Quality Improvement Reflection

Partnership for a Healthy Community
healthyhoi.org

ANNUAL MEETING

2023 Reflection

healthyhoi.org PartnershipforaHealthyCommunity

MISSION & VISION

A community-driven partnership of public and private partners working together to address priority health issues in Peoria, Tazewell, and Woodford Counties of Illinois.

Our vision for the tri-county region will be a thriving community that is inclusive, diverse, and sustainable to ensure health equity and opportunity for well-being for all.

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2023 Board Members

Phil Baer, Co-Chair
OSF Healthcare

Amy Fox, Co-Chair
TCHD

Sally Gambacorta, Vice-Chair
Carle Eureka Hospital

Hillary Aggertt
WCHD

Holly Bill
Hult Center for Healthy Living

Jay Collier
Carle Health

Lisa Fuller
OSF Healthcare

Ann Campen
Tazewood Center for Wellness

Beth Crider
Peoria ROE

Rebecca Crumrine
U of I Extension

Kate Green
Home for All COC

Monica Hendrickson
PCCHD

Tricia Larson
Tazewell Co. Board of Health

Craig Maynard
Eureka College

Nicole Robertson
American Cancer Society

Chris Setti
Greater Peoria EDC

Adam Sturdavant
OSF Medical Group, Pediatrics

Larry Weinzimmer
Bradley University

Jennifer Zammuto
HOI United Way

Group Agreements

Stay Present

Actively Participate

Give Space/Take Space

Allow Facilitator to Move Conversation Along

Be Open to New Ideas

Ask Questions

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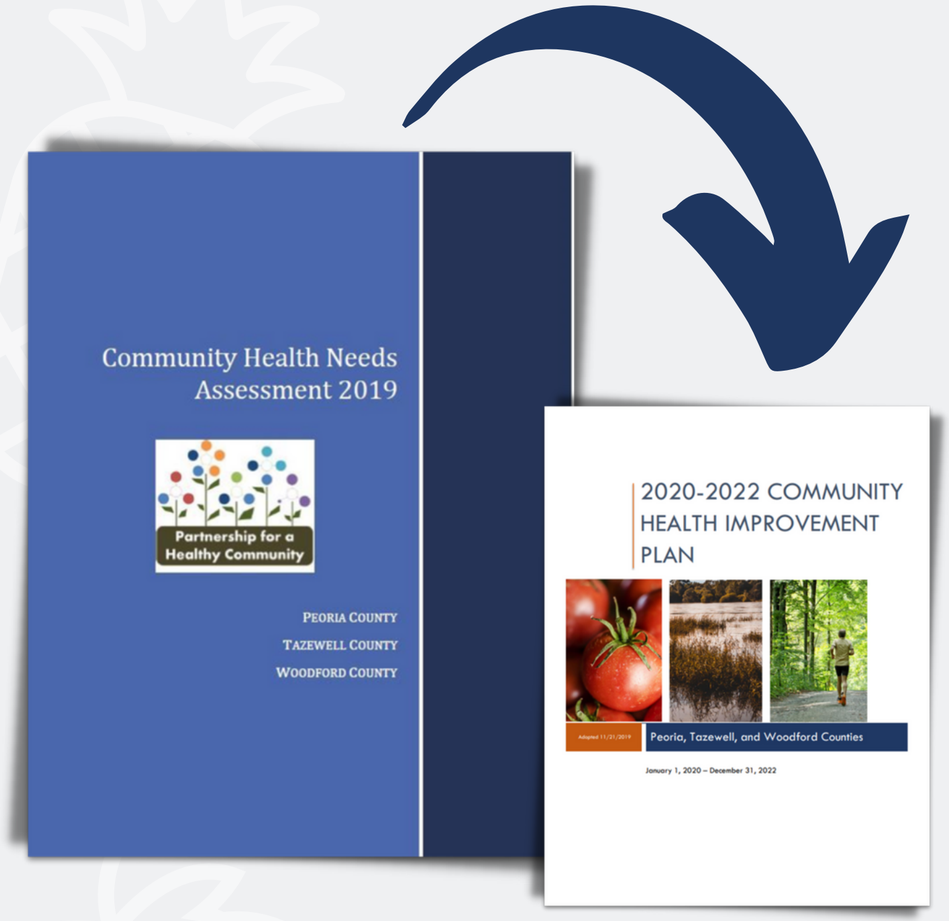
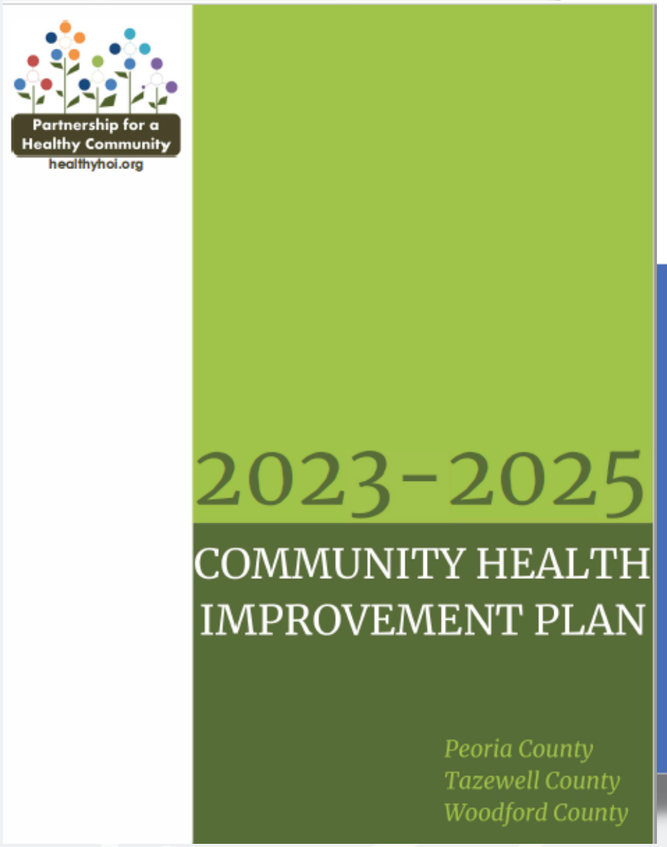

Community Health Needs Assessment 2019
Partnership for a Healthy Community
PEORIA COUNTY
TAZEWELL COUNTY
WOODFORD COUNTY

