Q4
2023

QUARTERLY REPORT

PFHC DATA TEAM

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SUMMARY

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

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

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

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

HEAL

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

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

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

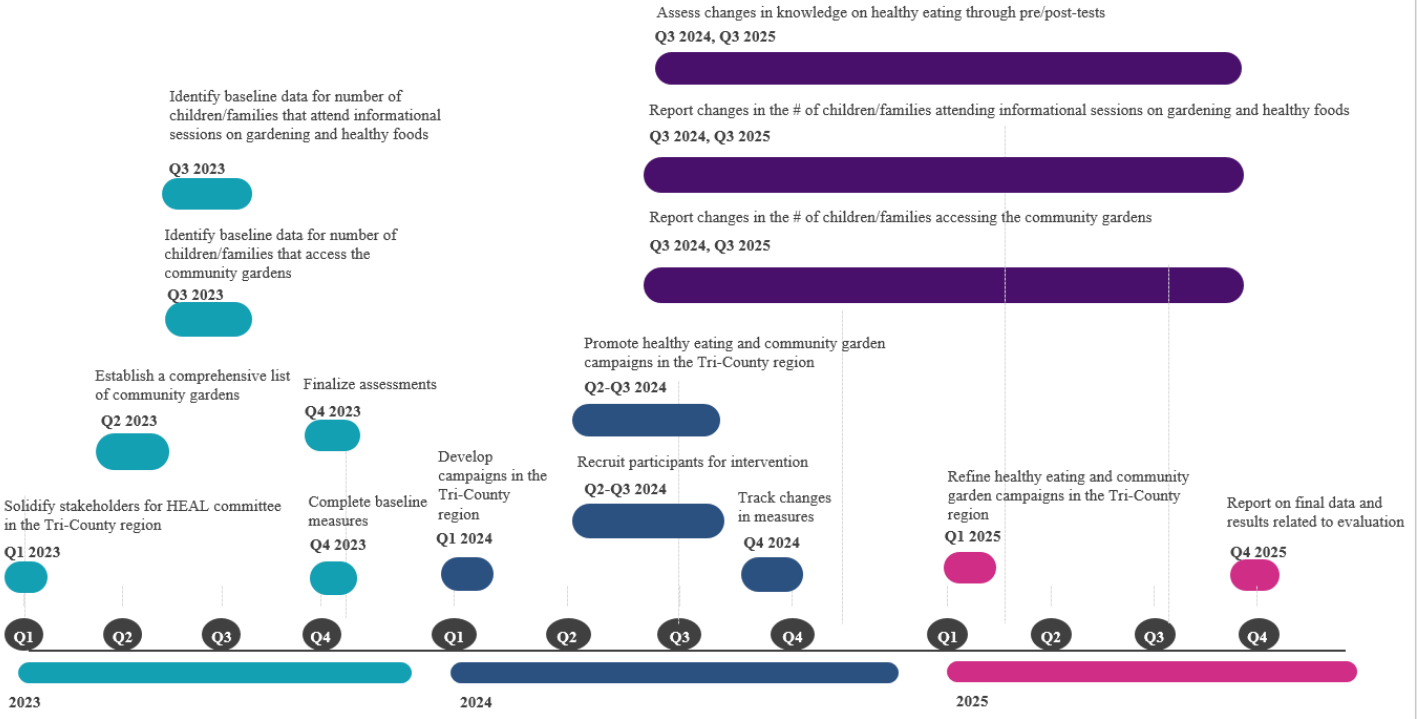
Food insecurity is as a lack of consistent access to enough, nutritious food for every person in a household to live an active, healthy life.

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

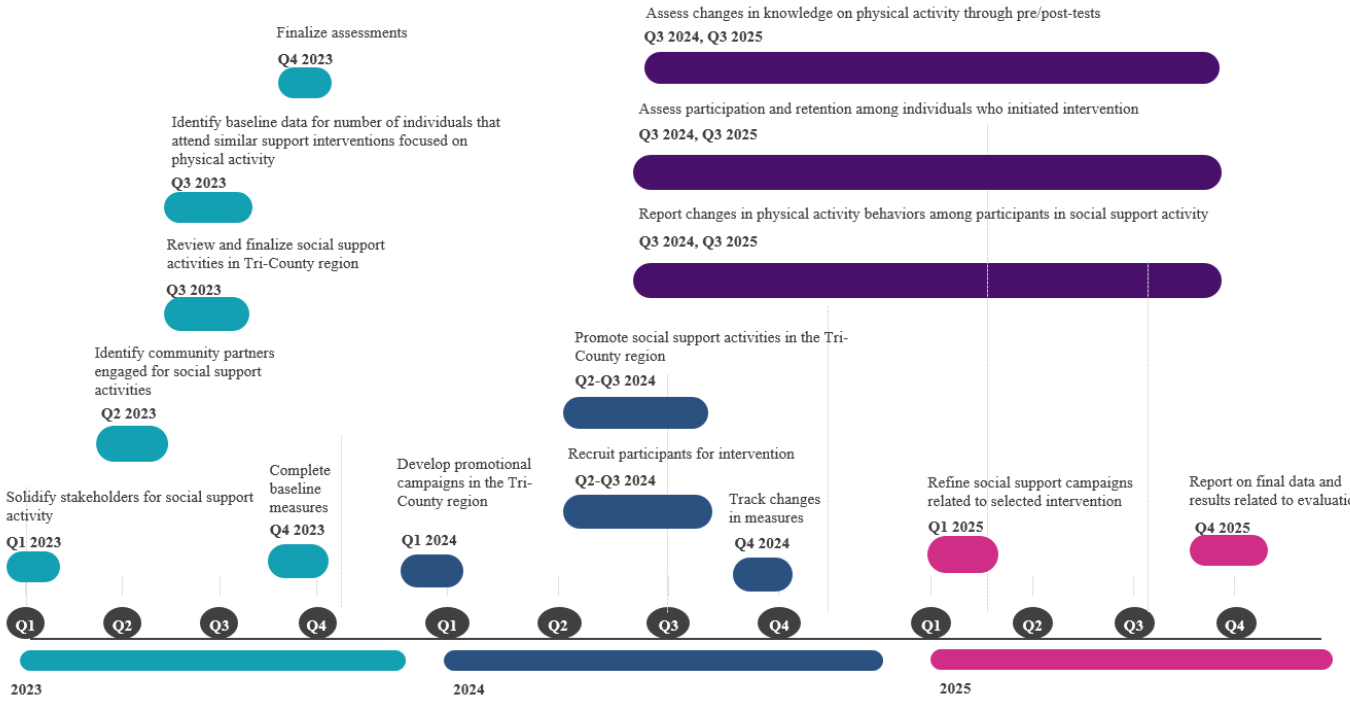
Evaluation metrics for each intervention

Roadmap of HEAL interventions

HEALTHY EATING



PHYSICAL ACTIVITY



Programmatic outputs

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

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

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

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

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

Current challenges or needs for selected interventions

Healthy Eating (HE)

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

Physical activity (PA)

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

Public health surveillance data

Healthy Eating (HE)

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

Data sources:

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

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

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

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

Physical activity (PA)

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

Data sources:

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

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

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

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

OBESITY

Obesity is defined in the CHNA as overweight and obese.

