthcare / Saint Francis Medical Center Park District(s) serving the tri-county Peoria City/County Health Department School districts within the tri-County Tazewell County Health Department Tri-County Regional Planning UnityPoint Health University of Illinois Extension Woodford County Health Department WIC</p>
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## Cancer

January 1, 2020 – December 31, 2022

HEALTH PRIORITY: CANCER (BREAST, LUNG, COLORECTAL)			
GOAL: REDUCE THE ILLNESS, DISABILITY AND DEATH CAUSED BY LUNG, BREAST AND COLORECTAL CANCER IN THE TRI-COUNTYAREA.			
	INTERVENTION STRATEGIES (Evidence-based)	EVALUATION PLAN	POTENTIAL RESOURCES/PARTNERS
<p><b>OBJECTIVE #1 (HP2020):</b> Reduce the female breast cancer death rate by 1%</p> <p>Baseline: Breast cancer age-adjusted death rate 2011-2015:</p> <ul style="list-style-type: none"> <li>• Peoria 22.7</li> <li>• Tazewell 18.7</li> <li>• Woodford 24.4</li> </ul>	<ul style="list-style-type: none"> <li>• Increase the proportion of women who receive a breast cancer screening</li> </ul>	<ul style="list-style-type: none"> <li>• Number of first-time breast cancer screenings</li> <li>• Number of breast cancer screenings (↑ 1.98% from 2017-2018 with a total of 41,113 screenings in 2018)</li> </ul>	<p>Advocate Eureka Hospital Hopedale Medical Complex OSF HealthCare Peoria City/County Health Department Susan G Komen Tazewell County Health Department UnityPoint Health- Peoria Woodford County Health Department</p>
<p><b>OBJECTIVE #2 (HP2020):</b> Reduce the colorectal cancer death rate by 1%</p> <p>Baseline: Colorectal cancer age-adjusted death rates 2011-2015:</p> <ul style="list-style-type: none"> <li>• Peoria 17.6</li> <li>• Tazewell 17.6</li> <li>• Woodford 20.7</li> </ul>	<ul style="list-style-type: none"> <li>• Increase the proportion of adults who receive a colorectal cancer screening based on the most recent guidelines</li> <li>• <u>Multicomponent Interventions—Colorectal Cancer</u></li> <li>• <u>Cancer Screening: Provider Assessment and Feedback – Colorectal Cancer</u></li> </ul>	<ul style="list-style-type: none"> <li>• Number of women and men over the age of 50 who have had an invasive or non-invasive colorectal cancer screening which include the following:                             <ul style="list-style-type: none"> <li>○ Colonoscopy</li> <li>○ Virtual colonoscopy</li> <li>○ Cologaurd</li> <li>○ FIT</li> <li>○ FOBT</li> </ul> </li> <li>• Number of first time invasive or non-invasive colorectal cancer screenings</li> </ul>	<p>Advocate Eureka Hospital CRR Life Hopedale Medical Complex OSF HealthCare Peoria City/County Health Department Tazewell County Health Department UnityPoint Health- Peoria Woodford County Health Department</p>

<p>OBJECTIVE #3 (HP2020): Reduce the lung cancer death rate by 1%</p> <p>Baseline: Lung cancer age-adjusted death rates 2011-2015:</p> <ul style="list-style-type: none"> <li>• Peoria 86.9</li> <li>• Tazewell 84.3</li> <li>• Woodford 56.5</li> </ul>	<ul style="list-style-type: none"> <li>• Reduce tobacco use by adults</li> <li>• Reduce the initiation of tobacco use among children, adolescents, and young adults</li> <li>• Increase the proportion of homes with an operating radon mitigation system for persons living in homes at risk for radon exposure</li> <li>• Increase lung cancer low dose CT screenings. <i>The U.S. Preventive Services Task Force (USPSTF) recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years.</i></li> </ul>	<ul style="list-style-type: none"> <li>• Tri-County population age 18 years and older report smoking cigarettes (current 19.1%)</li> <li>• Number of radon screenings and testing (IEMA permit database)</li> <li>• Number of mitigation systems per year</li> <li>• Primary care screenings for tobacco use</li> <li>• Number of lung cancer low dose CT screenings</li> <li>• Number of tobacco free policies created in Tri-County area</li> <li>• Number of SFIA compliance checks in the Tri-County area</li> <li>• Number of curriculum programs/educational sessions focusing on tobacco use prevention or cessation offered</li> <li>• Number of tobacco cessation programs offered</li> </ul>	<p>Advocate Eureka Hospital  City of East Peoria Policy Department  City of Peoria  City of Washington Police Department  Hopedale Medical Complex  IL Emergency Management Agency  OSF HealthCare  Peoria City/County Health Department  Peoria County Sherriff's Department  Peoria Park District youth group  Peoria Radon- Jim Emanuel  Tazewell County Health Department  Tazewell County Sherriff's Department  UnityPoint Health- Peoria  Woodford County Health Department  Woodford County Sherriff's Department</p>
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## Mental Health

January 1, 2020 – December 31, 2022

**HEALTH PRIORITY: MENTAL HEALTH**

**GOAL: IMPROVE MENTAL HEALTH AMONG TRI-COUNTY RESIDENTS THROUGH PREVENTATIVE STRATEGIES AND INCREASED ACCESS TO SERVICES.**

	INTERVENTION STRATEGIES (Evidence-based)	EVALUATION PLAN	POTENTIAL RESOURCES/PARTNERS
<p>OBJECTIVE #1: (HP2020) By December 31, 2022, decrease the number of suicides in the tri-county area by 10%.</p> <p><i>Baseline: Suicide deaths (per 100,000) – Tri-County 2015- Source: IDPH; PC 10.9; TC 12.0; WC 15.8; IL 9.5</i></p>	<ul style="list-style-type: none"> <li>• Increase knowledge of mental health and reduce stigma by providing Mental Health First Aid and Youth Mental Health First Aid</li> <li>• Universal school-based suicide awareness &amp; education programs</li> <li>• School based social emotional instructions</li> <li>• Behavioral health primary care integration</li> </ul>	<ul style="list-style-type: none"> <li>• Establish baseline; increase certifications by 10%</li> <li>• Establish baseline; increase number of students receiving suicide prevention education by 10%</li> <li>• Establish baseline; increase number of trauma-informed schools by 10%</li> <li>• Increase number of providers in primary care settings by 10%; Increase number of providers in specialized care settings by 10%; increase number of providers in prompt care settings by 10%</li> </ul>	<p>Advocate Eureka Hospital                      Children’s Home of Illinois                      Heart of IL United Way                      Hult Center for Healthy Living                      NAMI Tri-County                      OSF Saint Francis Medical Center                      Peoria City/County Health Department                      Peoria Regional Office of Education                      Tazewell County Health Department                      Tazewell/Woodford Regional Office of Education                      UnityPlace                      UnityPoint Health Peoria                      Woodford County Health Department</p>

