2025

Community Health Needs Assessment

Partnership for a Healthy Community

Peoria County
Tazewell County
Woodford County

Community Health Needs Assessment

2025

Collaboration for sustaining health equity

EXECUTIVE SUMMARY

The Tri-County Health Needs Assessment is a collaborative undertaking by Partnership for a Healthy Community to highlight the needs and well-being of Tri-County area residents. The Partnership for a Healthy Community is a multi-sector community partnership working to improve population health. This assessment, with the help of collaborative community partners, has identified numerous health issues impacting individuals and families in the Tri-County region. Prevalent themes include demographic composition, disease predictors and prevalence, leading causes of mortality, accessibility to health services, and healthy behaviors.

The results of this study can inform strategic decision-making, directly addressing the community's health needs. It was designed to assess issues and trends affecting the communities served by the collaborative and to understand the perceptions of targeted stakeholder groups.

This study includes a detailed analysis of secondary data to assess the community's health status. Information was collected from numerous secondary sources, both publicly and privately available data.

Additionally, primary data were collected for the general population and the at-risk or economically disadvantaged population. Areas of investigation included perceptions of the community health issues, unhealthy behaviors, issues with quality of life, healthy behaviors and access to medical care, dental care, prescription medication, and mental-health counseling. Social drivers of health were also analyzed to understand why certain population segments responded differently.

Ultimately, the collaborative team identified and prioritized the most important health-related issues in the Tri-County region. They considered health needs based on: (1) magnitude of the issue (i.e., what percentage of the population was impacted by the issue); (2) severity of the issue in terms of its relationship with morbidities and mortalities; and (3) potential impact through collaboration. Using a modified version of the Hanlon Method, three significant health needs were identified and determined to have equal priority:

- **Food Insecurity Among Youth**
- **Access to Mental Health**
- **Suicidal Thoughts and Behaviors**

The Partnership for a Healthy Community formed an ad hoc committee creating a collaborative team to facilitate the community health needs assessment. This collaborative team included members from: Carle Eureka Hospital, Carle Health Methodist Hospital, Carle Health Pekin Hospital, Carle Health Proctor Hospital, Bradley University, Heart of Illinois United Way, Heartland Health Services, OSF Saint Francis Medical Center, Peoria City/County Health Department, Tazewell County Health Department and Woodford County Health Department. They conducted the Tri-County community health needs assessment to highlight the health needs and well-being of residents in the Tri-County region.

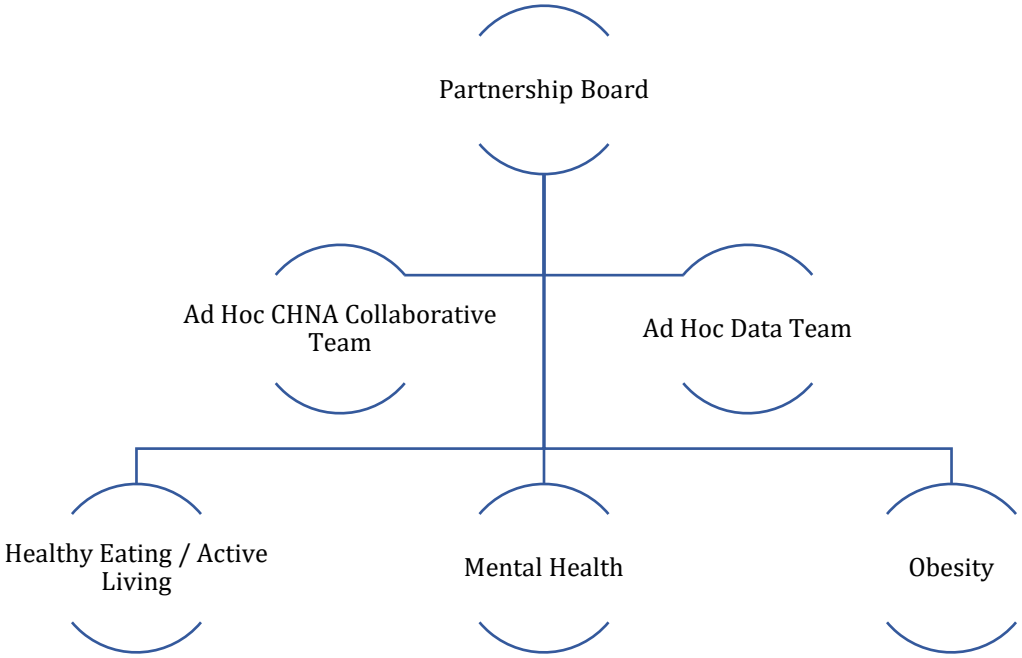
I. INTRODUCTION

Background

The Partnership for a Healthy Community (PFHC) is a community-driven effort to improve health and wellness in the Central Illinois Tri-County region. Multiple organizations, sectors, and the public participate in population health planning to identify and prioritize health needs and quality of life issues, map and leverage community resources, and form effective partnerships to implement health improvement strategies in Peoria, Tazewell, and Woodford Counties. Using actionable data to identify health needs and priorities, including those related to health disparities, health inequities, and the social drivers of health, members of the PFHC develop subsequent Community Health Improvement Plans. This collaborative effort allows members of the PFHC to share resources, to align strategies to address health needs, and to work as partners in improving community health.

The current structure of the PFHC, as shown in Figure 1- Partnership for a Healthy Community – Organization Chart, creates the organizational capacity for multiple stakeholders as well as fostering partnerships to address key strategic health priorities.

Figure 1- Partnership for a Healthy Community – Organization Chart

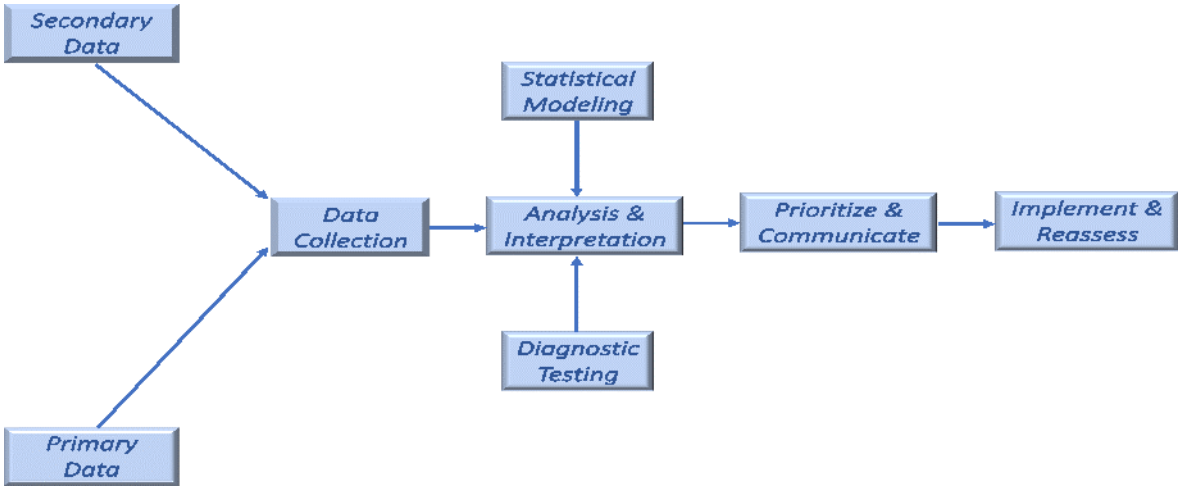


All members of the PFHC ad-hoc Community Health Needs Assessment (CHNA) collaborative team used the joint, collaborative CHNA to prepare Community Health Needs Assessment Reports. OSF Saint Francis Medical Center, Carle Health Methodist Hospital, Carle Health Pekin Hospital, and Carle Health Proctor Hospital used the CHNA to prepare and adopt a joint CHNA Report in compliance with Internal Revenue Code Section §501(r) and the final regulations published on December 31, 2014, to implement §501(r). These requirements are imposed on §501(c)(3) tax-exempt hospitals. Additionally, Carle Eureka Hospital used the CHNA to support the specific population it serves.

Illinois law requires certified local health departments to conduct a CHNA every three years and to complete a community health plan. Peoria City/County Health Department, Tazewell County Health Department, and Woodford County Health Department used the CHNA to satisfy the requirements imposed on health departments under 77 Ill. Adm. Code 600 to prepare an IPLAN, guided by the MAPP 2.0 process. In addition, other PFHC stakeholders used the CHNA to support health identification and improvement planning strategies.

The collaborative CHNA takes into account input from specific individuals who represent the broad interests of the community, including those with special knowledge of or expertise in public health. For this study, a community health-needs assessment is defined as a systematic process involving the community, to identify and analyze community health needs and assets in order to prioritize these needs, create a plan, and act upon unmet community health needs. Results from this assessment will be made widely available to the public. The fundamental areas of the CHNA are illustrated in Figure 2.

Figure 2



Collaborative Team and Community Engagement

To engage the entire community in the CHNA process, the PFHC ad-hoc collaborative team of health-professional experts and key community advocates was formed. Members of the team were carefully selected to ensure representation of the broad interests of the community. Specifically, team members included representatives from Carle Eureka Hospital, Carle Health Methodist Hospital, Carle Health Pekin Hospital, Carle Health Proctor Hospital, Bradley University, Heart of Illinois United Way, Heartland Health Services, OSF Saint Francis Medical Center, Peoria City/County Health Department, Tazewell County Health Department, and Woodford County Health Department. Note that the collaborative team provided input for all sections of the CHNA. Individuals, affiliations, titles, and expertise can be found in APPENDIX 1: MEMBERS OF COLLABORATIVE TEAM.

Engagement occurred throughout the process, resulting in shared ownership of the assessment. The entire collaborative team met in the first and second quarters of 2025. Additionally, numerous meetings were held between the facilitators and specific individuals during the process.

Notably, leadership from these organizations worked together as part of the Greater Peoria Healthcare Collaborative (GPHC). The GPHC is a community-driven partnership, aims to improve healthcare outcomes by fostering collaboration among organizations like Bradley University, Carle Health, Heartland Health Services, and OSF Saint Francis Medical Center, among others. Leaders from these organizations oversaw this collaborative process resulting in the CHNA to collectively tackle health issues in the region.

Definition of the Community

To determine the geographic boundaries for the primary and secondary markets for OSF Saint Francis Medical Center, Carle Health Methodist Hospital, Carle Health Pekin Hospital, and Carle Health Proctor Hospital, analyses were completed to identify what percentage of inpatient and outpatient activity was represented by Peoria, Tazewell, and Woodford counties, as these hospitals collectively define their communities to be the same. Data show that these three counties represent approximately 83% of all patients for these hospitals.

In addition to defining the community by geographic boundaries, this study targets the at-risk population as an area of potential opportunity to improve the health of the community. The at-risk population was defined as those individuals eligible to receive Medicaid based on the State of Illinois guidelines using household size and income level.

Purpose of the Community Health Needs Assessment

The collaborative CHNA has been designed to provide necessary information to the PFHC, which includes hospitals, local health departments, clinics, and community agencies, to create strategic plans in program design, access, and delivery.

Results of this study will act as a platform that allows healthcare organizations to orchestrate limited resources to improve management of high-priority challenges. By working together, hospitals, clinics, community agencies, and health departments will use this CHNA to improve the quality of health in the Tri-County region. When feasible, data are assessed longitudinally to identify trends and patterns by comparing with results from the 2022 CHNA and benchmarked with State of Illinois averages.

Community Feedback from Previous Assessments

The 2022 CHNA was widely shared with the community to allow for feedback. OSF Saint Francis Medical Center, Carle Eureka Hospital, Carle Health Methodist Hospital, Carle Health Pekin Hospital, and Carle Health Proctor Hospital posted both a full and summary version on their respective websites. To solicit feedback, a link - CHNAFeedback@osfhealthcare.org – was provided on each hospital's website; however, no feedback was received.

Although no written feedback was received by community members via the available mechanisms, verbal feedback from key stakeholders from community-service organizations was incorporated into the collaborative process.

Community Health Needs Assessment Report Approval

OSF Saint Francis Medical Center, Carle Eureka Hospital, Carle Health Methodist Hospital, Carle Health Pekin Hospital, and Carle Health Proctor Hospital used the collaborative CHNA to prepare their 2025 CHNA Reports and to adopt implementation strategies to address the significant health needs identified. The Peoria City/County Health Department, Tazewell County Health Department and the Woodford County Health Department used the collaborative CHNA to adopt community health plans to meet IPLAN requirements for local health department certification by the Illinois Department of Public Health (IDPH).

The Partnership for a Healthy Community is not required to perform a community health needs assessment; however, they are collaborating with the above organizations and using the collaborative CHNA in order to better serve the health needs of the Tri-County region.

OSF Saint Francis Medical Center, Carle Eureka Hospital, Carle Health Methodist Hospital, Carle Health Pekin Hospital, Carle Health Proctor Hospital, the Peoria City/County Health Department, the Tazewell County Health Department the Woodford County Health Department and the Partnership for a Healthy Community are the primary organizations responsible for conducting the CHNA. Implementation

strategies will be developed in coordination with other community social service agencies and organizations to address the significant health needs identified.

This CHNA Report was approved as follows.

Health Departments:

- Peoria City/County Health Department: August 18, 2025, issue statements were approved on June 23, 2025
- Tazewell County Health Department: August 25, 2025, issue statements were approved July 28, 2025
- Woodford County Health Department: September 28, 2025, issue statements were approved July 23, 2025

Hospital Systems:

- Carle Health West Region Board of Directors: July 17, 2025
- OSF Saint Francis Medical Center: September 29, 2025

Partnership:

- PFHC: August 28, 2025

2022 CHNA Health Needs and Implementation Plans

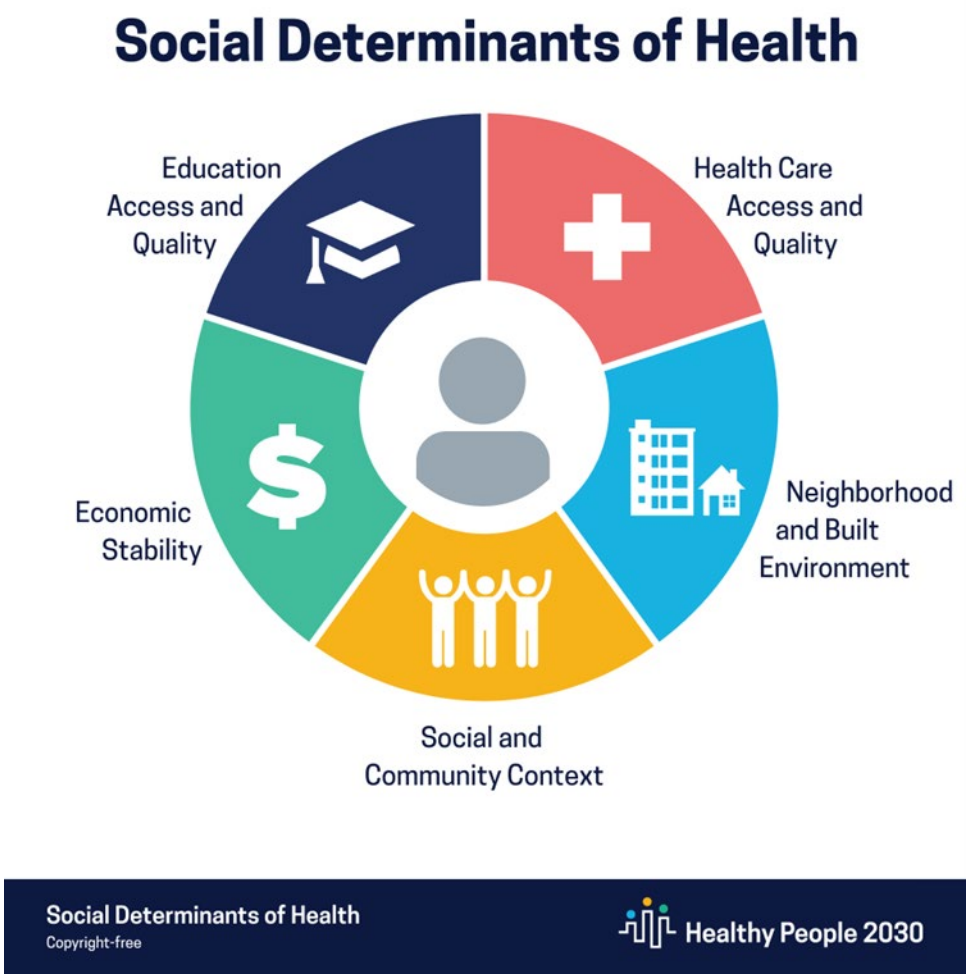
The 2022 CHNA for the Tri-County region identified three significant health needs. These included Healthy Eating/Active Living (defined as healthy eating and active living, access to food and food insecurity); Mental Health (defined as depression, anxiety, and suicide); and Obesity (defined as overweight and obese).

Specific actions were taken to address these needs. Detailed discussions of goals, strategies to improve these health needs, and impact can be seen in APPENDIX 2: ACTIVITIES RELATED TO 2022 CHNA PRIORITIZED NEEDS.

Social Drivers of Health

This CHNA incorporates important factors associated with Social Drivers of Health (SDOH). SDOH are crucial environmental factors, such as where people are born, live, work and play, which affect people's well-being, physical and mental health, and quality of life. Research by the U.S. Department of Health and Human Services, as part of *Healthy People 2030,* identifies five SDOH to include when assessing community health (Figure 3). Note this CHNA refers to social "drivers" rather than "determinants." According to the *Root Cause Coalition*, drivers are malleable, while determinants are not. However, the five factors included in Figure 2 remain the same, regardless of terminology used.

Figure 3



Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved November 1, 2024, from https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health

The CHNA includes an assessment of SDOH because these factors contribute to health inequities and disparities. Interventions without considering SDOH will have limited impact on improving community health for people living in underserved or at-risk areas.

II. METHODS

To complete the comprehensive community health needs assessment, multiple sources were examined. Secondary statistical data were used to assess the community profile, morbidity rates and causes of mortality. Additionally, a study was completed to examine perceptions of the community health-related issues, healthy behaviors, behavioral health, food security, social drivers of health and access to healthcare.

Secondary Data Collection

Existing secondary statistical data were first used to develop an overall assessment of health-related issues in the community. Within each section of the report, there are definitions, importance of categories, data and interpretations. At the end of each chapter, there is a section on key takeaways.

COMPdata Informatics (affiliated with Illinois Health and Hospital Association (IHA)) was used to identify six primary categories of diseases, including: age related, cardiovascular, respiratory, cancer, diabetes and infections. In order to define each disease category, modified definitions developed by Sg2 were used. Sg2 specializes in consulting for healthcare organizations. Their team of experts includes MDs, PhDs, RNs and healthcare leaders with extensive strategic, operational, clinical, academic, technological and financial experience.

By leveraging data reports and compiled information on regional population measures, we enhanced our understanding of the overall health and well-being of the Tri-County region. Public health surveillance systems (e.g. Behavioral Risk Factor Surveillance System (BRFSS)) are crucial for monitoring population health metrics. They provide valuable data on health behaviors, chronic diseases, and preventive practices, enabling public health officials to identify trends, plan interventions, and evaluate the effectiveness of health programs. Combining these data in combination with survey yields a more comprehensive understanding of the community perceptions, needs, and issues surrounding health and well-being.

Primary Data Collection

In addition to existing secondary data sources, a variety of data were collected. Following the MAPP 2.0 framework the main primary data sources included the Community Partner Assessment (CPA), Community Context Assessment (CCA), and Community Status Assessment (CSA).

CPA: The goal of the CPA was to explain the organizations involved with PFHC, focusing on each organization's internal strategies and the resources available to address community health issues. This survey specifically explored the organizations community work, the populations they serve, the focus of their organizations, and the strategies they employ. One representative from each organization in the partnership (n=18) completed a survey used to describe the capacity of each organization and alignment of health issues in the Tri-County region.

CCA: The purpose of the CCA was to identify the health issues and burdens among residents in the Peoria, Tazewell, and Woodford counties using qualitative methodology. These data were collected through a series of interviews and focus groups. These data collected were systematically analyzed to identify recurring themes and patterns, providing a deeper understanding of the community's health context.

CSA: The CSA was developed and refined by the PFHC to gather insights from residents in the Peoria, Tazewell, and Woodford counties. Convenience sampling was the method used to collect data from a broad range of community members. Each week the Data Team tracked the progress of completed surveys within the region, identifying populations that needed to be targeted to ensure the sample was representative of the community based on Census data. This process involved monitoring the number of responses and comparing them to demographic characteristics such as age, race/ethnicity, gender, and

poverty levels based on zip code reported from completed surveys. Weekly progress reports were emailed to the key stakeholders, detailing survey completion rates by county and region across demographic categories. This systematic approach ensured that the survey results accurately reflected the diverse population of the three counties.

The number of responses collected for the CSA ensured that county representation is accurately reflected in the data, with a margin of error less than 5% and a confidence level of 95%. Regional analyses were conducted to provide detailed insights, with results interpretable at a 5% margin of error and 90% confidence interval for all regions in Woodford County, most regions in Tazewell County, and approximately half of the regions in Peoria County. This rigorous approach to data collection and analysis guarantees that the findings are both reliable and representative of the diverse populations within the Tri-County region.

The following section describes the research methods used to collect, code, verify and analyze primary survey data (CSA). Specifically, it describes the research design used in this study: survey design, data collection and data integrity. The CSA is also referred to as the primary community survey used in the CHNA.

Survey Instrument Design

Initially, all publicly available health-needs assessments in the U.S. were assessed to identify common themes and approaches to collecting community health-needs data. By leveraging best practices from these surveys, a new survey in 2021 was designed for use with both the general population and the at-risk community. To ensure that all critical areas were being addressed, the entire collaborative team was involved in survey design/approval through several fact-finding sessions. Additionally, several focus groups met in the first and second quarters of 2024 to collect the qualitative information necessary to design survey items. Specifically, for the community health needs assessment, eight specific sets of items were included:

- **Ratings of health issues in the community** – To assess the importance of various community health concerns. Survey items included assessments of topics such as cancer, diabetes, and obesity.

- **Ratings of unhealthy behaviors in the community** – To assess the importance of various unhealthy behaviors. Survey items included assessments of topics such as violence, drug abuse, and smoking.

- **Ratings of issues concerning well-being** – To assess the importance of various issues relating to well-being in the community. Survey items included assessments of topics such as access to healthcare, safer neighborhoods, and effective public transportation.

- **Accessibility to healthcare** – To assess the degree to which residents could access healthcare when needed. Survey items included assessments of topics such as access to medical, dental, and mental healthcare, as well as access to prescription medication.

- **Healthy behaviors** – To assess the degree to which residents exhibited healthy behaviors. The survey items included assessments of topics such as exercise, healthy eating habits, and cancer screenings.
- **Behavioral health** – To assess community issues related to areas such as anxiety and depression.
- **Food security** – To assess access to healthy food alternatives.
- **Social drivers of health** – To assess the impact that social drivers may have on the above-mentioned areas.