2020-2022 COMMUNITY HEALTH IMPROVEMENT PLAN
Adopted 11/21/2019
Peoria, Tazewell, and Woodford Counties
January 1, 2020 – December 31, 2022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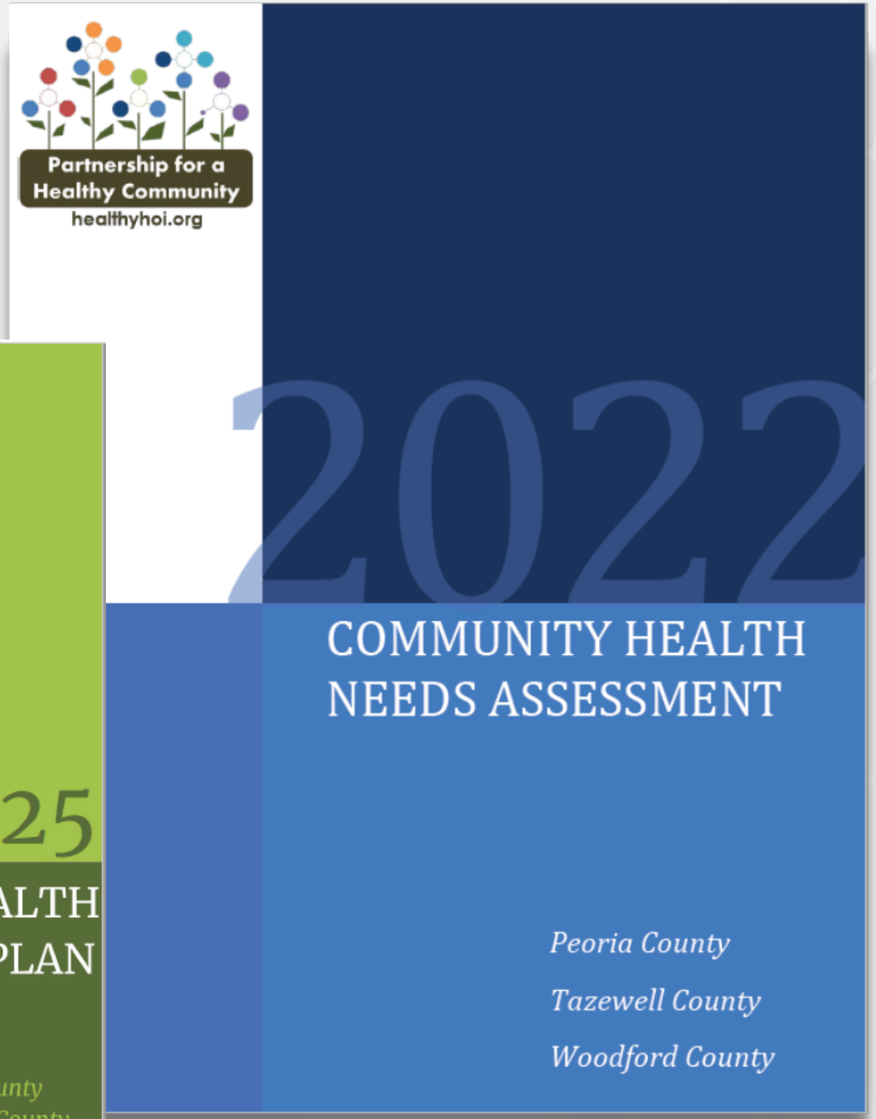
2023-2025
COMMUNITY HEALTH IMPROVEMENT PLAN
Peoria County
Tazewell County
Woodford County


Partnership for a Healthy Community
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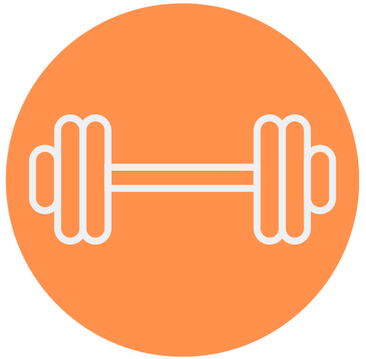
2022
COMMUNITY HEALTH NEEDS ASSESSMENT
Peoria County
Tazewell County
Woodford County

2023-2025 Priority Health Areas



Obesity

Healthy Eating, Active Living

Mental Health

Obesity

To positively impact the proportion of adults and adolescents identified as overweight or obese in the Tri County Area.

Obesity

Digital Interventions for Adolescents with Obesity

Strong People Healthy Weight

Obesity -Year One

STRONG People™
LIVING WELL

Strong People Healthy Weight

Evidence-based program focused on introducing physical activity and healthy diet for middle aged adults.

Obesity -Year One

STRONG People™ LIVING WELL

First area of focus is North-East Peoria County this area has the highest adult obesity rate of 47%.

Strong People Healthy Weight

- 12-week curriculum
- 30 minutes nutrition education
- 30 minutes physical activity
- Offered 2 x week
- Pilot in April 2024
- Peoria Park Dist. instructor completed training

Living Well baseline data:

Fitness testing measurements:

- Completed at Week 1 and Week 12
- Chair Stand (lower body strength)
- Arm Curl (upper body strength)
- Sit-and Reach (lower body flexibility)
- 8-foot up and go (agility and dynamic balance)
- 6-minute walk (aerobic endurance)

Obesity -Year One

Digital Interventions for Adolescents with Obesity

- Review of available Digital Interventions (Apps in Study and on Market)
  - Limitations: Not best practice Obesity treatment with age group, strict oversight needed by Trained Professionals

- Develop evidence-based practice toolkit for tri-county use
  - Increase comfort, ease, and practice of adolescent obesity treatment in Primary Care Setting

- Increase Capacity and align messaging to promote; WELL Program (Hult Center, Carle Health) and Healthy Kids U (OSF Healthcare)
  - Exploring (Expanded) MyChart utilization for delivering interventions

- Pursuing Grant Oppurtunity: Leveraging Social Media for Health Promotion in Adolescents
  - Goal: Focused Groups- studying Social Media Messaging around Obesity Treatment

Digital Interventions for Adolescents with Obesity

Obesity -Year One

Hult Center for healthy living

- The Wellness Education and Lifestyle Learning (WELL) Program is a health coaching program for youth and adolescents between the ages of 8 & 17 years who are considered to be overweight, obese, or morbidly obese, and at risk for developing type 2 diabetes.
  - 150+ youth & adolescents referred
  - 500+ hours of health coaching completed
  - 5 new schools established as health coaching locations
  - Communty RD added to program

HEALTHY kidsU®

- The Healthy Kids U clinic teaches healthy eating habits, portion control, meal planning and healthy levels of activity and exercise. Healthy Kids U is available to children or teens ages 2 to 18 years old who are referred by their primary health care provider.
  - Additional Dietician and Provider Onboarded
  - 3 Healthy Kids in Motion programs/Collab YMCA
  - Continued work to increase # of Person Served

Local Trending Data

BMI data was reviewed for a large sample population of children (3-17 years) living in the Tri-County area from 2021 to 2023. Findings include:

- **In 2023, 32.52% of children were classified as obese/overweight**
- **Obesity/overweight decreased by 2.92% for children of all ages from 2021 to 2023**
- **Obesity/overweight decreased by 1.54% for adolescents (12-17) from 2021 to 2023**

Healthy Eating, Active Living

Gardening

Increase Vegetable Consumption Among Children

Physical Activity

Increase Physical Activity Among Adults

Food System Partners

Increasing Access, Family Stabilization, Pantry Technical Assistance, and Supporting Healthy Food Policies

Healthy Eating, Active Living

Gardening

Tactic 1:

Gather baseline data around community gardens & school aged programming.