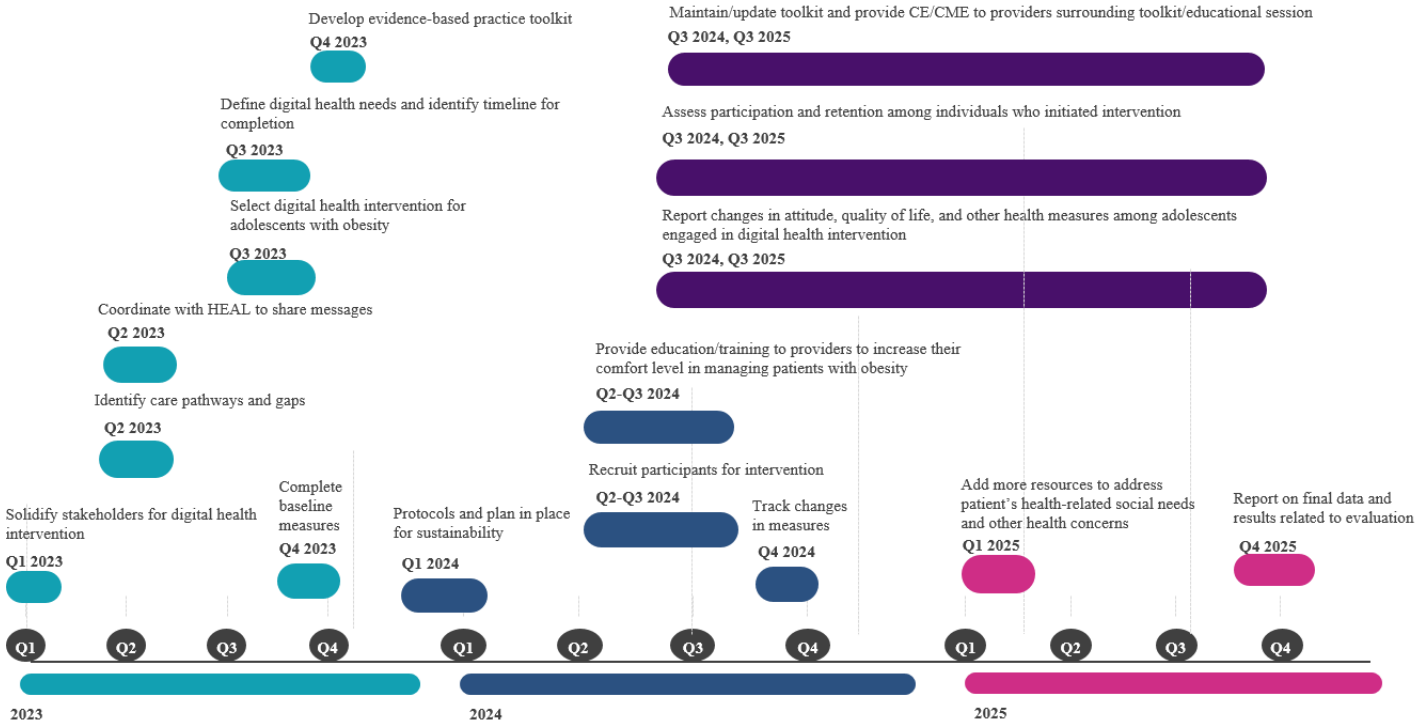
Obesity includes individuals who are overweight or obese. A weight that is higher than considered healthy for a given height, determined by Body Mass Index (BMI), is classified as overweight or obese. Prevalence of overweight and obesity is a risk factor for chronic disease and raises the risk of developing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

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

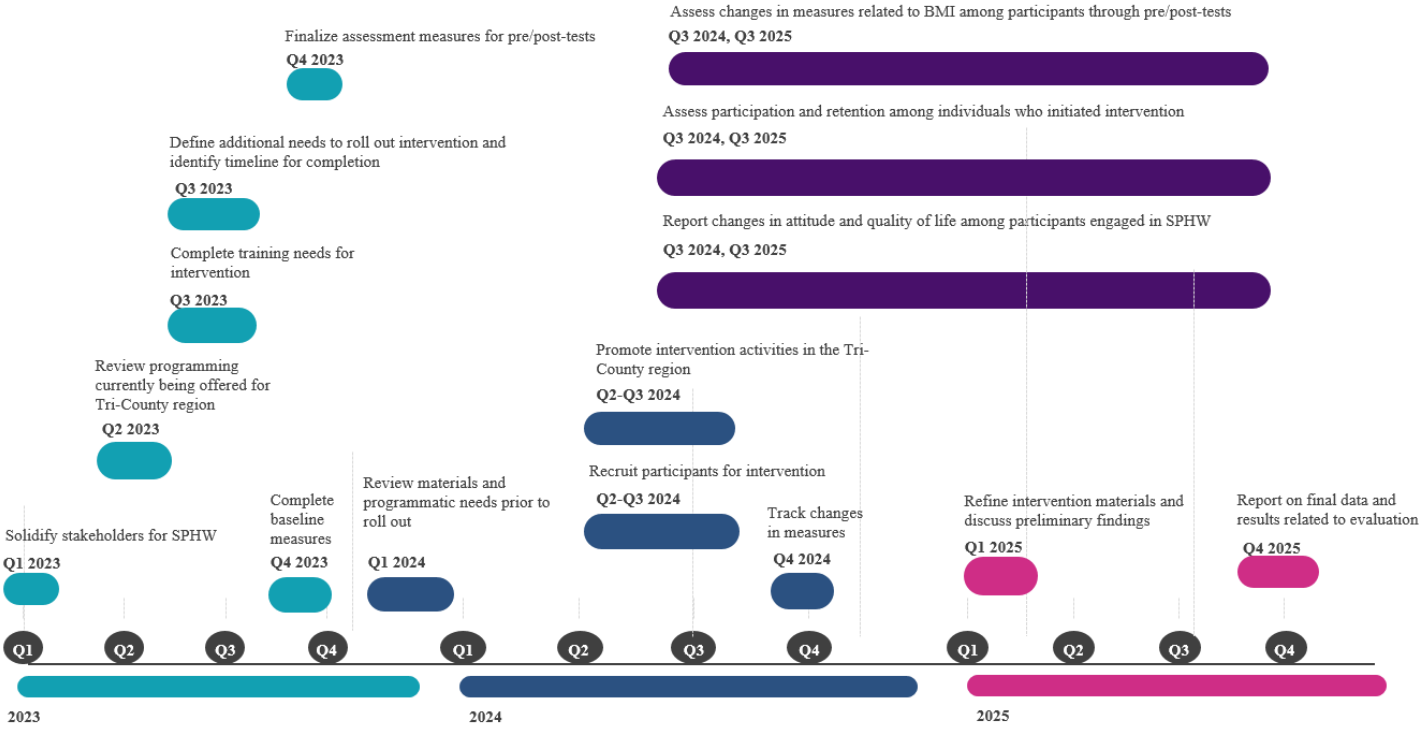
Evaluation metrics for each intervention

Roadmap of obesity interventions

OBESITY: DIGITAL HEALTH INTERVENTION AMONG ADOLESCENTS



OBESITY: STRONG PEOPLE HEALTHY WEIGHT (SPHW)



Programmatic outputs

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

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

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

Intervention Strategy: Strong People Healthy Weight (SPHW)

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

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

Current challenges or needs for selected interventions

Adolescent:

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

Strong People Healthy Weight (SPHW):