<p>OBJECTIVE #2: (HP2020) By December 31, 2022, decrease the number of residents in the tri-county areas who reported feeling depressed or anxious in the past 30 days by 10%.</p> <p>Baseline:</p> <ul style="list-style-type: none"> <li>10<sup>th</sup> and 12<sup>th</sup> grade students who have seriously considered suicide in past 12 months: 17.17% in the tri-county area. (PC 18%; TC 19.5%; WC 14%)</li> <li>Baseline: In the past 30 days, 46% of tri-county residents reported feeling depressed at least 1 to 2 days. 9% experienced depression more than 5 days in the past 30 days. (CHNA survey)</li> <li>Baseline: In the past 30 days 40% of tri-county residents reported they felt anxious or stressed at least 1 to 2 days in the past 30 days with 7% experiencing anxiety or stress more than 5 days.</li> <li>Baseline: In the past 30 days, 46% of tri-county residents reported feeling depressed at least 1 to 2 days. 9% experienced depression more than 5 days in the past 30 days.</li> <li>Baseline: 46% of respondents felt anxious in the last 30 days.</li> </ul>	<ul style="list-style-type: none"> <li>Increase knowledge of mental health and reduce stigma by providing Mental Health First Aid and Youth Mental Health First Aid</li> <li>Universal school-based suicide awareness &amp; education programs</li> <li>School based social emotional instructions</li> <li>Behavioral health primary care integration</li> </ul>	<ul style="list-style-type: none"> <li>Establish baseline; increase certifications by 10%</li> <li>Establish baseline; increase number of students receiving suicide prevention education by 10%</li> <li>Establish baseline; increase number of trauma-informed schools by 10%</li> <li>Increase number of providers in primary care settings by 10%; Increase number of providers in specialized care settings by 10%; increase number of providers in prompt care settings by 10%</li> </ul>	<p>Advocate Eureka Hospital          Children’s Home of Illinois          Heart of IL United Way          Hult Center for Healthy Living          NAMI Tri-County          OSF Saint Francis Medical Center          Peoria City/County Health Department          Peoria Regional Office of Education          Tazewell County Health Department          Tazewell/Woodford Regional Office of Education          UnityPlace          UnityPoint Health Peoria          Woodford County Health Department</p>
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**Substance Use**

January 1, 2020 – December 31, 2022

HEALTH PRIORITY: SUBSTANCE USE			
GOAL: REDUCE SUBSTANCE USE TO PROTECT THE HEALTH, SAFETY, AND QUALITY OF LIFE FOR TRI-COUNTY RESIDENTS.			
	INTERVENTION STRATEGIES (Evidence-based)	EVALUATION PLAN	POTENTIAL RESOURCES/PARTNERS
<p><b>OBJECTIVE #1 (HP2020):</b> <i>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.</i></p> <p>Baseline: 2018 IL Vital Records Overdose Data (Peoria-51, Tazewell-26, Woodford-3), 2017 Community Survey Data Population.</p>	<ul style="list-style-type: none"> <li>• Criminal Justice</li> <li>• Harm Reduction Efforts</li> <li>• Technology-enhanced classroom instruction</li> </ul>	<ul style="list-style-type: none"> <li>• 10% reduction in overdoses through use of Narcan and stable housing for frequent utilizers.</li> <li>• Increase Narcan distribution by 10%,</li> <li>• 9 schools enrolled in Prescription Drug Safety Program.</li> </ul>	<p>EVERFI Heart of IL United Way Continuum of Care Hult Center for Healthy Living Illinois Institute for Addiction Recovery Jolt Foundation Peoria City/County Health Department Peoria Substance Abuse Prevention (SAP) Coalition Phoenix Community Development Services Tazewell County Health Department – Drug-Free Communities UnityPlace Human Service Center UnityPoint Health - Peoria</p>
<p><b>OBJECTIVE #2 (HP2020):</b> <i>By December 31, 2022, increase the proportion of adolescents reporting never using substances in the tri-county area by 5% (CHNA survey)</i></p> <p>Baseline: Any Substance Used in the Past Year (Alcohol, Any Tobacco/Vaping, Cigarettes, Inhalants, Marijuana)</p> <ul style="list-style-type: none"> <li>• Peoria (33%-8<sup>th</sup>, 37%-10<sup>th</sup>, 53%- 12<sup>th</sup>)</li> <li>• Tazewell (29%-8<sup>th</sup>, 40%-10<sup>th</sup>, 61%-12<sup>th</sup>)</li> <li>• Woodford (20%-8<sup>th</sup>, 34%-10<sup>th</sup>, 53%-12<sup>th</sup>)</li> </ul>	<ul style="list-style-type: none"> <li>• Mass media campaigns against chemically-impaired driving / underage drinking and binge drinking</li> <li>• Youth leadership programs</li> <li>• Technology-enhanced classroom instruction</li> </ul>	<ul style="list-style-type: none"> <li>• Plan in Place</li> <li>• Increase number of students certified as peer educators by 10%</li> <li>• 9 schools enrolled in Prescription Drug Safety Program; Increase Knowledge</li> </ul>	<p>Hult Center for Healthy Living Peoria Substance Abuse Prevention (SAP) Coalition Tazewell County Health Department – Drug-Free Communities UnityPoint Health - Peoria</p>

## APPENDIX 3: COMMUNITY HEALTH NEEDS ASSESSMENT 2019 SUMMARY

# Community Health Needs Assessment 2019

PEORIA COUNTY

TAZEWELL COUNTY

WOODFORD COUNTY



*Collaboration for  
sustaining health equity*

## COMMUNITY HEALTH-NEEDS ASSESSMENT

The Partnership for a Healthy Community spearheaded a collaborative approach in conducting a Community Health-Needs Assessment (CHNA) for the Tri-county region. The Partnership for a Healthy Community (hereafter referred to as PFHC) is a multi-sector community partnership working to improve population health. The PFHC formed an ad-hoc committee creating a collaborative team to facilitate the CHNA. This collaborative team included members from: Advocate Eureka Hospital, Bradley University, Heart of Illinois United Way, Heartland Health Services, Hopedale Medical Complex, OSF Saint Francis Medical Center (OSF), Peoria City/County Health Department, Tazewell County Health Department, UnityPoint Health – Central IL (UnityPoint), and Woodford County Health Department. They conducted the Tri-County Community Health-Needs Assessment (CHNA) to highlight the health needs and well-being of residents in the Tri-County region.



Several themes are prevalent in the collaborative CHNA – 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. Results from this study can be used for strategic decision-making purposes as they directly relate to the health needs of the community. The study was designed to assess issues and trends impacting the communities served by PFHC stakeholders, as well as perceptions of targeted stakeholder groups.

In order to perform these analyses, information was collected from publicly available sources, as well as private sources of data. Additionally, survey data from 1,376 respondents in the community were assessed with a special focus on 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. Additionally, social determinants of health were analyzed to provide insights into why certain segments of the population behaved differently.

Ultimately, prioritization of the most significant health-related issues in the Tri-County region were identified. Health needs were based on:

- (1) magnitude of the issue (i.e., what percentage of the population was impacted by the issue);
- (2) severity of the issue in terms of its relationship with morbidities and mortalities;
- (3) potential impact through collaboration.