42
COMMUNITY GARDENS

2,002
FAMILIES SERVED

3,903
CHILDREN SERVED

31,784
LBS OF FOOD TO COMMUNITY

Healthy Eating, Active Living

Gardening

Tactic 2:

Implement garden-based learning sessions focused on gardening & healthy eating.

CURRICULUMS IDENTIFIED

STANDARDIZED EVALUATIONS COMPLETED

TOOLS TO BE SHARED WITH ORGANIZATIONS POTENTIALLY TEACHING/HOSTING SESSIONS WITH OPTION OF TRAINING

Healthy Eating, Active Living

Gardening

Tactic 3:

Promote campaigns focused on healthy eating and access to healthy foods

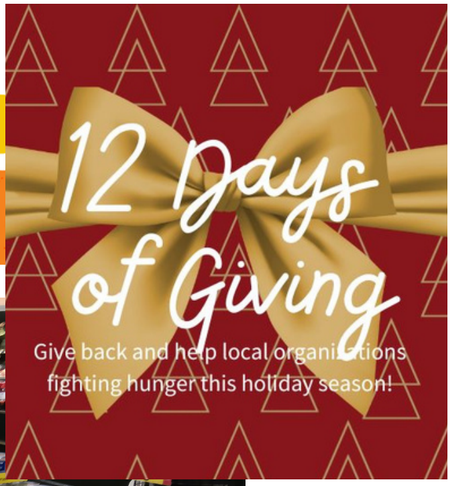
7

HEALTHY EATING CAMPAIGNS

3

TOOLKITS TO SUPPORT CAMPAIGNS

Community Toolkit



Healthy Eating, Active Living

Physical Activity

Tactics:

Increase data collection focusing on adult physical activity in the Tri-County Region
Increase number of partners organizations

14

PARTNER ORGANIZATIONS

18,817

PARTICIPANTS

CHAMPION PROGRAMS:

DIABETES PREVENTION PROGRAM
ILLINOIS WISEWOMAN PROGRAM
RIVERPLEX GROUP EXERCISE

Healthy Eating, Active Living

Physical Activity

Tactics:

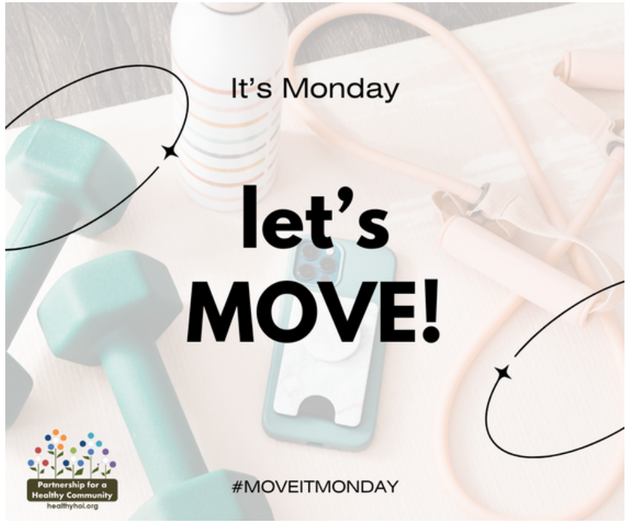
Increase number of campaigns focusing on physical activity campaigns
Increase number of events promoting physical activity

2

PHYSICAL ACTIVITY CAMPAIGNS

70

PARTICIPANTS AT EVENTS



Healthy Eating, Active Living

Food System Partners

16

FOOD PANTRY GRANTS

21

GARDEN GRANTS

379

UNIQUE RESPONDENTS TO SURVEY AT HISAPNIC PANTRIES

7

MOBILE FOOD PANTRIES

30,431

POUNDS OF FRESH PRODUCE DONATED TO THE EMERGENCY FOOD SYSTEM

290

FOOD RESOURCE REFERRALS

Mental Health

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

Mental Health

Culturally-Adapted Health Care

Telemedicine

Mental Health

Culturally-Adapted Health Care

- **Promote awareness & education to improve cultural competence related to mental health care.**
- **Provide educational training to healthcare professionals.**
- **Create policies to support culturally-adapted healthcare**
- **Create culturally- and linguistically-adapted materials**

Mental Health

Promoting Inclusive Care

Transgender Care Directory

Mental Health

Telemedicine

- Inventory resources
- Disseminate information about telepsych resources
- Support structured partnerships for telemedicine
- Expand locations providing telemedicine services
- Focus on underserved and rural areas

Mental Health

Telepsych Provider List

TELEPSYCH PROVIDER LIST

INTERNAL CARLE AND TRILLIUM PLACE TELEPSYCH PROVIDERS

Carle Atrium Psychiatry
900 Main St. Ste. 400 Peoria IL
P: 309-672-3100 F: 309-672-3131

- Dr. Kapil Aedma: Pediatric Telepsychiatry. Patient must attend first appt in office. Accepts several private insurance plans. Does not accept Medicaid.

Trillium Place Pekin
3248 Van De Ver Ave Pekin IL 61554
P. 309-347-5522 option 3 F. 309-347-7302

- Counseling ages 4 and up.
- Accepts all Medicaid plans and most private insurance plans. Cannot accept Tricare or Medicare for counseling.
- Offers telehealth option for counseling after patient gets established.
- Patients with Medicaid must do a walk-in assessment. Walk-in hours are Tuesday,

Mental Health

Looking Ahead

- Social Media Messaging
- Increase promotion of 2-1-1 and 9-8-8
- Increased CAHC trainings for providers
- Continue certifying residents in Mental Health First Aid (35 classes & 502 trained in 2023!)
- Increase engagement in CAHC and telepsych subcommittees

2023-2025 Priority Health Committee Leadership

Mental Health

JONATHAN GAUERKE

Carle Health

DAWN LOCHBAUM

OSF HealthCare Saint Francis Medical Center

Healthy Eating, Active Living

SHANITA WALLACE

Tazewell County Health Dept.