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

Public health surveillance data

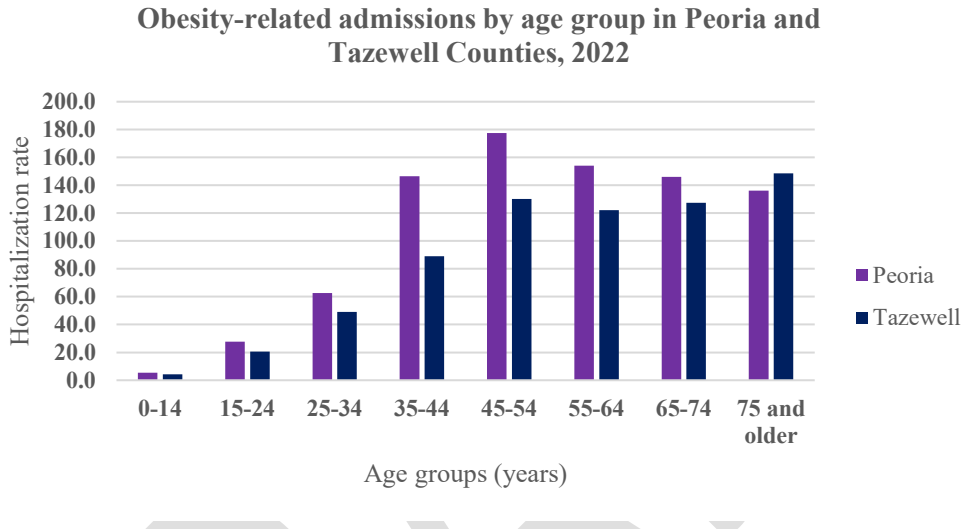
	Peoria	Tazewell	Woodford	Illinois	United States
Obesity among adults	36.1	35.6	33.9	33.9	33.0

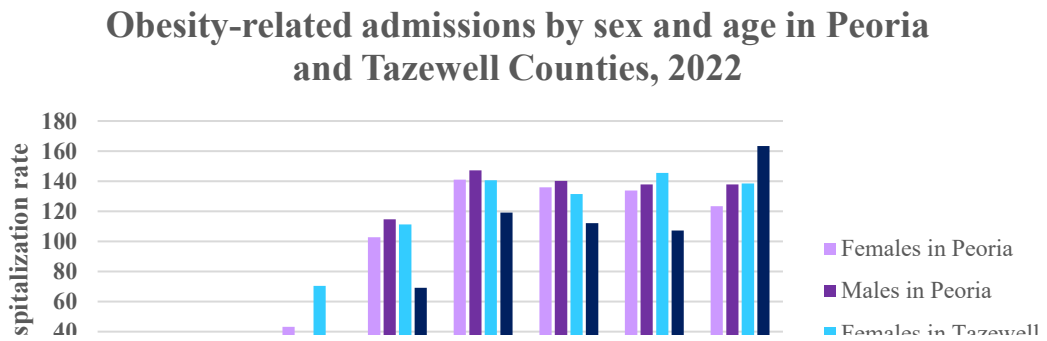
Data sources:

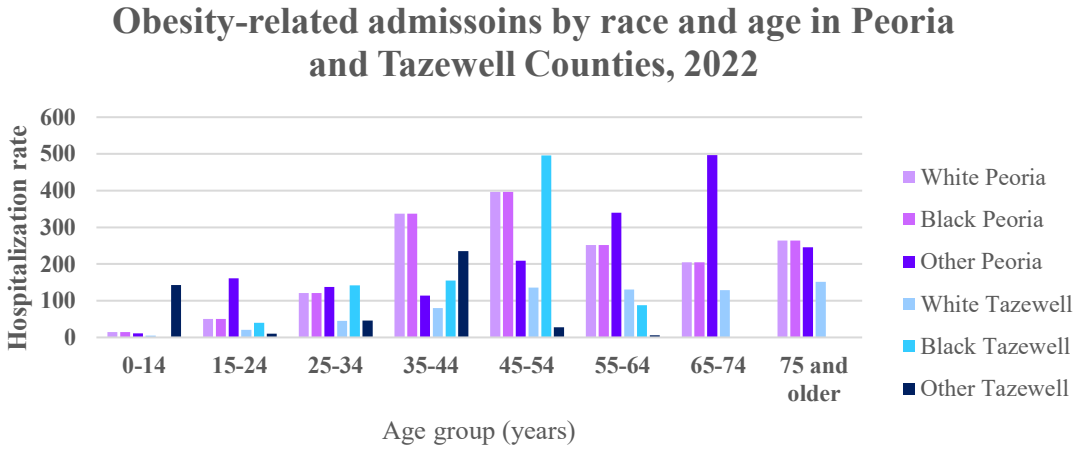
1. 2021 Behavior Risk Factor Surveillance System (BRFSS)

ESSENCE data

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







Additional health metrics related to obesity

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

Data sources:

1. 2021 Behavior Risk Factor Surveillance System (BRFSS)

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

MENTAL HEALTH

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

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

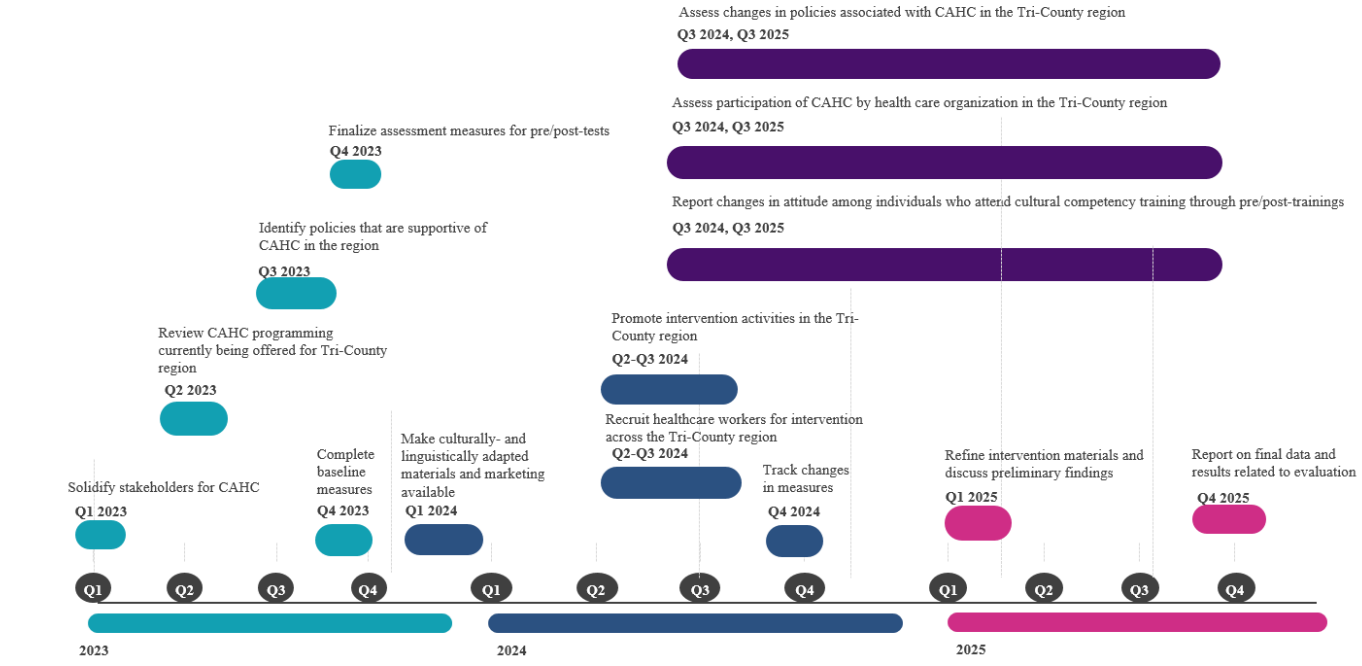
Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest. A diagnosis of depression includes symptoms that must last at least two weeks and represent a change in previous level of functioning; **Anxiety** involves an intense, excessive and persistent feeling of fear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

