Partnership for a Healthy Community
Board Meeting

October 26, 2023
1:00pm-2:30pm
Teams

AGENDA

1. **Approve 8/24/23 meeting minutes** (Action) **(Pages 2-5)**

2. **Committee Updates**
    a. HEAL **(Pages 6-14)**
        i. Social Media Reach
        ii. Hunger Action Month Report
        iii. Walking Challenges
    b. Mental Health **(Pages 15-20)**
    c. Obesity **(Pages 21-30)**
    d. Data Team **(Pages 31-66)**
    e. Website & Social Media
    f. Performance Management

3. **Healthcare Collaborative**

4. **Learning Collaborative**
    a. Racial, Justice, & Equity Commission Presentation – *Nicole Robertson*

5. **Board Business**
    a. PFHC Board Membership (Action)
    b. Timeline
    c. MAPP Model

6. **Miscellaneous**

Next Meeting:
Thursday, November 16, 2023
1:00pm-2:30pm
OSF Center for Health

Partnership for a Healthy Community Board
Meeting Minutes
August 24, 2023

Members Present:	Phil Baer	Amy Fox
	Sally Gambacorta	Holly Bill
	Adam Sturdavant	Jay Collier
	Nicole Robertson	Chris Setti
	Hillary Aggertt	Monica Hendrickson
	Kate Green	Beth Crider
	Jennifer Zammuto (via Teams)	
Others Present:	Amy Roberts	Megan Hanley
	Dr. Sara Donohue	Dr. Sara Kelly

Approval of 07/27/23 Meeting Minutes

Ms. Fox made a motion to approve the minutes from the July 27, 2023 meeting. Motion was seconded by Mr. Setti. Motion carried (13,0).

Committee Updates

HEAL

Ms. Aggertt stated that Hunger Action Month is in September and the bridge will be lit for it on September 1st and there is a walk on September 30th. The only entrance fee is bringing a green light food. Local pantries will be on sight to collect the food to take it back. A toolkit will be featured on the website highlighting how to get involved and all the different groups. All three counties are doing proclamations around food insecurity that month as well. The Nourish Your Neighbor campaign will continue with the help of HEAL partners, on September 16th from 10:00am to 2:00pm they will be collecting food at Kroger in Peoria, Tazewell, and Fulton County, which will go directly to food pantries that day. For physical activity, they have worked with the Data team to see how to increase participants and collect the data, from gyms, park districts, etc. The three health departments have agreed to purchase a walker/tracker app for a year to collect data. The app can collect any physical activity and can create teams, this will be an experiment to see if that works. There is some built environment work continuing being done in Peoria. Tazewell is working to do an active transportation plan in Pekin. They are trying to get a campaign together for the spring called Move Your Way, wanting people to move, giving credit to any activities.

Mental Health

Ms. Bill stated that not much has changed, but the Co-Chairs will have two different meeting groups to address the 2 separate areas. Dr. Fisher has joined the group, which has been helpful and her suggestion, which she was already working on, is creating toolkits for PCPs to help them handle easier or less severe cases. Will need a lead for the adult level toolkit. This will help reduce the wait list for providers. They also have performance management programs continuing from the previous cycle. For the telehealth side, they want specialty cared individuals tuning in on telehealth, but more for the secondary and primary level to not overuse the specialty levels if they don't need it. They have a ton of data, but how do they get the baseline they need. Dr. Kelly noted she can help.

Obesity

Mr. Baer stated that the Obesity team is working through a 3-tier intervention model and worked through the handout of the team's dashboard. They are working on making pediatric adolescent obesity care a leader driven priority. This section has treatment, counseling, other therapy and Dr. Christianson and Dr. Fisher are sharing tools and how treatment is happening now and identifying gaps. The programs that exist today seem to be maxed out, a system-level issue. The secondary target group was early on focused on finding an app that is easy and effective to engage the community to use, it would help with education and expanding knowledge around adolescent obesity. At this point, there are tools out there, but the effectiveness is questionable and unsure if they will help move the needle, not a lot of evidence out there. They are still flushing out what this could be, even with the electronic medical records. They were to also develop a standardized evidence-based toolkit for PCPs and adolescents. The other target area is how to engage with families for adolescents to be the most successful.

Data Team

Dr. Sara Kelly stated that they are developing a quarterly report. They are making sure they are looking through the health equity lense and social determinants of health. It will be lengthy, but will have it for the next meeting.

Website & Social Media

Ms. Aggertt said that she is working on getting that up and running and there is a lot at the beginning to get it updated. She asked that any action teams please go on there and make sure it's meeting their needs. She is still hoping that in September action team Co-Chairs will be updating their own information.

Performance Management

Cancer

Ms. Robertson stated that the Cancer Action Team met in May and August. One of the biggest deliverables is the community-wide screening days. The event was in May at the Pekin Carle location and OSF. Another one is scheduled for October 20th at Carle on North Allen and OSF at Route 91. Both hospital systems love that it's being promoted as a community-wide screening event, and they are on target to complete their goal. Ms. Robertson shared partnerships with the American Cancer Society, including transportation and lodging grants with OSF and Carle Methodist for cancer related treatment. She discussed what exactly it provides and how much it can cover. Ms. Robertson added they would like to ask for more money at a ministry level for the next cycle, which starts in April. There is a current partnership with Carle that is focusing on lung cancer screening with a grant of $20,000. Ms. Robertson is working with Heartland Health Services to increase their breast cancer screening rates, with another grant. Another program is, Road to Recovery and they have active drivers in all three counties and more, patients can get free transportation to and from cancer related appointments. The action team will collect all the data to prepare for a year end annual report. They also will be working on re-engaging members.

Substance Use

Megan Hanley, Substance Use Co-Chair, stated that the large groups meets every other month and the workgroups meet every month. All of the Health Departments are represented, harm reduction, and treatment partners. They are working on Narcan/harm reduction and outreach and August 31st is Overdose Awareness Day. There will be a press release and events, as well as the bridge being lit purple. They are also working on adolescent education on substance use prevention, making sure

school districts have access to some sort of education. Their measurement from that will be the IL Youth survey. The last thing they are working on is treatment provider through Katy Endress at PCCHD and Heartland, working on gap assessment and stigmas. In the Substance Use group, they have a member that works with the IL National Guard, narcotics enforcement division. Ms. Hendrickson added that PCCHD will be releasing 5 Narcan vending machines with the fentanyl test strips, working with Ms. Green to determine locations.

STI and Teen Pregnancy

Ms. Bill stated they have loosely resurrected the Reproductive Health workgroup. They have partners meeting together to focus on STIs and teen pregnancies in 61603, 61604, 61605 as the numbers are on the rise again. The group discussed what was done previously and that it seemed effective and how are they moving forward. They had used the CDC model previously, now changed to what works in schools: school health education, connecting young people to health services, and making school environments safer and more supportive. They are working together to see what is currently being done and what the gaps are. At this time, will be focusing on Peoria zip codes and youth.

Healthcare Collaborative

No update was given.

Board Business

Evaluation Presentation from Dr. Donohue

Dr. Donohue was asked by Ms. Hendrickson to do an evaluation of the CHNA and CHIP process at the end of her practicum. Dr. Donohue reviewed the information, and the presentation will be shared with the Board through email as well. She also suggested steps moving forward and ways to improve, which led the Board to a bigger discussion of timelines and how to move forward. Ms. Hendrickson added that this was to give feedback about how to move forward and realistic expectations. Partnership leadership transitions at the beginning of 2024, Ms. Aggertt will be taking on the next two years. The needs assessment which has been historically done with partnership of OSF will commence in July 2024. She stated the Partnership is to increase formalization and grow and get into budgets, work plans, and staffing or downgrade and go their own way. The other option is to sit in the middle about which entity can move things forward. On the intervention's standpoint, they are seeing things they can't move forward without funding or personnel. Ms. Fox added they need to have a discussion around maturity, freedom to act, ability to act, changing, etc.

Performance Management

This discussion point was not covered due to time.

Interventions: Barriers, Challenges, & Path Forward

Mr. Baer stated that the Obesity group has the adult and youth workgroups. On the adult side they are at a standstill, to implement a program in the community there is start up costs. For the training, it's $500 per instructor. There are some costs for equipment and each class size has a maximum capacity of 15 participants. Mr. Baer estimates $1200 to $1500 per location start up cost to provide this training, however, there won't be a reoccurring cost. They also wonder if it will be large and effective enough to move the needle. Ms. Fox added that Mental Health is having similar issues as well. Ms. Bill noted that Mental Health is top down driven and that these interventions were pulled out because they worked somewhere and should still push for those interventions that were selected. This discussion continued and due to lack of time Ms. Fox and Mr. Baer noted that

the discussion should continue to the next couple of months Board meetings to figure out how to move forward.

Miscellaneous/Member Announcements

There were no Miscellaneous or Member Announcements.

Healthy Eating and Active Living (HEAL) September 2023

HEAL is defined in the CHNA as healthy eating, active living, 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.

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

Objective HE1: By December 31, 2025, increase accessibility of healthy food in the Tri-County Region through the support of community gardens by 10%.

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

Tasks & Tactics	Evaluation Plan	Target & Data	Monthly Recap	Upcoming Work	Issues/Challenges
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.	By January 2024, recruit Woodford County community gardens.	37 gardens identified	Need to seek number of children and families accessing the garden	Unaware if gardens will have data collected for this growing season.
	# of children/families accessing the community gardens	April 2023 – Identify # of children and families that accessed the garden			
HE 2: Implement garden-based learning sessions focused on gardening and healthy eating.	# of children/families attending information sessions about gardening and healthy foods.	April 2023 – Identify # of children and families that attended garden-based learning	Survey disseminated July/August through WIC and other partners. Training for providers about different garden curriculum.	Timeline of training.	Lack of participation.

	Increase healthy eating knowledge through pre/post test evaluation per session by 75%				
HE 3: Promote campaigns focused on healthy eating and access to healthy foods.	# of healthy eating and community gardening campaigns in the Tri-County Region.	April 2023- Identify number of campaigns completed in 2022.	Campaigns for healthy eating and access: Nourish Your Neighbor, Hunger Action Month healthy donation lists Future campaign ideas: Kids cook Monday Ho Ho Hold Your Weight around holiday time 12 Days of Giving Gardening Tips	WIC reviewing Kids Cook Monday Rebecca to schedule meetings with partners to further discuss.	Continue to promote the campaigns.

Additional comments

- Diabetes Prevention Program – Hope Chest - Pekin, Wednesdays 10-11am beginning on October 11th.
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Goal: Improve overall healthy eating and physical activity in the Tri-County Region.

Objective HE2: By December 31, 2025, increase adults reporting exercising 1-5 days a week among the Tri-County Region by 1%

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

Tasks & Tactics	Evaluation Plan	Target & Data	Monthly Recap	Upcoming Work	Issues/Challenges
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.		Met with Dr. Sarah Kelly to discuss an app to measure physical activity. Walker Tracker provides a closed loop to collect information and data, map,	Research other apps. Discuss with Vendor about pricing, registration logistics, etc., Amy will contact.	Budget timing Will need all organizations to assist with promotion to be successful. Donations from other organizations to support marketing expenses.
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)*	HEAL orientation PowerPoint for 2023-2025 available for recruitment.	Develop tracking tool for measuring active members, events, etc.	