REBECCA CRUMRINE

U of I Extension

Obesity

AMANDA SUTPHEN

OSF HealthCare Saint Francis Medical Center

DYLAN HENRICKS

OSF HealthCare Saint Francis Medical Center

META RASK

OSF HealthCare Saint Francis Medical Center

Performance Management

Substance Use

Sexual and Reproductive Health

Cancer

Substance Use

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

Substance Use

2023-2025 Performance Management

- Increase Naloxone Access:
  - PCCHD placed 3 Narcan Vending Machines
  - Distributed over 4,600 units of Narcan in 2023

- Hosted 57 Tri-County first responders for education on Responding to substance use emergencies with compassion.

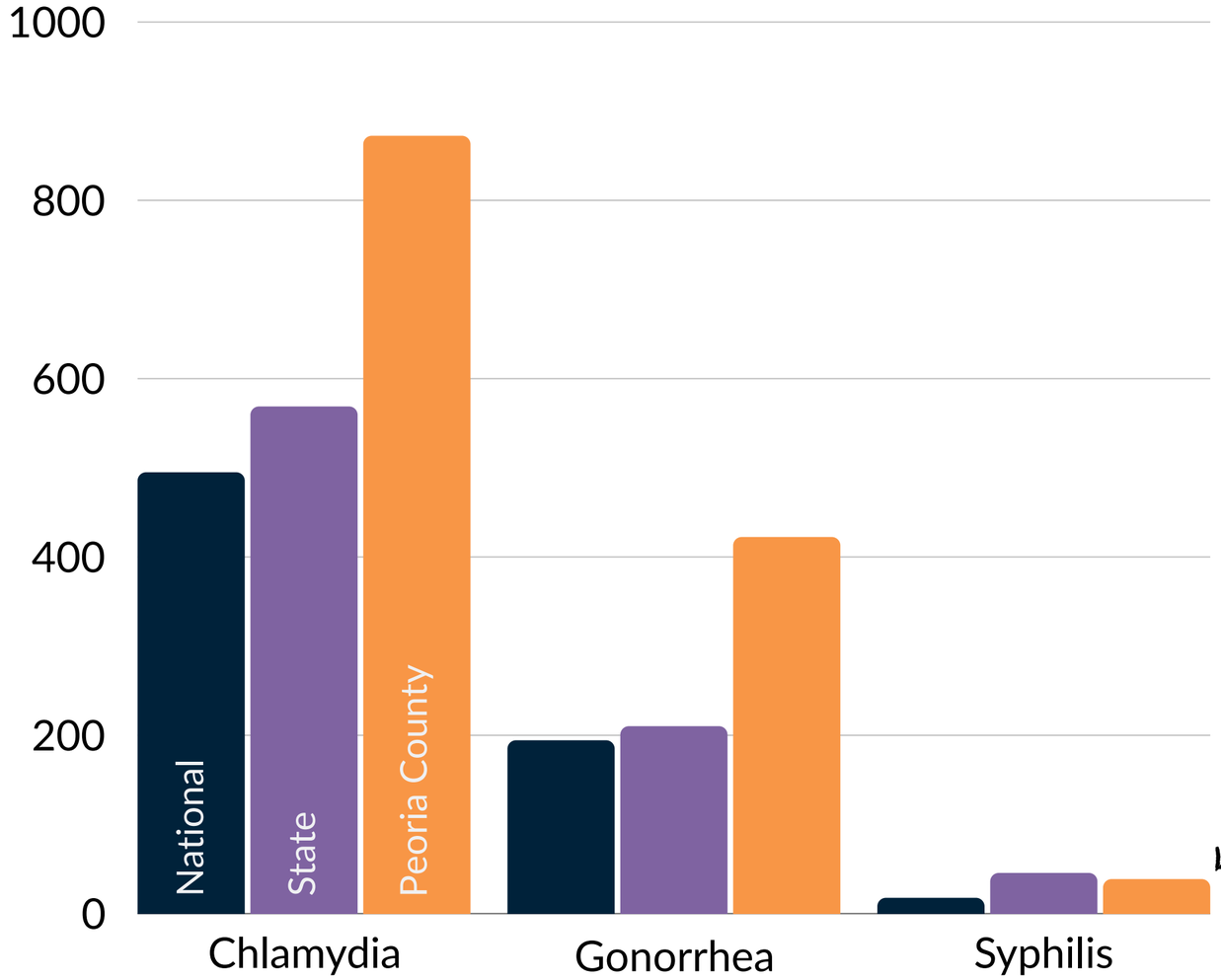
- Surveyed healthcare providers about MAT

- Promoted Red Ribbon Week activities
  - Tazewell County hosted assemblies in 6 different schools.

Sexual and Reproductive Health

Increase awareness of services and reduce STI transmission and teen pregnancy rates in the tri-county area.