Finally, demographic information was collected to assess background information necessary to segment markets in terms of the eight categories discussed above. A copy of the final survey is included in APPENDIX 4: SURVEY.

Sample Size

To identify our potential population, we first identified the percentage of the Tri-County population that was living in poverty. Specifically, we multiplied the population of the county by its respective poverty rate to identify the minimum sample size to study the at-risk population. The poverty rate for Tri-County is 16.8% in Peoria County, 8.9% in Tazewell County and 6.9% in Woodford County. The populations used for the calculation were 177,513 for Peoria County, 130,555 for Tazewell County, and 38,348 for Woodford County, yielding total residents living in poverty in the three counties at 29,822, 11,619, and 2,646, respectively.

A normal approximation to the hypergeometric distribution was assumed given the targeted sample size.

$n = (Nz2pq) / (E2 (N-1) + z2 pq)$

where:

n = the required sample size

N = the population size

z = the value that specified the confidence interval (use 95% CI)

pq = population proportions (set at .05)

E =desired accuracy of sample proportions (set at +/- .05)

For the total Tri-County area, the minimum sample size for aggregated analyses (combining at-risk and general populations) was 1,149 (Peoria 384, Tazewell 384, and Woodford 381). The data collection effort for this CHNA yielded a total of 3,220 responses. After cleaning the data for "bot" survey respondents, the sample was reduced to 2,399 respondents (Peoria 801, Tazewell 792, and Woodford 736). This met the threshold of the desired 95% confidence interval.

To provide a representative profile when assessing the aggregated population for the Tri-County region, the general population was combined with a portion of the at-risk population. To represent the at-risk

population as a percentage of the aggregate population, a random-number generator was used to select at-risk cases to include in the general sample. Additionally, efforts were made to ensure that the demography of the sample aligned with population demographics according to U.S. Census data. This provided a total usable sample of 2,329 respondents for analyzing the aggregate population. Sample characteristics can be seen in APPENDIX 4: SURVEY.

Data Collection

Survey data were collected in the 3rd and 4th quarters of 2024. To collect data in this study, two techniques were used. First, an online version of the survey was created. Second, a paper version of the survey was distributed. In order to be sensitive to the needs of respondents, surveys stressed assurance of complete anonymity. Note that versions of both the online survey and paper survey were translated into Spanish.

To specifically target the at-risk population, surveys were distributed at homeless shelters, food pantries and soup kitchens. Since the at-risk population was specifically targeted as part of the data collection effort, this became a stratified sample, as other groups were not specifically targeted based on their socio-economic status.

It is important to note that the use of electronic surveys to collect community-level data may create potential for bias from convenience sampling error. To account for potential bias in the community sample, a second control sample of data is periodically collected. This control sample consists of random patients surveyed at the hospital, assuming that patients receiving care represent an unbiased representation of the community. All questions on the patient version of the survey pertaining to access to healthcare are removed, as these questions are not relevant to current patients. Data from the community sample and the control sample are then compared using t-tests and tetrachoric correlations when appropriate. Results show that the community sample did not exhibit any significant patterns of bias. If specific relationships exhibited potential bias between the community sample and the control sample, they are identified in the social drivers sections of the analyses within each chapter.

Data Integrity

Comprehensive analyses were performed to verify the integrity of the data for this research. Without proper validation of the raw data, any interpretation of results could be inaccurate and misleading if used for decision-making. Therefore, several tests were performed to ensure the data were valid. These tests were performed before any analyses were undertaken. Data were checked for coding accuracy using descriptive frequency statistics to verify that all data items were correct. This was followed by analyses of means and standard deviations and comparisons of primary data statistics to existing secondary data.

Analytic Techniques

To ensure statistical validity, several different analytic techniques were used. Frequencies and descriptive statistics were employed to identify patterns in residents' ratings of various health concerns. Additionally, appropriate statistical techniques were used to identify existing relationships between perceptions, behaviors, and demographic data. Specifically bivariate and multivariate analytic strategies were utilized when appropriate.

Regional Analyses

To better understand health disparities across the Tri-County area, additional analyses were conducted with a focus on vulnerable populations. These analyses were guided by the Wheel of Power and Privilege, a framework that considers how intersecting identities—such as race, ethnicity, income, and housing stability—shape individuals' experiences with healthcare systems and health outcomes. This approach allowed for a more nuanced examination of how systemic inequities contribute to elevated suicide risk and barriers to care among marginalized groups.

Given the size and diversity of the Tri-County area, the region was divided into 13 sub-regions to facilitate more detailed, localized analyses. These sub-regions were defined based on zip code boundaries and included six regions in Peoria County, four in Tazewell County, and three in Woodford County. This regional breakdown enabled the identification of geographic differences in access to care, provider availability, and community-specific needs. By combining geographic and equity-focused lenses, the analyses provided a clearer picture of where targeted interventions are most needed and how they can be tailored to address the unique challenges faced by different communities within the Tri-County area.

CHAPTER 1 OUTLINE

CHAPTER 1: DEMOGRAPHY AND SOCIAL DRIVERS

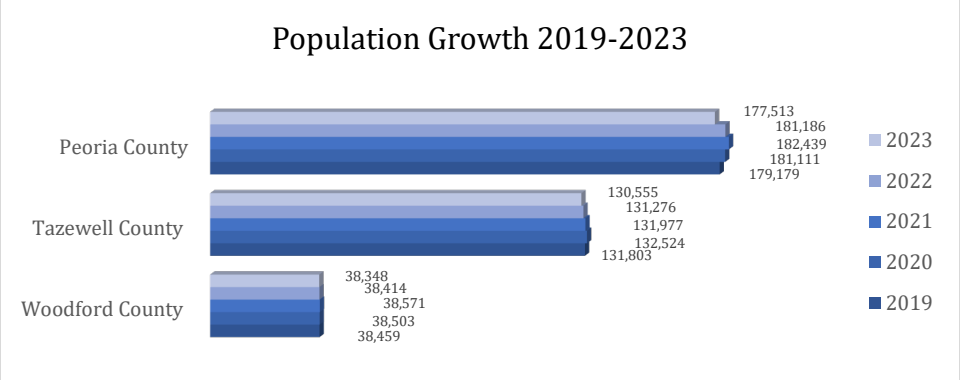
1.1 Population

Importance of the Measure: Population data characterize individuals residing in Peoria County, Tazewell County, and Woodford County. These data provide an overview of population growth trends and build a foundation for further analysis.

Population Growth

Data from the last census indicates the population of Peoria County has decreased slightly less than 1% between 2019 and 2023. During the same period, Tazewell County population decreased about 1% and Woodford County also decreased (0.3%) (Figure 4).

Figure 4



Source: United States Census Bureau

1.2 Age, Gender, and Race Distribution

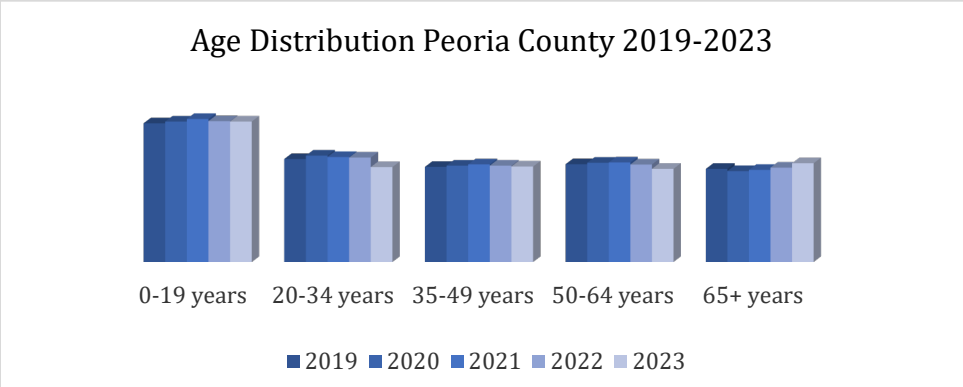
Importance of the Measure: Population data broken down by age, gender, and race groups provide a foundation to analyze the issues and trends that impact demographic factors including economic growth

and the distribution of healthcare services. Understanding the cultural diversity of communities is essential when considering healthcare infrastructure and service delivery systems.

Age

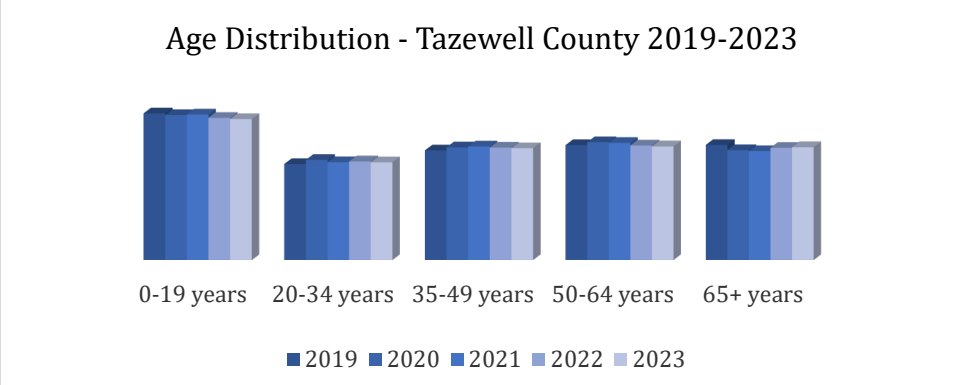
Figure 5, Figure 6, and Figure 7 illustrate the percentage of individuals in the Tri-County region in each age group. Peoria County had its largest decrease in the 20-34 age group (7.8%) and its largest increase in the 65+ age group (6%) between 2019 and 2023. Tazewell County had its largest decrease in the 0–19 age group (3.9%) and its largest increase in the 35–49 age group (2%). Woodford County had its largest decrease in the 50 – 64 age group (6.4%) and largest increase in the 65+ age group (6.9%) between 2019 and 2023.

Figure 5



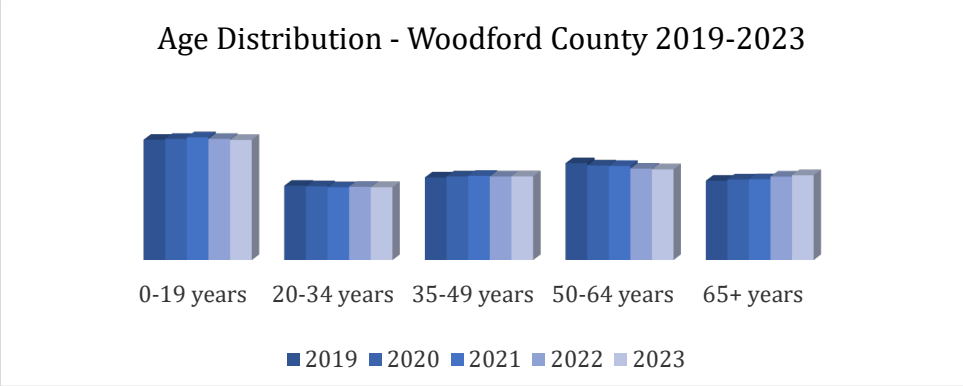
Source: United States Census Bureau

Figure 6



Source: United States Census Bureau

Figure 7

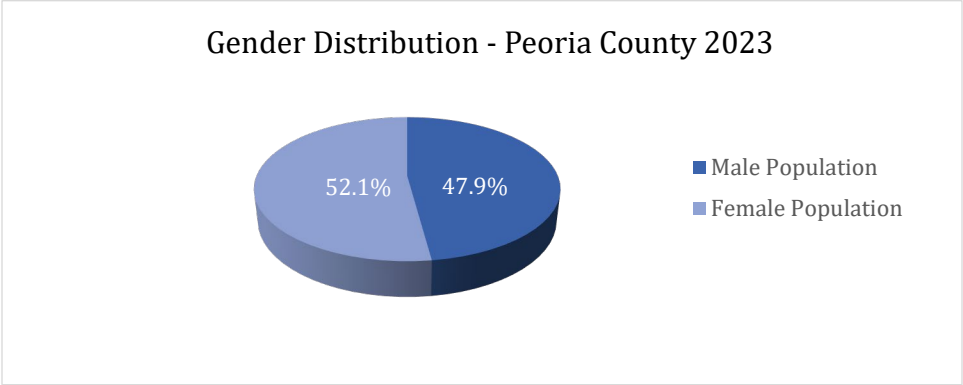


Source: United States Census Bureau

Gender

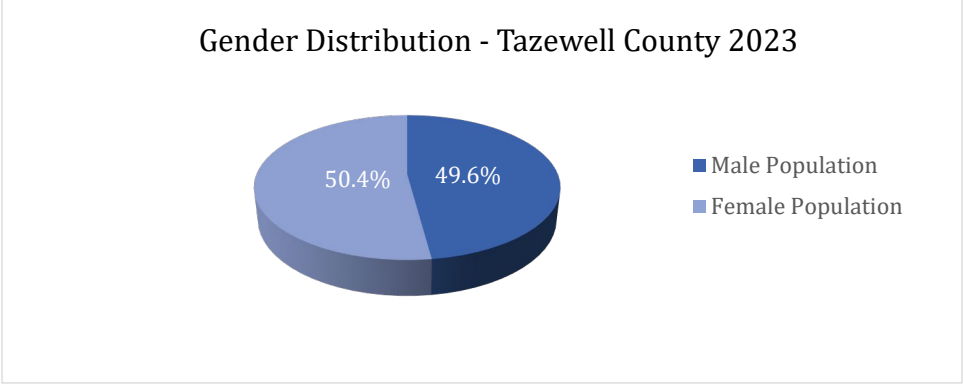
The gender distribution of residents in Peoria, Tazewell, and Woodford Counties is relatively equal among males and females (Figure 8, Figure 9, and Figure 10).

Figure 8



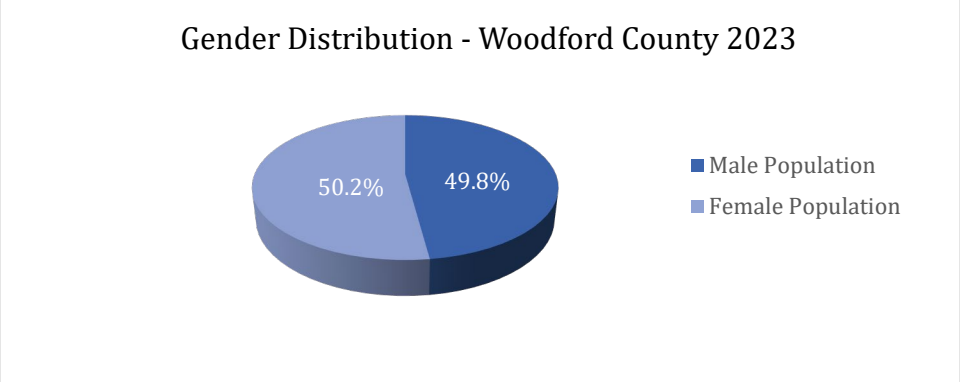
Source: United States Census Bureau

Figure 9



Source: United States Census Bureau

Figure 10



Source: United States Census Bureau

The Gender Pay Gap is a measure that depicts the average difference in earnings between men and women. The differences in pay matter significantly for health outcomes because women earning less are more likely to experience stress, anxiety, and depression. Additionally, lower income can limit access to healthcare services and nutritious food resulting in poorer overall health. The Gender Pay Gap for the Tri-County region ranges from 0.70 (Woodford County), 0.72 (Tazewell County), to 0.75 (Peoria County), all lower values than state (0.80) and national (0.81) estimates. This value depicts how much women earn on average for every $1 men earned annually based on data from the ACS (2019-2023).

Race

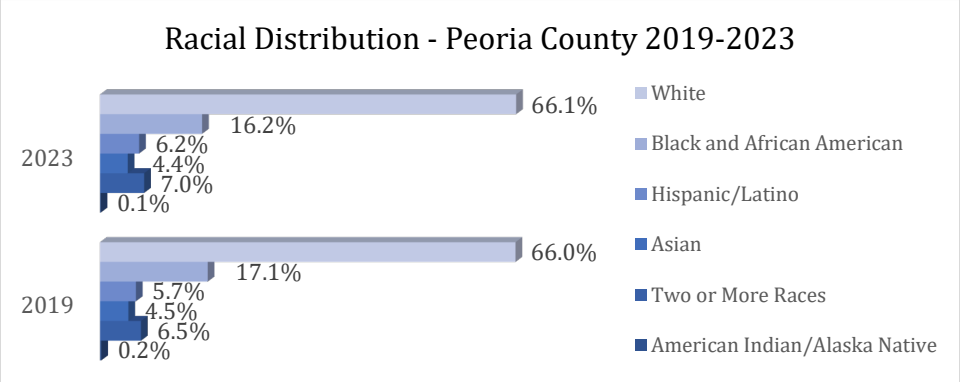
With regard to race and ethnic background, Peoria County is relatively diverse. Data from 2023 shows that the White ethnicity is 66.1% of the population, Black ethnicity comprises 16.2%, multi-racial ethnicity comprises 7%, Hispanic/Latino (LatinX) ethnicity comprises 6.2%, Asian ethnicity comprising 4.4%, and American Indian/Alaska Native ethnicity comprises 0.1% of the population (Figure 11).

Data from 2023 shows that in Tazewell County the White population is 91.8%. Hispanic/Latino (LatinX) and multi-racial ethnicities each comprise 2.8% of the population, Black ethnicity comprises 1.5%, Asian ethnicity comprises 1%, and American Indian/Alaska Native ethnicity comprises 0.1% of the population (Figure 12).

Similarly, data from 2023 shows that in Woodford County the White population is 94.1%, with multi-racial ethnicity comprising of 2.6%, Hispanic/Latino (LatinX) comprising 2.1%, Black ethnicity comprising 0.6%, Asian ethnicity comprising 0.5%, and American Indian/Alaska Native ethnicity comprising 0.1% of the population (Figure 13).

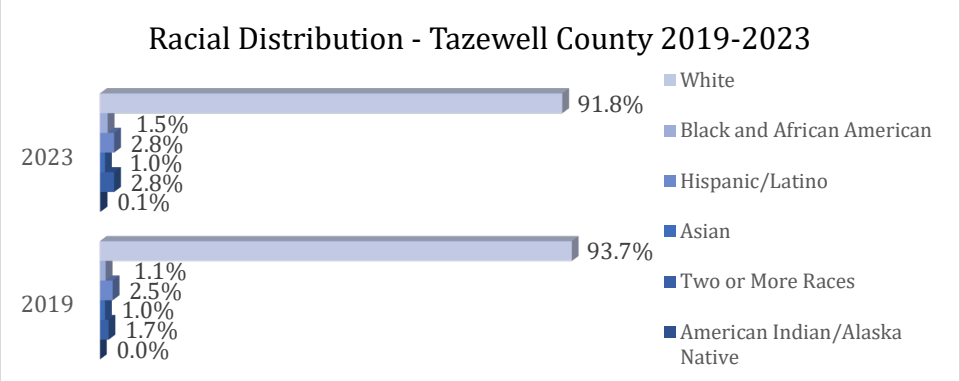
Notably, this report further explores additional differences in health issues, including mortality, in subsequent chapters. It highlights any disparities identified within the Tri-County region.

Figure 11



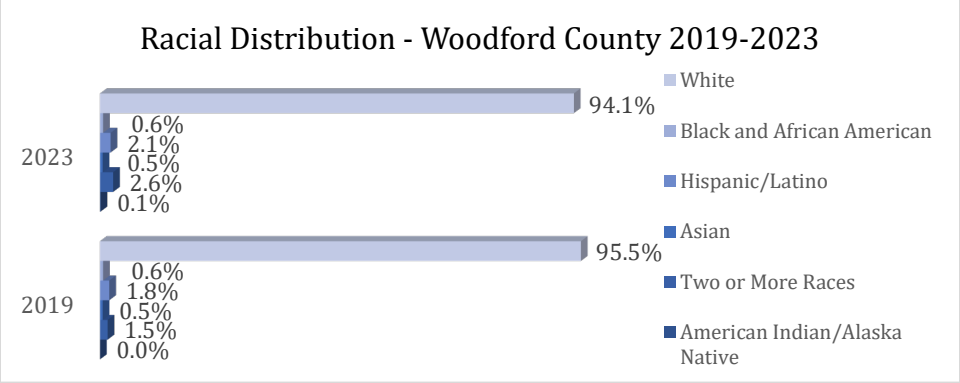
Source: United States Census Bureau

Figure 12



Source: United States Census Bureau

Figure 13



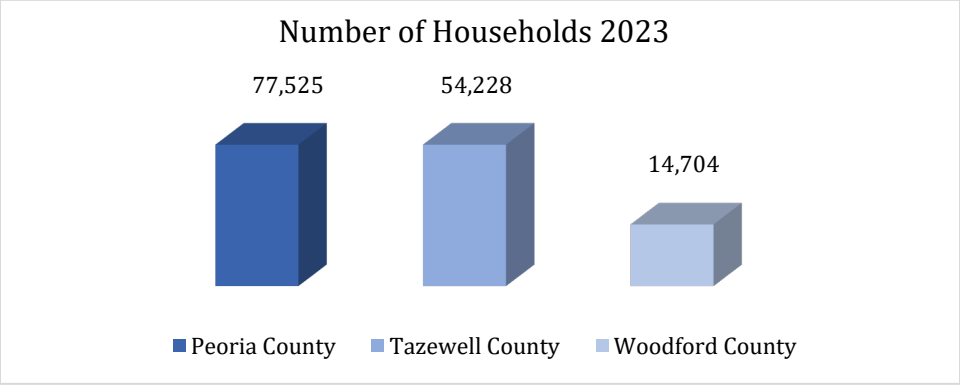
Source: United States Census Bureau

1.3 Household/Family

Importance of the Measure: Families are a vital component of a robust society in Peoria, Tazewell, and Woodford Counties, as they significantly impact the health and development of children and provide support and well-being for older adults.

The number of family households in the Tri-County area for 2023 are indicated in Figure 14.

Figure 14



Source: United States Census Bureau

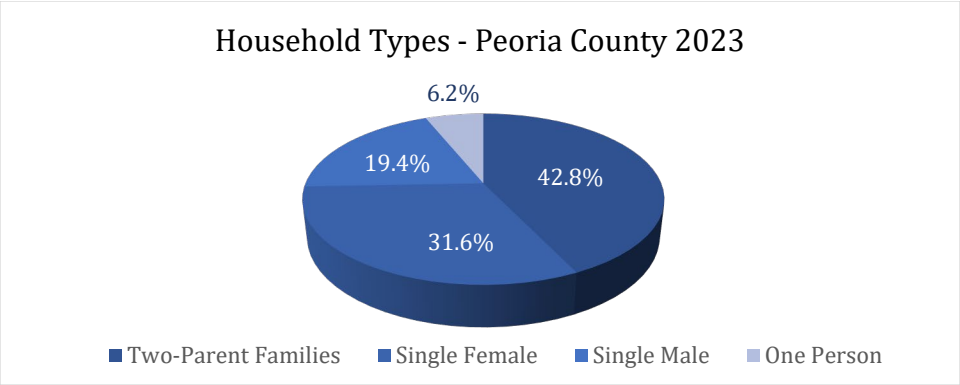
Family Composition

In Peoria County, data from 2023 show that two-parent families make up 42.8% of households, one-person households represent 6.2% of the county population, single-female head of households represent 31.6%, and single-male head of households represent 19.4% (Figure 15).