**Using a modified version of the Hanlon Method, the collaborative team prioritized four significant health needs:**

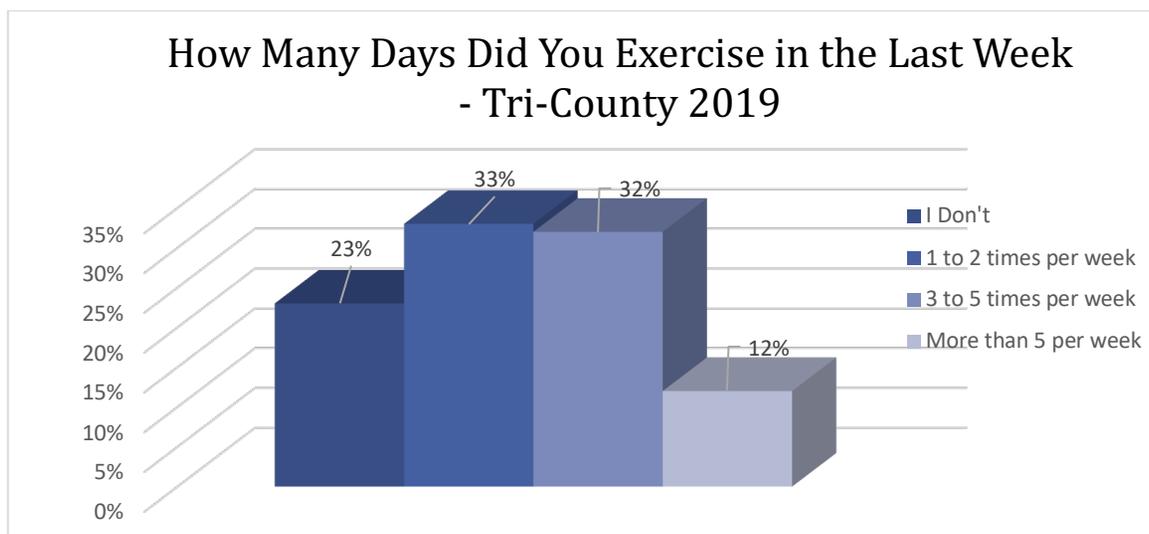
- **Healthy Eating/Active Living** – defined as active living and healthy eating, and their subsequent impact on obesity, access to food, and food insecurity
- **Cancer** - defined as incidence of breast, lung, and colorectal cancer and cancer screenings
- **Mental Health** - defined as depression, anxiety, and suicide
- **Substance Use** - defined as abuse of illegal and legal drugs, alcohol, and tobacco/vaping use

**I. HEALTHY BEHAVIORS –ACTIVE LIVING, HEALTHY EATING AND THEIR IMPACT ON OBESITY, ACCESS TO FOOD, AND FOOD INSECURITY**

**ACTIVE LIVING**

A healthy lifestyle, comprised of regular physical activity, has been shown to increase physical, mental, and emotional well-being. Consequently, regular physical activity is critical to preventative care

Note that 56% of respondents in the Tri-County region indicated they exercise 2 or fewer times per week. Note that 23% of respondents in the Tri-County region indicated that they do not exercise at all, and 33% of residents exercise only 1-2 times per week.

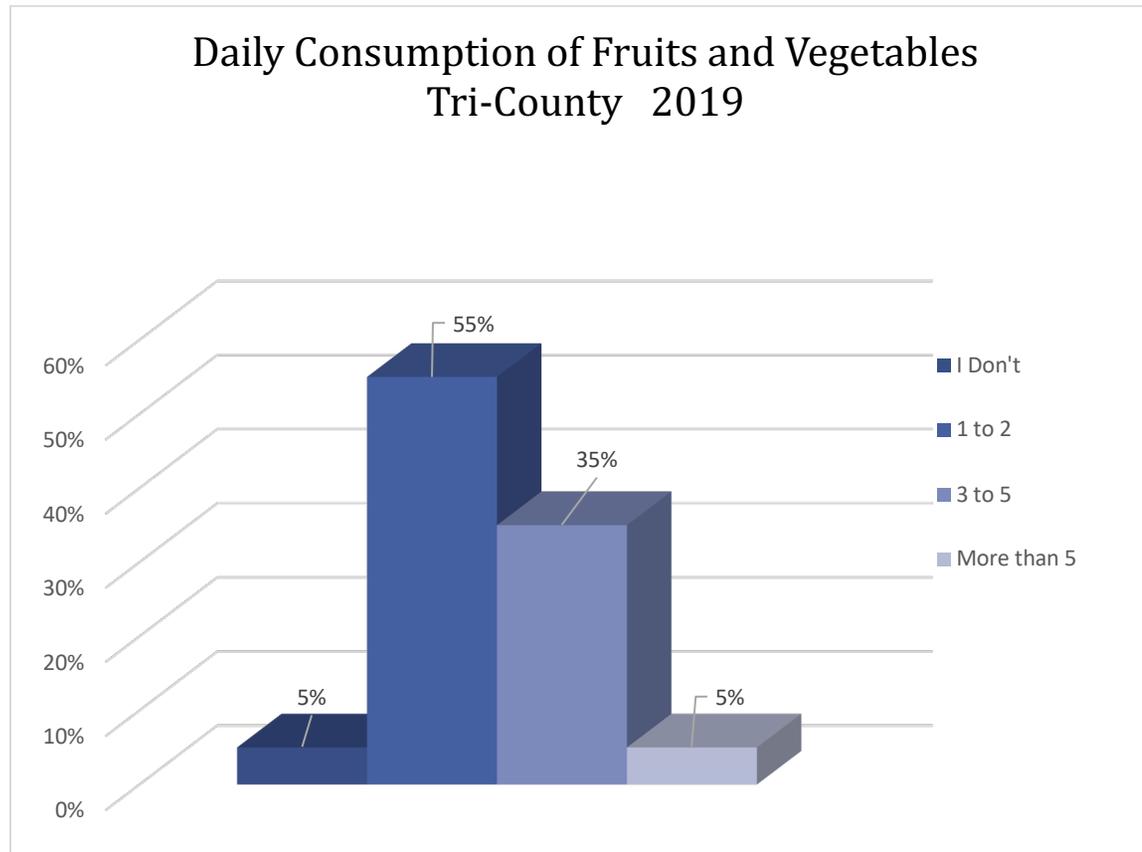


Source: CHNA Survey

## HEALTHY EATING

A healthy lifestyle, comprised of a proper diet, has been shown to increase physical, mental, and emotional well-being. Consequently, nutrition and diet are critical to preventative care.