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

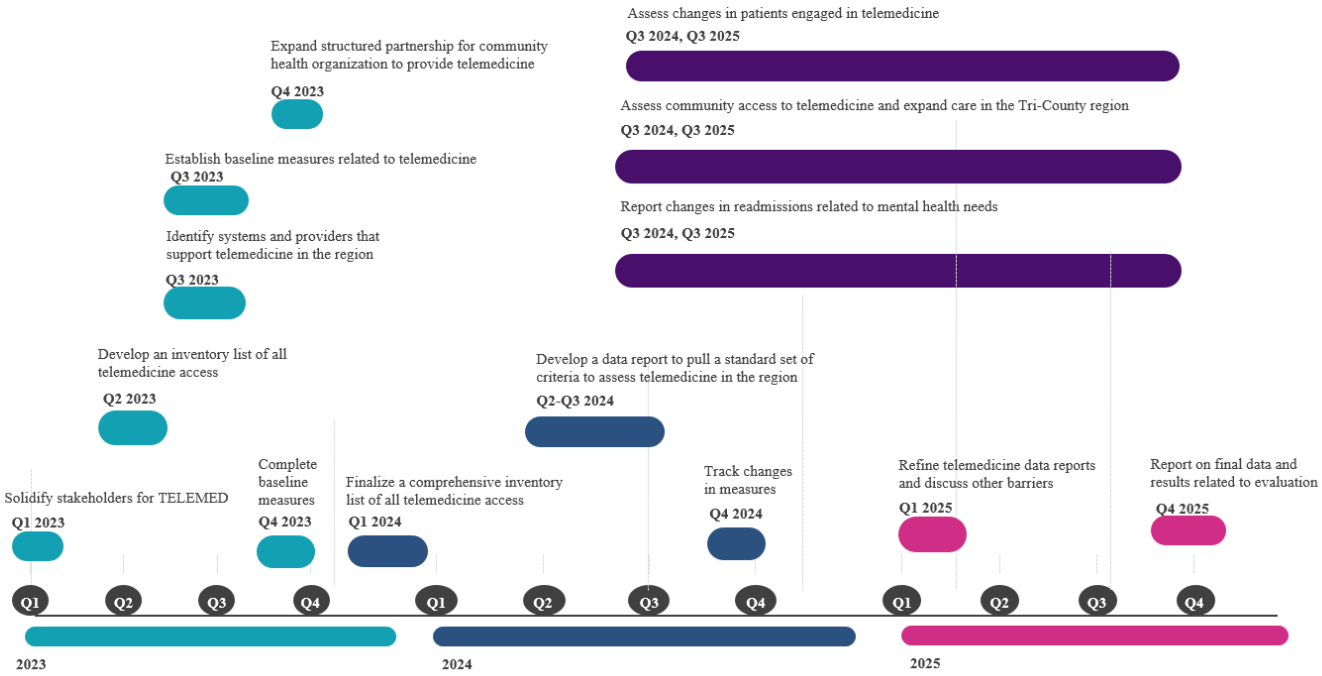
- *By December 31, 2025, decrease the number of suicides in the Tri-County area by 10%.*
- *By December 31, 2025, increase the proportion of children and adults with mental health problems in the Tri-County areas who get treatment by 10%.*

Evaluation metrics for each intervention

Roadmap of mental health interventions



MENTAL HEALTH: TELEMEDICINE



Programmatic outputs

Intervention Strategy: Culturally-Adapted Health Care (CAHC)

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

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

Intervention Strategy: Telemedicine (TELMED)

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

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

Current challenges or needs for selected interventions

Culturally Adapted Health Care (CAHC)

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

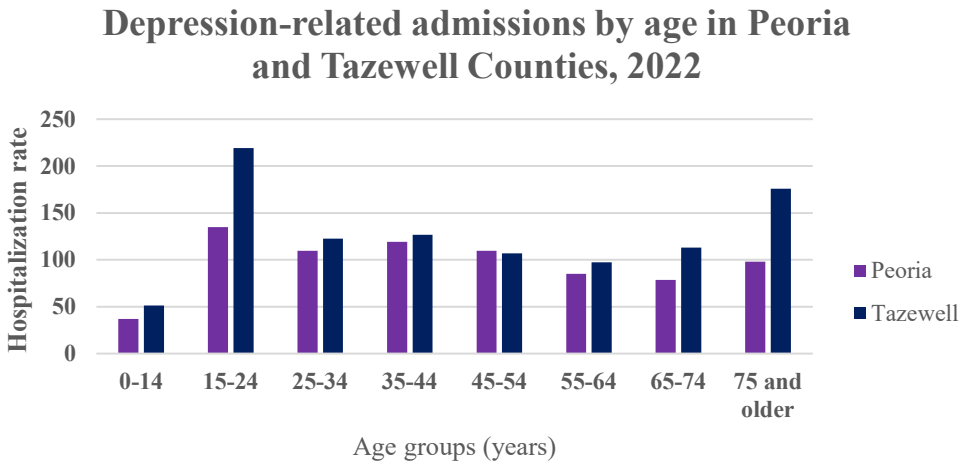
Telemedicine (TELMED)

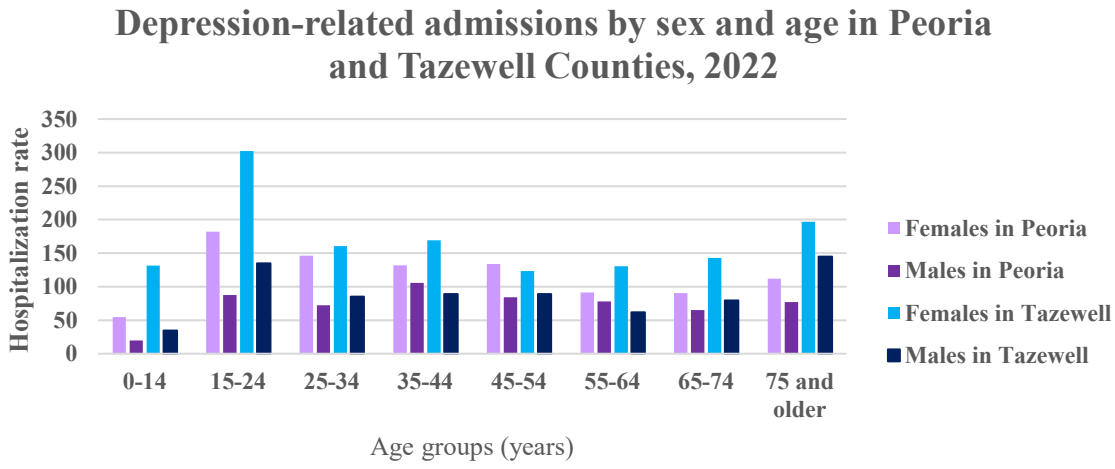
- Medicare changes that will impact hospitals providing telehealth (private providers will be able to continue).
- Need to identify what success is at Years 1-3
- Currently working on obtaining data from healthcare sources