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*	'Take a Walk Wednesday' campaign developed and launched via social media Wednesday in September to October 2023 to highlight the benefits of a simple walk. Partners share he PFHC FB post on their social media platforms. Move it Monday campaign will begin in January 2024 and run through March. Walker Tracker promotion and implement in Spring 2024.	Kim will compile reach of take a walk Wednesday.	-Retrieving data/metrics following campaigns has been difficult. We will be sharing on PFHC and asking individual organizations to share.
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*	Planning for Tri-County Hunger Action Walk date: September 30, 2023, 9-11am Location: OSF Route 91 Tri-County Trek is a desired platform to use come January 2024 for a year campaign. Partners will be surveyed on their interest to cost share the Tri-County Trek app.	Marketing has been approved and released. Midwest Food Bank & Peoria Area Food Bank are sponsoring the Bridge Lighting. Volunteers have signed up to help with the walk Kim will develop the survey to access Partner willingness to support the Tri-County Trek app.	Support for events from all partner organizations will be needed to sustain events.
Additional comments •					

Healthy Eating and Active Living (HEAL) October 2023

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	# of children/families accessing the community gardens	April 2023 – Identify # of children and families that accessed the garden			
HE 2: Implement garden-based learning sessions focused on gardening and healthy eating.	# of children/families attending information sessions about gardening and healthy foods.	April 2023 – Identify # of children and families that attended garden-based learning	Talked with Dr Kelly & Megan from TCHD about creating a standard evaluation that could be used by those doing education in the garden. This could help measure any efforts going on across all gardens. The curriculums we have could be used as	Future – continue to reach out to partners who may be interested in helping incentivize participation in	Numbers need to be a focus for upcoming months meeting as we close out 2023 and address our baseline from this year

	Increase healthy eating knowledge through pre/post test evaluation per session by 75%		a toolkit for partners looking to get involved and add more education at their sites. Reviewed the survey results for adult nutrition lessons in gardens from Tri-County. Survey reviewed some top barriers, incentives and educational subjects people were interested in. Team brainstormed what this could maybe look like for adults across the tri-county and how to best get people to the table for lessons. One thought that came up was using food as an incentive. Potentially have a box of food that people could take home to recreate a meal or recipe. Recipes/meal ideas were one of the top interested subjects. Possibility to work with our Food Banks and the LFPA grant to get local food boxes to share with participants? Rebecca to talk to other about the idea.	classes. Also partners who could potentially be a good place to host discussed. Rebecca to reach out to OSF Cancer Center. Mike thinks their kitchen and garden could be a good place to do some classes as we form this for our tri-county area. With receiving info through social media – opportunity to grow our partnership page again by creating events and publicizing through the page?	
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.	Hunger Action Month completed – 2023 HAM Toolkit was downloaded 12 times across 5 counties. Survey sent to those who downloaded to gather input for future iterations. Toolkit is added permanently to the Partnership Website. Future campaigns around HE 1. Holiday time Healthier Eating – Rebecca to circle back to Kate at the Y 2. 12 Days of Giving – Holiday Giving campaign around healthier food items for charitable food – toolkit being updated with input from our partners – need to create things for use on website and not just social	Work moving forward and mostly described in part 1 – campaign 1 complete and future campaigns in the work	None at this time

			media – maybe create a bulletin blurb for churches? 3. Produce usage (Farmer's market video with OSF) – check in on who created and can we do more in the future – no updates as of now 4. Gardening tips – maybe have time to work on what this could look like and – no updates as of now 5. Kids Cook Monday - https://www.mondaycampaigns.org/kids-cook-monday - WIC Tri-County Team to brainstorm what they think this campaign could look like		

Additional comments

- Diabetes Prevention Program – Hope Chest - Pekin, Wednesdays 10-11am
- Diabetes Prevention Program – Fondulac Library - Thursdays
- Diabetes Prevention Program – Creve Coeur Public Library -

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Tasks & Tactics	Evaluation Plan	Target & Data	Monthly Recap	Upcoming Work	Issues/Challenges
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 researched apps to track physical activity. Walker Tracker app – used in the past with events. Move Spring is another option for an app.	Amy/Hillary will review and seek product demonstration and will share with team Amy/Hillary to share proposal to HDs All to check with organization	Questions about the walker tracker app -# of walkers – is it per event or overall Organization barriers – branding as PFHC, marketing requests

				leadership for approval of promotion. Marketing plan committee – Erin Luckey, Amaya, Kim L, Christian	
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	Shanita provided onboarding for three new individuals; however, they are current partner organizations	Shanita to share the current partner lists	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 occurring. Destress Mondays November – December 2023 Move it Monday Campaign beginning in January through March 2024 – "Find the time to fit in fitness" 12 weeks	Kim L to provide report on reach Amy to request assistance with promotion from PFHC.	
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	Hunger Action Walk occurred on 9/30/23. Add report link here.		
Additional comments • Fit & Strong being offered by TCHD– 23 participants. 24 weeks for 2 times per week. Waiting list started for next session.					

2022 TRI-COUNTY HUNGER WALK

PEORIA | TAZEWELL | WOODFORD

FOOD SHOULD NOT BE AN IMPOSSIBLE CHOICE

SEPTEMBER 23 @ 6 PM

REGISTER FOR 1 OF 3 LOCATIONS

- FOREST PARK NATURE CENTER - PEORIA COUNTY
- PEKIN LAGOON - TAZEWELL COUNTY
- BLACK PARTRIDGE - WOODFORD COUNTY

Scan here to register for the Hunger Walk

WALK ENTRY FEE: A HEALTHY SHELF-STABLE FOOD ITEM PER WALKER. DONATED FOOD WILL BE DISTRIBUTED TO A LOCAL FOOD PANTRY.

Partnership for a Healthy Community
healthyhoi.org

Registration Link: go.illinois.edu/walk2022

Questions? Email: RACRUMRI@ILLINOIS.EDU or call 309.347.6614

2022 TRI-COUNTY HUNGER WALK

PEORIA | TAZEWELL | WOODFORD

GREEN LIGHT FOOD

Support your local food pantries by donating the following nutritious foods!

Fruits

Canned

- Mandarin Oranges
- Peaches
- Pineapple
- Pears
- Mixed Fruit

Other

- Fruit Cups
- Applesauce
- Raisins/Dried Fruit
- 100% Fruit Juice

No Added Sugar OR Packed in 100% Juice

Vegetables

Canned

- Carrots
- Peas
- Corn
- Mixed Vegetables
- Tomatoes
- Canned Soups
- Spaghetti Sauce

Low Sodium OR No Added Salt

Other

- Dried/Dehydrated Vegetables, no fat added
- 100% Vegetable Juice

Dairy

- Shelf-stable Lowfat Milk
- Evaporated Milk
- Powdered Milk

Lowfat

Whole Grains

- High Fiber/Low Sugar Cereal
- Whole Grain or Corn Torillas
- Whole Grain Bread
- Brown or Wild Rice
- Old-Fashioned Oatmeal
- Whole Grain Crackers
- Whole Grain Pasta
- Couscous
- Quinoa

Whole Grains

Proteins

- Canned Tuna (in water)
- Canned Salmon (in water)
- Canned Chicken (in water)
- Unsalted Nuts & Seeds
- Low Sodium Nut Butters
- Trail Mix
- Canned Beans
- Low Sodium Meat Jerky

Low Sodium

Look for pop-top cans or pouches!

Food is Medicine!

Green light foods have nutrients to keep your body healthy.

Illinois Extension
UNIVERSITY OF ILLINOIS URBANA-CHAMPAIGN

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Mental Health

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

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

Objective MH1: By December 31, 2025, decrease the number of suicides in the tri-county area by 10%

Objective MH2: By December 31, 2025, increase the proportion of children and adults with mental health problems in the tri-county areas who get treatment by 10%.

Intervention Strategy: Culturally-Adapted Health Care (CAHC)

Monthly Recap- All Activities

The September meeting took place on 9-19 and 10-17 at OSF Center for Health on Rt. 91.

(September) WHOLE GROUP DISCUSSION: The team reviewed a tiered approach suggested by the steering committee including three tiers – PREVENTION (social media campaigns, trainings for suicide prevention and Mental Health First Aid, etc), PRIMARY CARE (Telepsych; Equipping providers with toolkit to encourage and equip psych management at primary care level); and TERTIARY/SPECIALTY (Reducing the burden on specialty through Prevention and Primary Care); finally, spanning all three tiers includes Culturally-Adapted Health Care (CAHC) which can be integrated into each tier and systems-level policies and processes.

SUB GROUPS- CAHC and Telepsych split to discuss specific tactics.

CACH- Sub-group reviewed the recently-created model; discussed the importance of being true to CAHC and not just "checking the box" to reach the low-hanging fruit.

TELEHEALTH - First, the committee is completing a list of telepsych/mental health resources; the team is also coordinating with the Systems of Care (SOC) committee that is working across tri-county to have a coordinated system of mental health care for children and adolescents (Trillium Place grant funding). The SOC is working on integrating IRIS into each of the community agencies that can refer youth and families to mental health and social services and provide training for consistency. The group noted that it would be most beneficial to ensure that the care coordinators at each location (those who actually make the IRIS referrals) are trained on the mental health resource list. Mariela, the director of SOC, is creating a plan to do this. The team also met with Sara Kelly to review potential data points and is working with hospital analytics to determine what is measurable. OSF is adding another staff member to help contribute to the telehealth piece.

The group is unsure where the list of mental health providers should be stored; and having discussions on what is public-facing versus just a reference for agency/hospital staff. We discussed putting the list on the PFHC website, but the general public doesn't go there. We discussed 211 holding this and keeping it updated (Note that 211 only allows a few resources and is not comprehensive). We

need more discussion on how to help people navigate where they can receive care that they can afford and access. Mariela from Systems of Care is going to try IRIS and see if that is a solution for storing the list of providers and keeping it updated. Other ideas welcome.

Tasks & Tactics	Evaluation Plan	Target/Data	Monthly Recap	Upcoming Work	Issues/Challenges
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		Continued promotion of MHFA training being offered in the tri-county area.	Explore virtual options for MHFA.	MHFA is held as in-person training and needs to be explored more for virtual options due to being full day training. Time to complete training in-person has been identified as a barrier.
	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)		Other training curriculum beyond MHFA	Explore other training curriculum that is accessible and free to utilize.	*Open for discussion
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%		Subgroup to explore options for annual or bi-annual options.		
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%		Subgroup to explore options for policies.		
CAHC 4: Make culturally- and linguistically adapted materials and marketing available	Improve patient experience ratings (likelihood to recommend) by 1%		Subgroup to explore options for marketable materials.		

Additional Comments

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Objective MH2: By December 31, 2025, increase the proportion of children and adults with mental health problems in the tri-county areas who get treatment by 10%.					
Intervention Strategy: Telemedicine (TELMED)					
Tasks & Tactics	**Evaluation Plan**	**Target/Data**	**Monthly Recap**	**Upcoming Work**	**Issues/Challenges**
TELMED 1: Establish baseline, inventory available telemedicine among tri-county	Complete inventory list of all telemedicine access.	Inventory complete for telepsych providers.	*a comprehensive resource list has been created and is being shared with the System of Care committee; SOC will meet with local care coordinators who help connect family to mental health and social services via IRIS	*Determine where to store resource list both public-facing and for agency staff/providers. List will be added to PFHC website as a start to promoting the resources.	*Unsure where the list of resources should be stored/housed and who will continue to update this in future months/years- open for discussion.
TELMED 2: Disseminate information through 10 promotional campaigns on how to access (mental health) telemedicine	Increase # patients engaged in mental health telemedicine by 10%		Subgroup to explore options for promotional campaigns.		*Are we at the point where we can disseminate information for this? Do we have the capacity for telepsych in our community?
TELMED 3: Support the development of structured partnerships for community healthcare organizations to provide telemedicine	Increase # new patients enrolled in telemedicine by 10%				*Open for discussion
TELMED 4: Expand number of locations for community members to access telemedicine mental health care (community settings, OSF Strive, libraries, Wraparound Center, etc.)	Increase # telemedicine community access points by 10%				*Open for discussion
TELMED 5: Provide more than 100 residents access to mental health telemedicine appointments who are	Reduce # hospital readmissions among individuals who engage in telemedicine by 30%				*Open for discussion

either medically underserved or live in rural areas					

Additional Comments

The **Suicide Prevention Workgroup** met on 10-20-23 and Megan Hanley, TCHD epi, review recent spikes in TC for overdose suicide attempts among teens 14-16. Hult Center and TCHD worked together to send out an email to make principals aware of the issue and many resources for support. The committee is going to add this to its resource list to put on the suicide prevention page on the website. The team is also asking Peoria County coroner to present latest data to the committee within the next few months. Already, South Pekin Grade School has requested programming for K-8 and training for their staff/parents. Please see attached 1-pager for suicide prevention programming. Many toolkits need to be uploaded to the website once we are able to do so.