In Tazewell County, data from 2023 show that two-parent families make up 46.5% of households, one-person households represent 7.5% of the county population, single-female head of households represent 27%, and single-male head of households represent 19% (Figure 16).

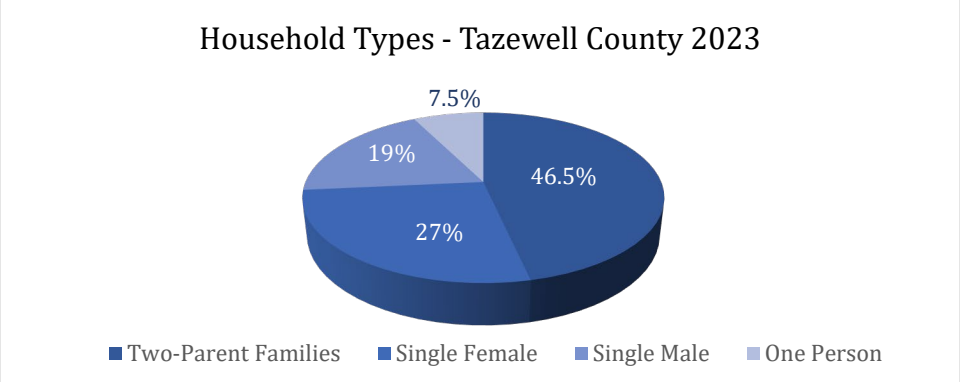
In Woodford County, data from 2023 show that two-parent families make up 59.9% of households, one-person households represent 4.9% of the county population, single-female head of households represent 21.5%, and single-male head of households represent 13.7% (Figure 17).

Figure 15



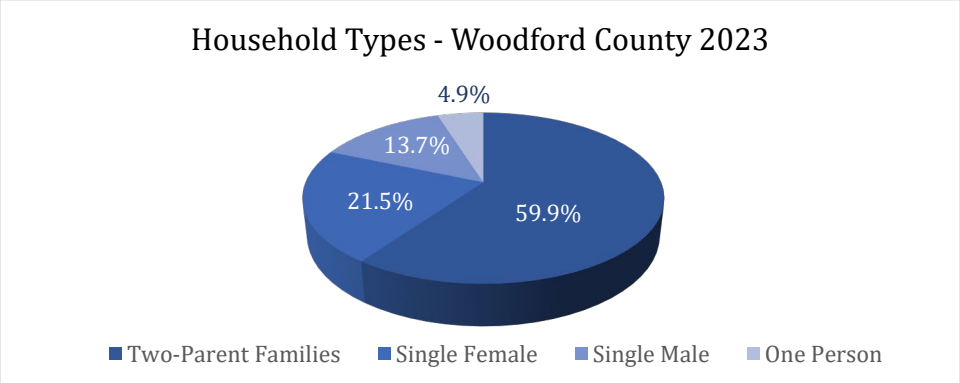
Source: United States Census Bureau

Figure 16



Source: United States Census Bureau

Figure 17

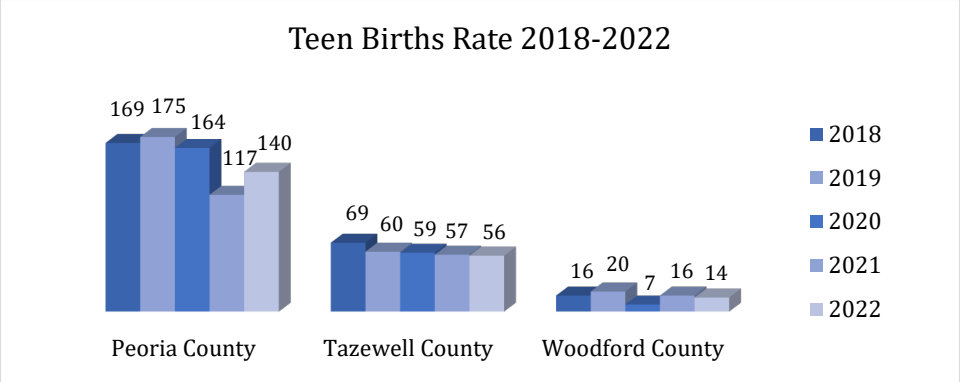


Source: United States Census Bureau

Early Sexual Activity Leading to Births from Teenage Mothers

From 2018 to 2022, the teen birth rate showed an overall decrease in Peoria (17%), Woodford (13%), and Tazewell Counties (19%). Although Peoria and Woodford experienced fluctuations, Tazewell exhibited a steady decline (Figure 18).

Figure 18



Source: Illinois Department of Public Health

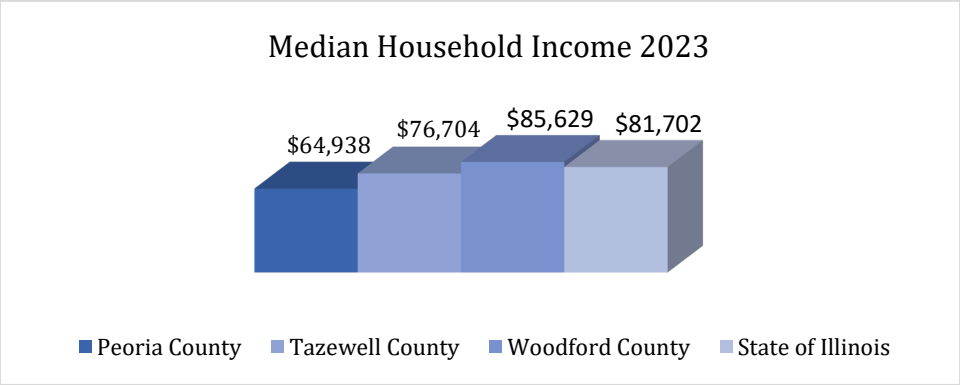
1.4 Economic Information

Importance of the Measure: Median income divides households into two segments, with one-half of households earning more than the median income and the other half earning less. Because median income is not significantly impacted by unusually high or low-income values, it is considered a more reliable indicator than average income. Living in poverty means lacking sufficient income to meet one's basic needs. Accordingly, poverty is associated with numerous chronic social, health, education, and employment conditions.

Median Income Level

In 2023, the median household income in Peoria ($64,938) and Tazewell Counties ($76,704) were lower than the State of Illinois amount ($81,702) (Figure 19). Woodford County ($85,629) had a median household income above the State of Illinois figure ($81,702).

Figure 19



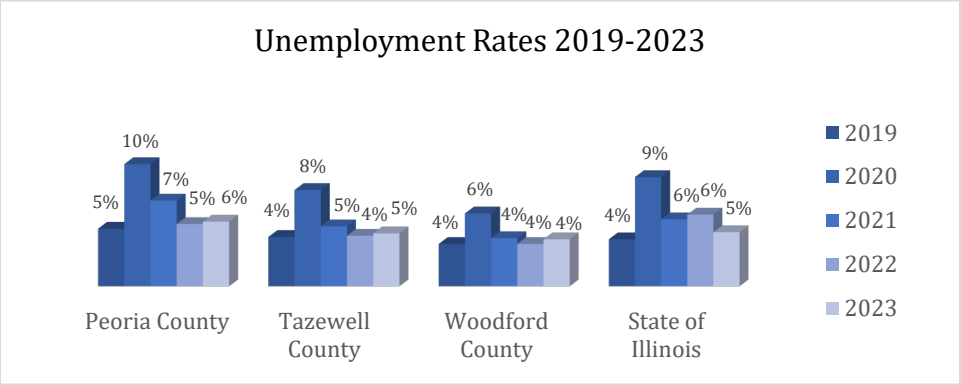
Source: United States Census Bureau

Unemployment

From 2019 through 2023, the Peoria County unemployment rate was higher than the State of Illinois unemployment rate, except during 2022. During the same period, the Tazewell County unemployment

rate was at or below the State of Illinois unemployment rate. Similarly, Woodford County maintained an unemployment rate at or below the State of Illinois unemployment rate from 2019 to 2023. Some of the increase in unemployment in 2020 may be attributed to the COVID-19 pandemic (Figure 20).

Figure 20

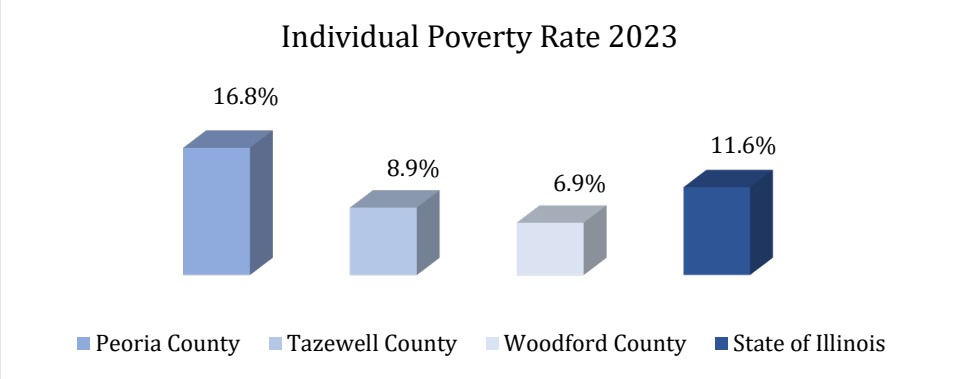


Source: Bureau of Labor Statistics

Individuals in Poverty

Poverty has a significant impact on the development of children and youth. Below is the poverty rate for all individuals across the Tri-County area for 2023. In Peoria County, the percentage of individuals living in poverty was 16.8%, which is higher than the State of Illinois individual poverty rate of 11.6%. In Tazewell County, the percentage of individuals living in poverty is 8.9%, which is lower than the State of Illinois poverty rate of 11.6%. In Woodford County, the percentage of individuals living in poverty is 6.9%, which is significantly lower than the State of Illinois poverty rate of 11.6% (Figure 21).

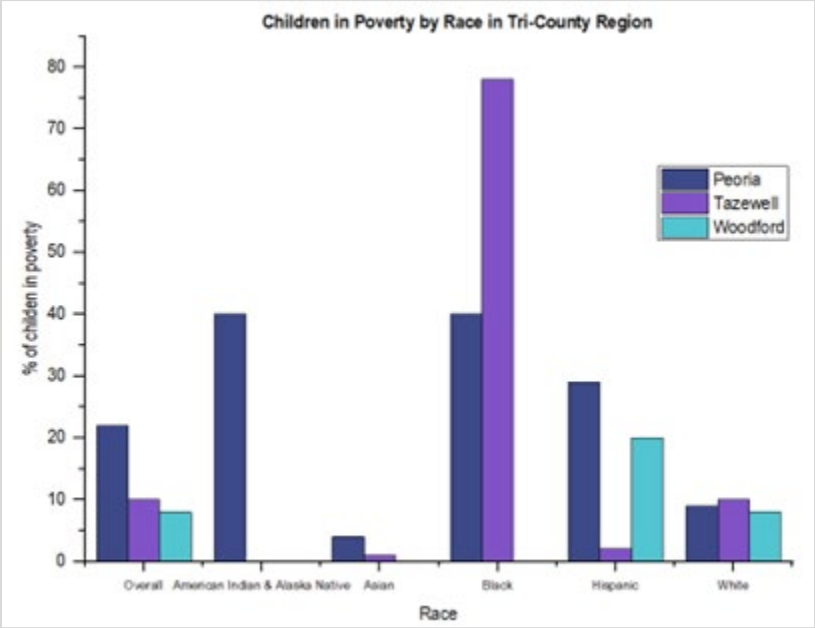
Figure 21



Source: United States Census Bureau

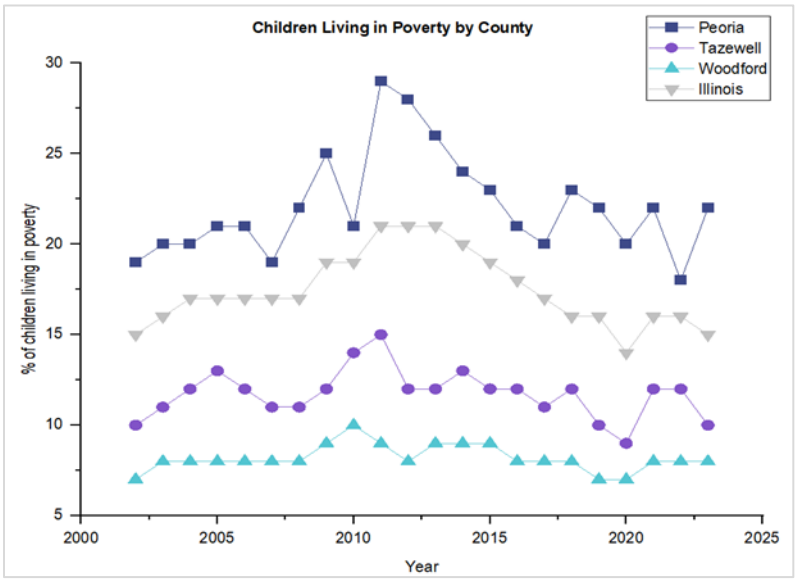
Understanding children living in poverty is crucial because poverty can lead to numerous health outcomes. Higher levels of children living in poverty can negatively impact population health and result in perpetual cycles of poor health and economic instability. The following figures depict the proportion of children living in poverty by county and race.

Figure 22



Source: United States Census Bureau

Figure 23



Source: United States Census Bureau

1.5 Education

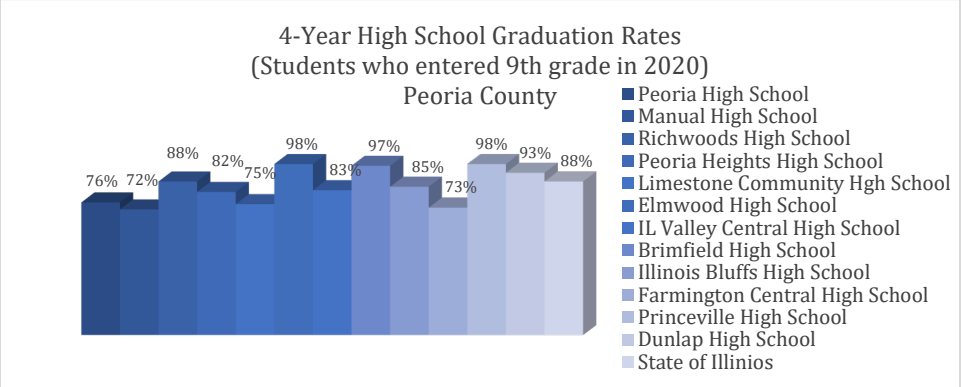
Importance of the Measure: According to the National Center for Educational Statistics, "The better educated a person is, the more likely that person is to report being in 'excellent' or 'very good' health, regardless of income." Research suggests that higher educational attainment and greater school success lead to better health outcomes and a higher likelihood of making healthy lifestyle choices. Consequently,

years of education are strongly related to an individual's propensity to earn a higher salary, secure better employment, and achieve multifaceted success in life.

Graduation Rates

Students who entered 9th grade in 2020 in Peoria County school districts, except Elmwood HS, Brimfield HS, Princeville HS, and Dunlap HS reported high school graduation rates that were at or below the State of Illinois average of 88% (Figure 24).

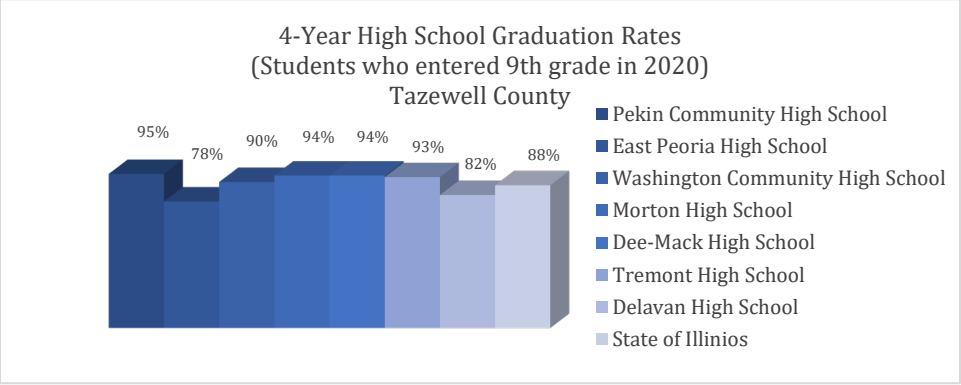
Figure 24



Source: Illinois Report Card

Students who entered 9th grade in 2020 in Tazewell County school districts, except East Peoria High School and Delavan High School, reported high school graduation rates that were above the State of Illinois average of 88% (Figure 25).

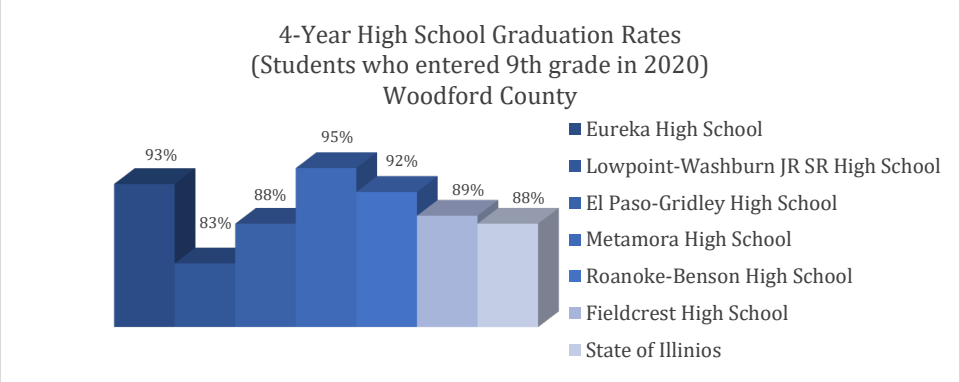
Figure 25



Source: Illinois Report Card

Students who entered 9th grade in 2020 in Woodford County school districts, except Lowpoint-Washburn JR SR High School reported high school graduation rates that were at or above the State of Illinois average of 88% (Figure 26).

Figure 26



Source: Illinois Report Card

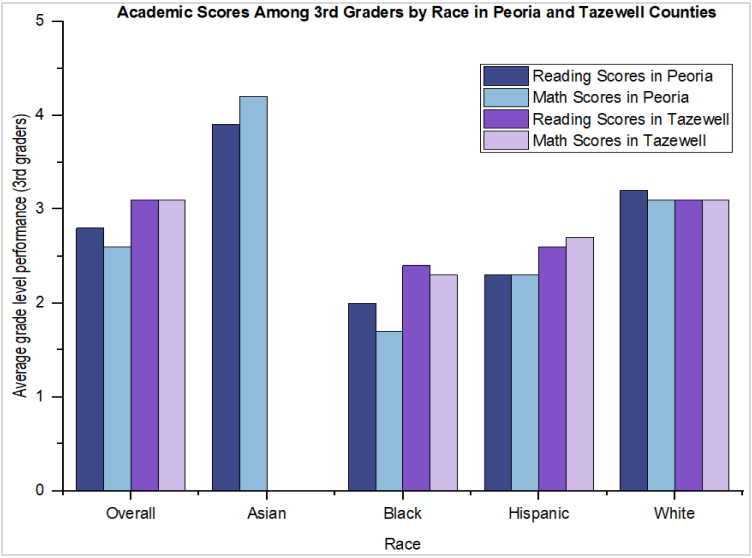
In addition to these graduation rates, the Stanford Education Data Archive collects and analyzes reading and math scores for 3rd graders across various districts and states. These scores provide insights into educational achievement and disparities that may exist. In particular, these scores provide the average grade level performance for these 3rd graders for reading and math-based data from 2019.

Table 1

Academic Score	Peoria County	Tazewell County	Woodford County	Illinois	United States
Reading	2.8	3.1	3.4	3.0	3.1
Math	2.6	3.	3.4	2.9	3.0

Source: Stanford Education Data Archive

Figure 27

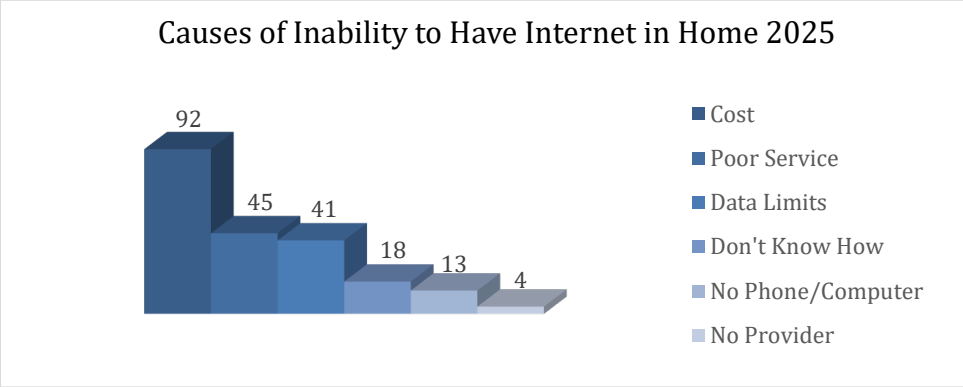


Source: Stanford Education Data Archive

1.6 Internet Accessibility

Survey respondents were asked if they had Internet access. Of respondents, 94% indicated they had Internet in their homes. For those who did not have Internet in their home, cost was the most frequently cited reason (92) (Figure 28). Note that these data are displayed in frequencies rather than percentages given the low number of responses.

Figure 28



Source: CHNA Survey

Social Drivers Related to Internet Access

Several factors show significant relationships with an individual's Internet access. The following relationships were found using correlational analyses:

- **Access to Internet** tends to be rated higher for women, younger people, those with higher education, those with higher income, and those in Woodford County. Access to Internet tends to be rated lower for those with an unstable housing environment and those in Peoria County.