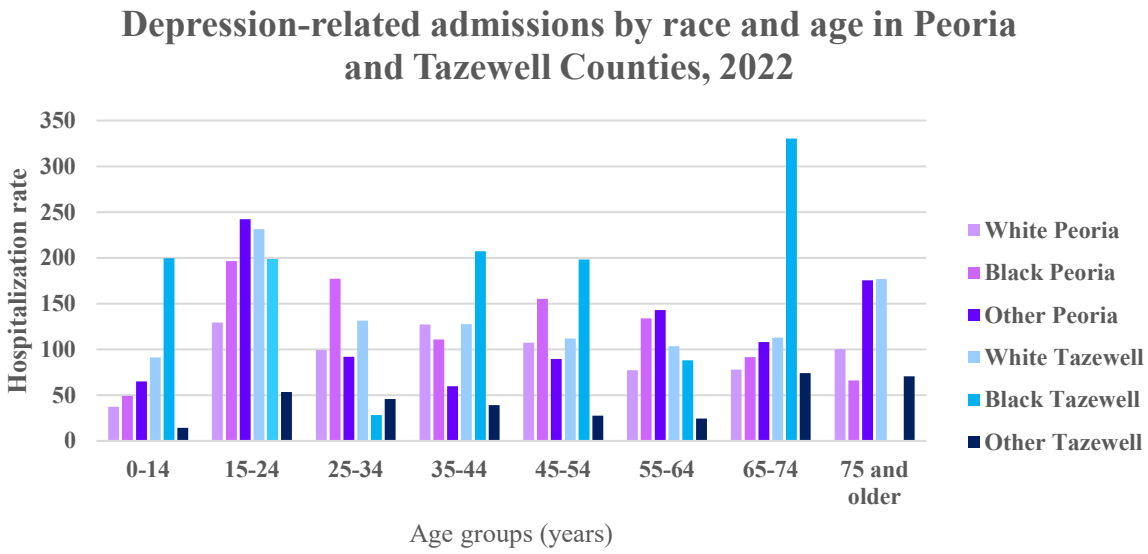
Public health surveillance

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

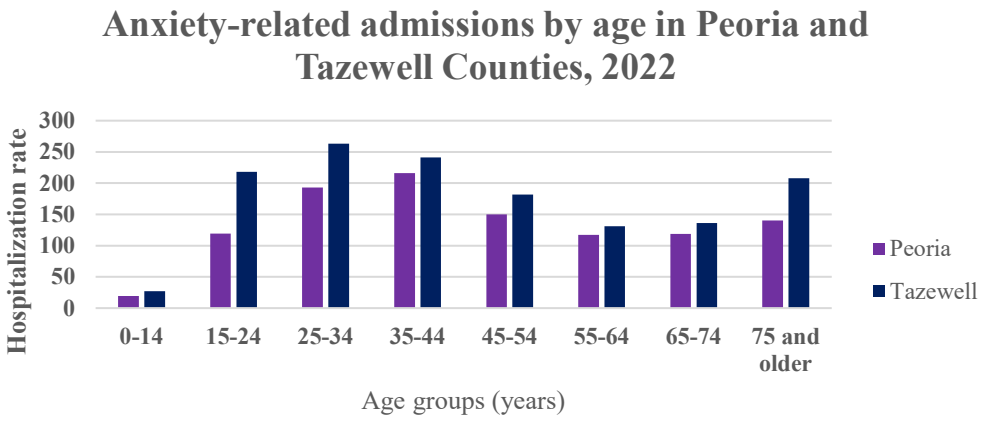
Depression

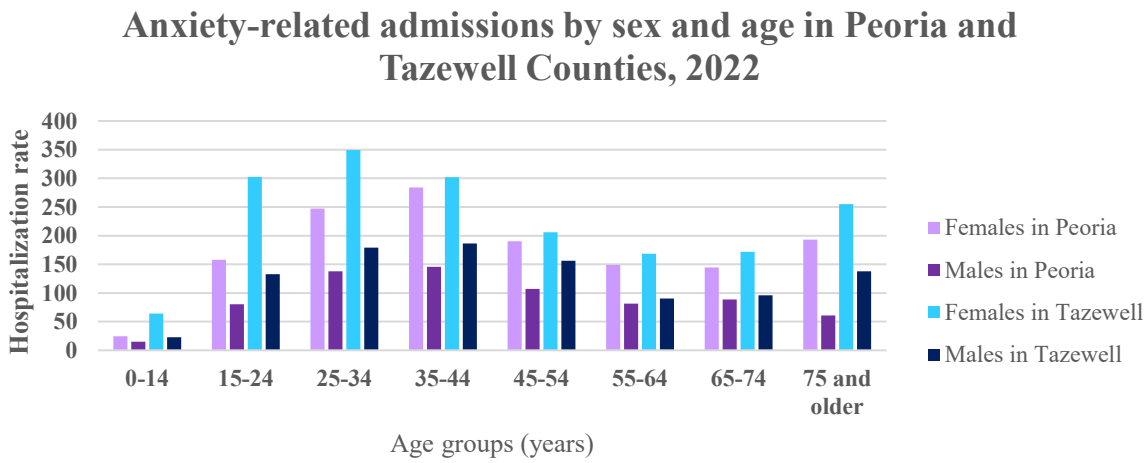

Depression-related admissions by age in Peoria and Tazewell Counties, 2022
Hospitalization rate
250
200
150
100
50
0
0-14
15-24
25-34
35-44
45-54
55-64
65-74
75 and older
Age groups (years)
Peoria
Tazewell

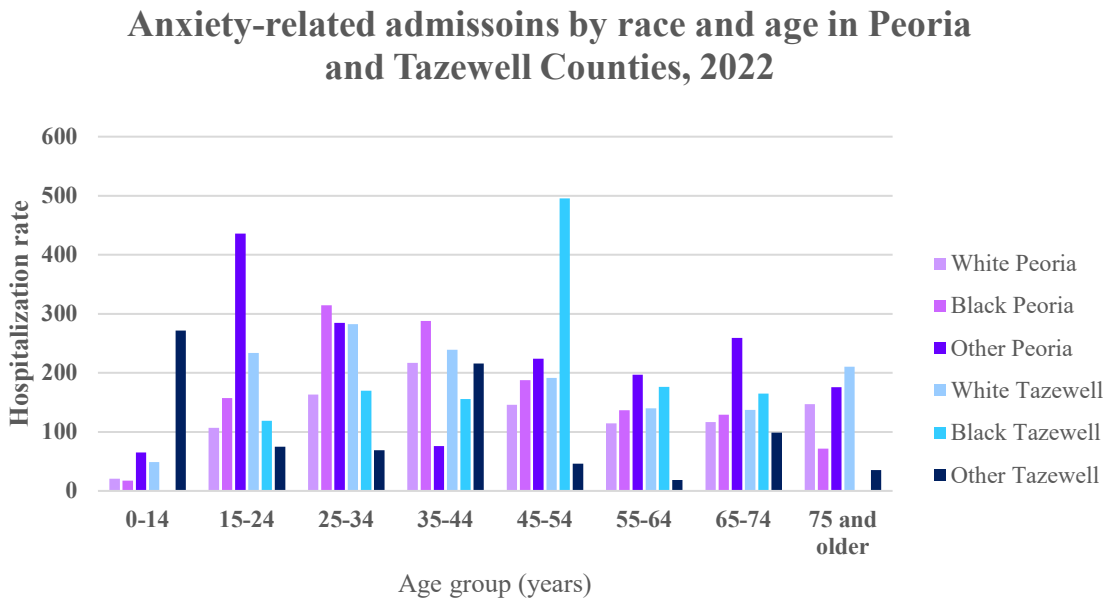

Depression-related admissions by sex and age in Peoria and Tazewell Counties, 2022
Hospitalization rate
350
300
250
200
150
100
50
0
0-14
15-24
25-34
35-44
45-54
55-64
65-74
75 and older
Age groups (years)
Females in Peoria
Males in Peoria
Females in Tazewell
Males in Tazewell