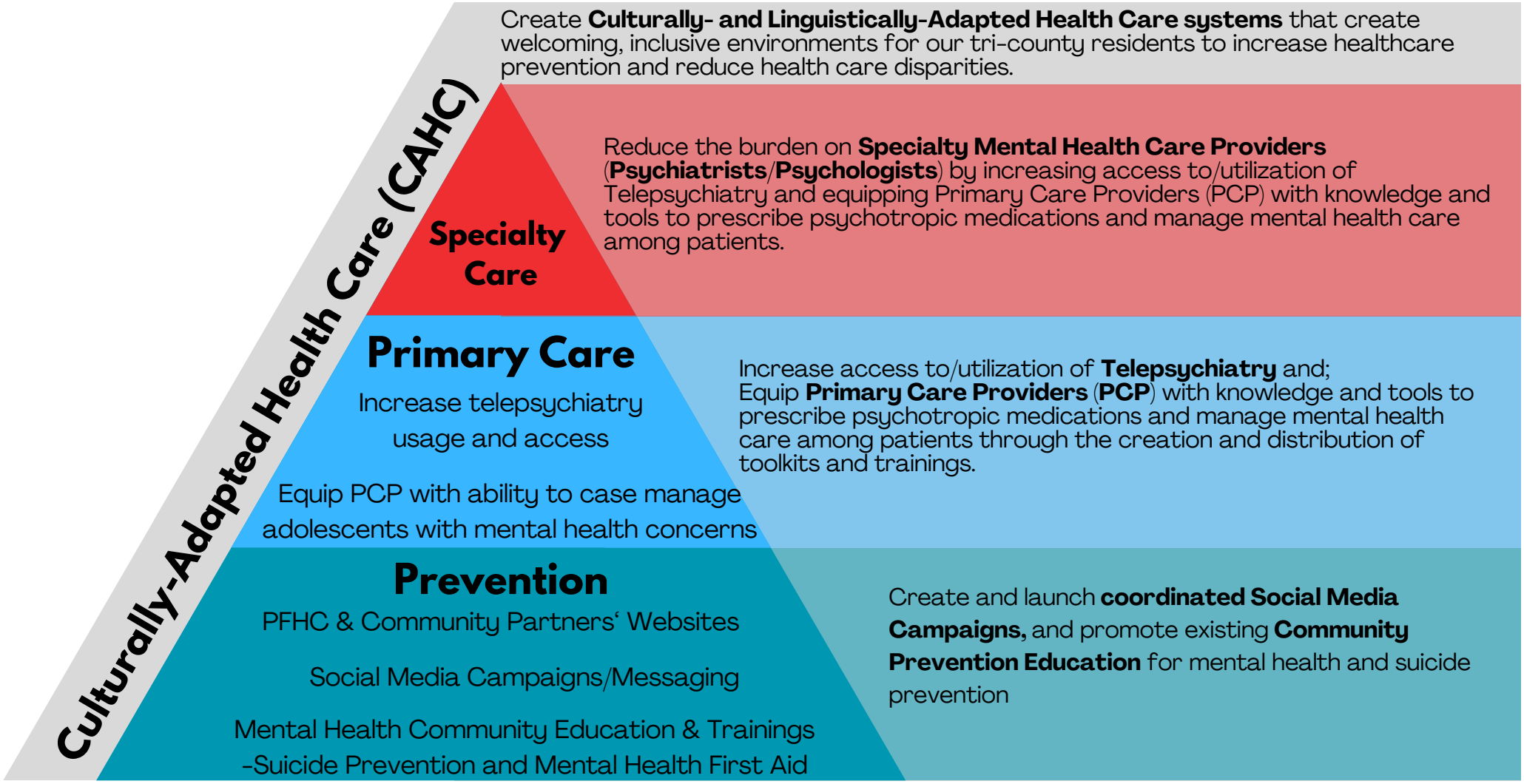
If any suicide prevention education/training/support is needed please reach out to Holly.

If any Mental Health First Aid needs, please reach out to Holly or Kim or Shanita at TCHD.

Mental Health Action Team
3-Year Framework

Objectives:

1. By December 31, 2025, decrease the number of suicides in the tri-county area by 10%.
2. By December 31, 2025, increase the proportion of children and adults with mental health problems in the tri-county area who get treatment by 10%.



Mental Health & Suicide Prevention in School Settings

Hult Center for healthy living

Mental Health

It's never too early to begin teaching youth about mental health. Early in life, children should learn and practice key social-emotional skills such as coping & problem-solving, healthy relationships, and conflict resolution. These skills strengthen protective factors that can help them navigate adversity later in life. Middle and high school students should feel comfortable talking about their mental health and locating resources to help themselves or a loved one. Finally, our young people's supportive adults (such as teachers, coaches. counselors, parents/caregivers) should be able to navigate these conversations with confidence. Schools should implement best practice policies and prevention programs to promote good mental health for staff and students.

Mental Health education is not meant to be sad or overwhelming. Education should be positive, trauma-informed, and empowering. Our recommended age-appropriate program sequence for mental health and suicide prevention for school settings is as follows:

1 Empower Staff & Parents

Prior to providing education to students, it's best practice to provide trainings and host open discussions with school staff and parents/caregivers.

- **Administrators & Mental Health Leads:** Consultation to Review Current Prevention & Postvention Policies & Resources (1 hour)
- **Staff:** QPR (Question, Persuade, Refer) Suicide Prevention Gatekeeper Training (1-2 hour certification training)
- **Parents:** QPR Gatekeeper Training or curriculum overview (1-2 hours)

2 Empower Students

The most rigorous education plan should be chosen for your students, however, one program has shown to increase knowledge and behavior as it relates to program objectives.

- **Pre-K through 3rd Grades:** Your Amazing Brain (1-2 lessons)
- **4th through 6th Grades:** We All Have Mental Health (1-4 lessons)
- **7th through 8th Grades:** Depression Awareness (1-4 lessons)
- **9th through 11th Grades:** Depression Education & Suicide Awareness (1-4 lessons)
- **12th Grade:** QPR Gatekeeper Training (1-2 hour certification program)

3 Create a Culture of Good Mental Health

Promote good mental health year-round at every opportunity.

- **Provide resources and opportunities to staff** (encourage classroom brain breaks, use mindful icebreakers at staff meetings, and provide opportunities for self-healing)
- **Promote mental health awareness months/days** (campaigns, tabling at lunch time, posters and positive messages in the hallways and break rooms, announcement messages)
- **Certified Peer Educators** can help you create healthier school campuses. Ask our team about training high school students to serve as peer educators.

Empowering schools to foster good mental health through social-emotional learning, mental health education, and suicide awareness.

Phone: (309) 692-6650 www.hulthealthy.org Email: info@hulthealthy.org

Obesity September 2023 Updates

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, 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.**

Goal: Reduce the proportion of residents with obesity in the Tri-County Region.

Objective O1: By December 31, 2025, reduce the proportion of adolescents with obesity in the TriCounty Region by 1%.

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

Tasks & Tactics	Evaluation Plan	Target/Data	Monthly Recap	Upcoming Work	Issues/Challenges
DHIAO 1: Identify baseline data, definitions and programming for digital health interventions in the tri-county area.	# of data points collected		Discussed Primary, Secondary, and Tertiary Levels of Prevention and Treatment. Outlined upcoming Goals, questions, timeline. **Dr. Christison is working on the OSF side, and Dr. Fischer and Dr. Sun are working on the Carle side- Dr. Christison presented to Carle Health pediatrics meeting this quarter; once we have shareable materials we will push to other health care systems;**	• Ensure whatever intervention we use can be used tri-county and not just one hospital, for example • YEAR 2 • Pilot chosen intervention	Need to follow up with Dr. Christison for further review and guidance. Discussed desire to have Pediatrician input into group Dr. Sturdavent for OSF note that as of 8/2023, waiting list is at 400+ for OSF's Health Kids U
	Define "Digital Health Interventions"	How Clinical?			
	Identify programming currently being offered.	To be reviewed and researched			

DHIAO 2: Promote through education and awareness utilizing social media communication.	# of promotional campaigns performed through the TriCounty Region.			• YEAR 1 • Coordinate with HEAL to share messages for primary prevention • Draft social media campaigns to target adolescents with obesity - can advertise for WELL and Healthy Kids U • Include HEAL and obesity messages in Hult Center's adolescent health education programs • YEAR 2 • Continue efforts from Year 1	
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		GOAL: Standardize Healthcare across the Tri-County for Adolescents Living with Obesity and Obesity-Related Diseases: 1:1 Counseling and Medication Management Make adolescent obesity management a leader-driven priority	• 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	

			-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	providers to increase their comfort level in managing patients with obesity • YEAR 3 • Maintain and update 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**	• **OSF ON call Connect?**	
DHIAO 5: Personalize program with Text Messaging, Health coaching calls, or Tele Visits	Pre/ Post changes in Biometrics			**Inquiry placed to Dr. Gorman about Possibility to pilot OSF On Call connect for Adolescent Obesity**	
Additional Comments					
Objective O2: By December 31, 2025, reduce the proportion of adults (women) with obesity in the TriCounty Region by 2%.					
Intervention Strategy: Strong People Healthy Weight (SPHW)					

Tasks & Tactics	Evaluation Plan	Target/Data	Monthly Recap	Upcoming Work	Issues/Challenges
SPHW 1: Collect Baseline data / ptogram information	# of establishments collecting adult physical activity data in the Tri-County Region.		**Meeting with current entities interested in hosting program – Strong People Living Well. This program has less weight training involved and more cardio type activities paired with nutritional education. Have commitments from Riverplex Peoria YMCA Hult Center Pekin Park District**	**Create high level budget to include training costs, program start up / ongoing costs (groceries for recipies). Equipment costs will not be as extensive as no weight training equipment needed** **Decide – will we charge participants and how much** **Will instructors need to be paid during class time** **Phil reaching out to Washington 5 points to see if interested in hosting program**	**As discussed at August board meeting, funding for program spread will be an ongoing issue. Investigated potential for grant funding. Phil has made contact with OSF Foundation who recommended we reach out to local foundations for support (Cat, State Farm, etc) Have contact at OSF who will help with making these connections**
SPHW 2: Develop recruitment campaign in the tri-county area.	Increase # of individuals registering for programs			**Still have open question regarding the portion of program that has recipies and food prep – are there special food handling requirements?**	
	# 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.				
Additional Comments					

Obesity October 2023 Updates

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, 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.**

Goal: Reduce the proportion of residents with obesity in the Tri-County Region.

Objective O1: By December 31, 2025, reduce the proportion of adolescents with obesity in the TriCounty Region by 1%.

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

Tasks & Tactics	Evaluation Plan	Target/Data	Monthly Recap	Upcoming Work	Issues/Challenges
DHIAO 1: Identify baseline data, definitions and programming for digital health interventions in the tri-county area.	# of data points collected		**-Dr. Christison is working on the OSF side, and Dr. Fischer and Dr. Sun are working on the Carle side- Dr. Christison presented to Carle Health pediatrics meeting this quarter; once we have shareable materials we will push to other health care systems;**	**-Meeting scheduled 10/23 with OSF ON call Leadership to evaluate possibility of utilizing on Call connect. Can we leverage Epic Care Companion which sends out updates and education to patients. Could develop own peds care plan with this option.** **-Peds workgroup meeting scheduled 10/26**	note that as of 8/2023, waiting list is at 400+ for OSF's Health Kids U
	Define "Digital Health Interventions"	How Clinical?			
	Identify programming currently being offered.	To be reviewed and researched			
DHIAO 2: Promote through education and awareness utilizing social media communication.	# of promotional campaigns performed through the TriCounty Region.			• YEAR 1 • Coordinate with HEAL to share	

				messages for primary prevention • Draft social media campaigns to target adolescents with obesity - can advertise for WELL and Healthy Kids U • Include HEAL and obesity messages in Hult Center's adolescent health education programs • YEAR 2 • Continue efforts from Year 1	
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**	• 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**	
Additional Comments					

Objective O2: By December 31, 2025, reduce the proportion of adults (women) with obesity in the TriCounty Region by 2%.

Intervention Strategy: Strong People Healthy Weight (SPHW)

Tasks & Tactics	Evaluation Plan	Target/Data	Monthly Recap	Upcoming Work	Issues/Challenges
SPHW 1: Collect Baseline data / ptogram information	# of establishments collecting adult physical activity data in the Tri-County Region.		**Meeting with current entities interested in hosting program – Strong People Living Well. This program has less weight training involved and more cardio type activities paired with nutritional education. Have commitments from Riverplex Peoria YMCA Hult Center Pekin Park District Will charge $2 per class / individual. Will not turn away if they cannot afford. This can help offset cost of supplies and groceries for nutritional component. Have**	**Facilitators to complete on line training Confirm Sites to host program Prep Sites Develop Class Schedule Market to communities**	**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**

			identified 2 individuals to train as facilitators		
SPHW 2: Develop recruitment campaign in the tri-county area.	Increase # of individuals registering for programs			**Still have open question regarding the portion of program that has recipies and food prep – are there special food handling requirements?**	
	# 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.				
Additional Comments					

Q3
2023

QUARTERLY REPORT

PFHC DATA TEAM

TABLE OF CONTENTS

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.