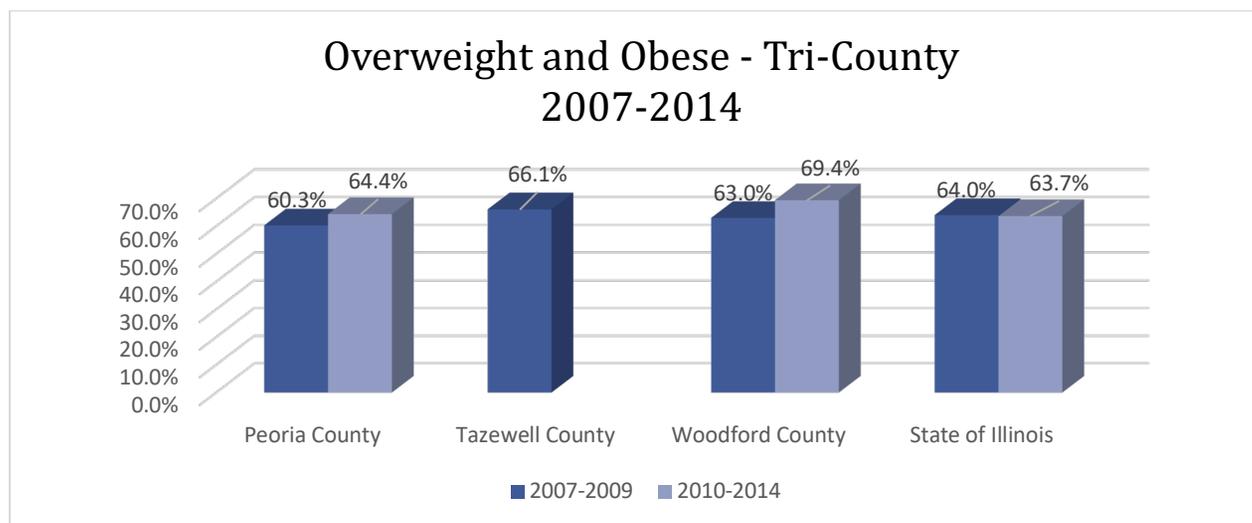
Almost two-thirds (60%) of Tri-County residents report no consumption or low consumption (1-2 servings per day) of fruits and vegetables per day. Note that the percentage of Tri-County residents who consume five or more servings per day is only 5%.



Source: CHNA Survey

## SUBSEQUENT OBESITY

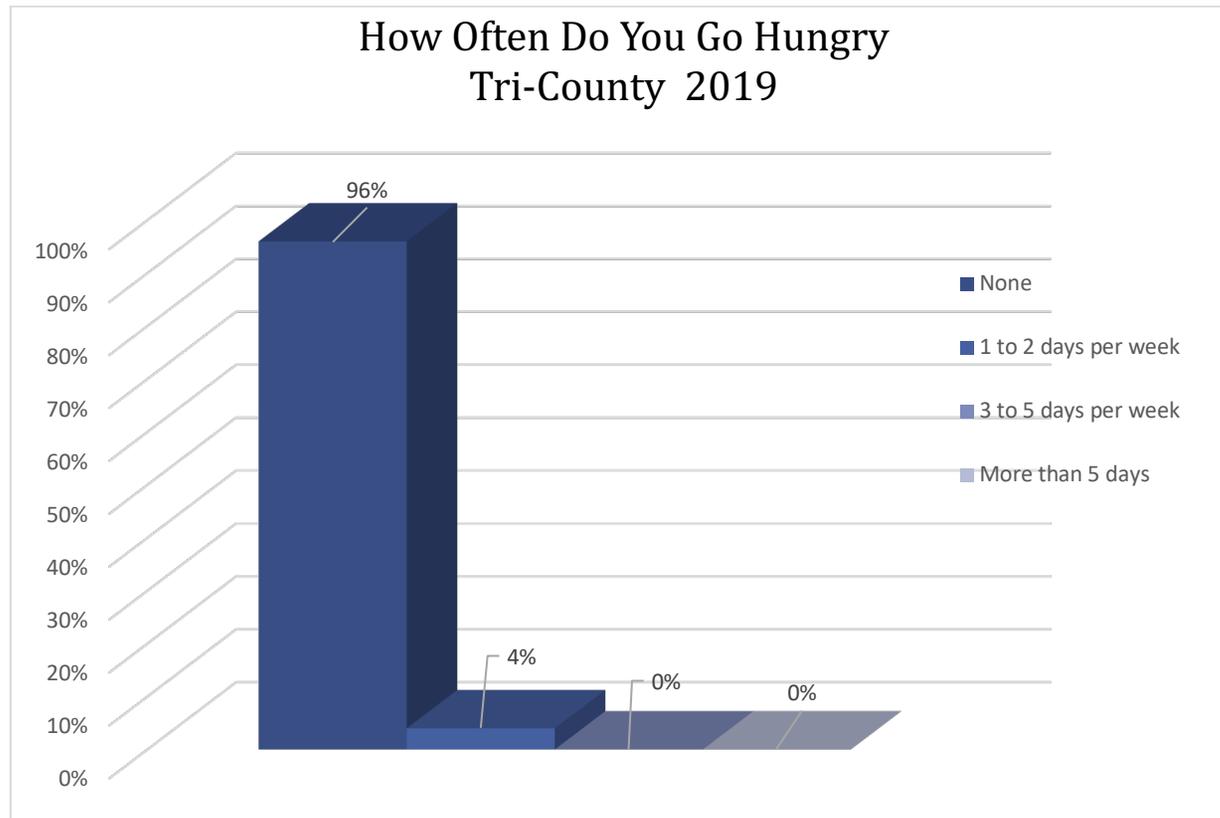
Healthy behaviors are directly related to issues such as obesity. In the Tri-County region, the number of people diagnosed with obesity and being overweight has increased from 2009 to 2014 (based on the most recent available data from 2014). Note specifically that the percentage of obese and overweight people is higher than State averages in all counties, ranging from 64.4% to 69.4%. Overweight and obesity rates in Illinois have decreased from 64% in 2009 to 63.7% in 2014. Moreover, survey respondents were asked to self-identify any health conditions. Note that being overweight (39%) was significantly higher than any other health conditions. The US Surgeon General has characterized obesity as “the fastest-growing, most threatening disease in America today.” According to the Obesity Prevention Initiative from the Illinois General Assembly, 20% of Illinois children are obese. The financial burden of overweight and obese individuals is staggering, as the estimated annual medical costs attributed to obesity in Illinois exceed \$3.4 billion, ranking Illinois 6<sup>th</sup> in the nation for obesity-attributed medical costs. With children, research has linked obesity to numerous chronic diseases including Type II diabetes, hypertension, high blood pressure, and asthma. Adverse physical health side effects of obesity include orthopedic problems due to weakened joints and lower bone density. Detrimental mental health side effects include low self-esteem, poor body image, symptoms of depression and suicide ideation. Obesity impacts educational performance as well; studies suggest school absenteeism of obese children is six times higher than that of non-obese children. With adults, obesity has far-reaching consequences. Testimony to the Illinois General Assembly indicated that obesity-related illnesses contribute to worker absenteeism, slow workflow, and high worker compensation rates. A Duke University study on the effects of obesity in the workforce noted 13 times more missed workdays by obese employees than non-obese employees. Nationwide, lack of physical activity and poor nutrition contribute to an estimated 300,000 preventable deaths per year.



Source: Illinois Behavioral Risk Factor Surveillance System

## ACCESS TO FOOD AND FOOD INSECURITY

It is essential 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. In the Tri-County region, approximately 4% of residents go hungry at 1-2 times per week.