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

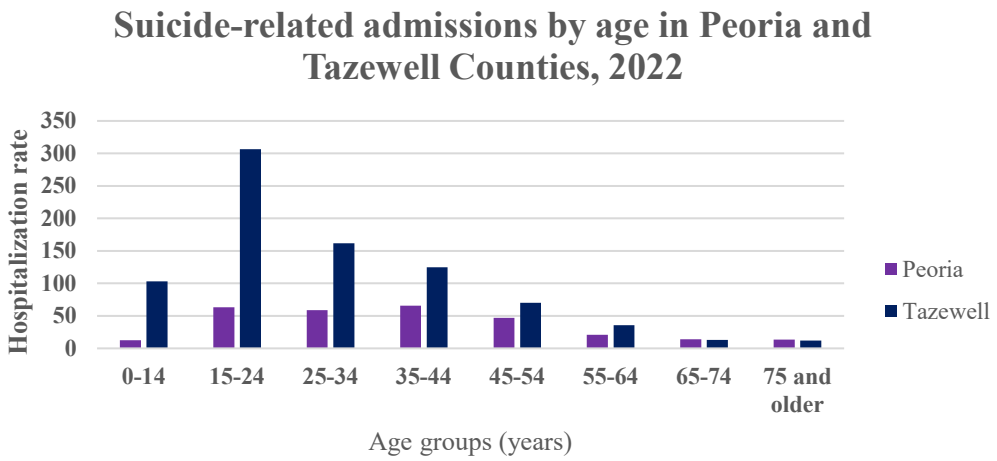
Anxiety

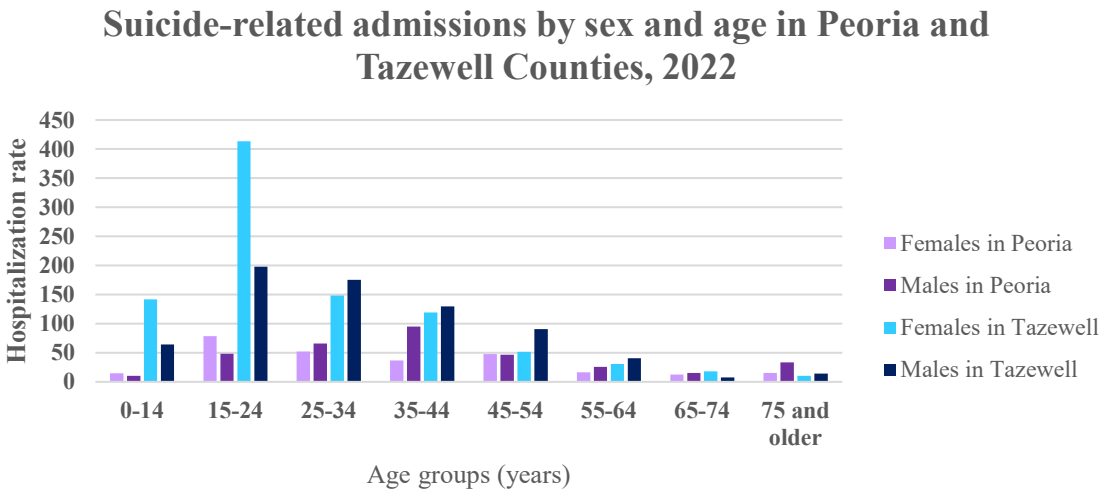

Anxiety-related admissions by age in Peoria and Tazewell Counties, 2022
Hospitalization rate
300
250
200
150
100
50
0
0-14
15-24
25-34
35-44
45-54
55-64
65-74
75 and older
Age groups (years)
Peoria
Tazewell

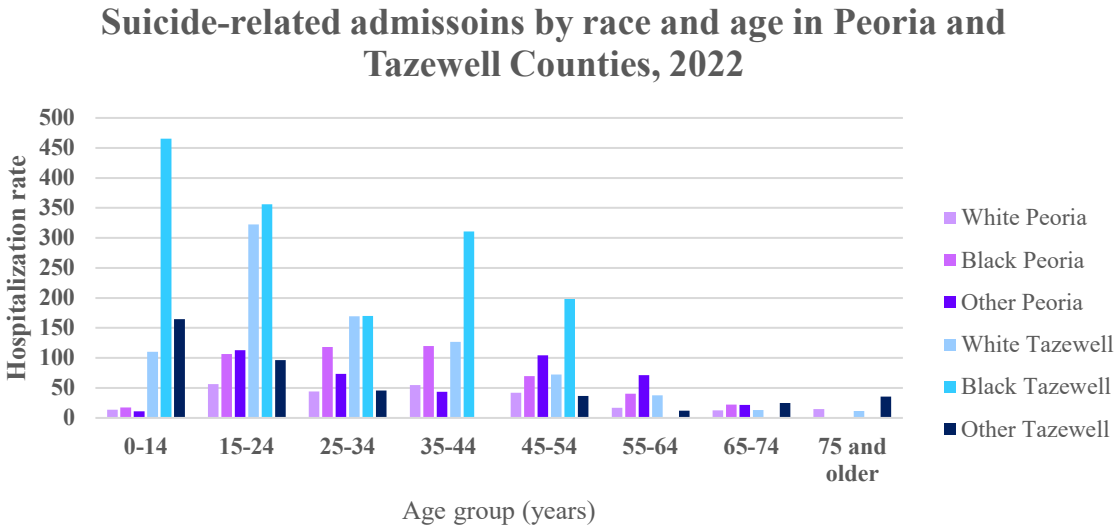

Anxiety-related admissions by sex and age in Peoria and Tazewell Counties, 2022
Hospitalization rate
400
350
300
250
200
150
100
50
0
0-14
15-24
25-34
35-44
45-54
55-64
65-74
75 and older
Age groups (years)
Females in Peoria
Males in Peoria
Females in Tazewell
Males in Tazewell


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

Suicide


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


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


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

Additional health metrics related to mental health

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

Data sources:

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

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

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

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

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

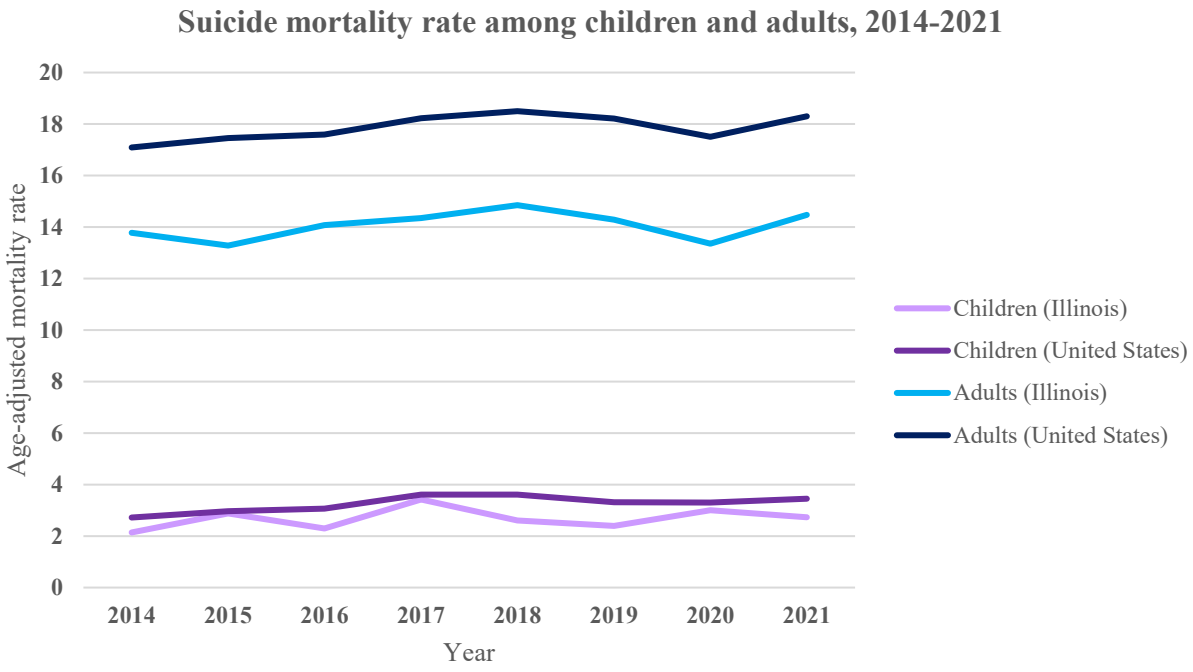
Alcohol-impaired driving deaths is a percentage of motor vehicle crash deaths with alcohol involvement. Alcohol-Impaired Driving Deaths are reported for the county of occurrence. This is because it is more likely that the drinking behavior that led to the driving crash happened where the accident occurred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

Suicide mortality data for the Tri-County region

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

Data sources:
1. 2014-2020 NCHS

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



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

Further examination of national suicide data

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

ADDITIONAL MEASURES RELATED TO COMMUNITY HEALTH

Population

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

Data source:

1. 2022 American Community Survey, Census.

Social determinants of health (SDOH)

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

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

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

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

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

SDOH measures by race

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

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

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

SDOH measures related to children

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

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

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

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

SDOH measures related to children by race

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

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

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

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

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

Additional measures related to health status

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

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

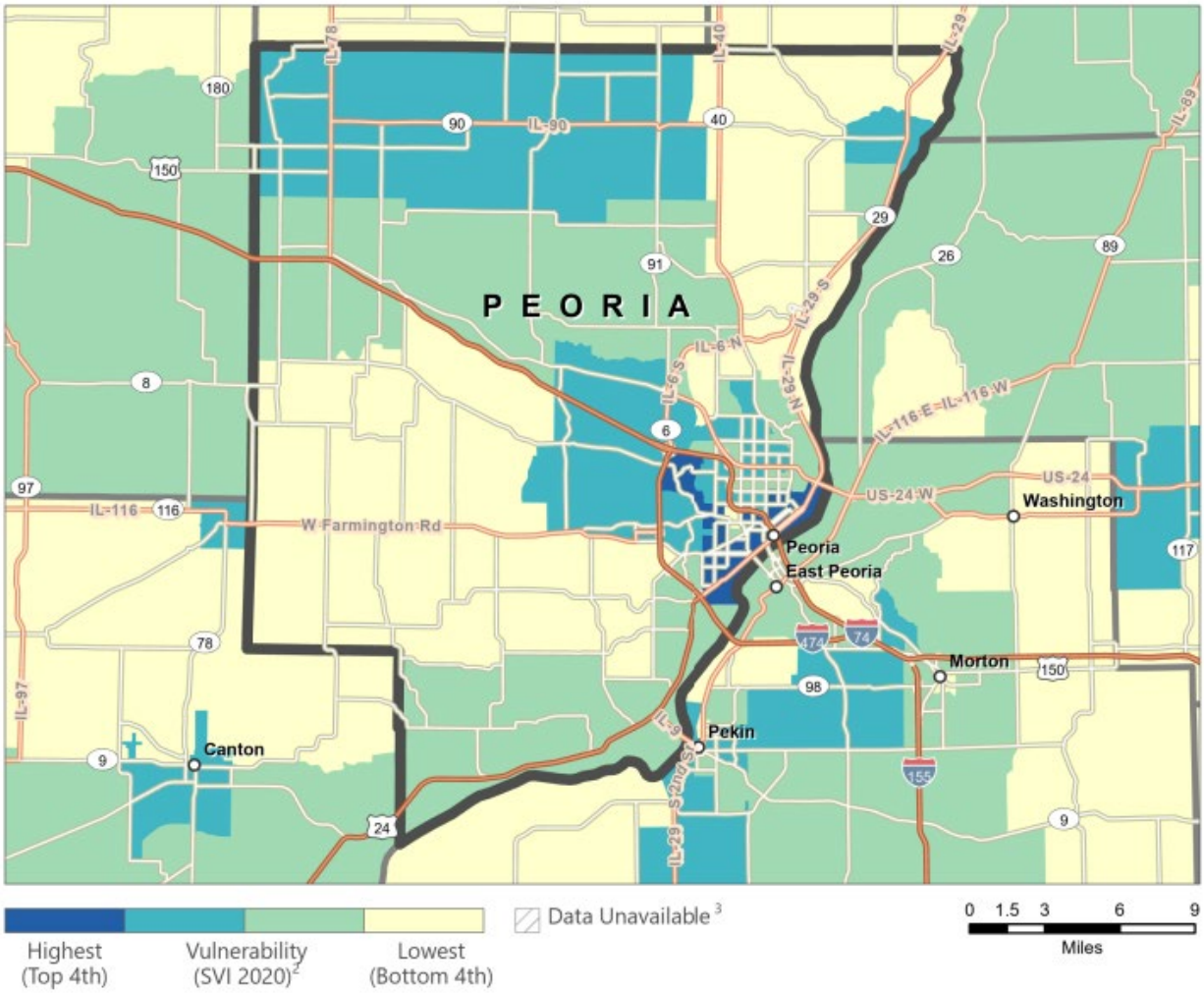
The data in the table above depicts the age-adjusted percentage of adults for the Tri-County region in comparison to Illinois and the US.