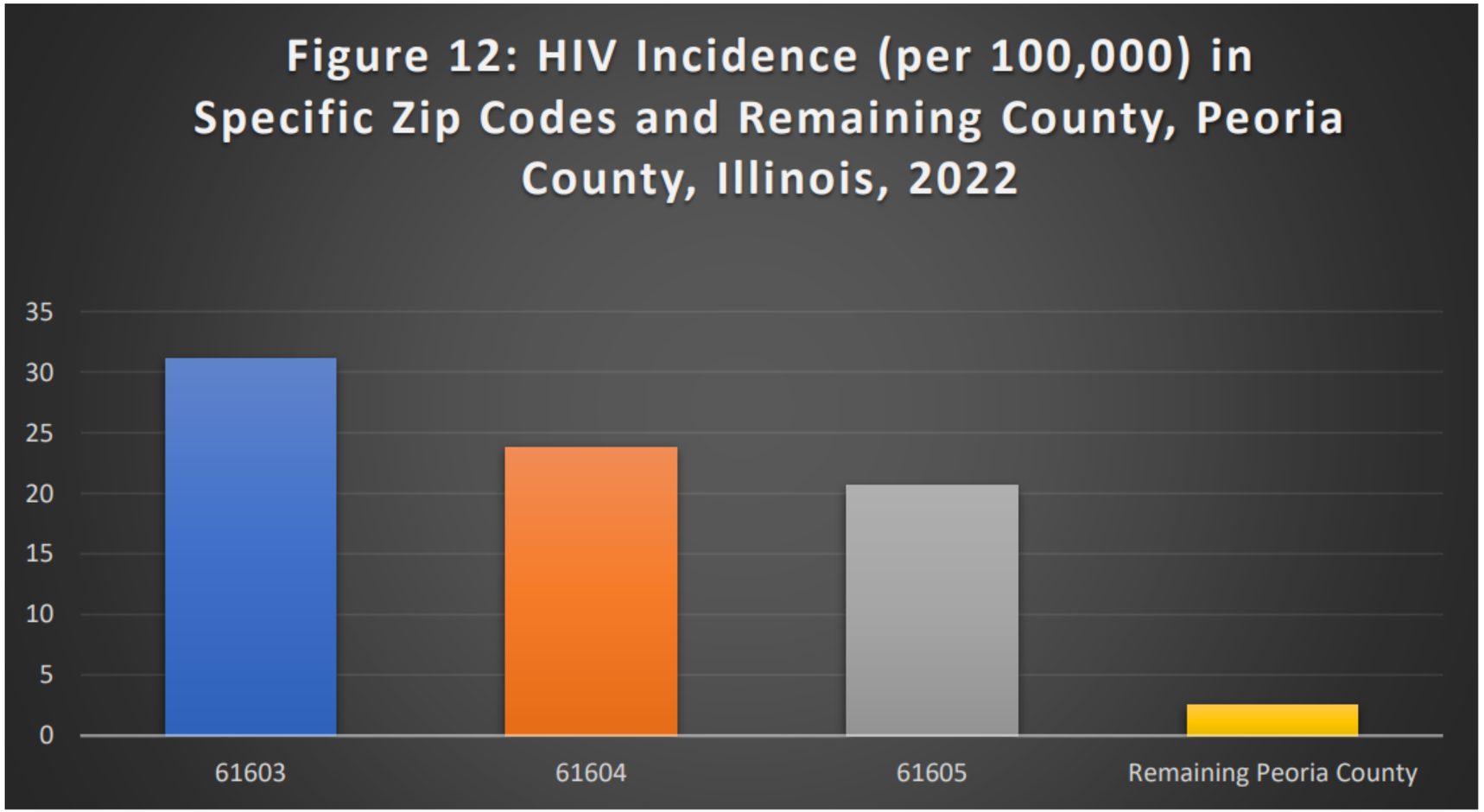
Sexual and Reproductive Health



Syphilis:
11.1% increase from 2021, which was a 19% increase from 2020

Download the PCCHD STI Report, 2022

Sexual and Reproductive Health



Data showing incidence per 100,000, per PCCHD 2022 data

Sexual and Reproductive Health

Teen Pregnancy

National: 15.4
State: 11.1
Peoria County: 20.8

Decrease from 30.2 in 2020

Data showing incidence per 1,000, per PCCHD 2021 data

Cancer

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

Cancer

2023 Performance Management:

- 2 community-wide screening days
  - May 19
  - October 20
  - lung, breast, colorectal, skin, oral cancer screenings
  - community education
- Lung Cancer Screening Day- November 11

Cancer

American Cancer Society®

Breast:
38,000+ screening mammograms

72.9% screening rate among women 50-74

Colorectal:
71% screening rate among adults 50-75

Data from CDC Places: Local Data for Better Health

Lung:
4,700+ LDCT screenings

Edwards Grant:
Final report to be released June 2024

Genetics:
10,300+ screenings

Patient Support: ACS grants

$30K lodging

$22.5K transportation

Cancer

2023 Funded Partnerships :

- I&I Lung Screening Initiative
  - Carle Methodist
  - $20K NFL Change Grant
  -

- Breast Health Task Force
  - Heartland Health Services
  - $20K Merck

Data Team

Goal

Track progress and challenges in the Tri-County region and provide timely feedback to the communities and board members on a variety of health metrics

- Work with committees to provide guidance on data-driven approaches to assess change

Who

Diverse set of stakeholders from the Tri-County region

- Representatives from 3 county health departments, 2 healthcare systems, medical school, and university

Data Team

Structure and data sources

Monthly reports are generated from the three committees and reported out

- Programmatic outputs
- Short-term outcomes
- Long-term outcomes
- Challenges and needs

Quarterly reports are created using data from monthly report

- Combine additional public health surveillance data

Annual data reports are generated in similar structure as quarterly reports

- Mortality and public health surveillance measures related to SDOH and health equity

Data reports

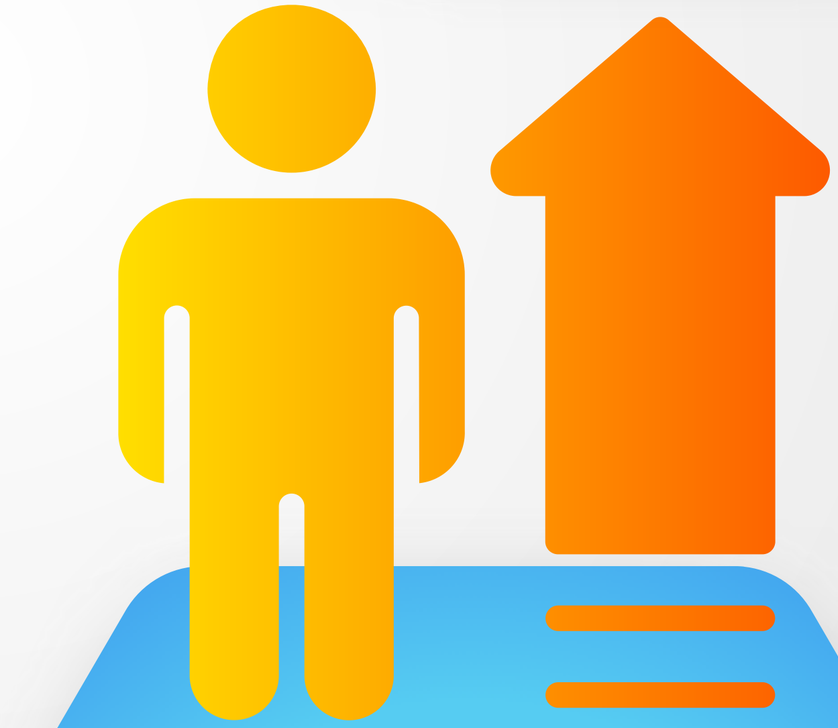
Priority areas

Each priority area has the following elements:

- Roadmap of interventions
- Programmatic outputs
- Current challenges or needs
- Public health surveillance

Goal

Outputs and outcomes are consistently assessed with hopes to improve the overall impact in the community



Additional surveillance

Population

Provide general understanding of the demographics and social determinants of health that impact health and well-being in our communities (e.g., Census, SVI)

Preventive measures

Assess a variety of prevention measures through surveillance data such as cancer screenings, vaccinations, and prevention visits

Risk behaviors

Examine certain risk behaviors to better understand population prevalence estimates

Health issues

Explore a variety of health outcomes: mortality, disability, maternal and child health, and dental issues using internal and external data sources

THANK YOU

If you have any further questions or would like to know more, please don't hesitate to reach out!