1.7 Key Takeaways from Chapter 1

- ✓ **POPULATION DECREASED OVER THE LAST 5 YEARS.**
- ✓ **POPULATION OVER AGE 65 IS INCREASING.**
- ✓ **SINGLE FEMALE HEAD-OF-HOUSE-HOUSEHOLD WAS 21.5%, 27% AND 31.6% OF THE POPULATION FOR THE THREE COUNTIES. HISTORICALLY, THIS DEMOGRAPHIC INCREASES THE LIKELIHOOD OF FAMILIES LIVING IN POVERTY.**
- ✓ **NEARLY HALF OF THE HIGH SCHOOLS IN THE TRI-COUNTY AREA HAVE GRADUATION RATES AT OR LOWER THAN STATE OF ILLINOIS AVERAGES.**

CHAPTER 2 OUTLINE

CHAPTER 2: PREVENTION BEHAVIORS

2.1 Accessibility

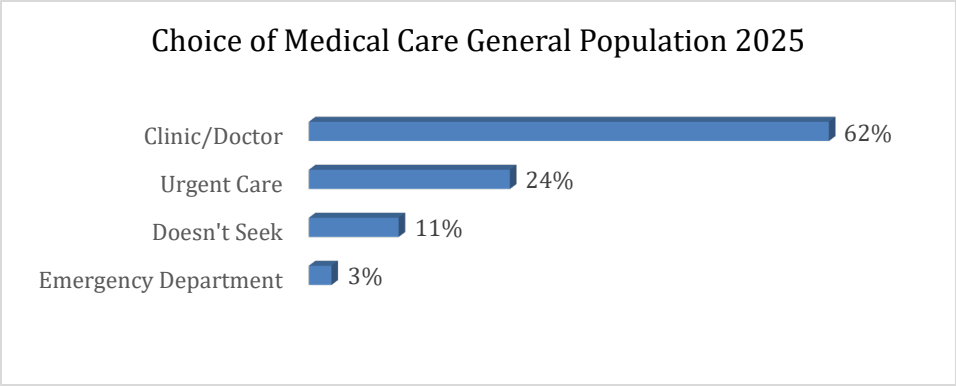
Importance of the Measure: It is critical for healthcare services to be accessible. Therefore, accessibility to healthcare must address both the associated financial costs and the supply and demand of medical services.

Choice of Medical Care

Survey respondents were asked to select the type of healthcare facility used when sick. Four different options were presented, including a clinic or doctor's office, urgent-care facility, did not seek medical treatment, and emergency department.

The most common response for source of medical care was clinic/doctor's office, chosen by 62% of survey respondents. This was followed by urgent care (24%), not seeking medical attention (11%), and the emergency department (3%) (Figure 29).

Figure 29



Source: CHNA Survey

Comparison to 2022 CHNA

Clinic/doctor's office decreased from 67% in 2022 to 62% in 2025. Much of this can be attributed to the increase in the use of urgent care facilities (20% in 2022 to 24% in 2025). While the percentage of people who did not seek medical treatment was 11% for 2022 and 2025, the emergency department slightly increased from 2% in 2022 to 3% in 2025.

Social Drivers Related to Choice of Medical Care

Several factors show significant relationships with an individual's choice of medical care. The following relationships were found using correlational analyses:

- **Clinic/Doctor's Office** tends to be used more often by women, older people, White people, those with higher income and people from Woodford County. Clinic/Doctor's office tends to be used less often by Black people, LatinX people, those with an unstable housing environment and people from Peoria County.

- **Urgent Care** tends to be used more by younger people, those with higher education, those with higher income, and people from Peoria County. Urgent care tends to be used less by people from Woodford County.

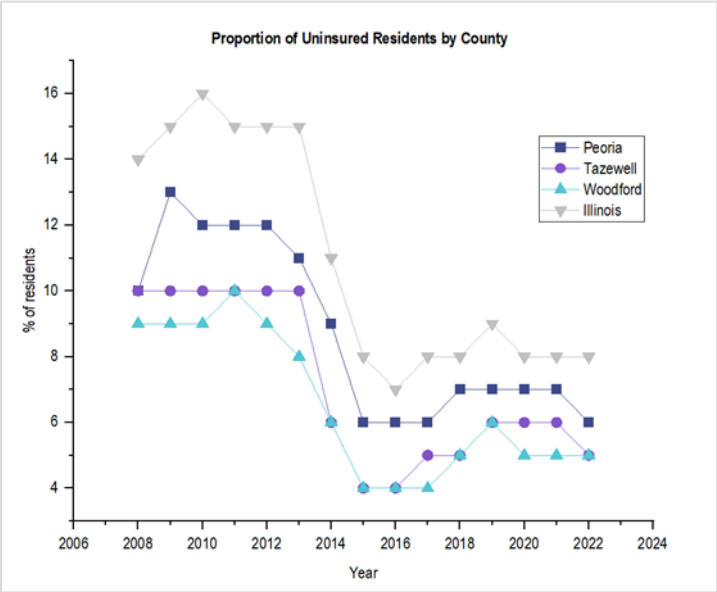
- **Emergency Department** tends to be used more often by men, Black people, LatinX people those with lower education, those with lower income, those with an unstable housing environment, and people from Peoria County. Emergency department tends to be used less by White people and people from Tazewell County.

- **Do Not Seek Medical Care** tend to be rated higher by men, younger people, Black people, those with lower education, those with lower income, and people from Peoria County. Does not seek medical care tends to be rated lower by White people.

Insurance Coverage

National estimates for the Tri-County region illustrate that the proportion of residents who are uninsured have decreased over time. Moreover, the proportion of residents uninsured in the Tri-County region remains lower than the State of Illinois levels (Figure 30).

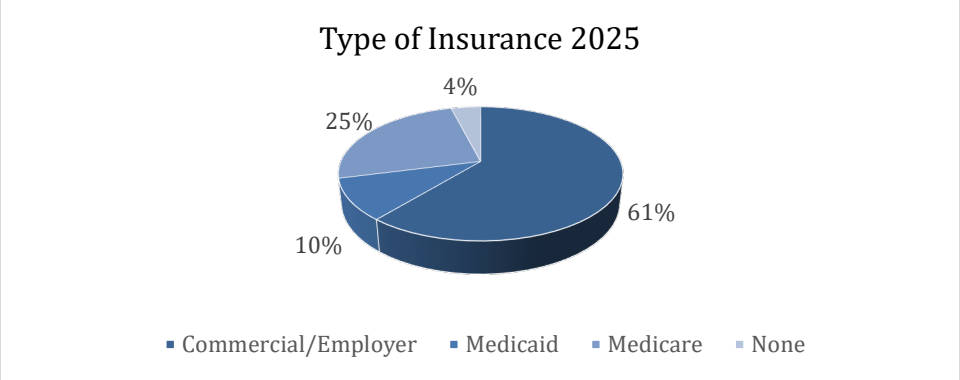
Figure 30



Source: United States Census Bureau

According to survey data, 61% of respondents are covered by commercial/employer insurance, followed by Medicare (25%), Medicaid (10%), and no insurance (4%) (Figure 31).

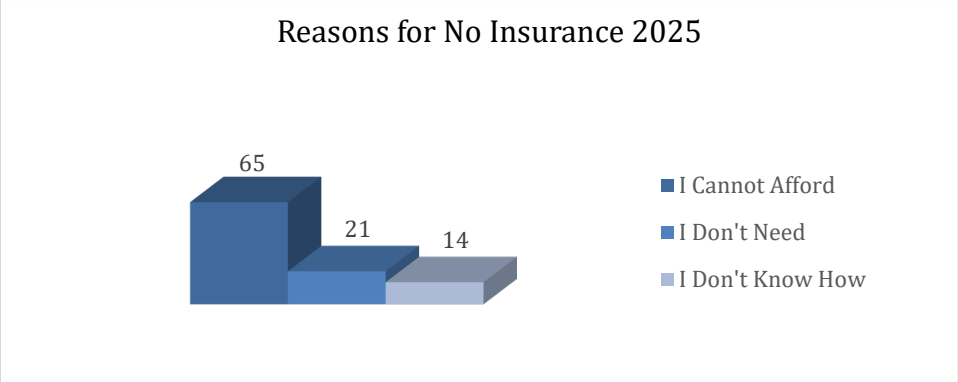
Figure 31



Source: CHNA Survey

Data from the survey show that for the 4% of individuals who do not have insurance, the most prevalent reason was cost (65) (Figure 32). Note that these data are displayed in frequencies rather than percentages given the low number of responses.

Figure 32



Source: CHNA Survey

Social Drivers Related to Type of Insurance

Several characteristics show significant relationships with an individual's type of insurance. The following relationships were found using correlational analyses:

- **Medicare** tends to be used more by older people, those with lower education, those with lower income, and people in Woodford County. Medicare tends to be used less often by residents of Peoria and Tazewell Counties.

- **Medicaid** tends to be used more frequently by younger people, Black people, those with lower education, those with lower income, and people with an unstable housing environment. Medicaid is used less by White people.

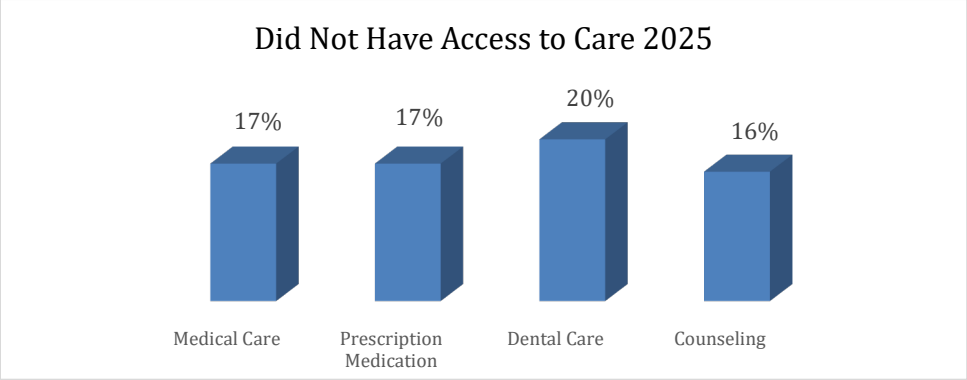
- **Commercial/employer insurance** is used more often by women, younger people, White people, those with higher education, those with higher income, and Tazewell County residents. Commercial/employer insurance is used less by Black people, those with an unstable housing environment, and Woodford County residents.

- **No Insurance** tends to be reported more often by younger people, Black people, LatinX people, those with lower education, those with lower income, those with an unstable housing environment, and residents of Peoria. No insurance tends to be reported less often by White people.

Access to Care

In the CHNA survey, respondents were asked, "Was there a time when you needed care but were not able to get it?" Access to four types of care were assessed: medical care, prescription medication, dental care, and counseling. Survey results show that 17% of the population did not have access to medical care when needed; 17% of the population did not have access to prescription medication when needed; 20% of the population did not have access to dental care when needed; and 16% of the population did not have access to counseling when needed (Figure 33).

Figure 33



Source: CHNA Survey

Social Drivers Related to Access to Care

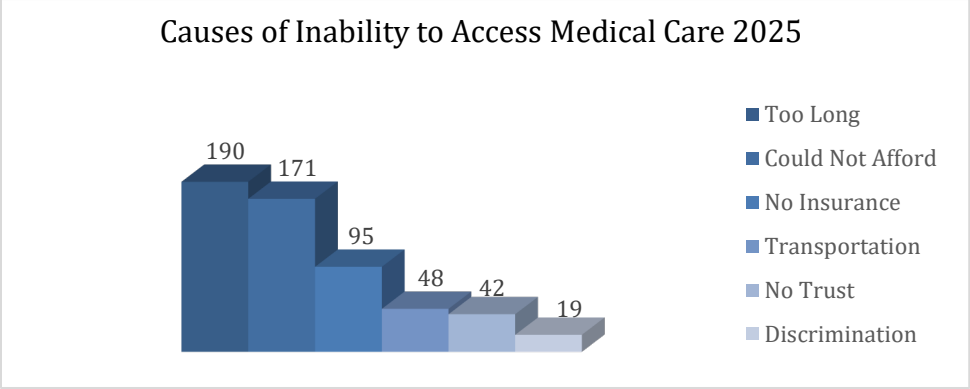
Several characteristics show a significant relationship with an individual's ability to access care when needed. The following relationships were found using correlational analyses:

- **Access to medical care** tends to be higher for older people, White people, those with higher education, those with higher income, and residents of Woodford County. Access to medical care tends to be lower for Black people, LatinX people, and those with an unstable housing environment.
- **Access to prescription medications** tends to be higher for men, older people, White people, those with higher education, those with higher income and residents of Woodford County. Access to prescription medications tends to be lower for those with an unstable housing environment.
- **Access to dental care** tends to be higher for men, older people, White people, those with higher education, and those with higher income. Access to dental care tends to be lower for Black people and those with an unstable housing environment.
- **Access to counseling** tends to be higher for men, older people, White people, those with higher income and those with a stable housing environment. Access to counseling tends to be lower for those with an unstable housing environment.

Reasons for No Access – Medical Care

Survey respondents who reported they were not able to get medical care when needed were asked a follow-up question. Based on frequencies, the leading causes of the inability to gain access to medical care were too long to wait for an appointment (190), could not afford co-pay (171), and no insurance (95) (Figure 34).

Figure 34

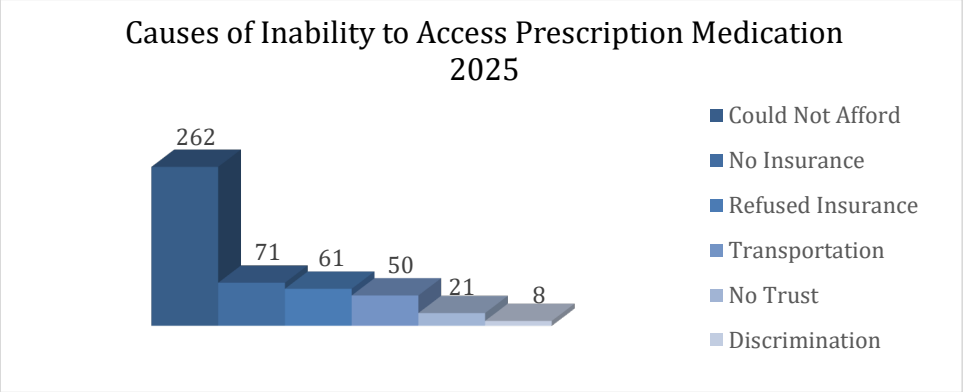


Source: CHNA Survey

Reasons for No Access – Prescription Medication

Survey respondents who reported they were not able to get prescription medication when needed were asked a follow-up question. Based on frequencies, the leading cause of the inability to gain access to prescription medicine was the inability to afford copayments or deductibles (262) (Figure 35).

Figure 35

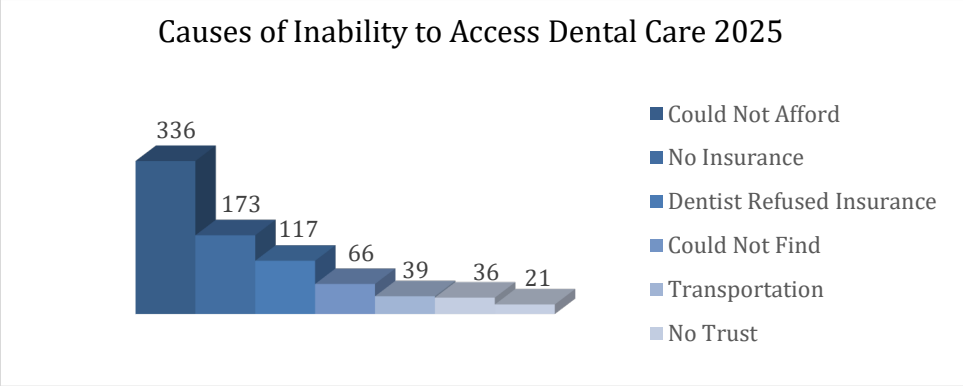


Source: CHNA Survey

Reasons for No Access – Dental Care

Survey respondents who reported they were not able to get dental care when needed were asked a follow-up question. Based on frequencies, the leading causes were inability to afford copay or deductible (336), no insurance (173), and dentist refusal of insurance (117) (Figure 36).

Figure 36

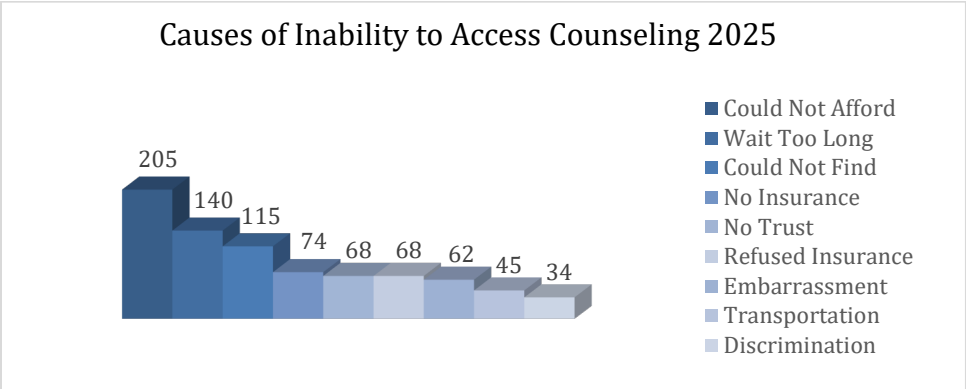


Source: CHNA Survey

Reasons for No Access – Counseling

Survey respondents who reported they were not able to get counseling when needed were asked a follow-up question. Based on frequencies, the leading causes of the inability to gain access to counseling were the inability to afford co-pay (205), wait was too long (140) and could not find counselor (115) (Figure 37).

Figure 37



Source: CHNA Survey

Comparison to 2022 CHNA

Access to Medical Care - results show a decline in the percentage of people who were able to obtain medical care, decreasing from 90% in 2022 to 83% in 2025.

Access to Prescription Medication - results show a decline in the percentage of people who were able to obtain prescription medication, decreasing from 88% in 2022 to 83% in 2025.

Access to Dental Care - results show a slight decline in the percentage of people who were able to obtain dental care, decreasing from 81% in 2022 to 80% in 2025.

Access to Counseling - results show an improvement in the percentage of people who were able to obtain counseling, from 80% in 2022, to 84% in 2025.

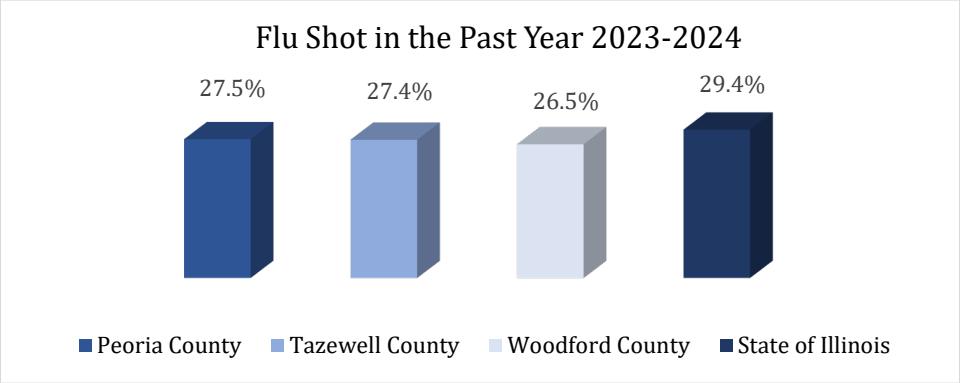
2.2 Wellness

Importance of the Measure: The overall health of a community is impacted by preventative measures, including immunizations and vaccinations. Preventative healthcare measures, such as getting a flu shot, engaging in a healthy lifestyle, and undertaking screenings for diseases, are essential to combating morbidity and mortality while reducing healthcare costs.

Frequency of Flu Shots

Figure 38 shows that, from the period 2023 to 2024, 27.5% of people in Peoria County received a flu shot, 27.4% of people in Tazewell County received a flu shot, and 26.5% of people in Woodford County received a flu shot. All three counties report lower than the State of Illinois average of 29.4%.

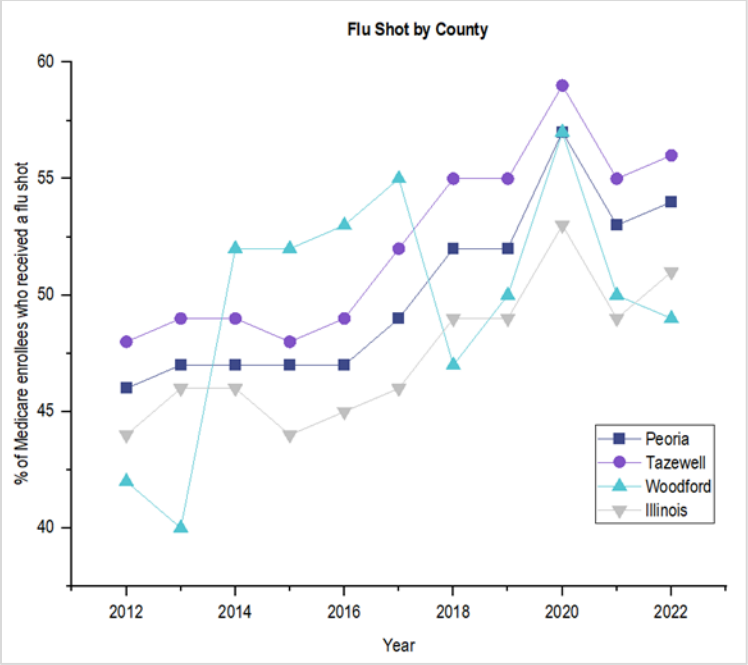
Figure 38



Source: Illinois Department of Health

Given that older adults are at higher risk of mortality due to influenza and other respiratory illnesses, it is essential to understand the uptake of such prevention measures, such as receiving a flu shot. The figure below depicts the prevalence of Medicare enrollees who received a flu shot between 2012-2022 by county. Over this time period the proportion of Medicare enrollees increased with the highest proportion of residents being in Tazewell, Peoria, followed by Woodford (Figure 39).

Figure 39

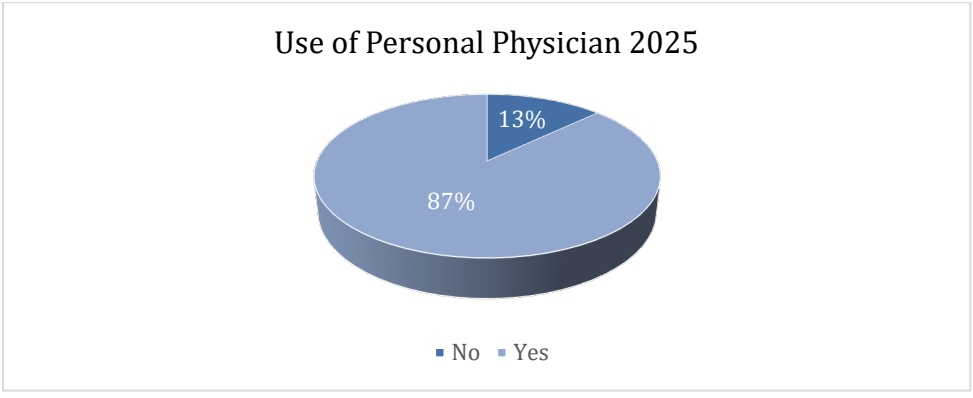


Source: Centers for Medicare & Medicaid Services (CMS)

Personal Physician

The CHNA survey asked respondents if they had a personal physician. Having a personal physician suggests that individuals are more likely to get wellness check-ups and less likely to use an emergency department as a primary healthcare service. According to survey data, 87% of residents have a personal physician (Figure 40).