Source: CHNA Survey

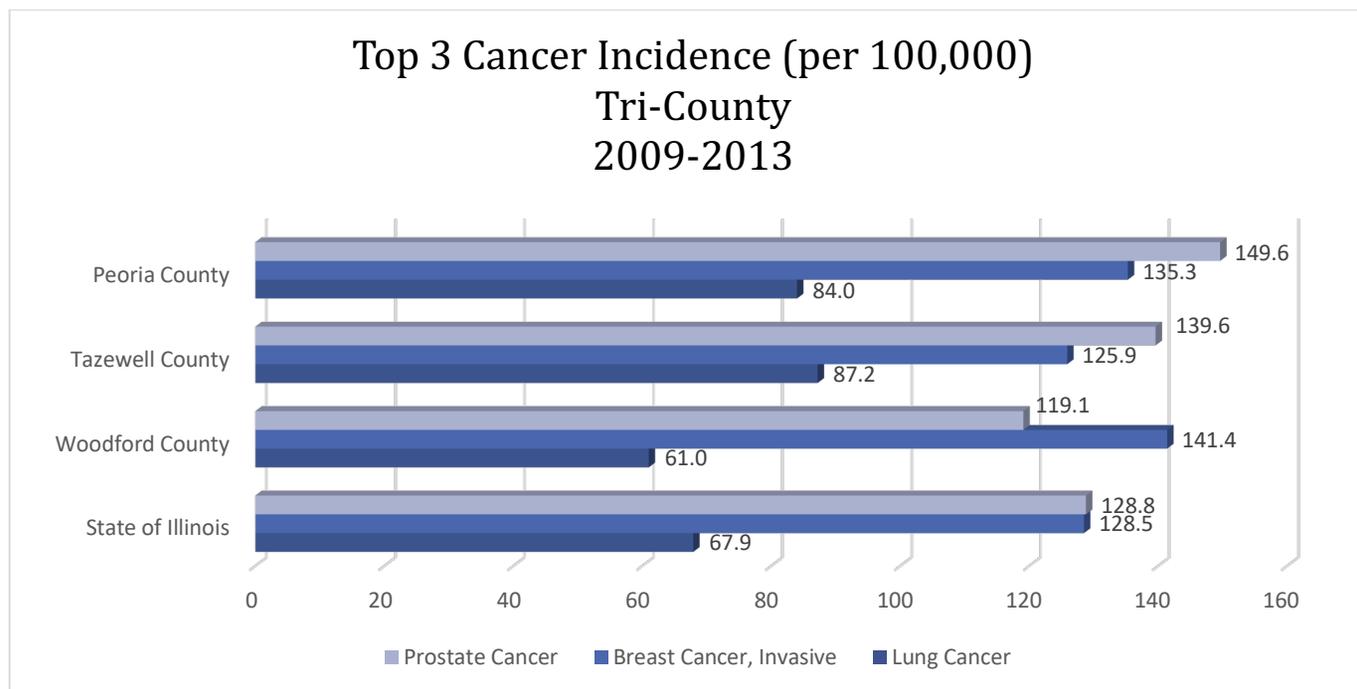
## II. CANCER – INCIDENCE OF BREAST, LUNG, AND COLORECTAL CANCER AND CANCER SCREENINGS

### BREAST CANCER

Cancer is the first or second leading cause of mortality in all three counties in the Tri-County region. Breast, lung, and colorectal cancer are more prevalent in the Tri-County region when compared with the State of Illinois. Breast cancer is the most common cancer in women in Illinois. The incidence of breast cancer per 100,000 residents in the Tri-County region is 134.2 people per 100,000 compared to Illinois State average of 128.5.

### LUNG CANCER

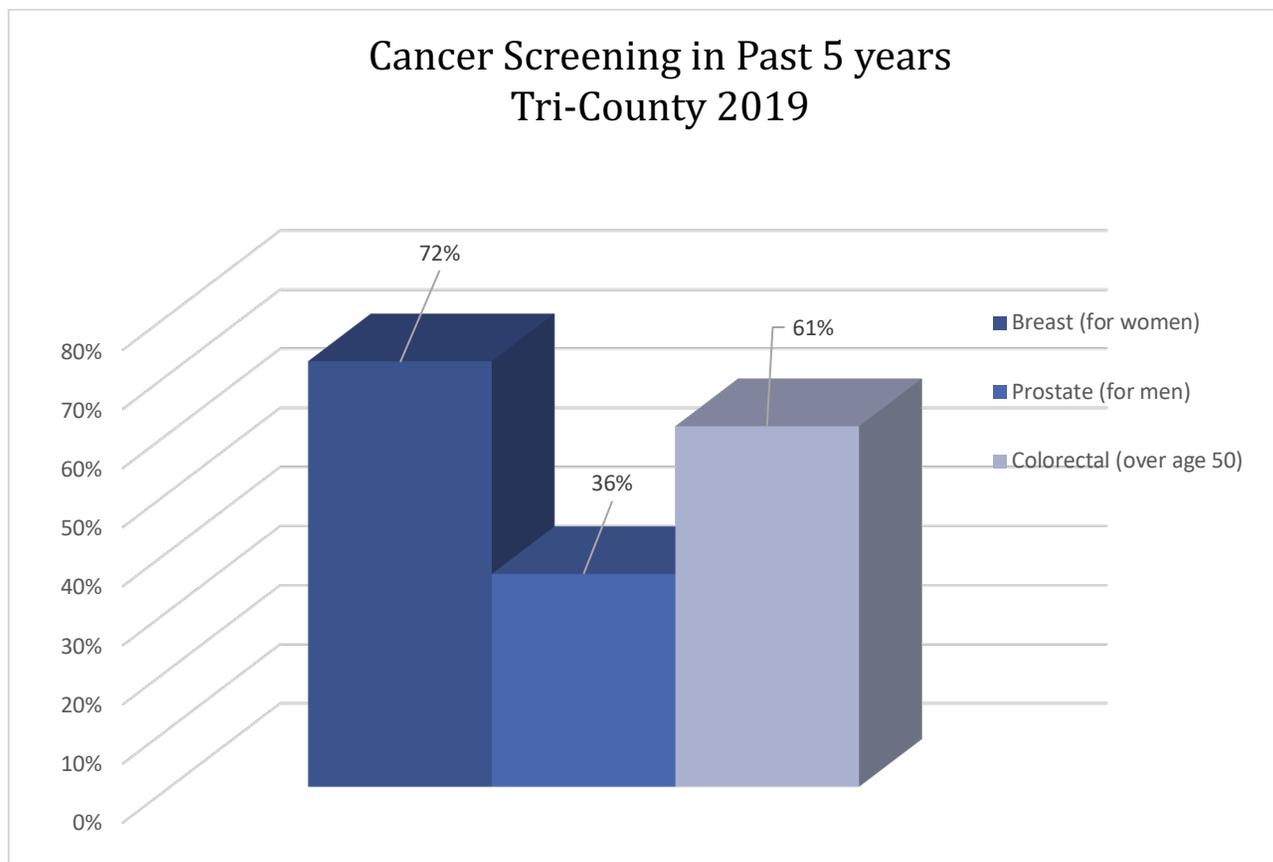
Lung cancer is second most common cancer among men and women in Illinois. The incidence of lung cancer per 100,000 residents in the Tri-County region is 79.7 people per 100,000 compared to Illinois State average of 67.9. Incidence of smoking in the Tri-County area (19.1%), is higher than State of Illinois averages (18.4%). Moreover, in 2018, 10% of the Tri-County population smoked and/or vaped 5 or more time per day.