Sara Warfield Kelly, Ph.D., M.P.H.
Research Assistant Professor
University of Illinois College of Medicine in Peoria
Email: skelly88@uic.edu

CSA TIMELINE

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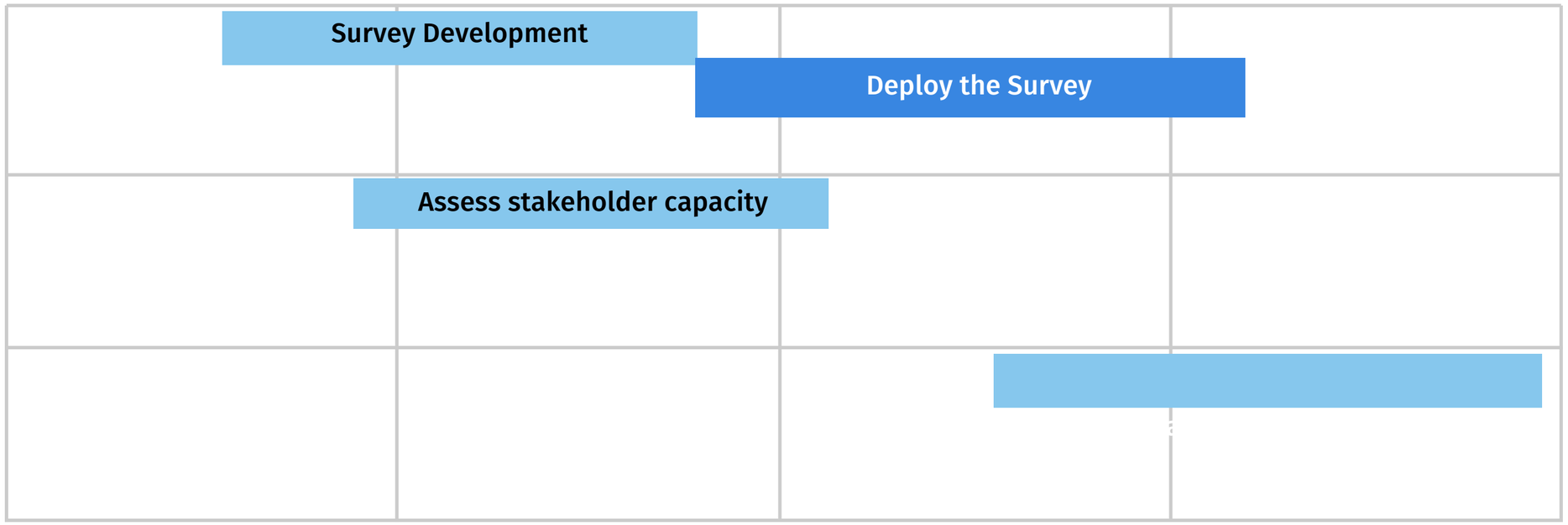
2024

1st Quarter	2nd Quarter	3rd Quarter	4th Quarter



CSA/CHIP TIMELINE

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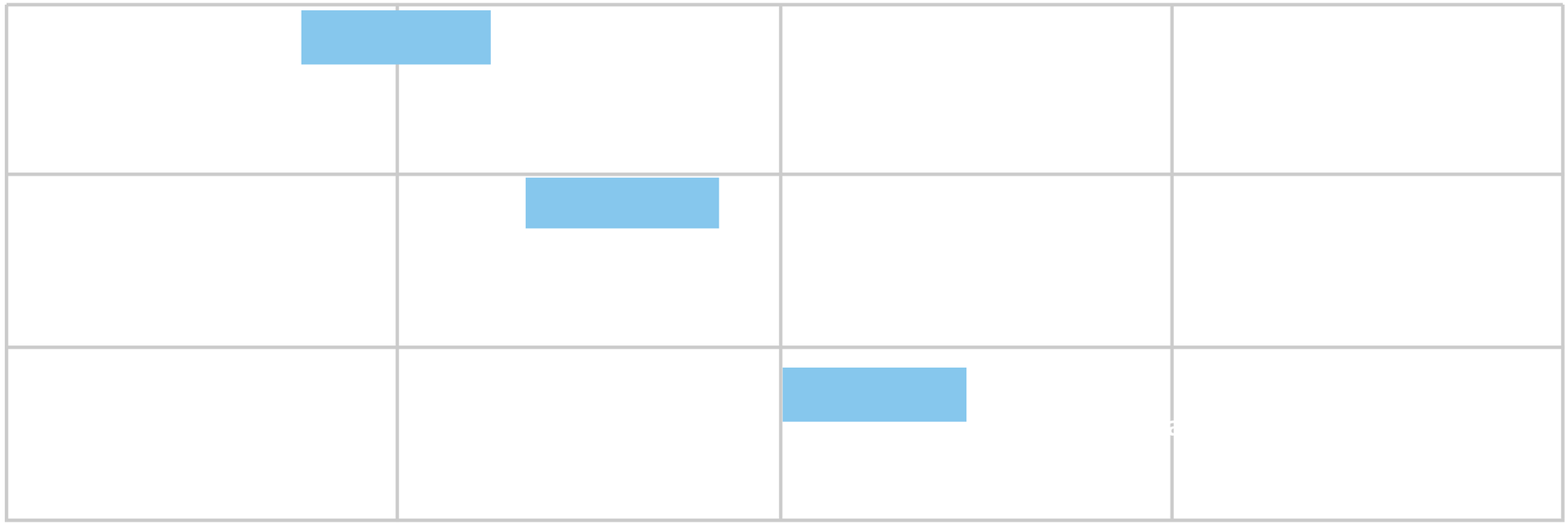
2025	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Prioritization				
Select Interventions				
Finalize summaries of issues and implementation strategies				