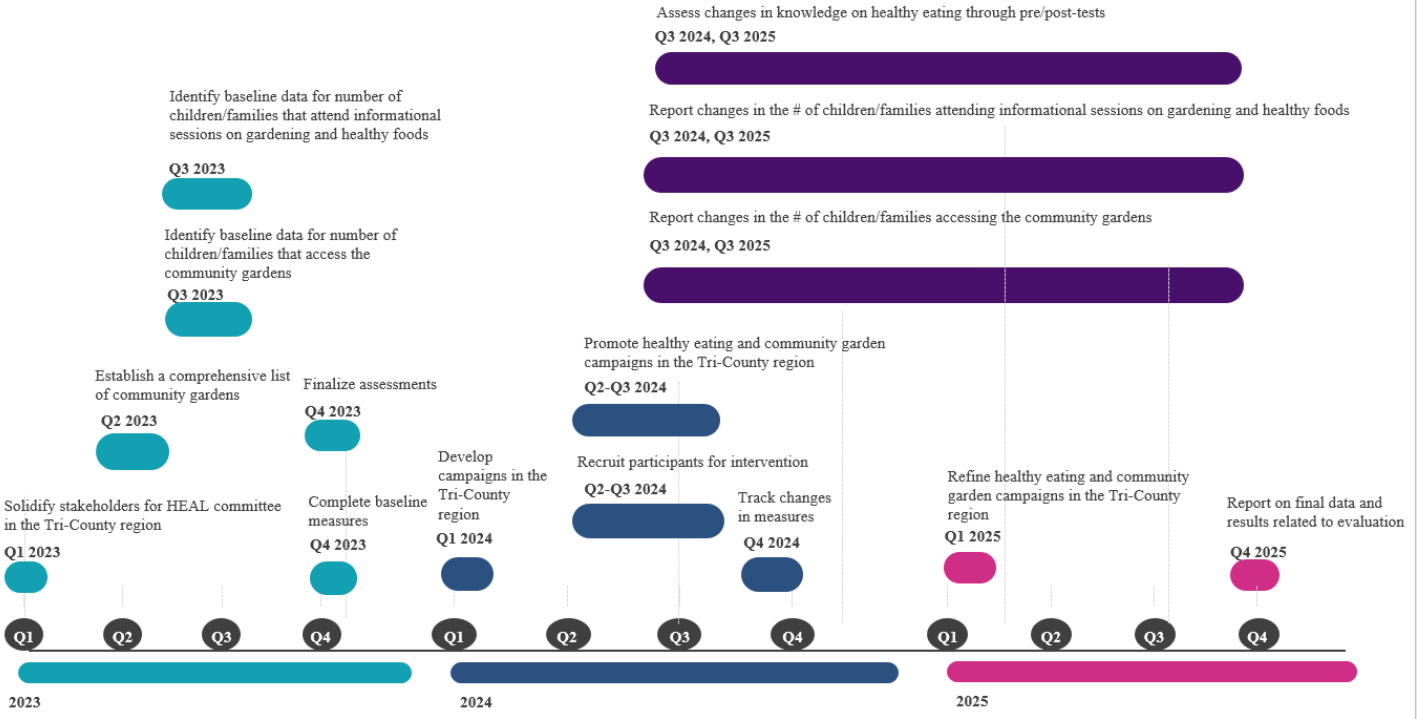
Food insecurity is as a lack of consistent access to enough, nutritious food for every person in a household to live an active, healthy life.

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.

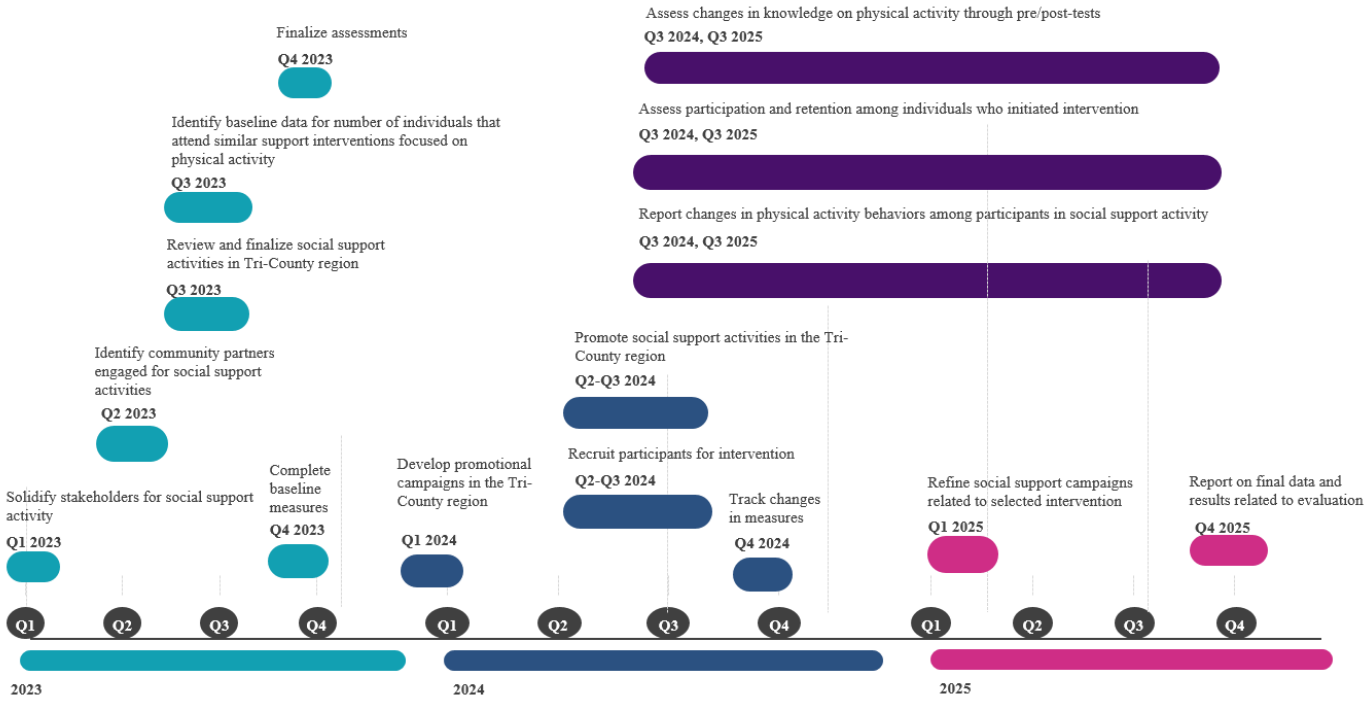
Evaluation metrics for each intervention

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 (08/23)**	**Upcoming Work**
Gather baseline data around community gardens and school-aged programming.	Complete a comprehensive list establishing locations of community gardens and school aged gardening programs.	By January 2024, recruit Woodford County community gardens. *(Data being collected- due Q4 2023)*	No further work completed on list during month of July	Plan: Members of HE group to meet in August to refine our contacts so we can assign people to contact gardens at meeting in September – gather baseline data around number accessing gardens With new list of gardens – possibility for this to be kept up and used in a mapping of locations.
	# of children/families accessing the community gardens	April 2023 – Identify # of children and families that accessed the garden *(Data being collected- due Q4 2023)*		
Implement garden-based learning sessions focused on gardening and healthy eating.	# of children/families attending information sessions about gardening and healthy foods.	April 2023 – Identify # of children and families that attended garden-based learning	St Ann's continued their program with kids – Rebecca reached out to Dylan about setting up a time	Becca will talk with Hort Lead. Potentially plan as team for education in off season from gardens. Is it better to do a kick off late winter?

	Increase healthy eating knowledge through pre/post test evaluation per session by 75%		to talk. Will circle back. Team is considering how to hold maybe some trainings for interested schools/partners so they feel equipped to utilize the garden curriculums identified by the group. Trainings could support afterschool programs & school programs in being equipped to implement curriculum. Survey for adults is still out and available- Rebecca to check back in with WICs and see where we are at with response numbers and if we need to do a little more targeted distribution in any areas.	Will want to have a standardized evaluation that could help us gather numbers of people attending and increase of healthy eating knowledge.
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.	Hunger Action Month has been a huge focus – part of our Tri-County Hunger Action Month Activities has been education especially around healthy donations to our charitable food system. All the Hunger Action Month materials are close to being completed – partners can download the toolkit and use the posts and language as well as share about any other activities/resources soon! Group will be updated when available. Will track with survey around usage post campaign with those who	Still working on planning what next steps will look like. Rebecca to meet with Kate from the Y about the Holiday Idea. Rebecca to email WIC leads about potential of the kids cook Monday and working on this in the WIC team?

			download the toolkit. Future campaigns around HE 1. Holiday time Healthier Eating – Rebecca to talk to Kate at the Y 2. Produce usage (Farmer's market video with OSF) – check in on who created and can we do more in the future 3. Gardening tips – maybe have time to work on what this could look like and 4. Kids Cook Monday - https://www.mondaycampaigns.org/kids-cook-monday	

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 (08/23)**	**Upcoming Work**
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.	*Data being collected- due Q4 2023*	Meeting with data team is needed to address issues/challenges being faced.	Amy will contact the data team for a meeting.
Recruit additional Tri-County partner participation in the HEAL action team	Increase # of partners recruited by 6.	*Baseline: 9 partners (different organizations)*	HEAL orientation PowerPoint for 2023-2025 available for recruitment. For data and evaluation - identify definition of "partner participation"	Hilary will add to PFHC website when website is ready for update. Shanita needs to discuss with Dr. Kelly to determine definition
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*	'Take a Walk Wednesday' campaign will be developed and launched via social media Wednesday in September – October 2023 to highlight the benefits of a simple walk. Move it Monday campaign will begin in January 2024 and run through March. Partners will be survey regarding their organizations ability/willingness to participate in the campaigns by share the PFHC FB post on their social media platforms.	Kim & Jovon will create the 'Take a Walk Wednesday' social media campaign. Kim will develop survey for distribution among partners.
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*	Planning for Tri-County Hunger Action Walk date: September 30, 2023, 9-11am Location: OSF Route 91 Tri-County Trek is a desired platform to use come January 2024 for a year campaign. Partners will be surveyed on their interest to cost share the Tri-County Trek app.	Marketing has been approved and released. Midwest Food Bank & Peoria Area Food Bank are sponsoring the Bridge Lighting. Volunteers have signed up to help with the walk Kim will develop the survey to access Partner willingness to support the Tri-County Trek app.

Current challenges or needs for selected interventions

Healthy Eating (HE)

- Collecting baseline data has been delayed due to gardens being in full swing but will be working on collecting this in the next few months.
- Requested support for sharing Hunger Action Month activities, toolkit, etc. A letter of support (LOS) will be sent to the Partnership Board and is asking for this to be shared to reach a larger audience.

Physical activity (PA)

- Recently met with data team and are working together to ensure data collection will be able to assess changes among PA among adults engaged in this intervention.