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

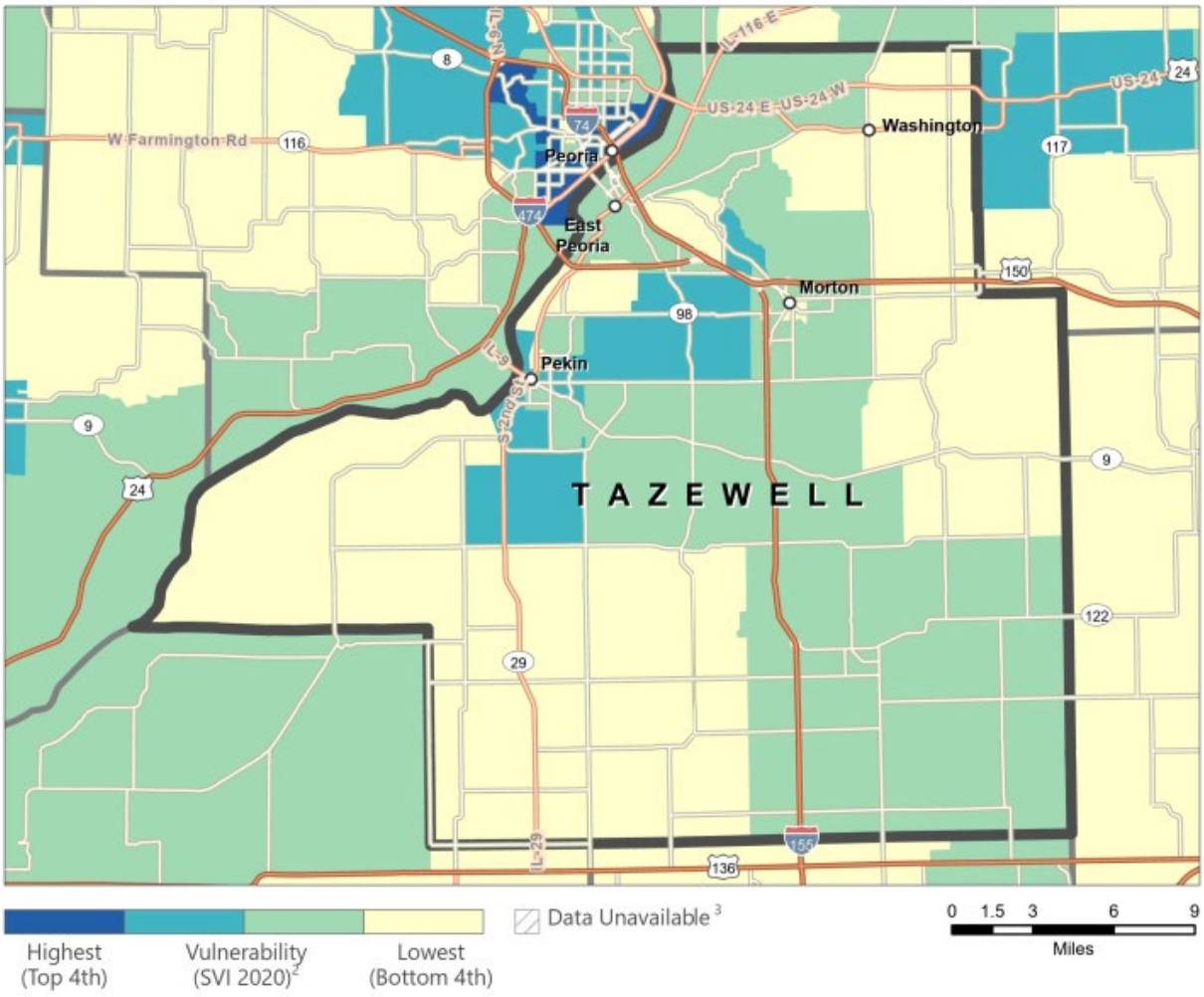
Social Vulnerability Index

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

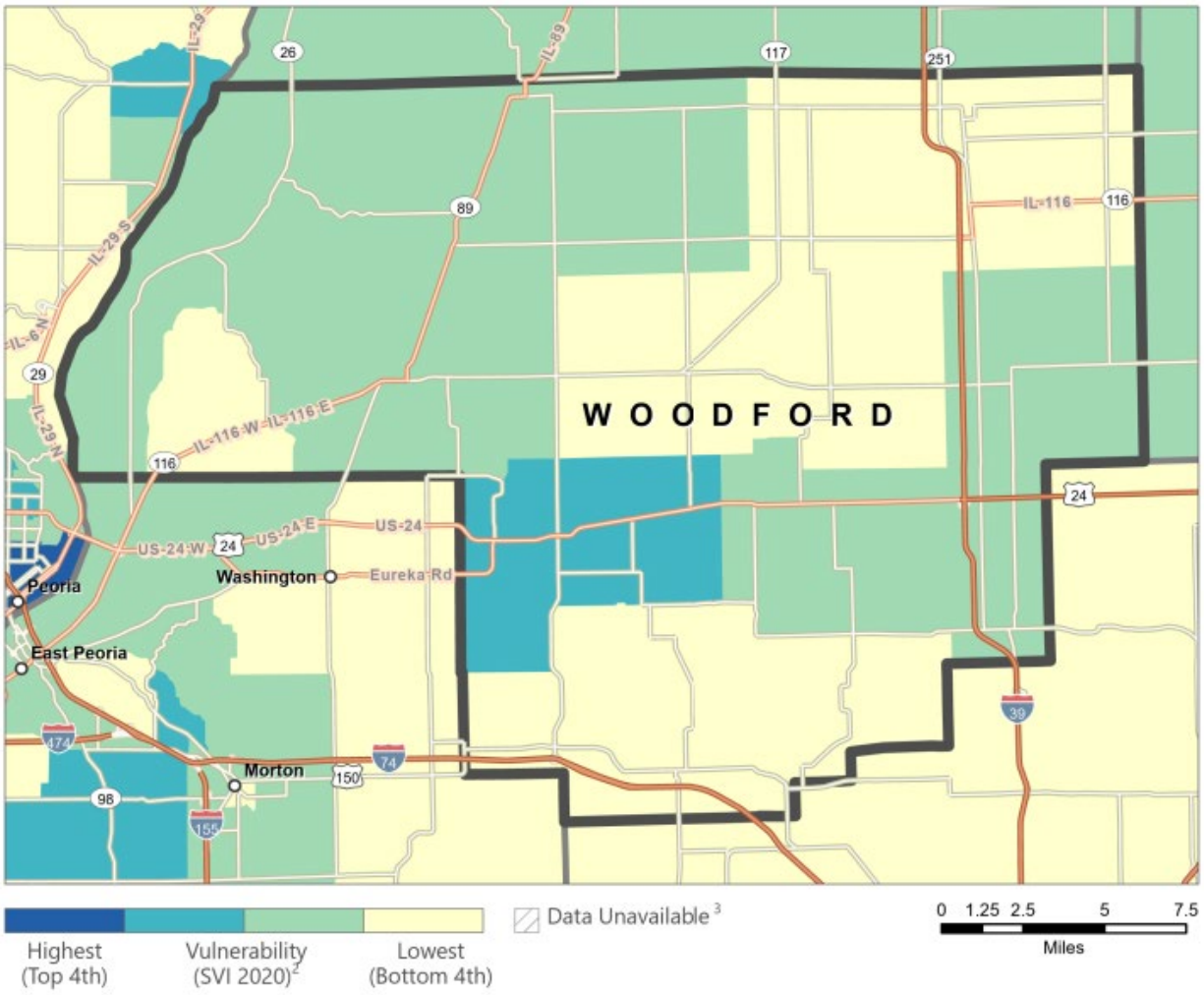
Peoria County, 2020



Tazewell County, 2020



Woodford County, 2020



Prevention

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

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

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

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

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

Prevention measures by race

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

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

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

Cancer

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

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

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

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

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

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

Mammogram by race

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

Data sources:
1. 2020 Mapping Medicare Disparities Tool

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

Health risk behaviors

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

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

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

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

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

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

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

Maternal and child health

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

Data sources:
1. 2014-2020 NCHS

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

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

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

Maternal and child health measures by race

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

Data sources:
1. 2014-2020 NCHS

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

Dental

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

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

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

Disability

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

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

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

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

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

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

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

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

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

Mortality

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

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

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

Leading causes of death for the Tri-County region

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

Data sources:
1. 2018-2020 CDC WONDER

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

Years of Potential Life Lost & Life expectancy

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

Data sources:
1. 2018-2020 NCHS

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

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

Age-adjusted death rate by race/ethnicity

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

Data sources:
1. 2018-2020 NCHS

Injury death rate by race/ethnicity

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

Data sources:
1. 2018-2021 NCHS

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

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

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

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

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

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

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

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

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

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

Additional mortality data for the Tri-County region

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

Data sources:
1. 2014-2020 NCHS

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

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

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

Data sources:
1. 2014-2020 NCHS

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

NEXT STEPS

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

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