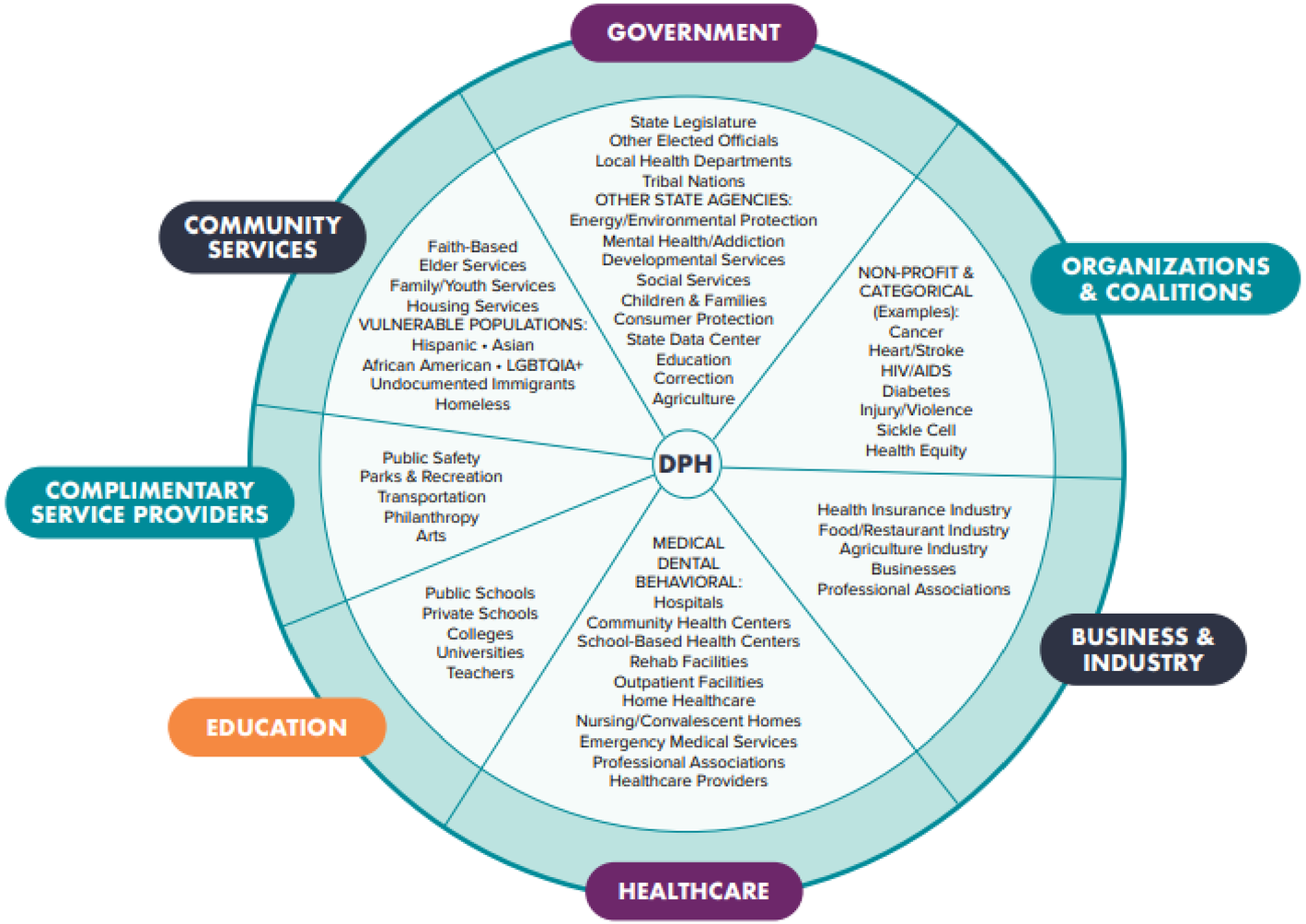
MAPP

- MAPP is an opportunity to strategically work toward a community-owned vision through collective action.

MAPP Changes

- Expand applicability to a broader variety of communities
- Enhanced focus on community engagement
- Include Health Equity with a different lens
- Shift from 4 assessments to 3:
  - Community Status Assessment (replaces CHNA)
  - Community Partner Assessment (replaces LPHSA)
  - Community Context Assessment (replaces FOC & Community Themes & Strengths)