Figure 40



Source: CHNA Survey

Comparison to 2022 CHNA

Results show that the percentage of people with a personal physician were 87% in both 2022 and 2025.

Social Drivers Related to Having a Personal Physician

The following characteristics show significant relationships with having a personal physician. The following relationships were found using correlational analyses:

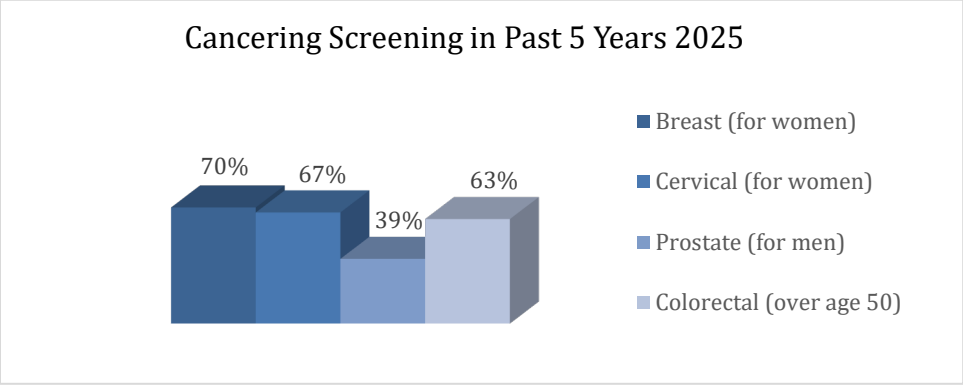
- **Having a personal physician** tends to be higher for women, older people, White people, those with higher education, those with a higher income, and residents of Woodford County. Having a personal physician tends to be lower for Black people, LatinX people, those with an unstable housing environment, and those residents of Peoria County.

Cancer Screening

Early detection of cancer may greatly improve the probability of successful treatment. In the case of colorectal cancer, early detection of precancerous polyps can prevent cancer. Specifically, four types of cancer screening were measured: breast, cervical, prostate, and colorectal.

Results from the CHNA survey show that 70% of women had a breast screening and 67% of women had a cervical screening in the past five years. For men, 39% had a prostate screening in the past five years. For women and men over the age of 50, 63% had a colorectal screening in the last five years (Figure 41).

Figure 41

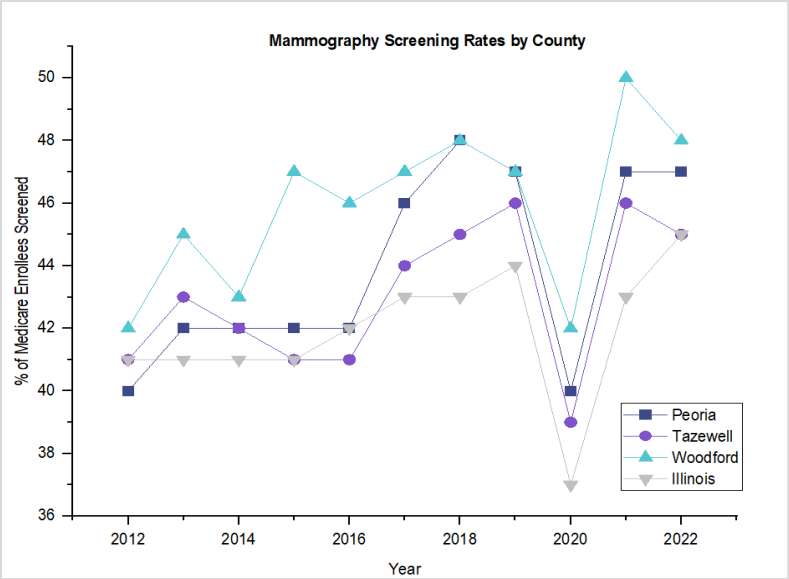


Source: CHNA Survey

Mammography screening rates for the Tri-County region are higher than state averages for most years between 2012-2022. Although screening rates were low during the COVID-19 pandemic, they substantially increased in following years across the region. The counties with the highest proportion of Medicare enrollees who were screened for breast cancer by mammography were Woodford, Peoria,

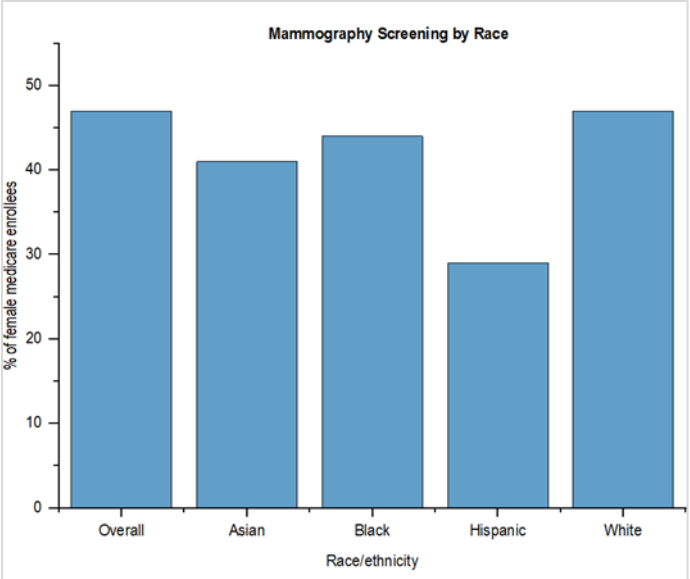
followed by Tazewell (Figure 42). Additional differences are noted by race for this measure as well, with a lower proportion of Hispanic, Asian, and Black females that are Medicare enrollees (Figure 43).

Figure 42



Source: Centers for Medicare & Medicaid Services (CMS)

Figure 43



Source: Centers for Medicare & Medicaid Services (CMS)

Comparison to 2022 CHNA

Cancer screening rates from 2022 to 2025 remained relatively stable. Specifically:

In 2022 and 2025, 70% of women had a breast screening.

Cervical screenings for women decreased, from 72% in 2022, to 67% in 2025.

Prostate screenings for men increased, from 35% in 2022 to 39% in 2025.

Colorectal screenings for men and women over the age of 50 remained constant at 63% in both 2022 and 2025.

Social Drivers Related to Cancer Screenings

Multiple characteristics show significant relationships with cancer screening. The following relationships were found using correlational analyses:

- **Breast screening** tends to be more likely for older women, White women, those with higher education, and those with higher income. Breast cancer screening tends to be lower Black women, LatinX women, and those with an unstable housing environment.
- **Cervical screening** tends to be more likely for younger women, White women, those with higher education, those with higher income, and women from Woodford County. Cervical cancer screening tends to be lower for Black women and those with an unstable housing environment.
- **Prostate screening** tends to be more likely for older men, White men, those with higher education, and those with higher income. Prostate screening is less likely for men from Tazewell County.
- **Colorectal screening** tends to be more likely for older people, White people, those with higher education, those with higher income, and those from Woodford County. Colorectal screening tends to be less likely for Black people, LatinX people, those with an unstable housing environment, and residents of Peoria County.

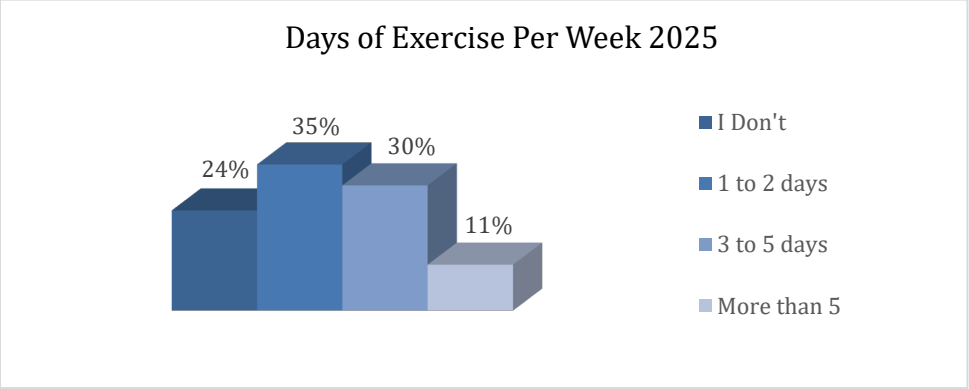
Physical Exercise

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

Prevalence estimates from national surveillance (2022 BRFSS) assess the percentage of adults age 18 and over who report no leisure-time physical activity. Higher rates of physical inactivity are estimated for Peoria (25%) compared to state (22%) and national (23%) estimates. Tazewell and Woodford Counties have similar estimates of physical inactivity at 21% and 22%, respectively.

Specifically, 24% of respondents indicated that they do not exercise at all, while the majority (65%) of residents, exercise 1-5 times per week (Figure 44).

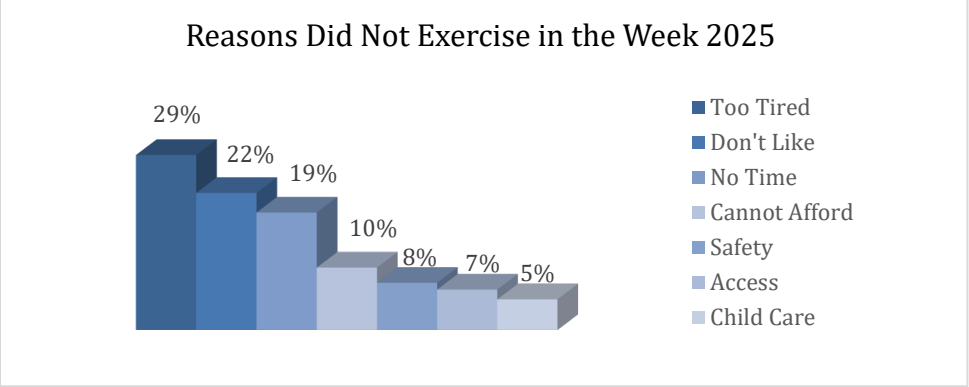
Figure 44



Source: CHNA Survey

To find out why some residents do not exercise at all, a follow up question was asked. The most common reasons for not exercising are being too tired (29%), dislike of exercise (22%), and not having enough time (19%) (Figure 45).

Figure 45



Source: CHNA Survey

Comparison to 2022 CHNA

There has been an increase in exercise. In 2022, 72% of residents indicated they exercised, compared to 76% in 2025.

Social Drivers Related to Exercise

One characteristic shows a significant relationship with frequency of exercise. The following relationships were found using correlational analyses:

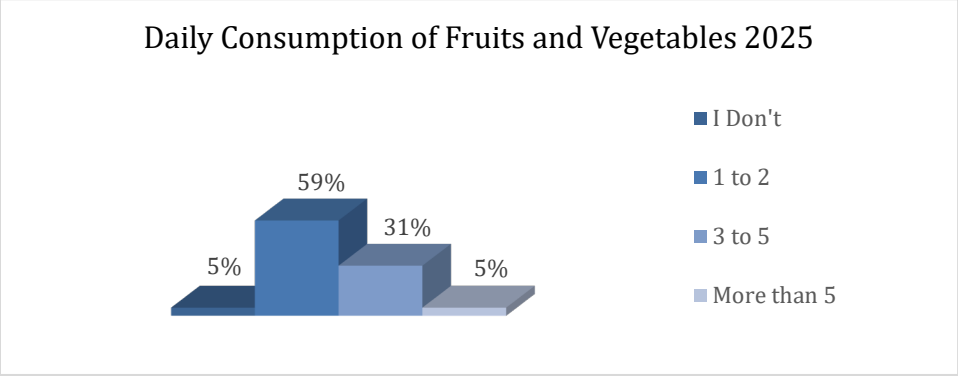
- **Frequency of exercise** tends to be rated higher for those with higher education and those with higher income. Frequency of exercise tends to be rated lower for those with an unstable housing environment.

Healthy Eating

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

Two-thirds (64%) of residents report no consumption or low consumption (1-2 servings per day) of fruits and vegetables per day. Note that the percentage of residents who consume five or more servings per day is only 5% (Figure 46).

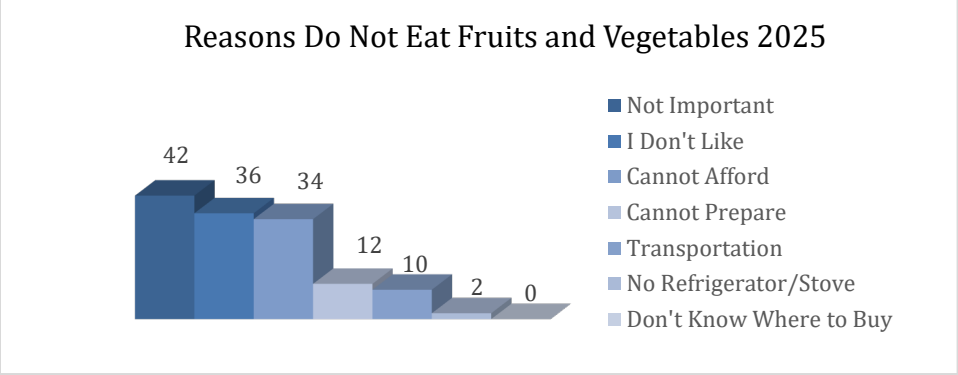
Figure 46



Source: CHNA Survey

Those individuals who indicated they do not eat any fruits or vegetables were asked a follow up question. The most frequently cited reasons for failing to eat more fruits and vegetables are lack of importance (42), dislike (36), and inability to afford (34) (Figure 47).

Figure 47



Source: CHNA Survey

Comparison to 2022 CHNA

There has been an increase in the frequency of healthy eating. In 2022, 33% of respondents indicated they had three or more servings of fruits and vegetables per day, compared to 36% in 2025.

Social Drivers Related to Healthy Eating

Multiple characteristics show significant relationships with healthy eating. The following relationships were found using correlational analyses:

- **Consumption of fruits and vegetables** tends to be more likely for women, older people, those with higher education, and those with higher income. Consumption of fruits and vegetables tends to be less likely for those with an unstable housing environment.

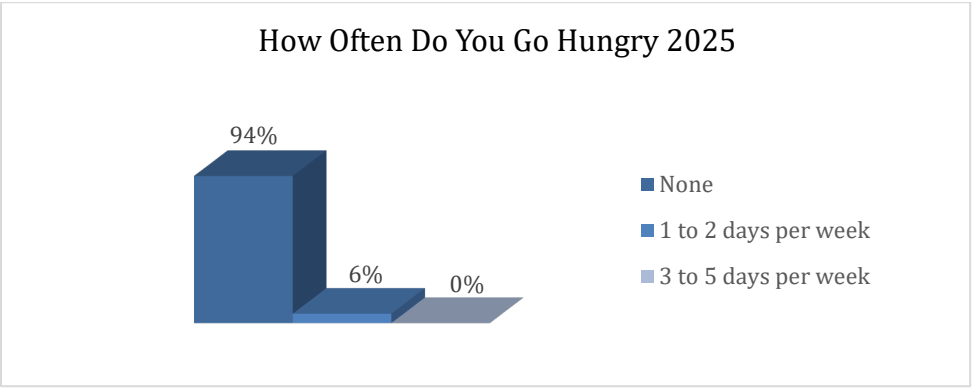
2.3 Understanding Food Insecurity

Importance of the measure: It is essential that everyone has access to food and drink necessary for living healthy lives. Food insecurity exists when people don't have physical and economic access to sufficient, safe and nutritious food that meets their dietary needs for a healthy life.

Prevalence of Hunger

Respondents were asked, "How many days a week do you or your family members go hungry?" The vast majority of respondents indicated they do not go hungry (94%); however, 6% indicate they go hungry between 1 and 2 days per week (Figure 48).

Figure 48



Source: CHNA Survey

Comparison to 2022 CHNA

There has been an increase in people who experience hunger. Specifically, in 2022, 3% of respondents indicated they go hungry, compared to 6% in 2025.

Social Drivers Related to Prevalence of Hunger

Multiple characteristics show significant relationships with hunger. The following relationships were found using correlational analyses:

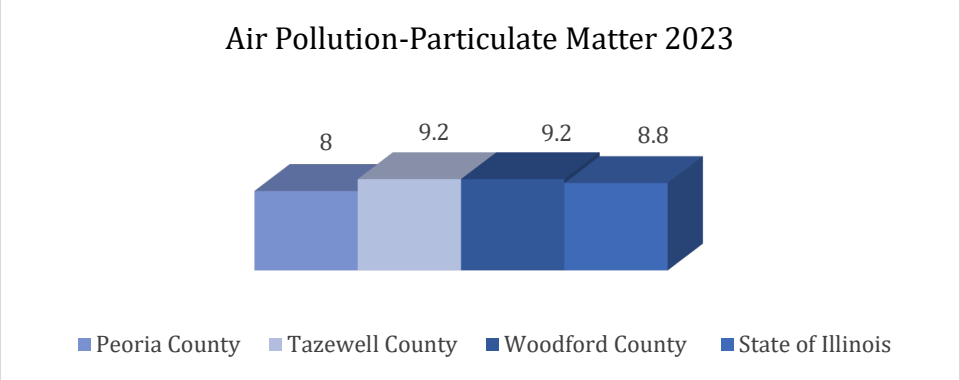
- **Prevalence of Hunger** tends to be higher for Black people and those with an unstable housing environment. Prevalence of hunger tends to be less likely for White people, those with higher education, those with higher income, and residents of Woodford County.

2.4 Physical Environment

Importance of the Measure: According to the County Health Rankings & Roadmaps, Air Pollution - Particulate Matter (APPM) is the average daily density of fine particulate matter in micrograms per cubic meter (PM2.5) in a county. Fine particulate matter is defined as particles of air pollutants with an aerodynamic diameter less than 2.5 micrometers. These particles can be directly emitted from sources such as forest fires, or they can form when gases are emitted from power plants, manufacturing facilities and automobiles.

The relationship between elevated air pollution, particularly fine particulate matter and ozone, and compromised health has been well documented. Negative consequences of ambient air pollution include decreased lung function, chronic bronchitis, asthma and other adverse pulmonary effects. The APPM for Peoria County (8) is lower than the State of Illinois average (8.8), while Tazewell and Woodford Counties (9.2) are each higher than the State of Illinois average (8.8) (Figure 49).

Figure 49



Source: County Health Rankings & Roadmaps

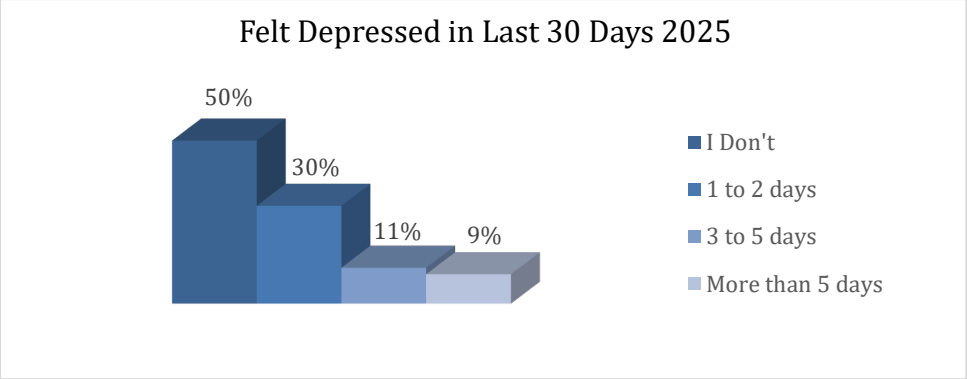
2.5 Health Status

Importance of the Measure: Self-perceptions of health can provide important insights to help manage population health. These perceptions not only provide benchmarks regarding health status but also offer insights into how accurately people perceive their own health.

Mental Health

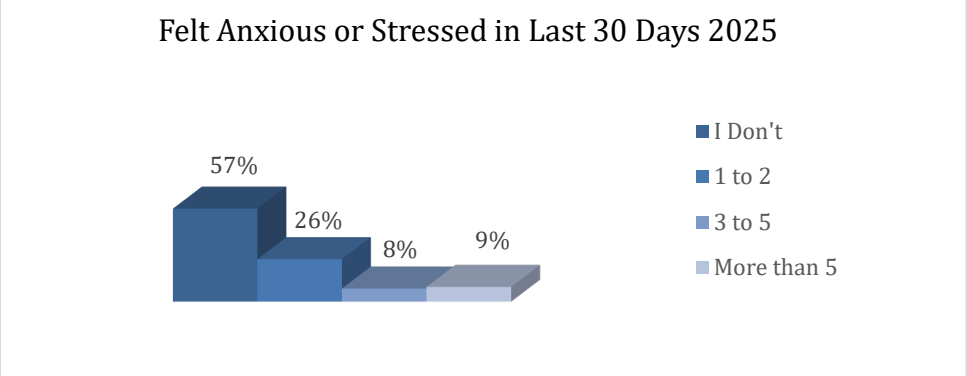
The survey asked respondents to indicate specific issues, such as depression and stress/anxiety. Of respondents, 50% indicated they did not feel depressed in the last 30 days (Figure 50) and 57% indicated they did not feel anxious or stressed (Figure 51).

Figure 50



Source: CHNA Survey

Figure 51



Source: CHNA Survey

Comparison to 2022 CHNA

There has been an improvement in mental health. In 2022, 58% of respondents indicated they felt depressed in the last 30 days, compared to 50% in 2025. In 2022, 52% of respondents indicated they felt stressed or anxious in the last 30 days, compared to 43% in 2025.

Social Drivers Related to Behavioral Health

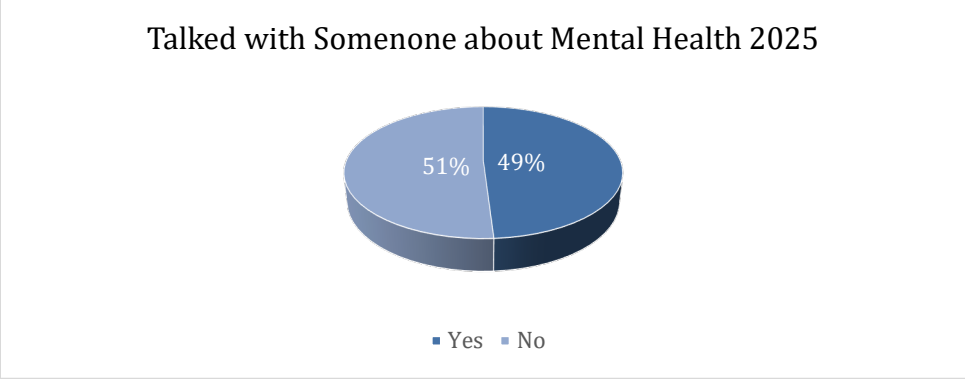
Multiple characteristics show significant relationships with behavioral health. The following relationships were found using correlational analyses:

- **Depression** tends to be rated higher for women, younger people, those with lower income, those with an unstable housing environment, and residents of Peoria County. Depression tends to be rated lower by residents of Woodford County.