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

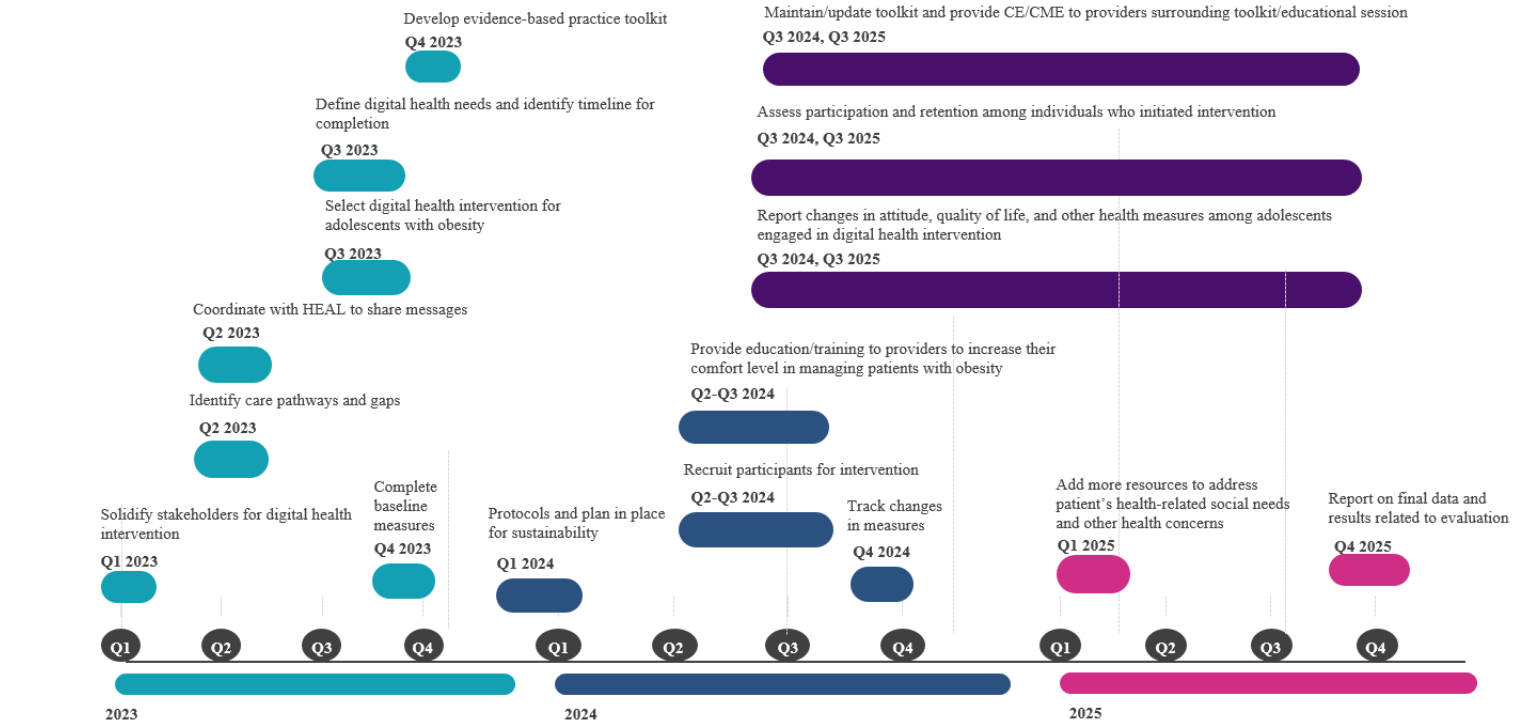
Obesity is defined in the CHNA as overweight and obese.

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.**

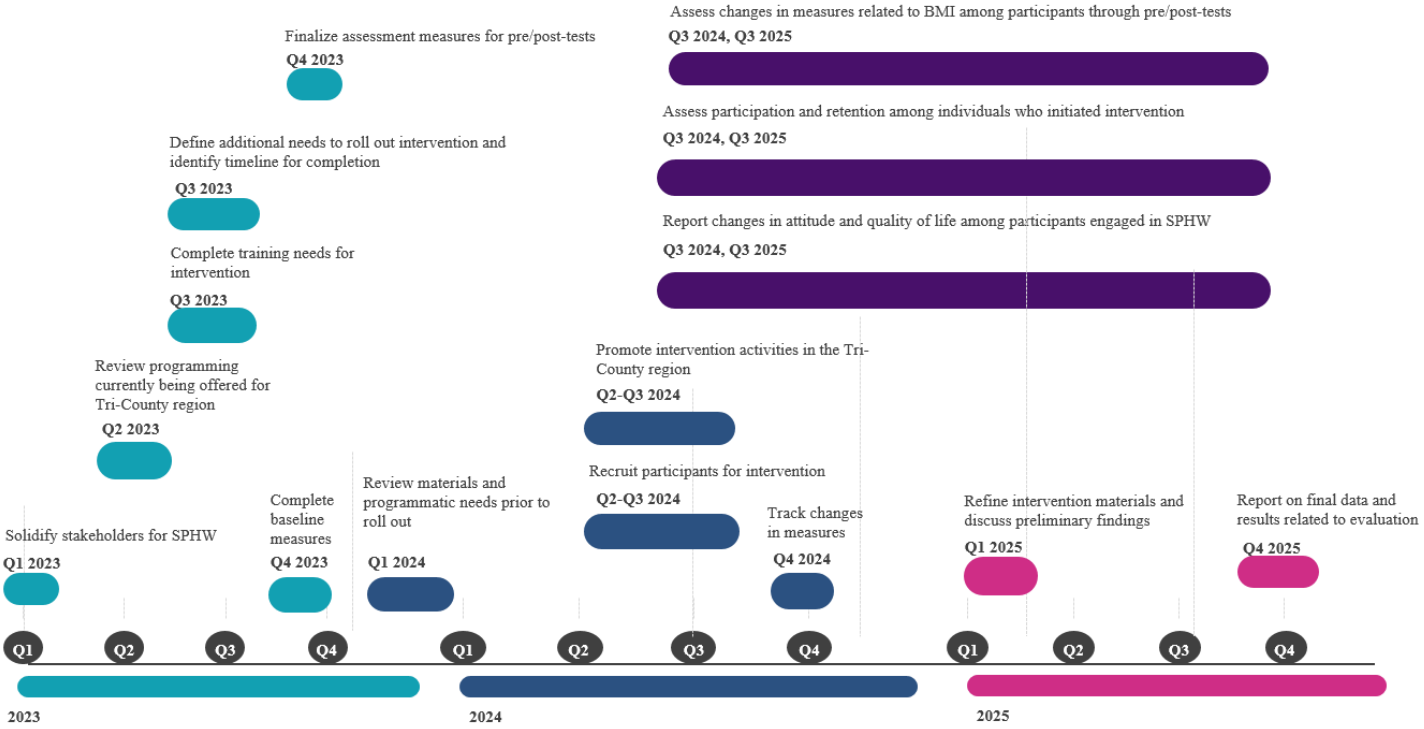
The overall goal is by the end of 2025, to reduce the proportion of residents with obesity in the Tri-County region.

Evaluation metrics for each intervention

Roadmap of obesity interventions



OBESITY: 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 (07/23)**	**Upcoming Work**
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.	*Data being collected- due Q4 2023*	Discussed Primary, Secondary, and Tertiary Levels of Prevention and Treatment. Outlined upcoming Goals, questions, timeline	• Ensure whatever intervention we use can be used tri-county and not just one hospital, for example • YEAR 2 • Pilot chosen intervention
Promote through education and awareness utilizing social media communication.	# of promotional campaigns performed through the Tri-County Region.	*Data being collected- due Q4 2023*		• YEAR 1 • Coordinate with HEAL to share messages for primary prevention • Draft social media campaigns to target adolescents with obesity - can advertise for WELL and Healthy Kids U • Include HEAL and obesity messages in Hult Center's adolescent health education programs • YEAR 2

				• Continue efforts from Year 1
Collaborate with healthcare providers for enrollment.	% of individuals completing digital health program report improved weight related measures.	*Data due Q3 2024, Q3 2025*		• 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 and update toolkit • Offer continuing education/training as requested • Add more resources to address patients' health-related social needs and other health concerns
	10-15% improvement in BMI	*Data due Q3 2024, Q3 2025*		
	% retention of registered individuals for one month of the program	*Data due Q3 2024, Q3 2025*		
Promote behavioral change through use of technology devices.	Pre / Post changes is behavior	*Assessments to be finalized by Q4 2023*		• Ask Dr. Kelly if she came across any interventions that may work for our target population
Personalize program with Text Messaging, Health coaching calls, or Tele Visits	Pre/ Post changes in Biometrics	*Assessments to be finalized by Q4 2023*		Explore MyChart as an option for delivering digital health interventions for patients enrolled in Healthy Kids U (OSF) and/or WELL Program (Hult)

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 (07/23)**	**Upcoming Work**
Collect Baseline data	# of establishments collecting adult physical activity data in the Tri-County Region.	*Data being collected- due Q4 2023*	Meta, Phil, and Nick A. met with Dr. Rebecca Seqwil-Fowler, creator of the SPSB programs to better understand requirements for participation and which program would be suitable for to implement in Tri-County. Plan to obtain benchmark info from additional communities that have implemented Montana State: Lynn Paul Strong Heart Wisconsin: trained leader	Core SPSB programs Living well (aerobic & diet) Strong People (strength train) Strong Hearts (weight loss)
Develop recruitment campaign in the Tri-County area.	Increase # of individuals registering for programs	*Data being collected- due Q4 2023*	Increase more entities within the Tri-County area. As of now we have Peoria Y, PPD, U of I.	
	# of promotional campaigns performed in the Tri-County area.	*Data being collected- due Q4 2023*		

Provide a Leadership workshop to educate and inform about program.	# of participants in the workshop	*Data due Q3 2024, Q3 2025*		
Partner with community resources to establish class locations.	% of retention of registered individuals through completion of program.	*Data due Q3 2024, Q3 2025*		
	# of individuals completing SPHW program report having improved weight related measures.	*Data due Q3 2024, Q3 2025*		
	Enrollment of 25 participants quarterly within the Tri-County area.	*Data due Q3 2024, Q3 2025*		
Share success stories of the program within the tri-county program	# of pre/post test changes in biometrics and behavior.	*Assessments to be finalized by Q4 2023*		

Current challenges or needs for selected interventions

Adolescent:

- Need to follow up with clinical provider (Dr. Christison) for further review and guidance.
- Discussed desire to have Pediatrician input into group to include Dr. Sturdavent

Strong People Healthy Weight (SPHW):

- Cost ($500 for each instructor).
    - There is no option for train the trainer. You must go through the training to teach the classes.
        - Online workshop includes: manuals, competence quizzes, safety, evidenced based program with marketing materials.
    - In-person training starts at $6k w/ travel. Other considerations are equipment used for classes, hand or ankle weights
- Collecting baseline data—SPSB does not require any data collection.

Public health surveillance data

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

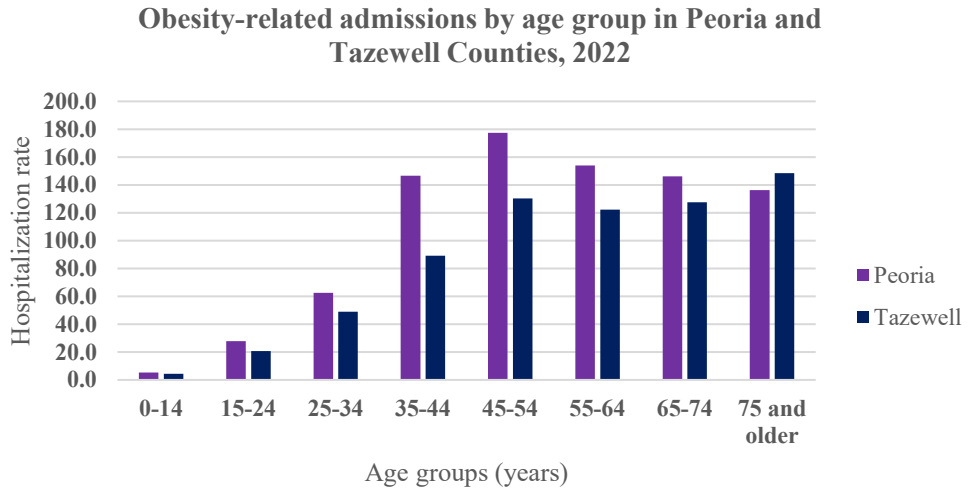
Data sources:

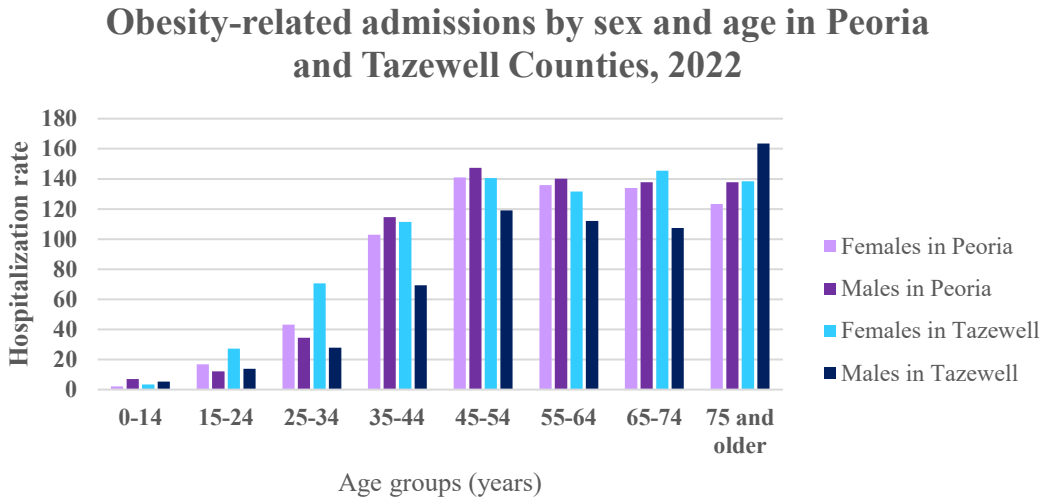
1. 2021 Behavior Risk Factor Surveillance System (BRFSS)

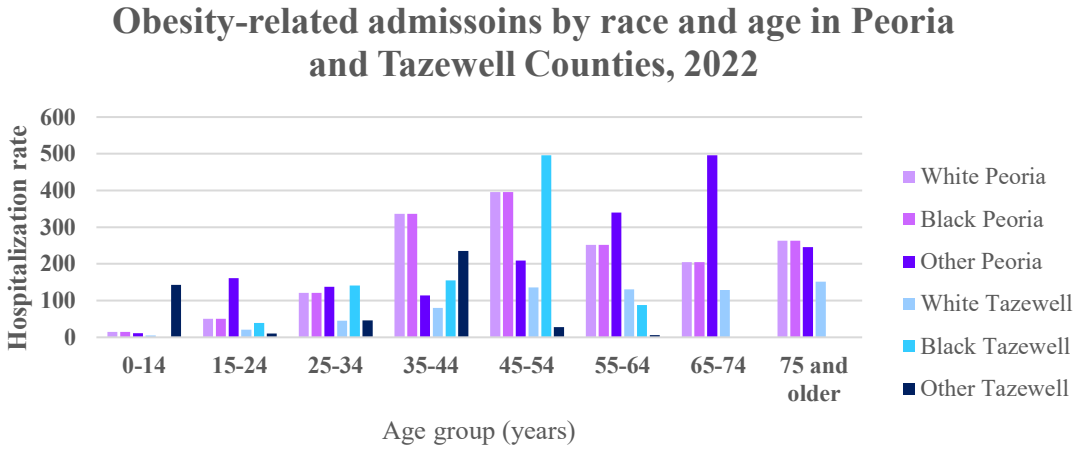
ESSENCE data

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.

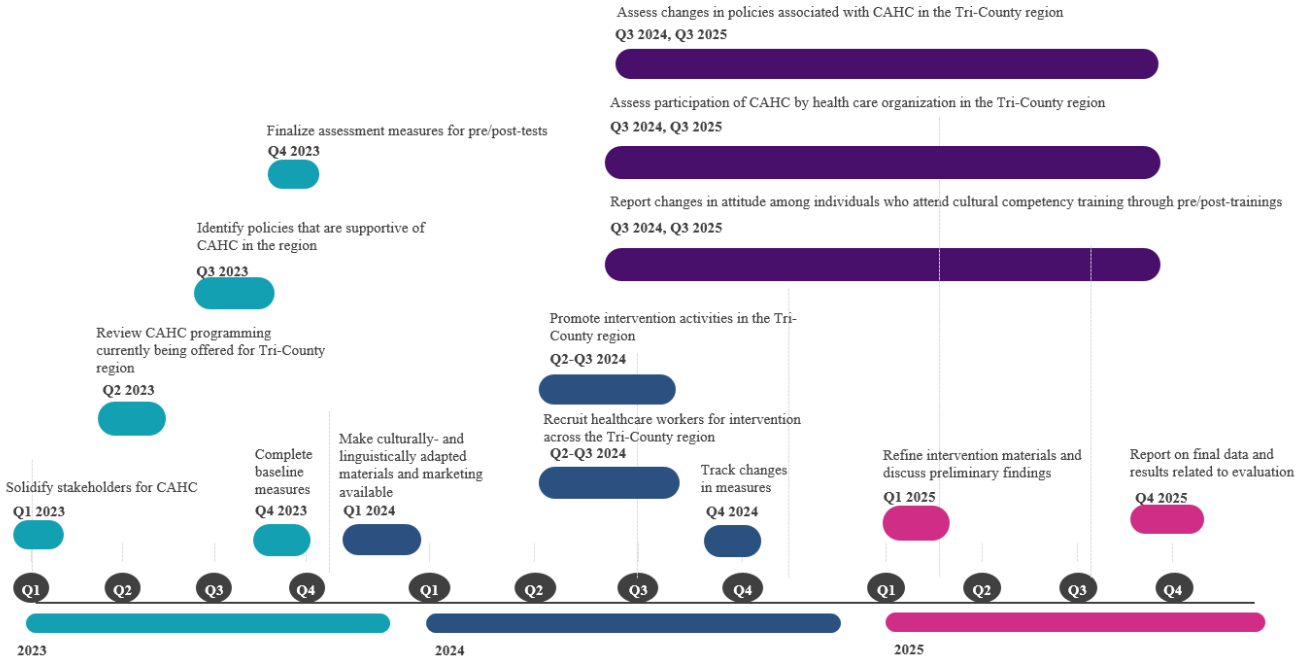
The overall goal is to improve mental health, specifically in regards to suicide, depression, and anxiety within the Tri-County region. Specifically, the following long-term objectives are going to be worked on through two selected health interventions: culturally adapted health care (CAHC) and telemedicine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

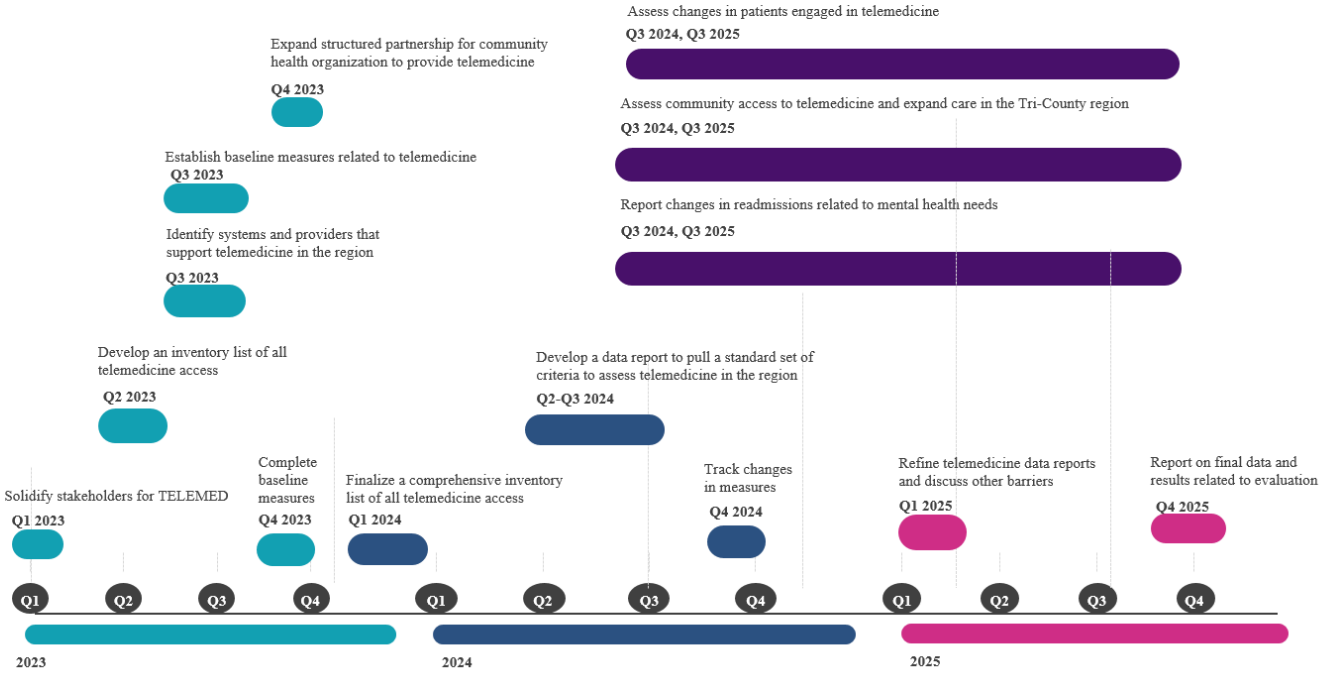
Evaluation metrics for each intervention

Roadmap of mental health interventions

MENTAL HEALTH: CULTURALLY-ADAPTED HEATLH CARE



MENTAL HEALTH: TELEMEDICINE



Programmatic outputs

Intervention Strategy: Culturally-Adapted Health Care (CAHC)

Tasks & Tactics	Evaluation Plan	Target/Data	Monthly Recap (08/23)	Upcoming Work
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	*Data due Q3 2024, Q3 2025*	*Meeting attendance is increasing; new representatives have joined and has been beneficial to the conversations	*Team is determining training plans for each healthcare entity *Team is identifying trainings that can be utilized across partner agencies as hospital trainings are only available to hospital staff at this time * UICOMP librarians have been engaged for literature search related to verified surveys and protocols that have been shown to increase cultural competency. When these are obtained, they will be analyzed for applicability to our region so the best fit surveys and training can be utilized
	More than 50% of the individuals who attended the sessions will self-report improvement in behaviors after cultural competence training(s)	*Data due Q3 2024, Q3 2025*		
	More than 70% of the individuals who attended the session will self-report improvement in attitudes after cultural competence training(s)	*Data due Q3 2024, Q3 2025*		

Provide tailored educational trainings bi-annually to healthcare professional in the tri-county region	Establish baseline, increase # providers completing cultural competence trainings by 10%	*Data due Q3 2024, Q3 2025*	*Committee is partnering with the tri-county cadre for MHFA to bring more awareness to the training and impact on the community for everyday living and professional scope of CAHC. Focus on Youth & Adult curriculums for full exposure.	*Team is determining training plans for each healthcare entity * Community Presentations to enhance CAHC knowledge to committee, community, and workplaces: CI Friends-Safe Zone training Future: JOLT, Access Center- Trillium Place, STRIVE, Online trainings
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%	*Data due Q3 2024, Q3 2025*		*Team is determining policies and plans for matching patient backgrounds/preferences to provider at each healthcare entity
Make culturally- and linguistically adapted materials and marketing available	Improve patient experience ratings (likelihood to recommend) by 1%	*Data due Q3 2024, Q3 2025*		*Team is determining existing efforts and future plans for CAHC materials at each healthcare entity

Intervention Strategy: Telemedicine (TELMED)

Tasks & Tactics	Evaluation Plan	Target/Data	Monthly Recap (08/23)	Upcoming Work
Establish baseline, inventory available telemedicine among tri-county	Complete inventory list of all telemedicine access.	*Data due Q4 2023*	*The team agreed that telehealth services will likely decline due to providers preferring in-office care; in addition, laws are changing for hospitals and reimbursement	*Team is inventorying telemedicine resources for tri-county *Carle Health has a dashboard that shows up-to-date telehealth services over time
Disseminate information through 10 promotional campaigns on how to access (mental health) telemedicine	Increase # patients engaged in mental health telemedicine by 10%	*Data due Q3 2024, Q3 2025*		
Support the development of structured partnerships for community healthcare organizations to provide telemedicine	Increase # new patients enrolled in telemedicine by 10%	*Data due Q3 2024, Q3 2025*		
Expand number of locations for community members to access telemedicine mental health care (community settings, OSF	Increase # telemedicine community access points by 10%	*Data due Q3 2024, Q3 2025*		

Strive, libraries, Wraparound Center, etc.)				
Provide more than 100 residents access to mental health telemedicine appointments who are either medically underserved or live in rural areas	Reduce # hospital readmissions among individuals who engage in telemedicine by 30%	*Data due Q3 2024, Q3 2025*		