Source: <http://dph.illinois.gov/sites/default/files/publications/County-Sec1-Site-Specific-Cancer-Incidence-ers1605.pdf>

## COLORECTAL CANCER

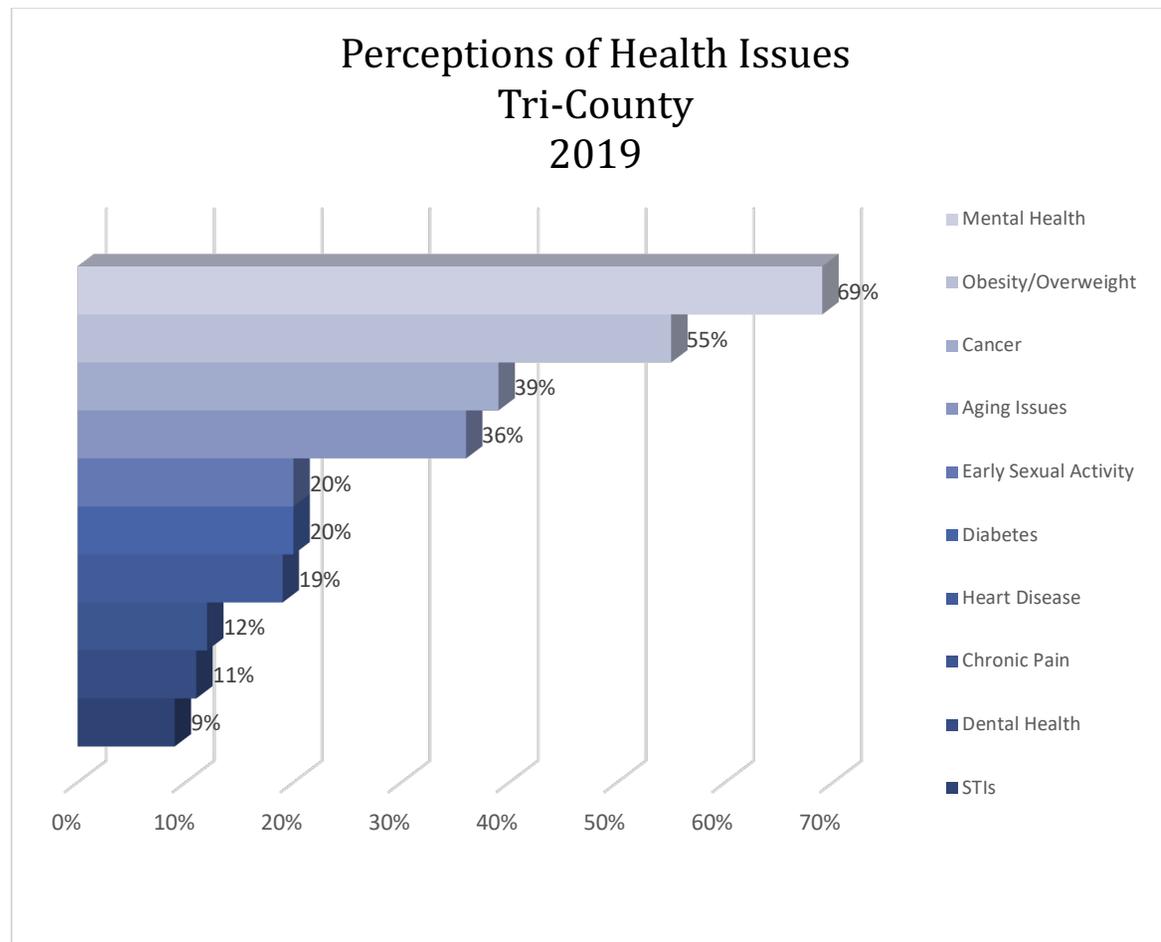
Colorectal cancer is the third most common cancer among men and women in Illinois. All three counties in the Tri-County area report higher incident and age-adjusted death rates for colorectal cancer compared to the State of Illinois, the U.S. and are above the are 3-6% higher than the HP2020 target. While early detection of precancerous polyps can prevent colorectal cancer, 39% of the population over 50 years old in the Tri-County area has not had a colorectal screening in the past five years.



Source: CHNA Survey

### III. MENTAL HEALTH – DEPRESSION, ANXIETY, AND SUICIDE

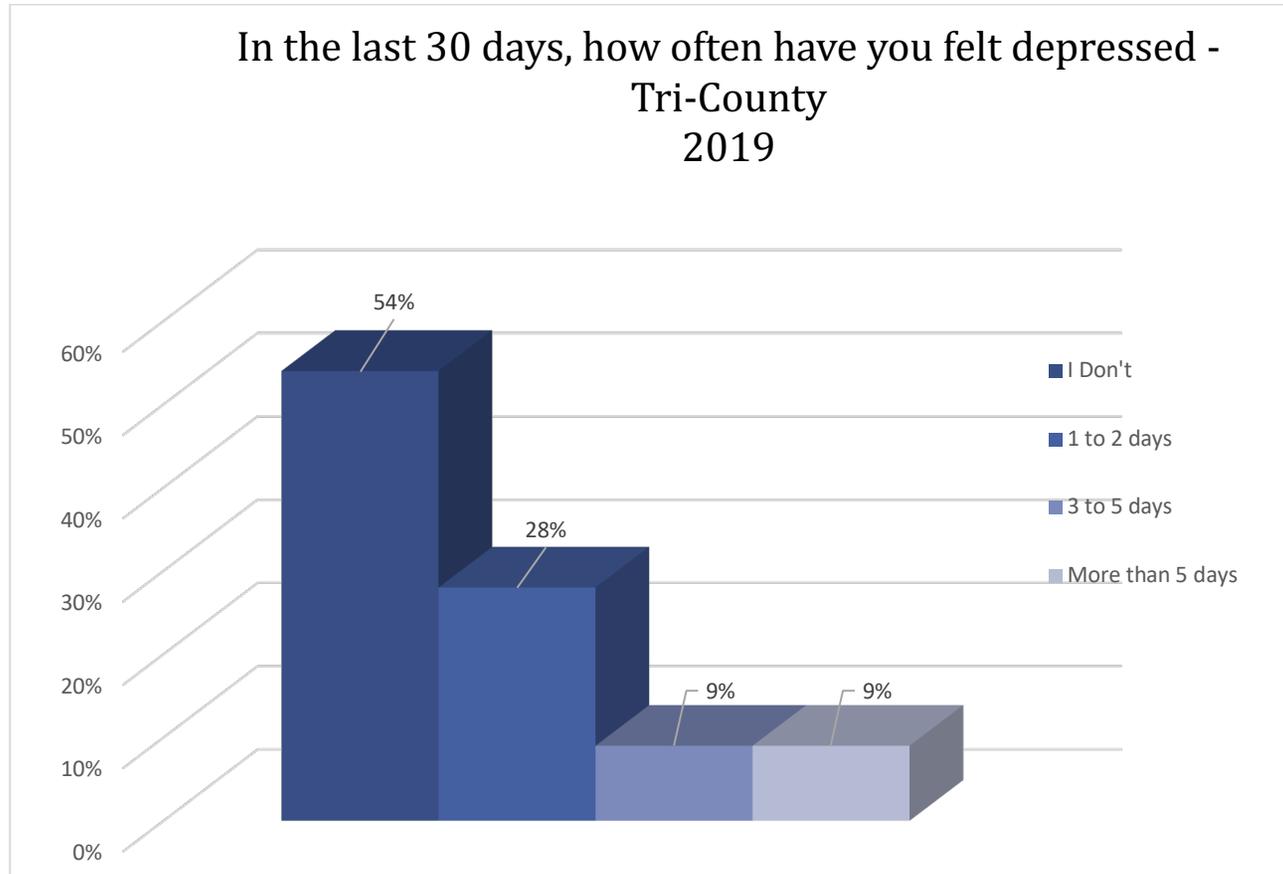
According to the CHNA survey, 33% of respondents talked to someone about their mental health in the last 30 days. In the Tri-County area, almost 1/3 (31.3%) of 10<sup>th</sup> grade students indicated that in the past 12 months they felt so sad or hopeless almost every day for two weeks or more in a row that they stopped some usual activities. Mental health was rated as the most important health issue in the community by 69% of survey respondents.