- **Stress and anxiety** tend to be rated higher for women, younger people, those with lower education, those with lower income, and those with an unstable housing environment. Stress and anxiety tend to be rated lower by residents of Woodford County.

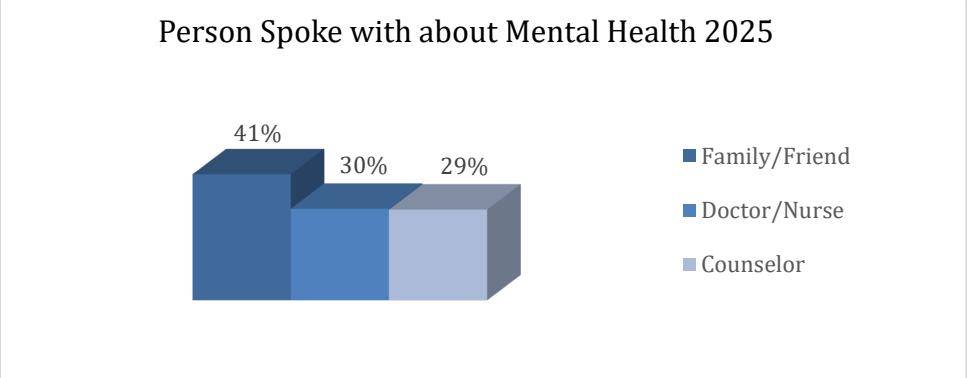
Respondents were asked if they spoke with anyone about their mental health in the past year. Of respondents, 49% indicated that they spoke to someone (Figure 52), with the most common response being a family member or friend (41%) (Figure 53).

Figure 52



Source: CHNA Survey

Figure 53



Source: CHNA Survey

Social Drivers Related to Behavioral Health

Multiple characteristics show significant relationships with behavioral health. The following relationships were found using correlational analyses:

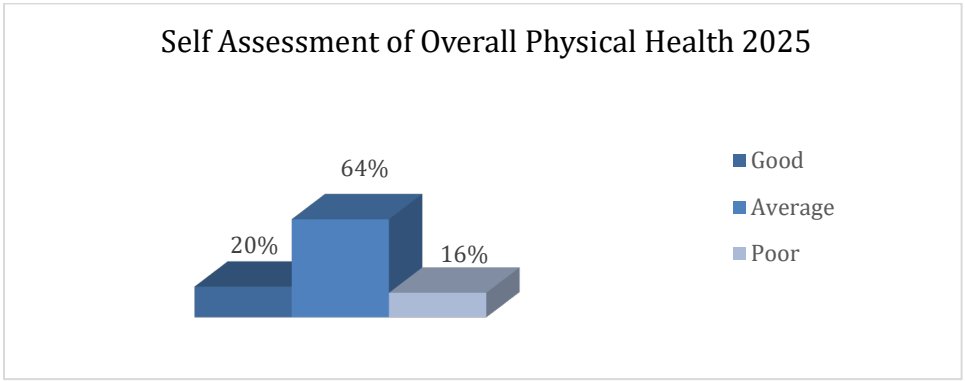
- **Depression** tends to be rated higher for women, young people, those with lower income, those in an unstable housing environment, and residents who live in Peoria County. Depression tends to be rated lower for residents of Woodford County.

- **Stress and anxiety** tend to be rated higher for young people, women, those with lower income, and those in an unstable housing environment. Stress and anxiety tend to be rated lower for residents of Woodford County.

Self-Perceptions of Overall Health

In regard to self-assessment of overall physical health, 16% of respondents report having poor physical health (Figure 54).

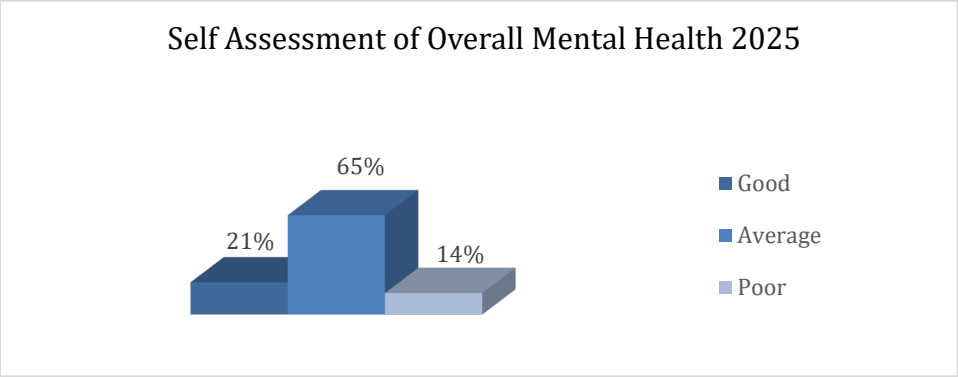
Figure 54



Source: CHNA Survey

In regard to self-assessment of overall mental health, 14% of respondents stated they have poor overall mental health (Figure 55).

Figure 55



Source: CHNA Survey

Comparison to 2022 CHNA

In terms of physical health, 16% of respondents reported being in poor health in both 2022 and 2025. Regarding mental health, fewer people saw themselves in poor health in 2025 (14%), compared to 2022 (16%).

Social Drivers Related to Self-Perceptions of Health

Multiple characteristics show significant relationships with self-perceptions of health. The following relationships were found using correlational analyses:

- **Perceptions of physical health** tend to be more positive for older people, White people, those with higher education, and those with higher income. Perceptions of physical health tend to be less positive for Black people and those with an unstable housing environment.

- **Perceptions of mental health** tend to be more positive for men, older people, those with higher education, those with higher income, and residents of Woodford County. Perceptions of mental health tend to be less positive for Black people, LatinX people, and those with an unstable housing environment.

2.6 Key Takeaways from Chapter 2

- ✓ **INCREASED UTILIZATION OF URGENT CARE AND EMERGENCY DEPARTMENT AS A PRIMARY SOURCE OF HEALTHCARE.**
- ✓ **INCREASED RATE OF PEOPLE WHO DO NOT HAVE ACCESS TO MEDICAL CARE, PRESCRIPTION MEDICATION, AND DENTAL CARE.**
- ✓ **ACCESS TO COUNSELING HAS IMPROVED.**
- ✓ **PROSTATE SCREENING IS RELATIVELY LOW COMPARED TO OTHER TYPES OF CANCER SCREENING.**
- ✓ **THE MAJORITY OF PEOPLE EXERCISE LESS THAN 2 TIMES PER WEEK AND CONSUME 2 OR FEWER SERVINGS OF FRUITS/VEGETABLES PER DAY.**
- ✓ **THERE WAS A DECREASE IN PEOPLE WHO EXPERIENCE DEPRESSION AND IN PEOPLE WHO EXPERIENCE STRESS/ANXIETY AS WELL AS A DESCREASE IN THOSE WHO SEE THEMSELVES IN POOR HEALTH.**
- ✓ **PREVALENCE OF HUNGER HAS INCREASED.**

CHAPTER 3 OUTLINE

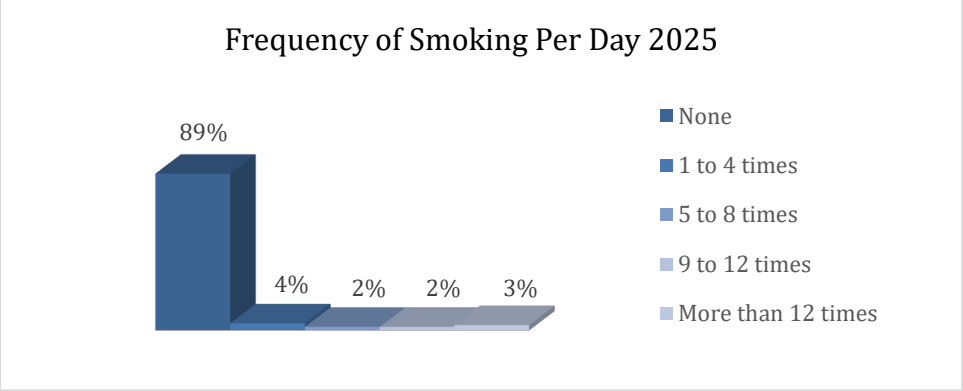
CHAPTER 3: SYMPTOMS AND PREDICTORS

3.1 Tobacco Use

Importance of the Measure: To appropriately allocate healthcare resources, a thorough analysis of the leading indicators regarding morbidity and disease must be conducted. In this way, healthcare organizations can target affected populations more effectively. Research suggests that tobacco use facilitates a wide variety of adverse medical conditions.

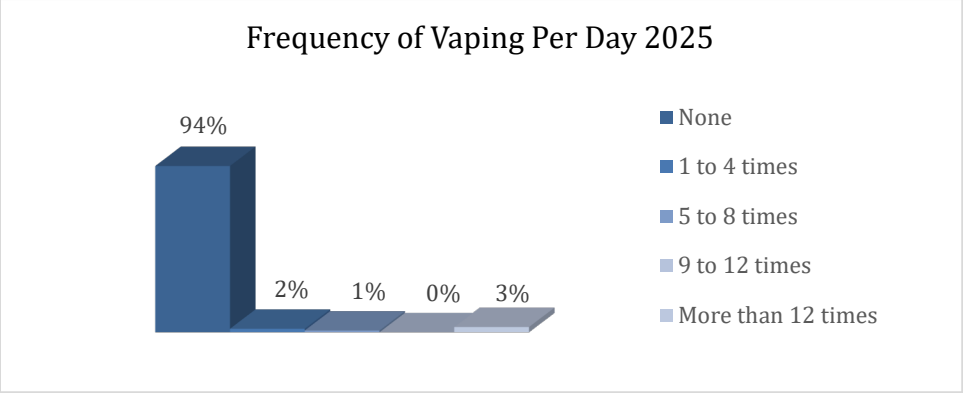
CHNA survey data show 89% of respondents do not smoke, and 3% state they smoke more than 12 times per day (Figure 56). Additionally, 94% of respondents do not vape, and 3% state they vape more than 12 times per day (Figure 57).

Figure 56



Source: CHNA Survey

Figure 57



Source: CHNA Survey

Comparison to 2022 CHNA

Results between 2022 and 2025 show that smoking rates have remained relatively constant, with 11% of respondents reporting they smoke. Comparatively, vaping rates have increased. In 2022, 4% of respondents indicated they vape, compared to 6% in 2025.

Social Drivers Related to Smoking or Vaping

Multiple characteristics show significant relationships with smoking or vaping. The following relationships were found using correlational analyses:

- **Smoking** tends to be rated higher by Black people, those with lower education, those with lower income, and those with an unstable housing environment. Smoking tends to be rated lower by White people.
- **Vaping** tends to be rated higher by younger people, those with lower education, those with lower income, and those in an unstable housing environment.

3.2 Drug and Alcohol Use

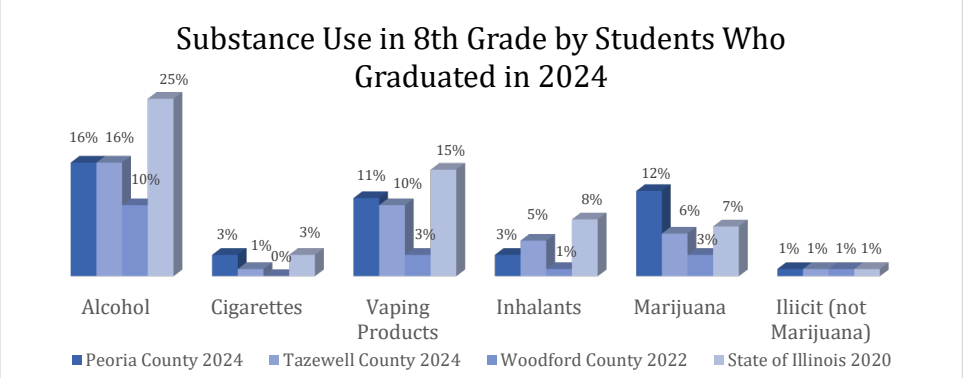
Importance of the Measure: Alcohol and drugs impair decision-making, often leading to adverse consequences and outcomes. Research suggests that alcohol is a gateway drug for youth, leading to increased usage of controlled substances in adulthood. Accordingly, the substance use values and behaviors of high school students are a leading indicator of adult substance use.

Youth Substance Use

Data from the Illinois Youth Survey measures illegal substance use (alcohol, tobacco, and other drugs – mainly marijuana) among adolescents. Peoria County and Tazewell County data is reported for 2024, Woodford County data is reported for 2022, and the State of Illinois data is reported for 2020.

Peoria County rates are at or below the State of Illinois averages in all categories among 8th graders, except for marijuana. Tazewell County rates are below the State of Illinois averages in all categories among 8th graders, except Illicit drugs, which is the same rate. Woodford County rates are below the State of Illinois averages in all categories among 8th graders, except illicit drugs, which is the same rate (Figure 58).

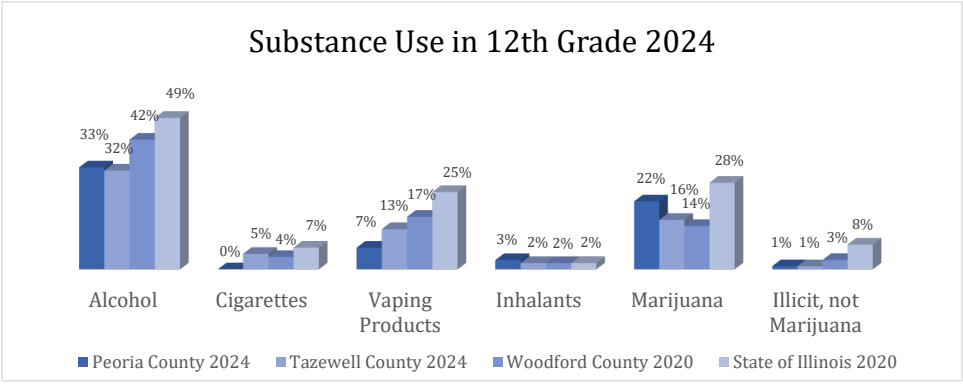
Figure 58



Source: University of Illinois Center for Prevention Research and Development

Among 12th graders, Peoria County rates are below the State of Illinois averages in all categories except inhalants, which is slightly higher. Tazewell County rates are below the State of Illinois averages in all categories among 12th graders, except inhalants, which is the same. Woodford County rates are below the State of Illinois averages in all categories among 12th graders, except inhalants, which is the same (Figure 59).

Figure 59

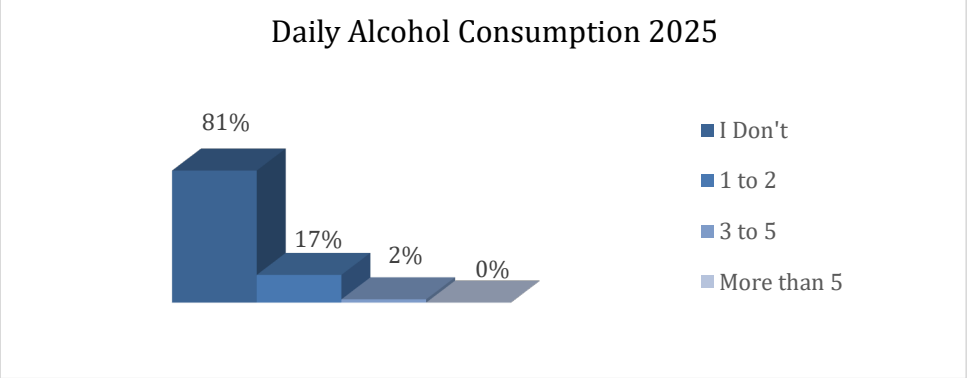


Source: University of Illinois Center for Prevention Research and Development

Adult Substance Use

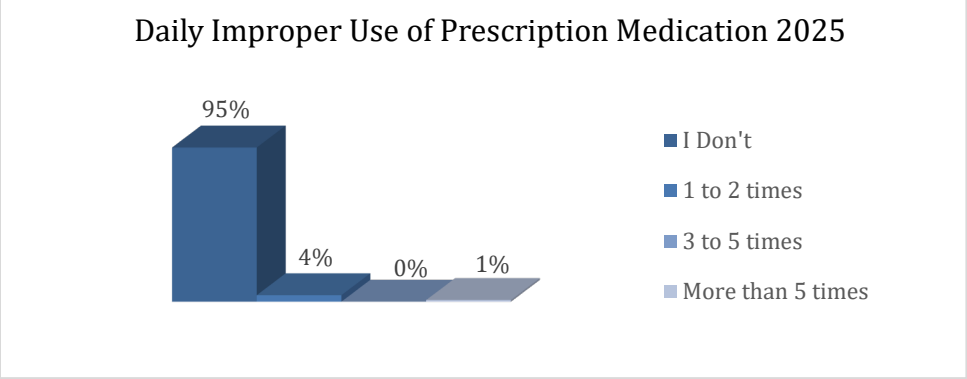
The CHNA survey asked respondents to indicate usage of several substances. Of respondents, 81% indicated they did not consume alcohol on a typical day (Figure 60); 95% indicated they do not take prescription medication improperly on a typical day (Figure 61); 92% indicated they do not use marijuana on a typical day (Figure 62); and 99% indicated they do not use illegal substances on a typical day (Figure 63).

Figure 60



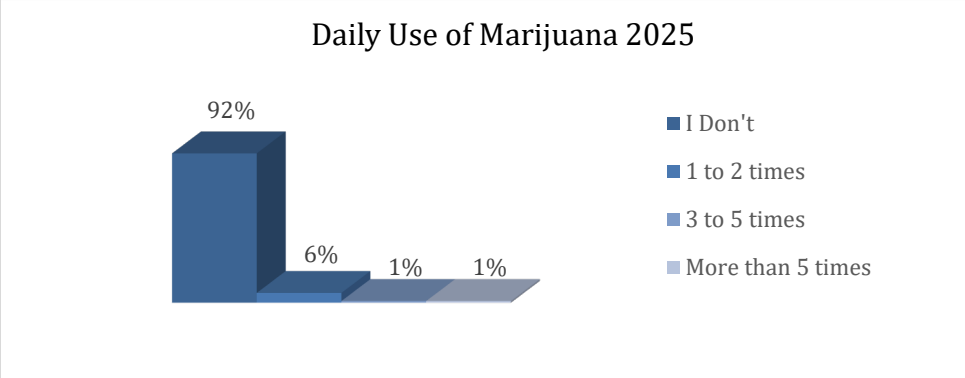
Source: CHNA Survey

Figure 61



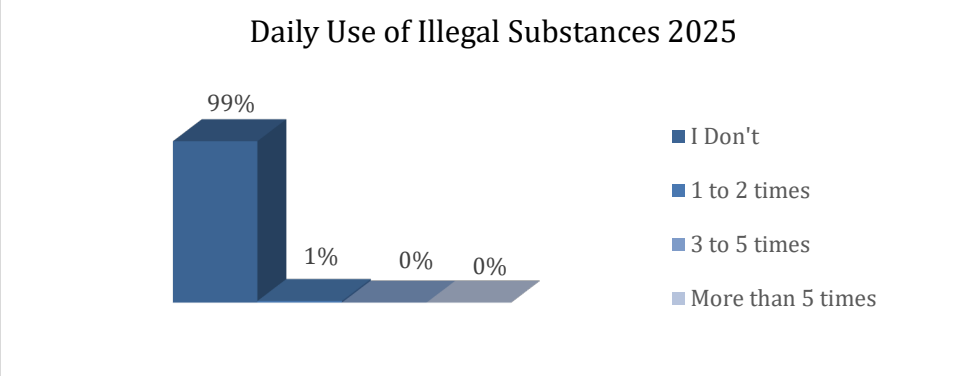
Source: CHNA Survey

Figure 62



Source: CHNA Survey

Figure 63



Source: CHNA Survey

Social Drivers Related to Substance Use

Multiple characteristics show significant relationships with substance abuse. The following relationships were found using correlational analyses:

- **Consumption of Alcohol** tends to be rated higher by men and residents of Peoria County. Consumption of alcohol tends to be rated lower by White people and residents of Tazewell County.

- **Misuse of prescription medication** tends to be rated higher by those with lower education, those with lower income, and those with an unstable housing environment.

- **Use of Marijuana** tends to be rated higher by younger people, Black people, those with lower education, those with lower income, those in an unstable housing environment, and residents of Peoria County. Use of marijuana tends to be rated lower by White people and residents of Woodford County.

- **Use of illegal substances** tends to be rated higher by Black people, those with lower education, those with lower income, those with an unstable housing environment, and residents of Peoria County.

Table 2 and Table 3 highlight the differences in subpopulations prevalence estimates for marijuana use.

Table 2

Youth Marijuana Use	
Higher prevalence rates	**No differences**
Multiracial and Black/AA (recent and lifetime use)	Gender (recent use)
Hispanic youth reported the highest rate of early onset of marijuana use (before 13 years old)	
Females more often reported using at least once in their lifetime compared to their male peers	
Males more often reported early onset compared to female peers	

Source: Youth Risk Behavior Surveillance System (YRBSS) data

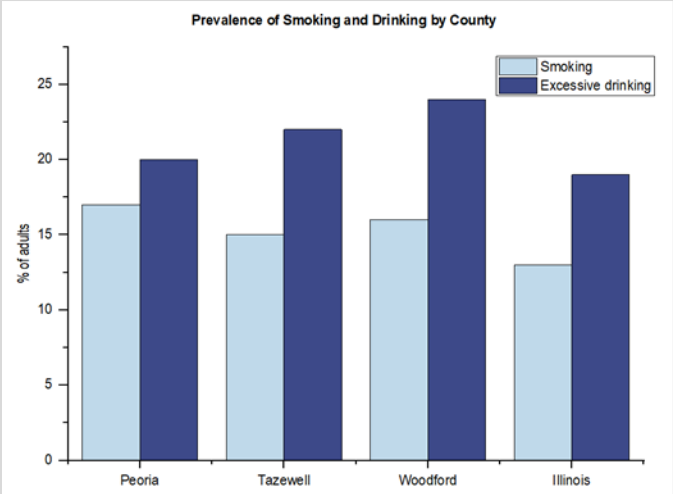
Table 3

Adult Marijuana Use	
Higher prevalence rates	**No differences**
Multiracial and Black/AA (recent and lifetime use)	
Males more often reported recent use	

Source: Behavioral Risk Factor Surveillance System (BRFSS) data

The prevalence of adults who smoke in the Tri-County region is higher than state and national estimates. Data from the 2022 BRFSS estimated that 17% of adults in Peoria smoke, followed by 16% of Woodford, and 15% in Tazewell. In addition, BRFSS data estimates a higher prevalence of adults who excessively drink in the region as well, with highest prevalence in Woodford County followed by Tazewell, and Peoria, respectively (Figure 64).