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.
- Possible cost barriers to trainings and surveys (TBD)
- Need: fostering engagement from all team members
- *In addition to CAHC work, the team has identified a barrier for accessing mental health care. Mental health providers are overwhelmed, and it is difficult for patients who need it most to get an appointment. The committee identified that primary care providers can manage some patients at the primary care level, which would reduce the burden on specialists. Dr. Ashley Fischer is creating a toolkit for pediatricians for training and support; she needs assistance with compiling the research and wrapping up the toolkit for pediatric providers. This would be a great project for a resident or intern. If you are interested, please reach out to the chairs or H.Bill and they can connect you. Additionally, we need a provider who can take on creating a toolkit for adult providers. If you know of someone who can assist with this using the template that Dr. Fischer is creating, please let us know. Additional pieces that could use assistance are: how to track referrals to determine which PCPs would benefit from education on managing psychiatric conditions; how will we provide ongoing education for providers; what online platform will we use to disseminate these materials*

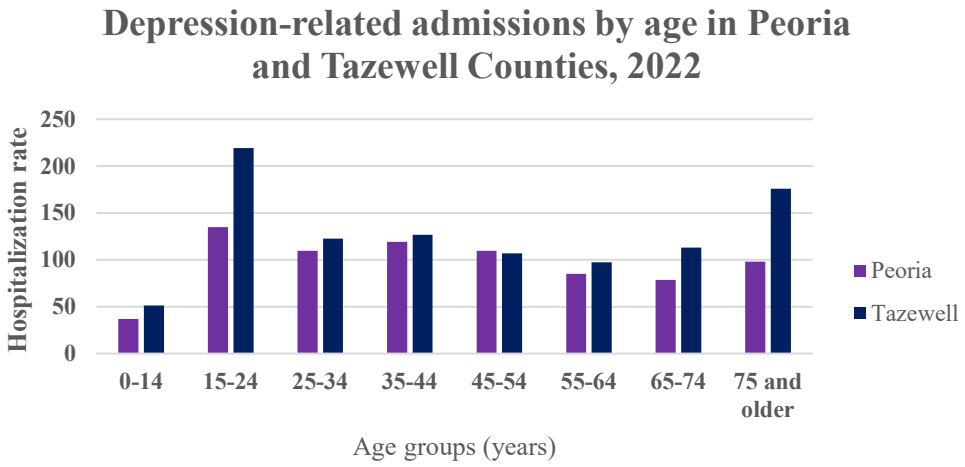
Telemedicine (TELMED)

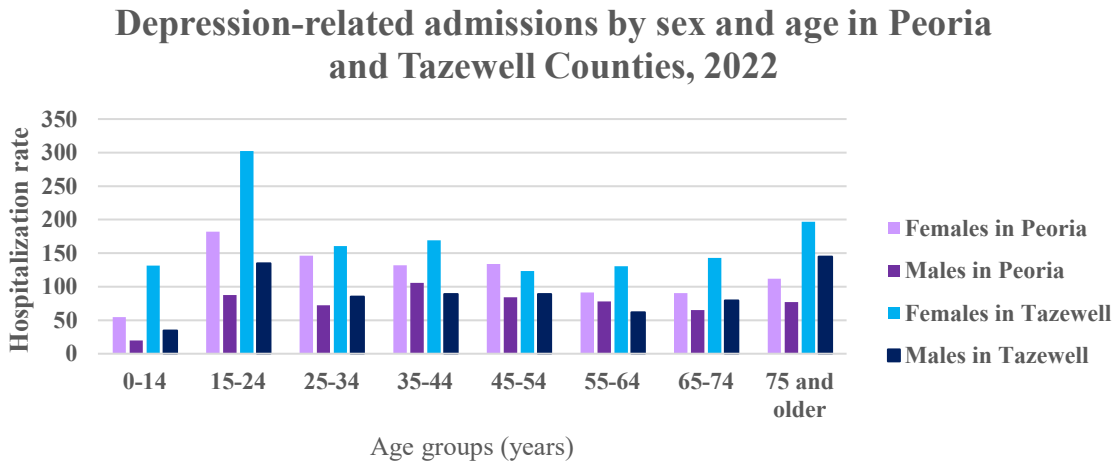
- OSF data not obtained at this time
- Currently working on obtaining data from other healthcare sources (data team working with chairs/co-chairs)
- *Additional: Suicide Prevention Workgroup Update: The Suicide Prevention Workgroup is continuing to meet from the previous cycle. They are requesting a page/section on the website to include: Toolkits, Best Practices, and Grief Book Recommendations; The hope is to complete all documents, brand as PFHC, and reduce meetings to annual/as needed so that efforts can be focused on new interventions. The team agrees that once these items are complete they will only need to be updated on the website if information changes.*

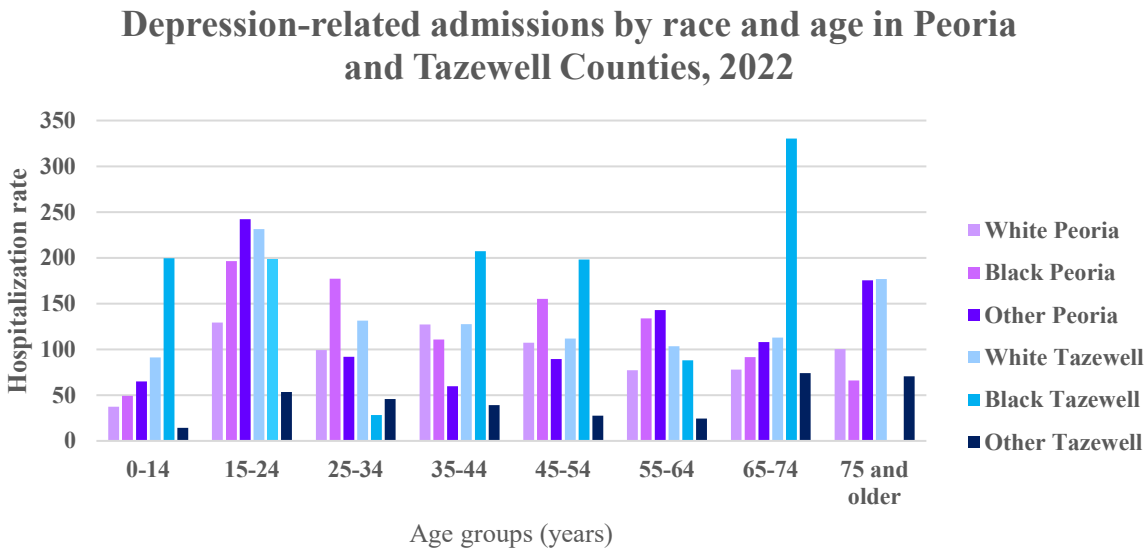
Public health surveillance

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.

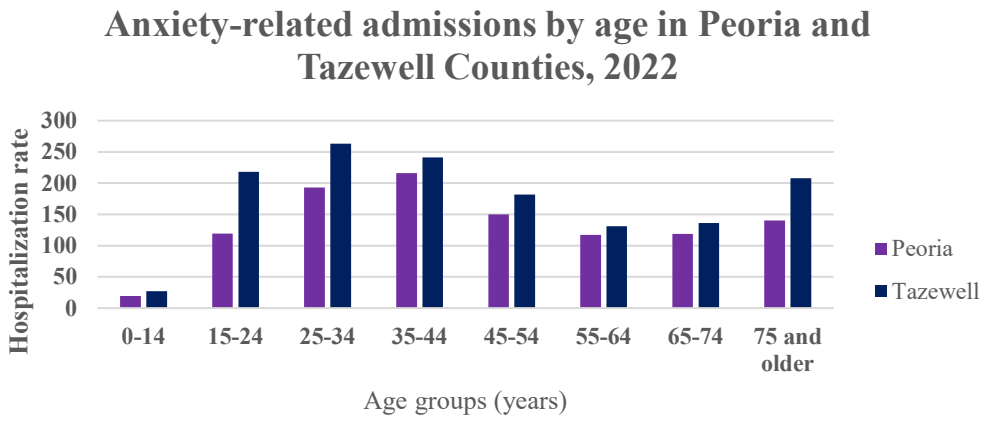
Depression

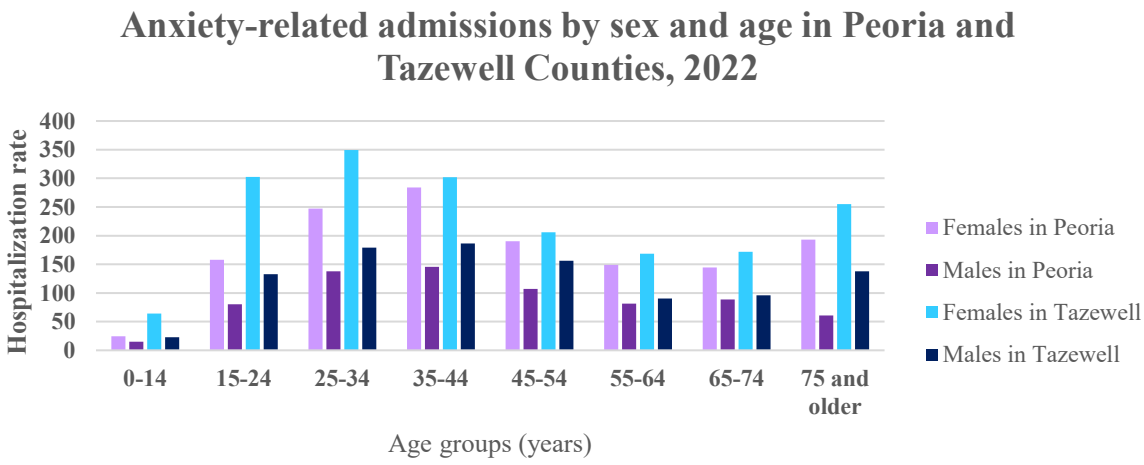

Depression-related admissions by age in Peoria and Tazewell Counties, 2022
Hospitalization rate
250
200
150
100
50
0
0-14
15-24
25-34
35-44
45-54
55-64
65-74
75 and older
Age groups (years)
Peoria
Tazewell

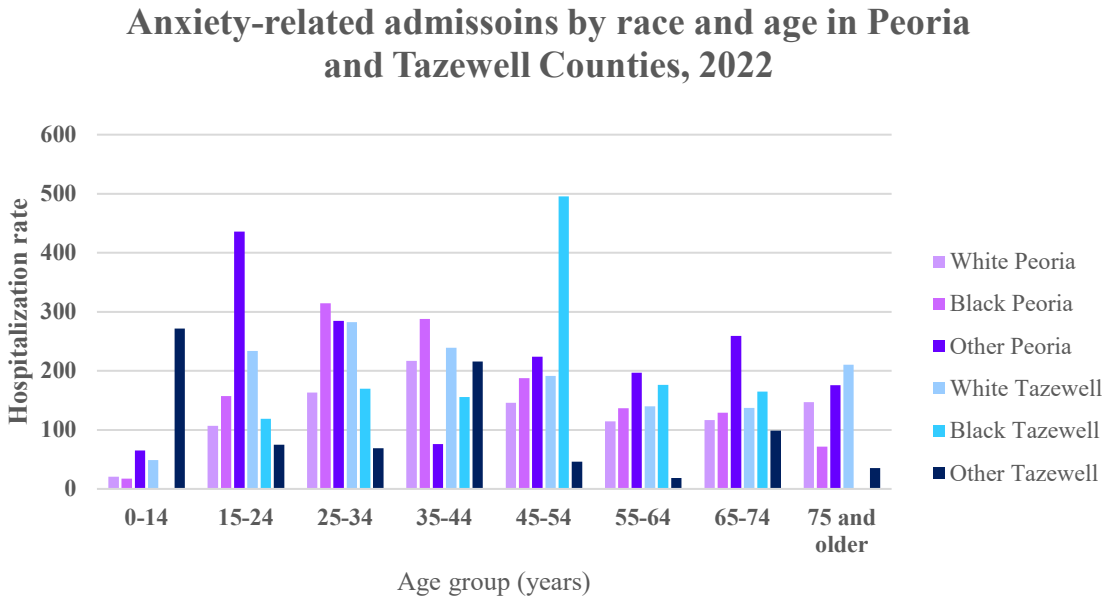

Depression-related admissions by sex and age in Peoria and Tazewell Counties, 2022
Hospitalization rate
350
300
250
200
150
100
50
0
0-14
15-24
25-34
35-44
45-54
55-64
65-74
75 and older
Age groups (years)
Females in Peoria
Males in Peoria
Females in Tazewell
Males in Tazewell