Who is involved



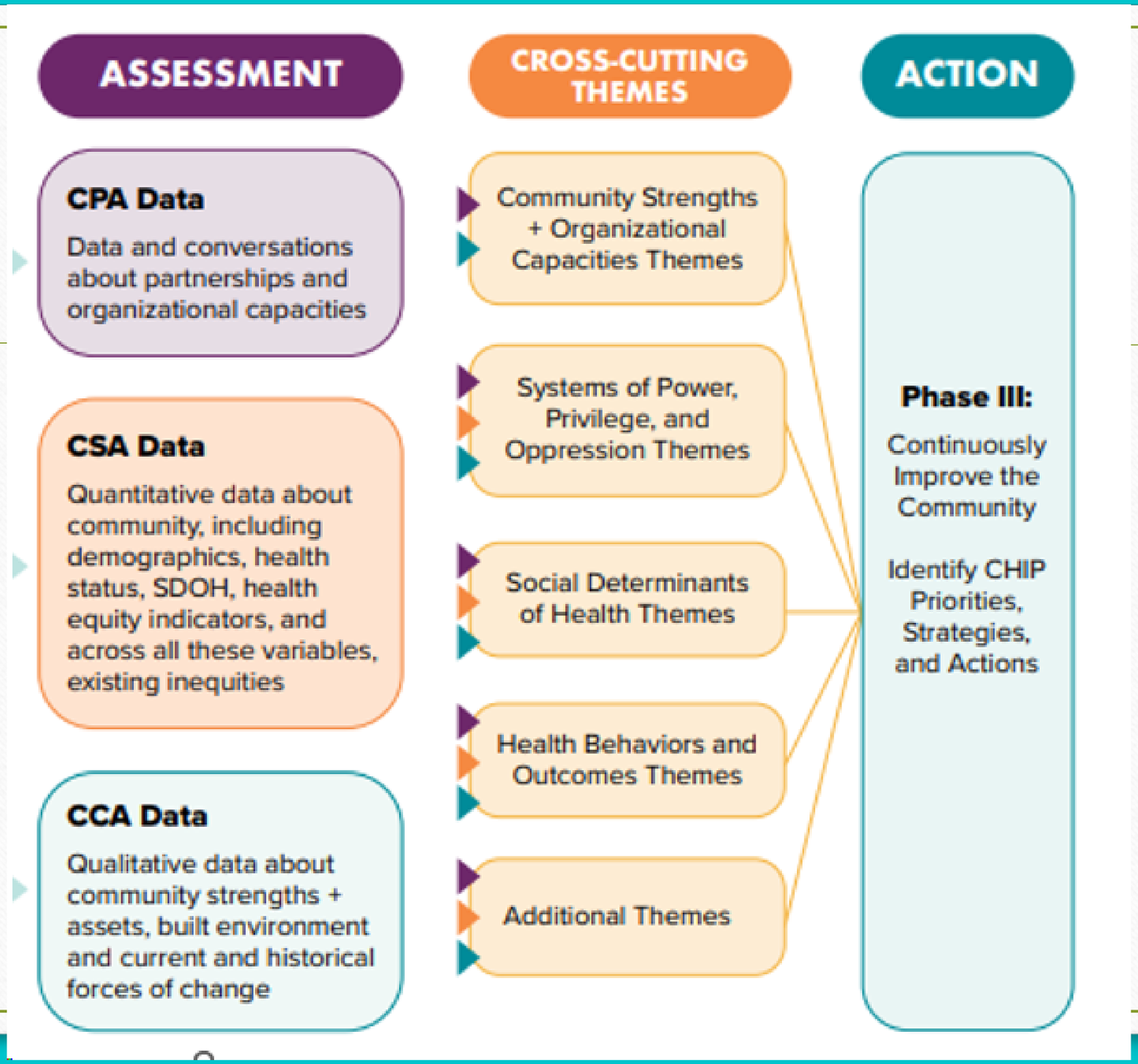
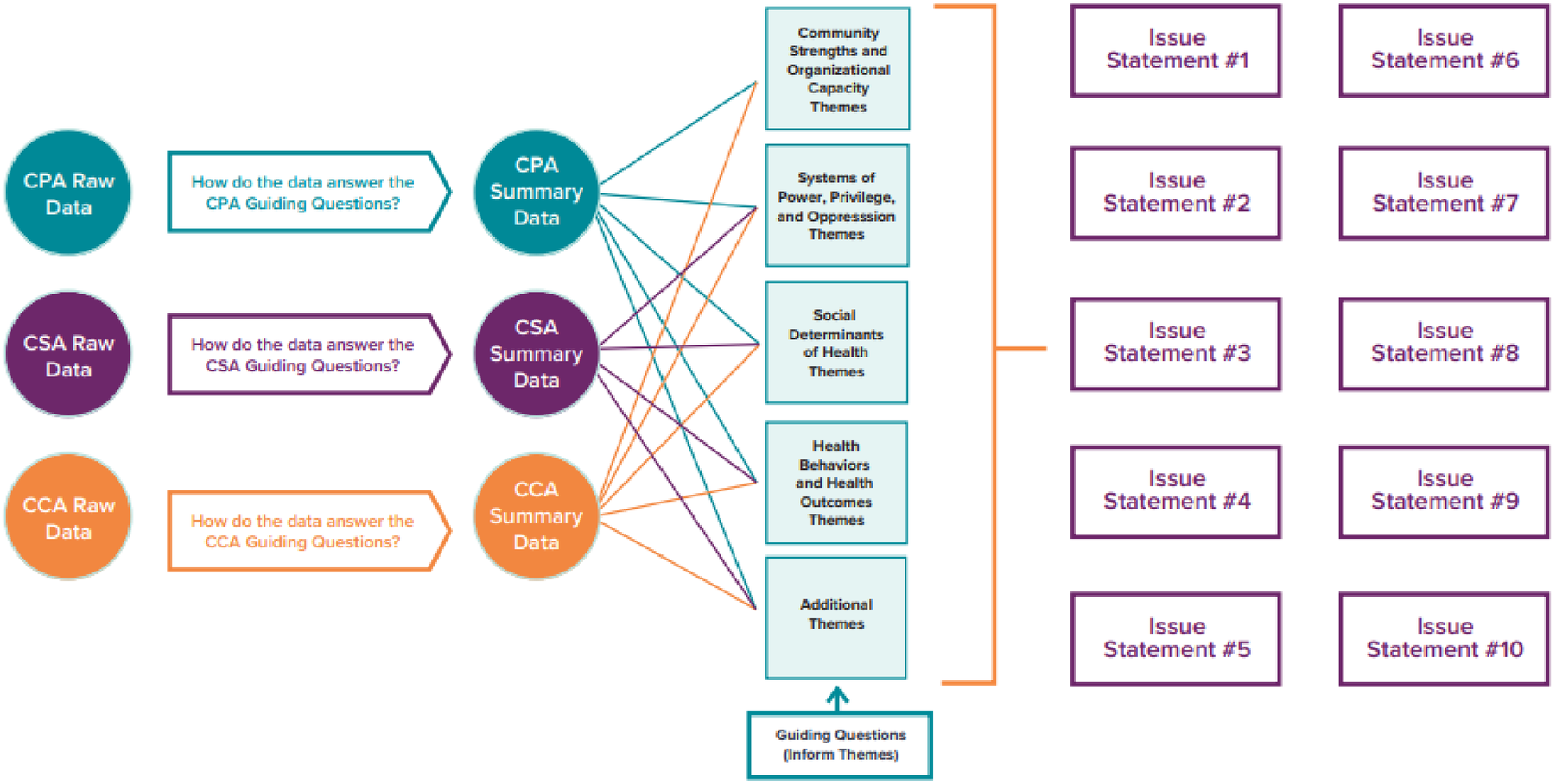

ASSESSMENT
CROSS-CUTTING THEMES
ACTION
CPA Data
Data and conversations about partnerships and organizational capacities
CSA Data
Quantitative data about community, including demographics, health status, SDOH, health equity indicators, and across all these variables, existing inequities
CCA Data
Qualitative data about community strengths + assets, built environment and current and historical forces of change
Community Strengths + Organizational Capacities Themes
Systems of Power, Privilege, and Oppression Themes
Social Determinants of Health Themes
Health Behaviors and Outcomes Themes
Additional Themes
Phase III:
Continuously Improve the Community
Identify CHIP Priorities, Strategies, and Actions

FIGURE 1. *Data-Triangulation Process*



Aligning this model will ensure equity and align PHAB Standards.

Health equity

"Health equity is the assurance of the conditions for optimal health for all people."

Optimal health means physical, mental, social, cultural, and spiritual well-being, beyond the lack of disease or infirmity.

Jones, C. (2014). Systems of power, axes of inequity: Parallels, intersections, braiding the strands. Medical Care, 52(10,Suppl. 3), S71-75. Retrieved from www.tfah.org/wp-content/uploads/202/08/Jones_Systemsofpower.pdf

Power, Privilege and oppression

Table discussions

Group Expectations of Involvement

- Each organization will have at least one person, and a maximum of three people participate in each MAPP meeting. Ideally, those are the same three people who participate throughout the process and staff do not change.
- Each organization will try to miss no more than three meetings and will review notes/meeting summaries to catch up if they miss a meeting.
- Each organization commits to completing each Assessment promptly.
- Each organization commits to helping identify and apply the suggestions emerging from the MAPP collective, and assessments as they relate to their work and capacity.
- Each organization commits to learning more about power, reflecting on power dynamics within their organization, and being willing to address power imbalances among partners.

Community Partner Survey:

- Identify and align community assets
- Identify gaps within the capacity of our community.
- Identify underlying issues of the ‘system’
  - how we can collaboratively work together.

  - We are asking partners to continue through the process.
    - Organizational examples (housing, heart disease, etc.)

Survey Info

The survey takes approximately 15 - 20minutes (56 questions).
Only 1 survey per organization
- If you are part of a system, identify the buckets within the system.
    - If you are healthcare and you have multiple locations that serve different purposes, you would complete per location.
        - If you have one entity with satellite clinics offering the same services, you complete one survey.

        - Identify a leader of each organization to facilitate a conversation within the organization

        - Have a consensus to submit your answers.
    - When reflecting on populations served or services provided use the 80/20 rule.

Next Steps:

Quality Improvement Survey
Complete by **March 31, 2024**

- Community Partner Assessment
  - **Complete by April 31, 2024**

How can YOU get involved?

Join a Committee

Visit our Website

www.healthyhoi.org

Contact Us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