Source: CHNA Survey

## DEPRESSION

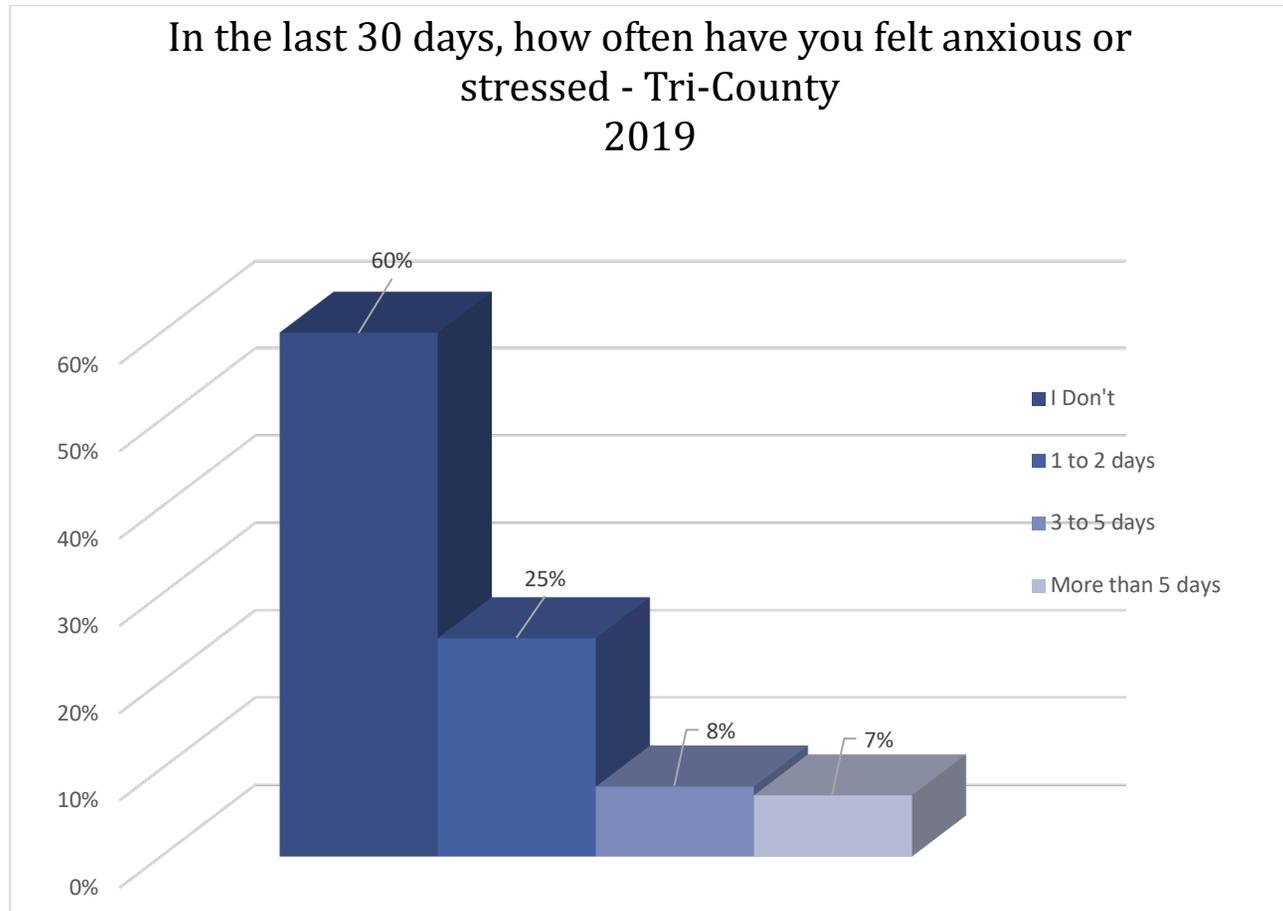
According to the CHNA survey, 46% of respondents felt depressed in the last 30 days. Specifically, 28% of respondents felt depressed 1-2 days and 18% felt depressed 3 or more days in the last 30 days.