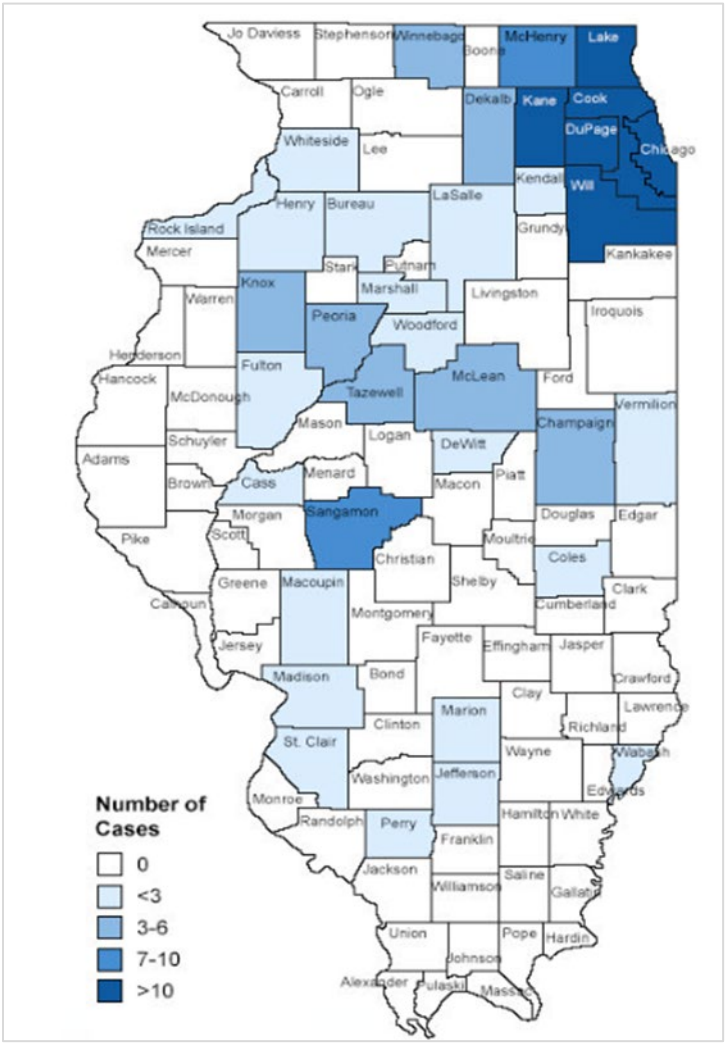
Figure 64



Source: Behavioral Risk Factor Surveillance System (BRFSS)

In recent years, e-cigarette or vaping has become a growing public health issue especially among youth. Although cigarette smoking is declining among Illinois youth, e-cigarette use is increasing substantially. Data Source: University of Illinois Urbana Champaign, Center for Prevention Research and Development, Illinois Youth Survey, 2018. The IYS is funded by the Illinois Department of Human Services, Bureau of Substance Use Prevention and Recovery. The following map (Figure 65) illustrates e-cigarette or vaping product use associated with lung injury, with a median age of 22 years and range of 13-85 years.

Figure 65



Source: Illinois Department of Human Services, Bureau of Substance Use Prevention and Recovery

3.3 Obesity

Importance of the Measure: Individuals who are obese place greater stress on their internal organs, thus increasing their propensity to utilize health services. Research strongly suggests that obesity is a significant problem facing youth and adults nationally, in Illinois, and within Tri-County. The US Surgeon General has characterized obesity as "the fastest-growing, most threatening disease in America today." According to the Obesity Prevention Initiative from the Illinois General Assembly, 20% of Illinois children are obese.

With children, research has linked obesity to numerous chronic diseases, including Type II diabetes, hypertension, high blood pressure, and asthma. Adverse physical health side effects of obesity include orthopedic problems due to weakened joints and lower bone density. Detrimental mental health side effects of obesity include low self-esteem, poor body image, symptoms of depression and suicide ideation. Obesity also impacts educational performance; studies suggest school absenteeism of obese children is six times higher than that of non-obese children.

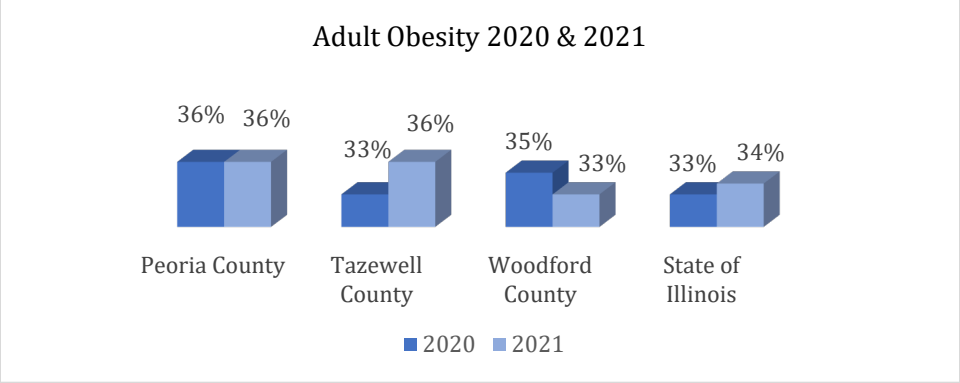
With adults, obesity has far-reaching consequences. Testimony to the Illinois General Assembly indicated that obesity-related illnesses contribute to worker absenteeism, slow workflow, and high worker compensation rates. A Duke University study on the effects of obesity in the workforce noted 13 times more missed workdays by obese employees than non-obese employees. Nationwide, lack of physical activity and poor nutrition contribute to an estimated 300,000 preventable deaths per year.

In Peoria County, the percentage of people diagnosed with obesity has remained at 36% from 2020 to 2021. Tazewell County has seen an increase in the percentage of people diagnosed with obesity from 33% in 2020 to 36% in 2021. Woodford County has seen a decrease from 35% in 2020 to 33% in 2021.

Note specifically that the percentage of obese people has increased from 33% in 2020 to 34% in 2021 for the State of Illinois (Figure 66). Obesity is defined as body mass index (BMI) greater than or equal to 30 kg/m2 (age-adjusted).

Additionally, 2025 CHNA survey respondents indicated that being overweight was their most prevalently diagnosed health condition.

Figure 66

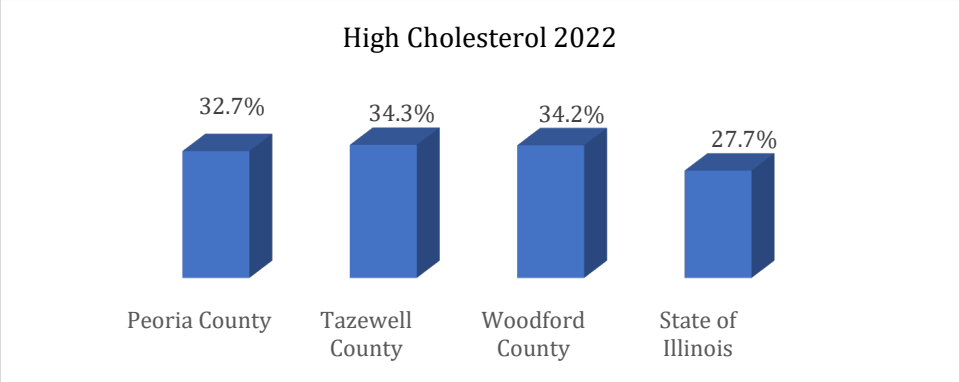


Source: County Health Rankings & Roadmaps

3.4 Predictors of Heart Disease

Residents in the Tri-County area report a higher than State of Illinois average prevalence of high cholesterol (Figure 67).

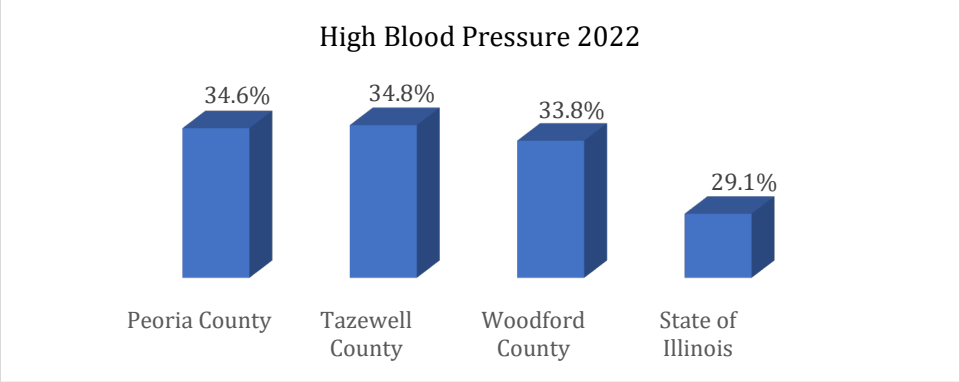
Figure 67



Source: Stanford Data Commons

With regard to high blood pressure, residents in the Tri-County area report a higher rate than the State of Illinois as a whole (Figure 68).

Figure 68



Source: Stanford Data Commons

3.5 Key Takeaways from Chapter 3

- ✓ **VAPING RATES HAVE INCREASED.**
- ✓ **SUBSTANCE USE AMONG 8TH GRADERS IS AT OR BELOW STATE AVERAGES IN MOST CATEGORIES. HOWEVER, MARIJUANA IS SIGNFICIANTLY HIGHER IN PEORIA COUNTY THAN THE STATE OF ILLINOIS AVERAGE.**
- ✓ **SUBSTANCE USE AMONG 12TH GRADERS IS AT OR BELOW STATE AVERAGES IN MOST CATEGORIES. HOWEVER, INHALANT USE IS HIGHER FOR PEORIA COUNTY THAN THE STATE OF ILLINOIS AVERAGE.**
- ✓ **PEORIA AND TAZEWELL COUNTIES HAVE OBESITY RATES HIGHER THAN THE STATE OF ILLINOIS AVERAGE.**
- ✓ **PREDICTORS OF HEART DISEASE ARE SIGNIFICANTLY HIGHER THAN STATE OF ILLINOIS AVERAGES.**
- ✓ **5% OF RESPONDENTS INDICATE THAT THEY MISUSE PRESCRIPTION MEDICATION.**

CHAPTER 4 OUTLINE

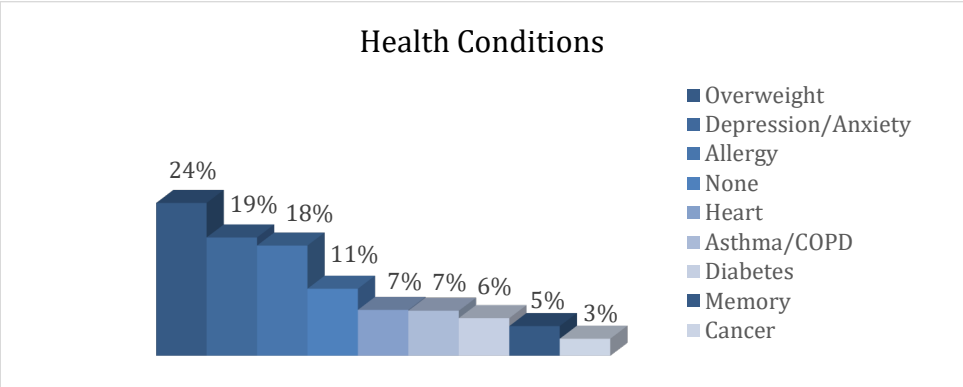
CHAPTER 4: MORBIDITY AND MORTALITY

Given the lack of recent disease/morbidity data from existing secondary data sources, much of the data used in this chapter was manually gathered from Tri-County region hospitals using COMPdata Informatics. Note that hospital-level data only show hospital admissions and does not reflect outpatient treatments and procedures.

4.1 Self-Identified Health Conditions

Survey respondents were asked to self-identify any health conditions. The highest rated health conditions were being overweight (24%), depression/anxiety (19%), and allergies (18%). Often percentages for self-identified data are lower than secondary data sources.

Figure 69



Source: CHNA Survey

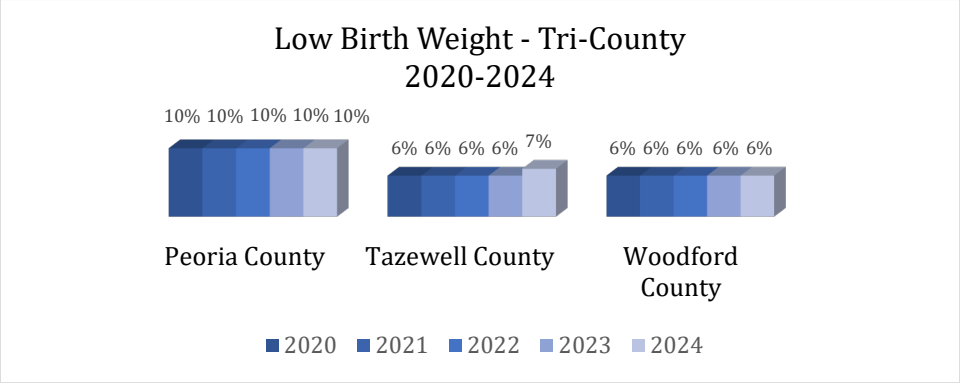
4.2 Healthy Babies

Importance of the Measure: Regular prenatal care is vital for producing healthy babies and children. Screening and treatment for medical conditions, as well as identifying and intervening in behavioral risk factors associated with poor birth outcomes, are crucial. Research suggests that women who receive adequate prenatal care are more likely to have better birth outcomes, such as full-term and normal-weight babies.

Low Birth Weight Rates

Low birth weight rate is defined as the percentage of infants born below 2,500 grams or 5.5 pounds. Very low birth weight rate is defined as the percentage of infants born below 1,500 grams or 3.3 pounds. In contrast, the average newborn weighs about 7 pounds. The percentage of babies born with low birth weight in Peoria County remained at 10% from 2020 to 2024. The percentage of babies born with low birth weight in Tazewell County stayed at 6% between 2020 and 2023 then increased to 7% in 2024. The percentage of babies born with low birth weight in Woodford County has remained at 6% from 2020 to 2024 (Figure 70).

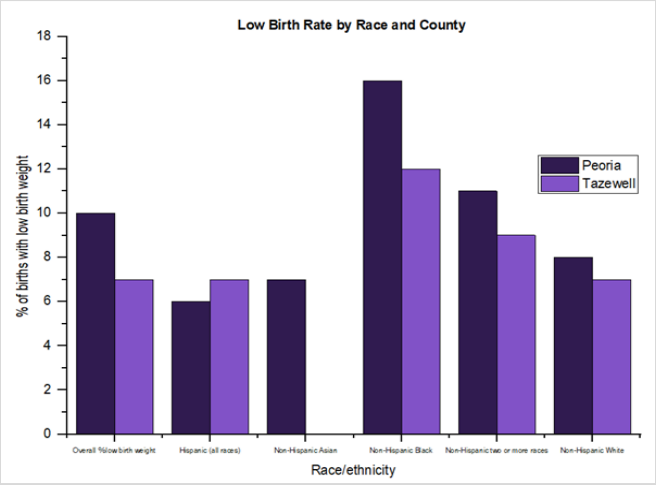
Figure 70



Source: County Health Rankings & Roadmaps

Notably, low birth rate in the Tri-County region differs based on race/ethnicity. The following figure illustrates the proportion of babies born with low birth weight by race for Peoria and Tazewell (Figure 71).

Figure 71



Source: 2017-2023 National Center for Health Statistics - Natality Files

4.3 Cardiovascular Disease

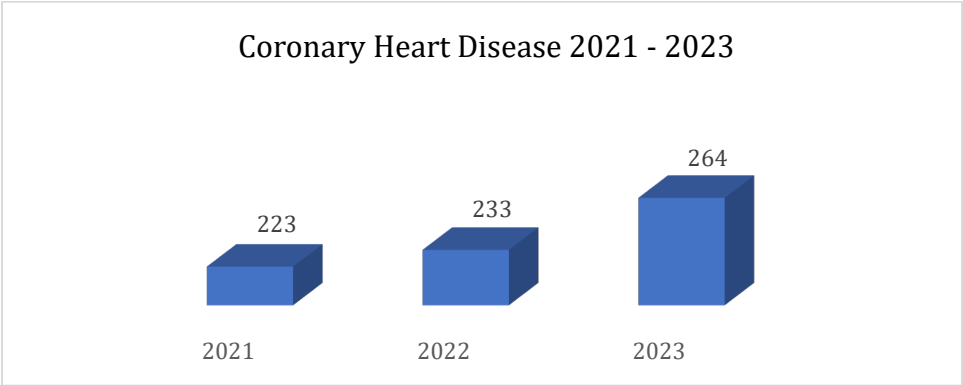
Importance of the Measure: Cardiovascular disease encompasses all diseases of the heart and blood vessels, including ischemic (also known as coronary) heart disease, cerebrovascular disease, congestive heart failure, hypertensive disease, and atherosclerosis.

Coronary Atherosclerosis

Coronary Heart Disease, sometimes called atherosclerosis, can slowly narrow and/or harden the arteries throughout the body. Coronary artery disease is a leading cause of death for Americans. Most of these deaths resulting from heart attacks caused by sudden blood clots in the heart's arteries.

The number of cases of coronary atherosclerosis complication at Tri-County area hospitals increased from 223 in 2021 to 264 in 2023 (Figure 72).

Figure 72

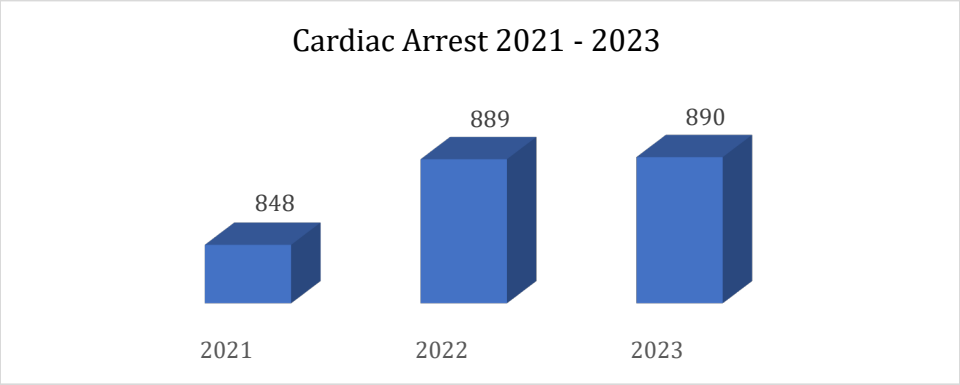


Source: COMPdata Informatics

Cardiac Arrest

Cases of dysrhythmia and cardiac arrest at Tri-County area hospitals increased from 848 in 2021 to 890 in 2023 (Figure 73). Note that hospital-level data only show hospital admissions.

Figure 73

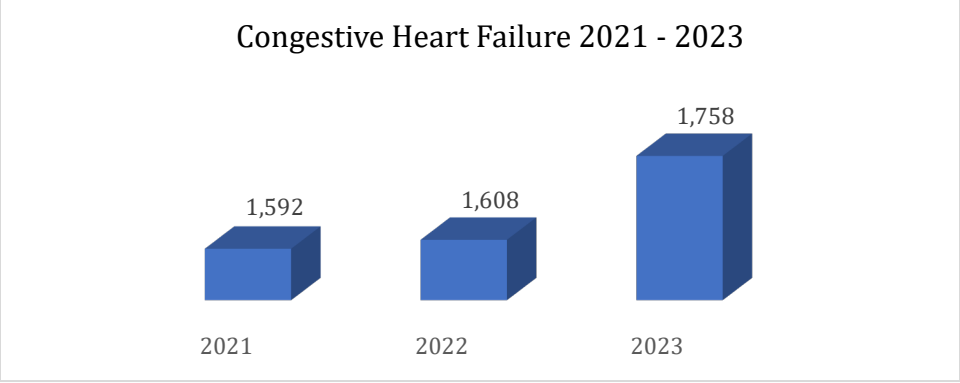


Source: COMPdata Informatics

Heart Failure

The number of treated cases of heart failure at Tri-County area hospitals increased from 1,592 in 2021 to 1,758 in 2023 (Figure 74).

Figure 74

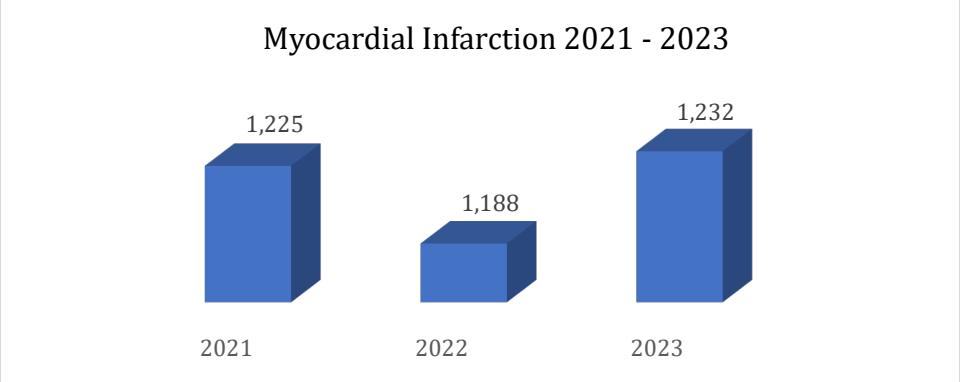


Source: COMPdata Informatics

Myocardial Infarction

The number of treated cases of heart failure at Tri-County area hospitals fluctuated but increased overall from 2021 to 2023. Cases decreased from 1,225 in 2021 to 1,188 in 2022, then increased to 1,232 in 2023 (Figure 75).

Figure 75

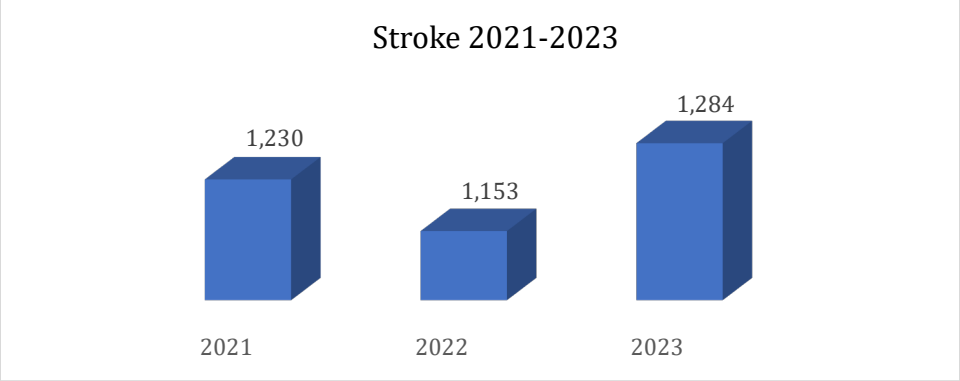


Source: COMPdata Informatics

Strokes

The number of treated cases of stroke at Tri-County area hospitals fluctuated but increased overall from 2021 to 2023. Cases decreased from 1,230 in 2021 to 1,153 in 2022, then increased to 1,284 in 2023 (Figure 76).