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

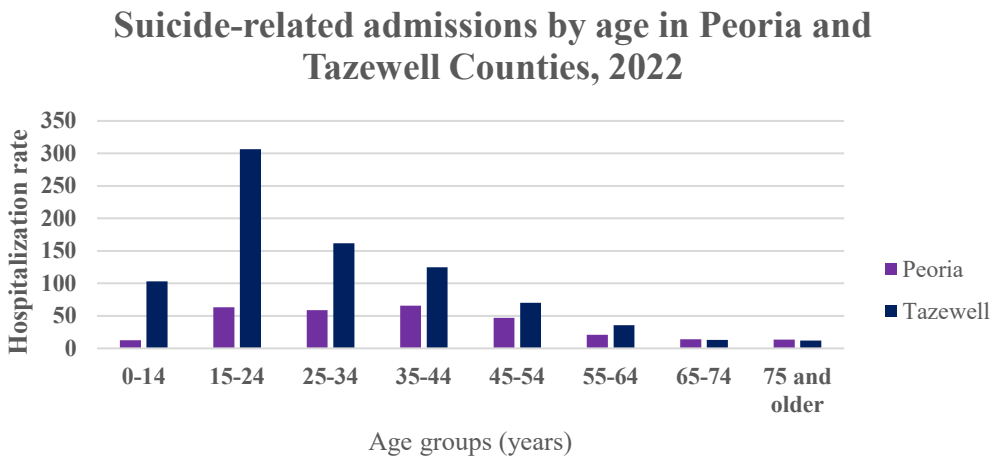
Anxiety

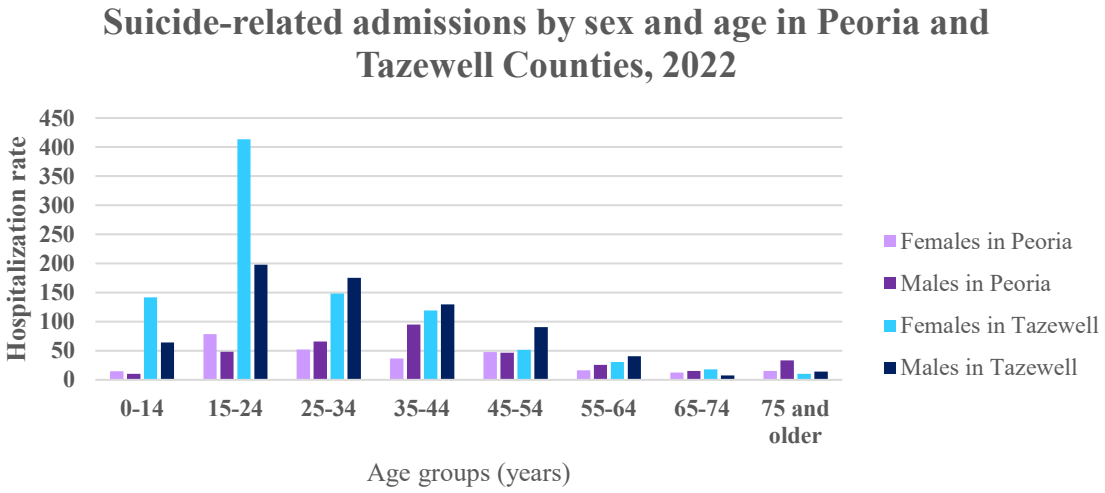

Anxiety-related admissions by age in Peoria and Tazewell Counties, 2022
Hospitalization rate
300
250
200
150
100
50
0
0-14
15-24
25-34
35-44
45-54
55-64
65-74
75 and older
Age groups (years)
Peoria
Tazewell

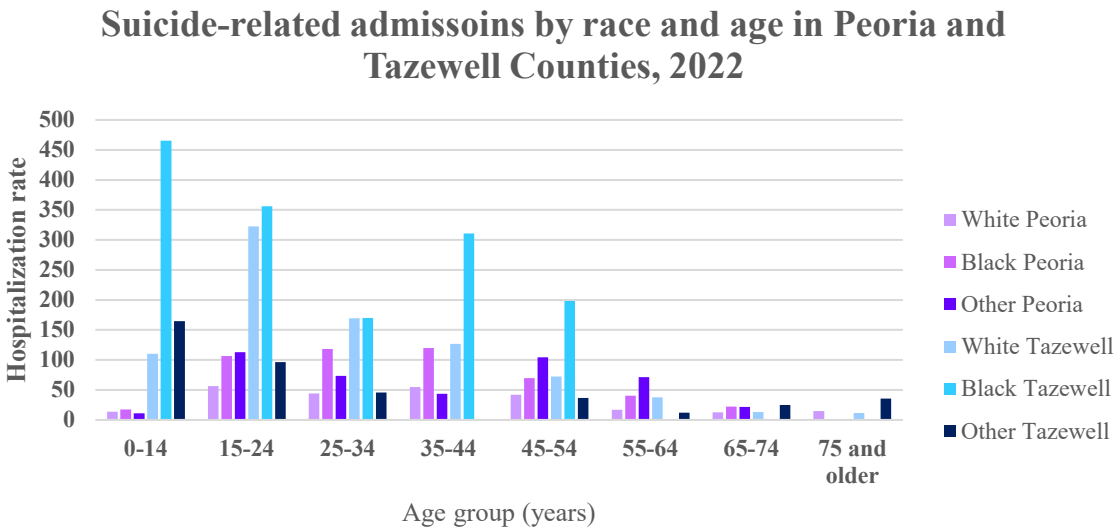

Anxiety-related admissions by sex and age in Peoria and Tazewell Counties, 2022
Hospitalization rate
400
350
300
250
200
150
100
50
0
0-14
15-24
25-34
35-44
45-54
55-64
65-74
75 and older
Age groups (years)
Females in Peoria
Males in Peoria
Females in Tazewell
Males in Tazewell


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.

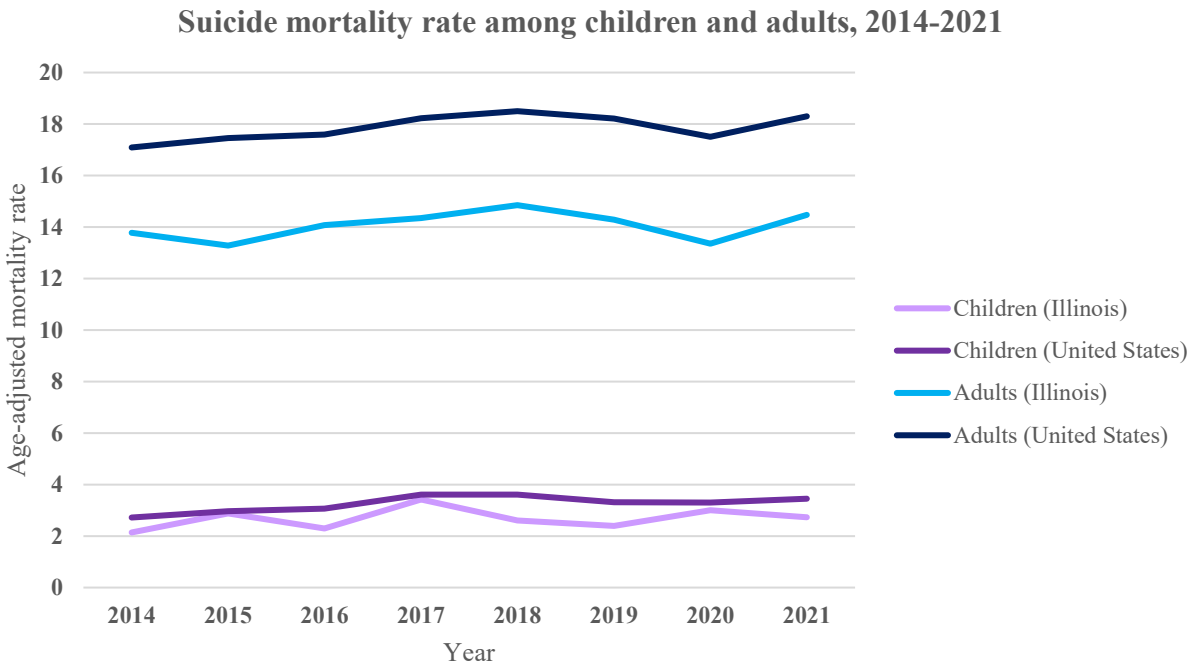
Alcohol-impaired driving deaths is a percentage of motor vehicle crash deaths with alcohol involvement. Alcohol-Impaired Driving Deaths are reported for the county of occurrence. This is because it is more likely that the drinking behavior that led to the driving crash happened where the accident occurred 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 for Woodford County for black residents due to population size.

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 for Woodford County for black residents due to population size.

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 for Woodford County for black residents due to population size.

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).

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 due to small numbers.

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 due to small numbers.

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 due to small numbers.

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

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	Unreliable

Data sources:
1. 2018-2020 CDC WONDER

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

SUPP: Data are suppressed due to small numbers.

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.

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
Injury mortality rate	88.8	65.2	59.6	69.8	76.0
Motor vehicle mortality rate	10.6	9.3	14.7	8.8	12.0
Drug overdose mortality rate	26.0	18.0	8.7	23.8	23.0
Firearm fatalities rate	13.1	7.5	7.8	11.8	12.0
Homicide mortality rate	9.1	1.8	SUPP	8.0	6.0

Data sources:
1. 2014-2020 NCHS

SUPP: Data are suppressed due to small numbers.

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

Upcoming additions that will be addressed in the annual report:

- Updates on health areas that are currently in performance management
    - Additional measures related to those outcomes will also be further assessed
- Additional best practice or evidence-based interventions that are being conducted and related to health priority areas or per the community stakeholder request
- Additional mortality measures will be reported using CDC WONDER database. The following topics will be explored, in particular to identify potential disparity in the region that the PFHC should be aware of for the region.
    - **Obesity:** E66.1 (drug-induced obesity), E66.2 (severe obesity with alveolar hypoventilation), E66.3 (overweight), E66.8 (other forms of obesity), E66.9 (unspecified obesity), E66.0 (obesity due to excess calorie intake), E66.01 (severe obesity due to excess calories), and E66.09 (other forms of obesity caused by excess calorie intake).
    - **Additional deaths related to HEAL and obesity**: diseases of heart and cerebrovascular diseases
    - **Deaths related to mental health**:
        - Causes of death due to alcohol, drugs, or suicide: X60-X84 (Intentional self-harm), Y10-Y34 (Injury/poisoning of undetermined intent), Y87.0/Y97.2 (Sequelae of intentional self-harm/event of undetermined intent)
        - Causes of death due to drug poisoning: F11-F16, F18-19 (mental and behavioral disorders due to drug use excluding alcohol and tobacco), X40-X44 (accidental poisoning by drugs, medicaments and biological substances), X60-X64 (intentional self-poisoning by drugs, medicaments and biological substances), X85 (assault by drugs, medicaments and biological substances), Y10-Y14 (poisoning by drugs, medicaments and biological substances, undetermined intent)
        - Alcohol-specific deaths: E24.4 (alcohol-induced pseudo-Cushing's syndrome), F10 (mental and behavioral disorders due to use of alcohol), G31.2 (degeneration of nervous system due to alcohol), G62.1 (alcoholic polyneuropathy), G72.1 (alcoholic myopathy), I42.6 (alcoholic cardiomyopathy), K29.2 (alcoholic gastritis), K70 (alcoholic liver disease), K85.2 (alcohol-induced acute pancreatitis), K86.0 (alcohol induced chronic pancreatitis), Q86.0 (fetal induced alcohol syndrome (dysmorphic)), R78.0 (excess alcohol blood levels), X45 (accidental poisoning by and exposure to alcohol, X65 (intentional self-poisoning by and exposure to alcohol), Y15 (poisoning by and exposure to alcohol, undetermined intent)
    - **Firearm mortality, including gun violence mortality:** W32-W34 (accidental discharge of firearm), X72-X74 (intentional self-harm by firearm), X93-X95 (assault by firearm), Y22-Y24 (firearm discharge undetermined intent), and Y35. 0 (legal intervention involving firearm discharge)
    - **Overdose mortality rate**: X40-44, X60-X64, X85, and Y10-Y14
    - **Infant mortality:** Deaths among individuals under 1 year of age
    - **Child mortality:** Deaths among individuals age 18 years and under
    - **Injury mortality:** U01-U03, V01-Y36, Y85-Y87, Y89