Source: CHNA Survey

## ANXIETY

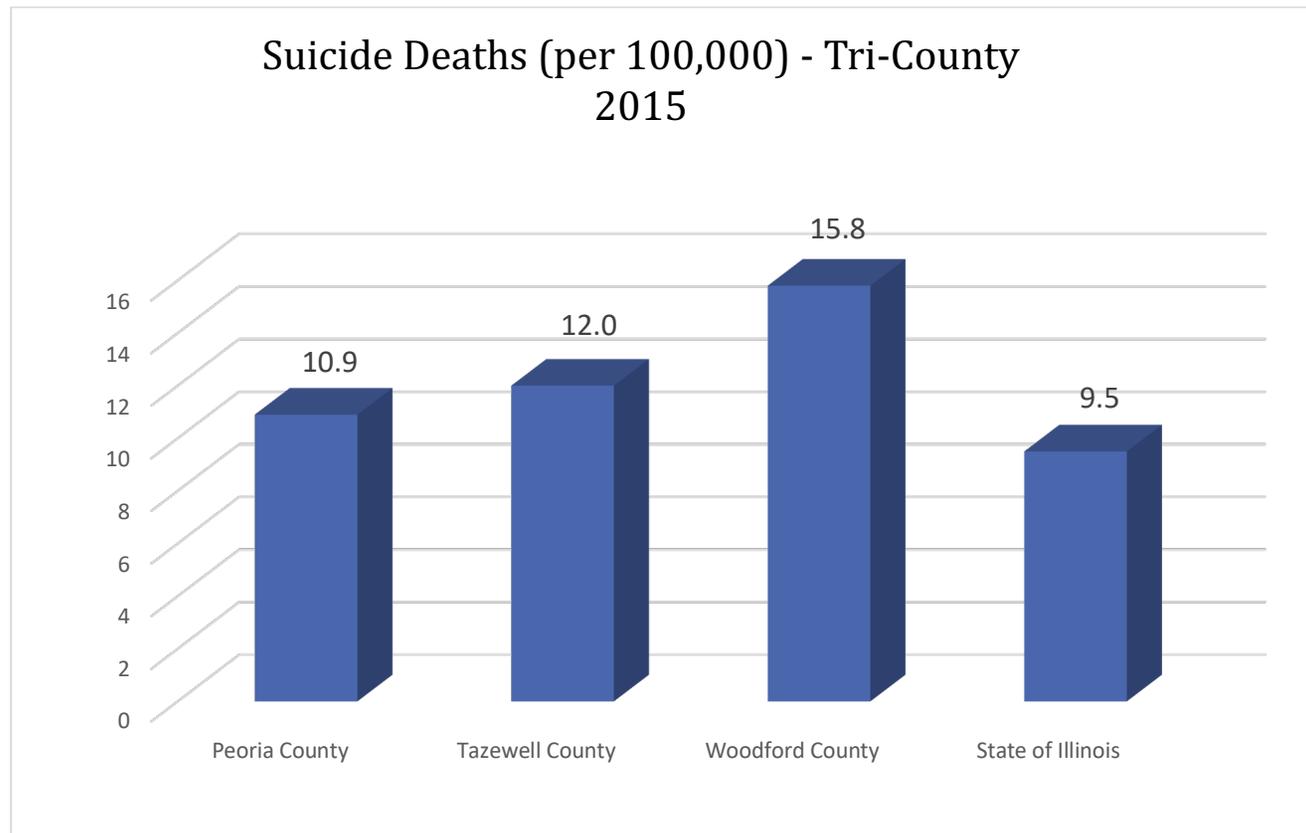
According to the CHNA survey, 40% of respondents felt anxious in the last 30 days. Specifically, 25% of respondents felt anxious 1-2 days and 15% felt anxious 3 or more days in the last 30 days.



Source: CHNA Survey

## SUICIDE

In the Tri-County region, all three counties had higher suicide rates than State of Illinois averages (based on the most recent available data from 2015). Specifically, suicide rates per 100,000 residents were 10.9 in Peoria County, 12.0 in Tazewell County and 15.8 in Woodford County. The State of Illinois average was 9.5 suicide deaths per 100,000 residents. In the Tri-County area, 16.7% of 10<sup>th</sup> graders indicated they seriously considered attempting suicide in the past 12 months.

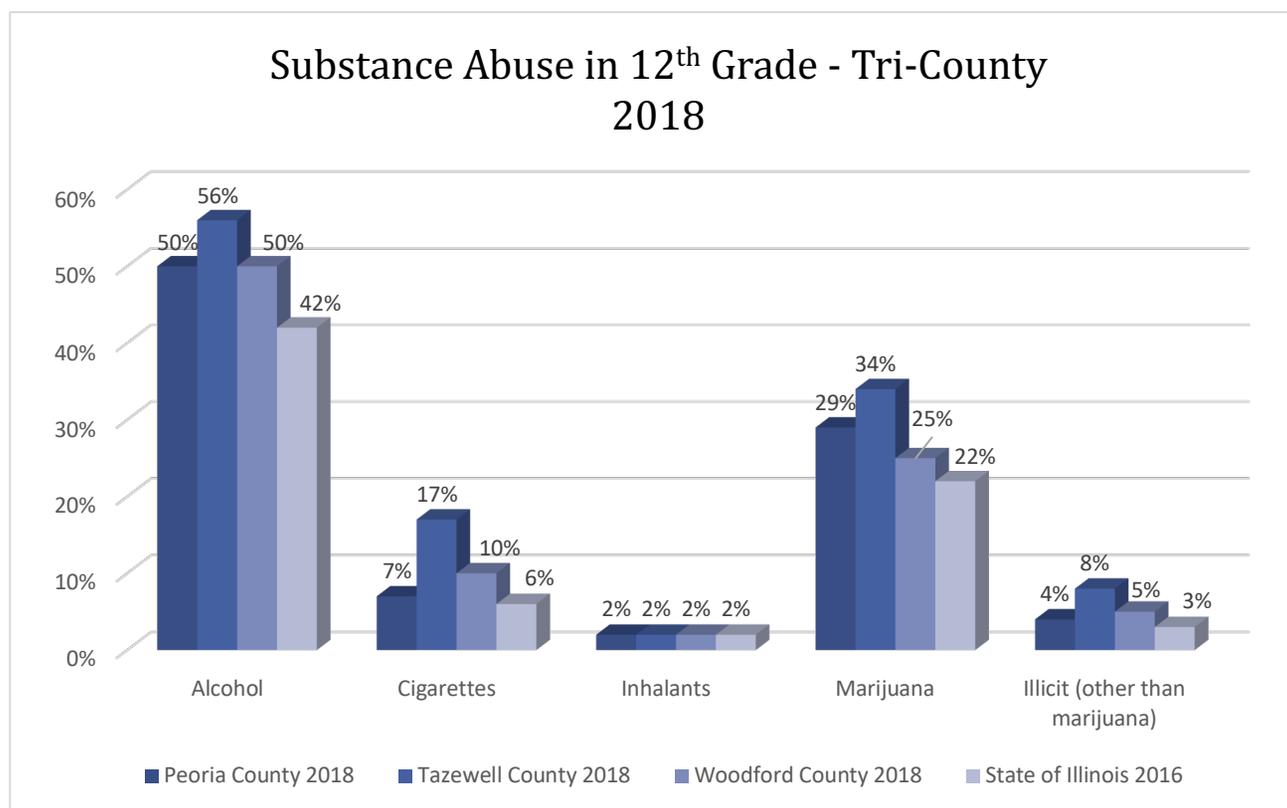


Source: Illinois Department of Public Health

## IV. SUBSTANCE USE – ABUSE OF ILLEGAL AND LEGAL DRUGS, ALCOHOL, AND TOBACCO/VAPING USE

### SUBSTANCE USE

Alcohol and drugs impair decision-making, often leading to adverse consequences and outcomes. Research suggests substance use values and behaviors of students is a leading indicator of adult substance use in later years. Data from the 2018 Illinois Youth Survey measures illegal substance use for alcohol, cigarettes, inhalants, marijuana and other illicit drugs among adolescents. For all three counties, 12<sup>th</sup> graders are at or above State averages in all categories. Moreover, CHNA survey results show that 16% of the Tri-County population uses substances (either legal or illegal) on a typical day to make themselves feel better.



Source: University of Illinois Center for Prevention Research and Development

## PFHC Ad-Hoc CHNA Collaborative

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## Facilitator

Laurence G. Weinzimmer (Principal Investigator), Bradley University