Figure 76



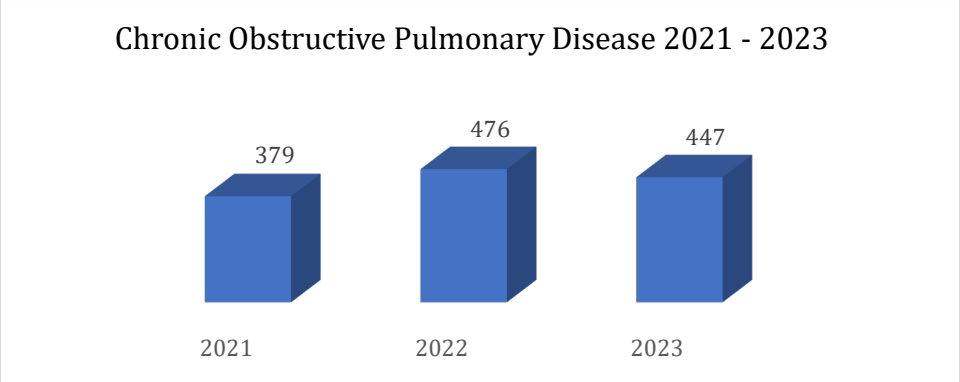
Source: COMPdata Informatics

4.4 Respiratory

Importance of the Measure: Diseases of the respiratory system include acute upper respiratory infections such as influenza, pneumonia, bronchitis, asthma, emphysema, and Chronic Obstructive Pulmonary Disease (COPD). These conditions are characterized by breathlessness, wheezing, chronic coughing, frequent respiratory infections, and chest tightness. Many respiratory conditions can be successfully controlled with medical supervision and treatment. However, children and adults who do not have access to adequate medical care are likely to experience repeated serious episodes, trips to the emergency room and absences from school and work. Hospitalization rates illustrate the worst episodes of respiratory diseases and serve as a proxy measure for inadequate treatment.

Treated cases of COPD at Tri-County area hospitals fluctuated but increased overall from 2021 to 2023. Cases increased from 379 in 2021 to 476 in 2022, then decreased to 447 in 2023 (Figure 77).

Figure 77



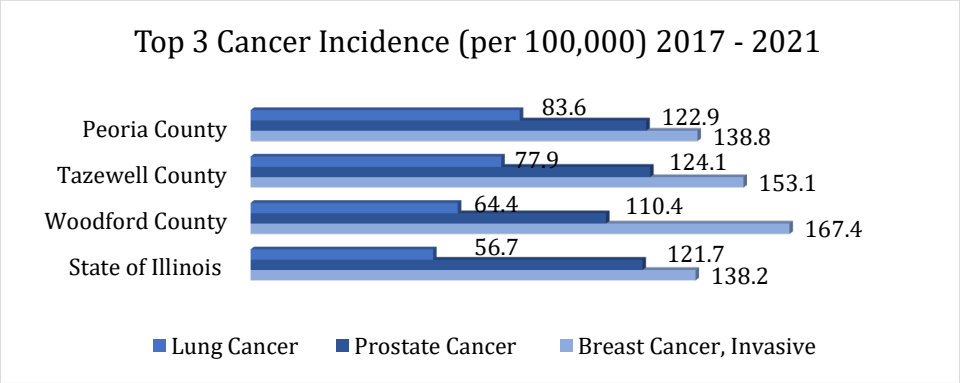
Source: COMPdata Informatics

4.5 Cancer

Importance of the Measure: Cancer is caused by the abnormal growth of cells in the body, and many causes of cancer have been identified. Generally, each type of cancer has its own symptoms, outlook for cure, and methods for treatment. Cancer is one of the leading causes of death in the Tri-County.

The top three prevalent cancers in the Tri-County are illustrated in Figure 78. Specifically, cancer rates in Peoria and Tazewell Counties reported higher rates of all three cancers compared to the State of Illinois rates. Woodford County reported higher rates of lung and breast cancer compared to the State of Illinois rates.

Figure 78



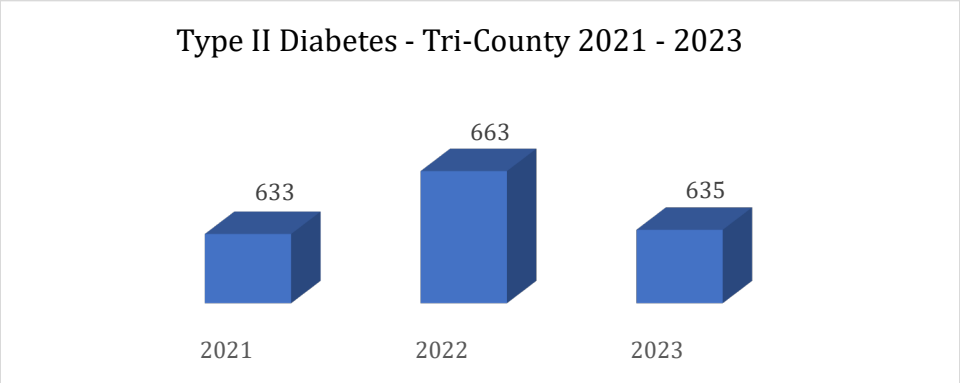
Source: Illinois Department of Public Health – Cancer in Illinois

4.6 Diabetes

Importance of the Measure: Diabetes is the leading cause of kidney failure, adult blindness, amputations, and it is a leading contributor to strokes and heart attacks. It is estimated that 90-95% of individuals with diabetes have Type II diabetes (previously known as adult-onset diabetes), while only 5-10% of individuals with diabetes have Type I diabetes (previously known as juvenile diabetes).

Inpatient cases of Type II diabetes from the Tri-County fluctuated but increased overall from 2021 to 2023. Cases increased from 633 in 2021 to 663 in 2022, then decreased to 635 in 2023 (Figure 79).

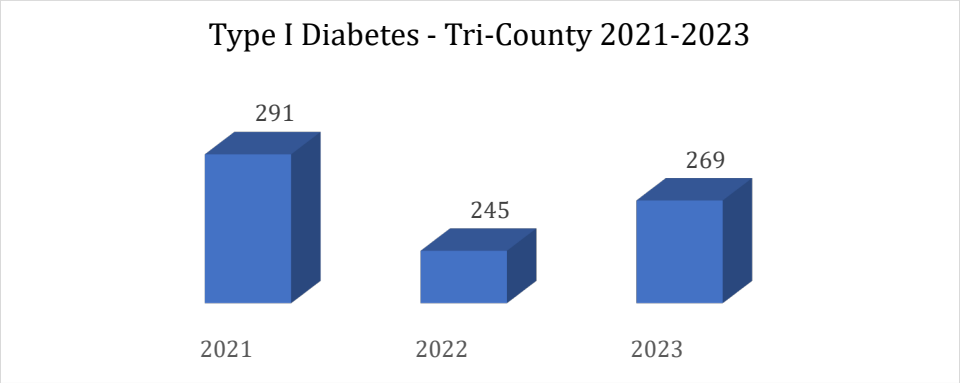
Figure 79



Source: COMPdata Informatics

Inpatient cases of Type I diabetes fluctuated but decreased overall between 2021 and 2023. Cases decreased from 291 in 2021 to 245 in 2022, then increased to 269 in 2023 (Figure 80).

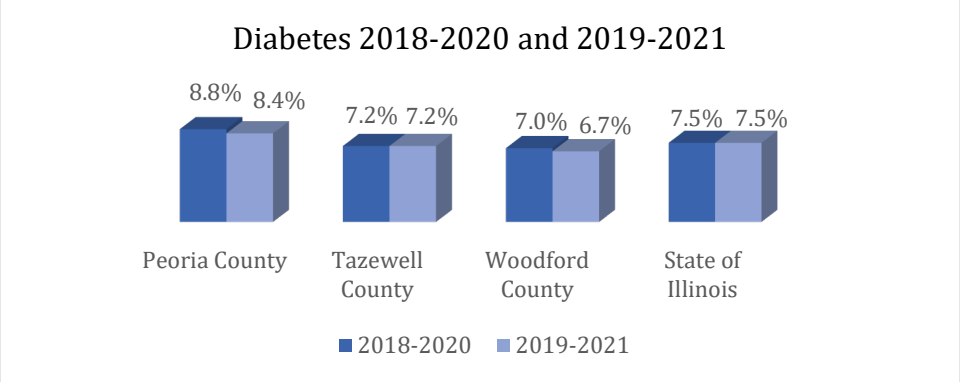
Figure 80



Source: COMPdata Informatics

Data show that 8.4% of Peoria County residents have diabetes, which is above the State of Illinois average of 7.5%. Tazewell (7.2%) and Woodford (6.7%) Counties' rates are below the State of Illinois average (Figure 81).

Figure 81



Source: Center for Disease Control (CDC)

4.7 Infectious Diseases

Importance of the Measure: Infectious diseases, including sexually transmitted infections and hepatitis, are related to high-risk sexual behavior, drug and alcohol use, limited access to healthcare, and poverty. It would be highly cost-effective for both individuals and society if more programs focused on prevention rather than treatment of infectious diseases.

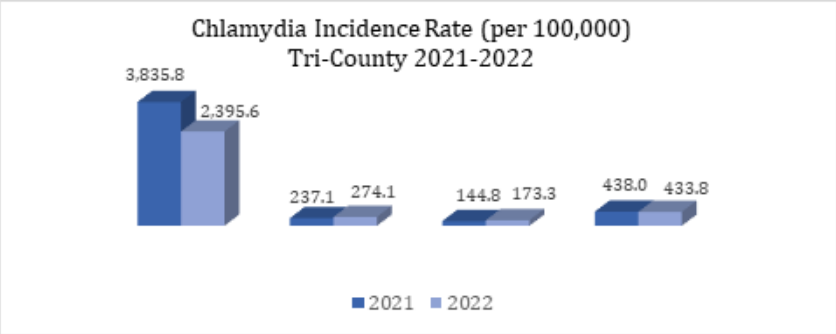
Chlamydia and Gonorrhea Cases

The data for the number of infections of chlamydia in the Tri-County area from 2021 to 2022 indicate an increase, except in Peoria County, which decreased. The State of Illinois, incidence of chlamydia decreased from 438 in 2021 to 433.8 in 2022 (Figure 82).

Peoria County reported a significantly higher incidence rate of Chlamydia than the other Tri-Counties and the State of Illinois. The highest concentration of chlamydia cases in Peoria County is still found within the 61603, 61604, and 61605 zip codes. These three zip codes accounted for 66.5% of chlamydia cases within Peoria County, while the combined population of these three zip codes only accounts for 33.5% of the total population of Peoria County. This percentage is comparable to 2021 in which 66% of all chlamydia cases were among residents of these three zip codes.

Rates of chlamydia among Black/African American (AA) females were nine times that of their White counterparts. For Black males, they are more than 15 times that of their White counterparts. Rates of gonorrhea among Black/African American females were nine times that of their White counterparts. For Black males, they were 30 times that of their White counterparts. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group, religion, socio-economic status, gender, age, location, gender identity, sexual orientation or other characteristics historically linked to discrimination or exclusion. This creates a disproportionate burden of preventable disease.

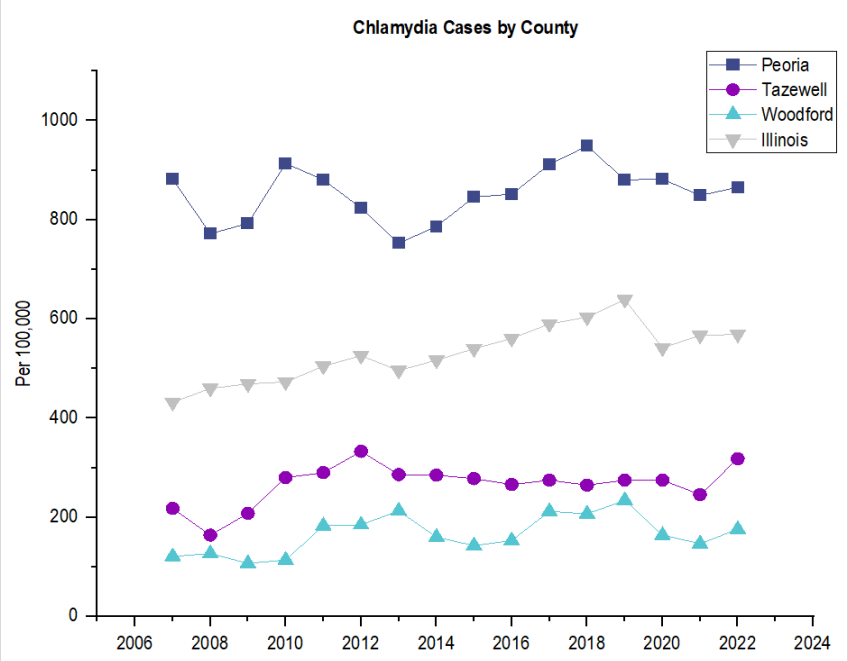
Figure 82



Source: Illinois Department of Public Health

The trend of Chlamydia cases per 100,000 population between 2007 and 2022 is illustrated in Figure 83 for the Tri-County region in comparison to state rates. Of note, Peoria is continuing to get worse in this issue.

Figure 83



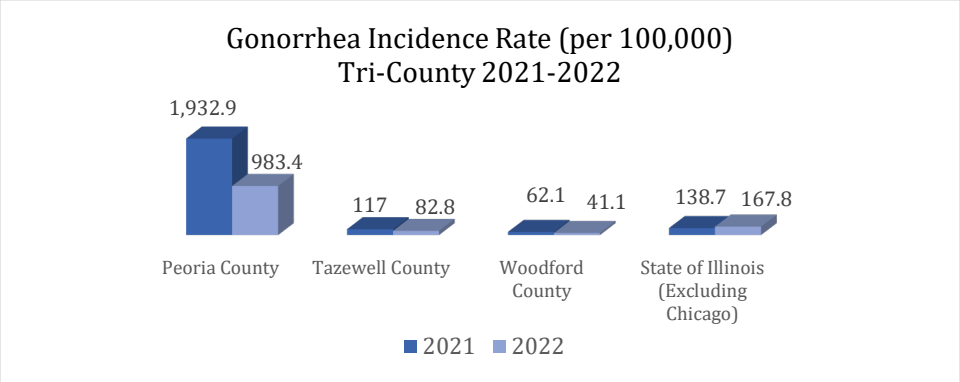
Source: National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), CDC

The data for the number of infections of gonorrhea in the Tri-County area from 2021 to 2022 indicate a decrease, while the State of Illinois rate increased. The Gonorrhea incidence rates for all counties in the Tri-County region are trending downwards (Figure 84). Peoria County reported a significantly higher incidence rate of Gonorrhea than the other Tri-Counties.

Gonorrhea infection rates continue to differ greatly by age, race, and region in Peoria County, with incidence rates being highest among individuals between the ages of 15 and 29, individuals reporting Black/AA race, and individuals residing in the 61603, 61604, and 61605 zip codes.

In 2022, there were 765 confirmed cases of gonorrhea reported to the Peoria City/County Health Department, an overall incidence of 422.4 per 100,000. This is a 27% decrease in comparison to the previous year when there were 1,051 confirmed cases of gonorrhea in Peoria County.

Figure 84



Source: Illinois Department of Public Health

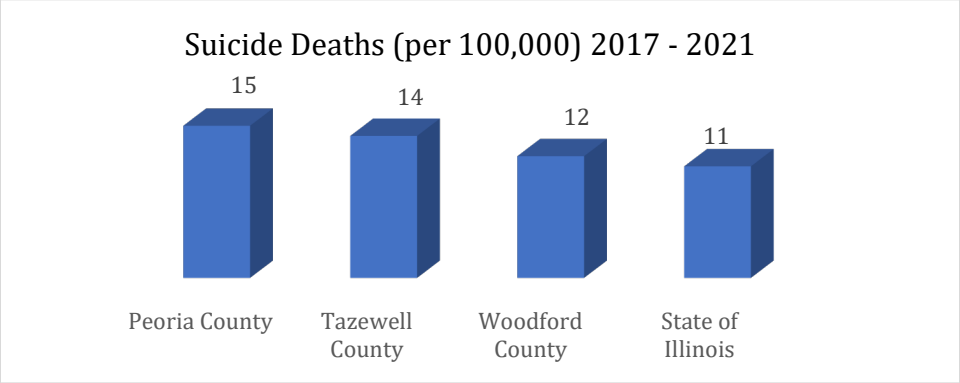
4.8 Injuries

Importance of the Measure: Suicide is intentional self-harm resulting in death. These injuries often indicate serious mental health problems requiring the treatment of other trauma-inducing issues.

Suicide

The number of suicides in the Tri-County region indicates a higher incidence compared to the State of Illinois incidence rate between 2017 and 2021 (Figure 85).

Figure 85



Source: Illinois Department of Public Health

4.9 Mortality

Importance of the Measure: Presenting data that focuses on causes of mortality provides an opportunity to define and quantify which diseases are causing the most deaths.

The leading causes of death in the State of Illinois and the Tri-County are similar as a percentage of total deaths in 2022. Diseases of the heart (20.8%) and cancer (18.4%) are the leading causes of death in Peoria County. Diseases of the heart (19.7%) and cancer (19.6%) are the leading causes of death in Tazewell County. Diseases of the heart (25.7%) and cancer (18.3%) are the leading causes of death in Woodford County (Table 4).

Table 4

Top 5 Leading Causes of Death for all Races by Counties and State of Illinois, 2022				
Rank	Peoria County	Tazewell County	Woodford County	State of Illinois
1	Diseases of Heart (20.8%)	Diseases of Heart (19.7%)	Diseases of Heart (25.7%)	Diseases of Heart (21.8%)
2	Malignant Neoplasm (18.4%)	Malignant Neoplasm (19.6%)	Malignant Neoplasm (18.3%)	Malignant Neoplasm (19.2%)
3	Accidents (8.0%)	Accidents (6.2%)	Alzheimer Disease (7.1%)	Accidents (6.1%)
4	COVID-19 (5.6%)	Cerebrovascular Disease (6.2%)	Chronic Lower Respiratory Disease (5.6%)	COVID-19 (5.8%)
5	Cerebrovascular Disease (5.4%)	Chronic Lower Respiratory Disease (5.5%)	Cerebrovascular Disease (5.4%)	Cerebrovascular Disease (5.4%)

Source: Illinois Department of Public Health

4.10 Key Takeaways from Chapter 4

- ✓ **BREAST AND LUNG CANCER RATES ARE HIGHER THAN STATE OF ILLINOIS AVERAGES IN ALL THREE COUNTIES.**
- ✓ **WHILE STATE OF ILLINOIS AVERAGES HAVE BEEN STABLE, DIABETES IS TRENDING DOWNWARD IN THE TRI-COUNTY AREA, BUT PEORIA COUNTY REMAINS HIGHER THAN THE STATE OF ILLINOIS.**
- ✓ **SUICIDE RATES ARE HIGHER THAN STATE OF ILLINOIS INCIDENCE RATE FOR ALL COUNTIES IN THE TRI-COUNTY REGION.**
- ✓ **SEXUALLY TRANSMITTED INFECTIONS IN PEORIA COUNTY ARE SIGNIFICANTLY HIGHER THAN THE OTHER COUNTIES AND STATE OF ILLINOIS AVERAGES.**
- ✓ **CANCER AND HEART DISEASE ARE THE LEADING CAUSES OF MORTALITY IN THE TRI-COUNTY AREA. ACCIDENTS AND ALZHEIMER'S DISEASE RANK THIRD, DEPENDING ON COUNTY.**

CHAPTER 5 OUTLINE

CHAPTER 5: PRIORITIZATION OF HEALTH-RELATED ISSUES

In this chapter, the most critical health-related needs in the community are identified. To accomplish this, community perceptions of health issues, unhealthy behaviors and issues related to well-being were first considered. Key takeaways from each chapter were then used to identify important health-related issues in the community. Next, a comprehensive inventory of community resources was completed; and finally, the most significant health needs in the community are prioritized.

Specific criteria used to identify these issues included: (1) magnitude in the community; (2) severity in the community; (3) potential for impact to the community.

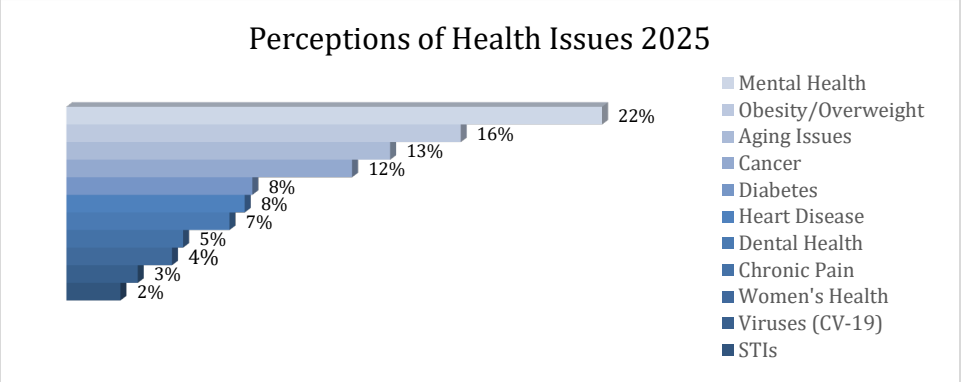
5.1 Perceptions of Health Issues

The CHNA survey asked respondents to rate the three most important health related issues in the community from 11 different options.

The highest rated health issues were mental health (22%), followed by obesity/overweight (16%), aging issues (13%), and cancer (12%) (Figure 86).

Note that perceptions of the community were accurate in some cases. For example, mental health is a significant issue in the Tri-County area. Also, obesity is an important concern, and the survey respondents accurately identified these as important health issues. However, some perceptions were inaccurate. For example, while heart disease is a leading cause of mortality, it is ranked relatively low.

Figure 86

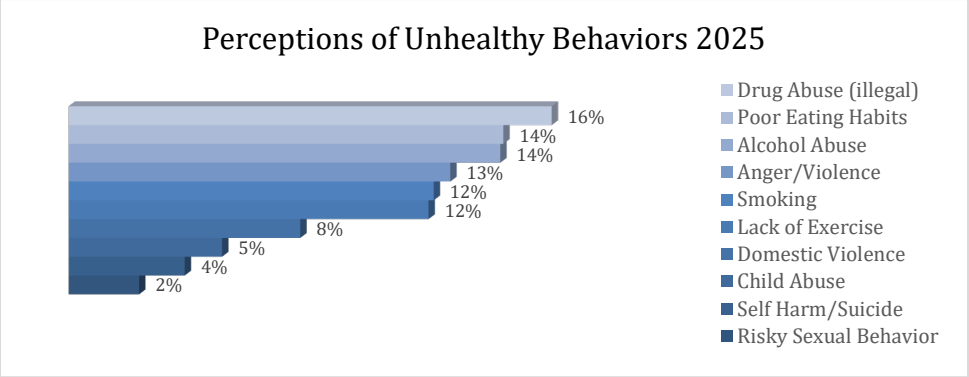


Source: CHNA Survey

5.2 Perceptions of Unhealthy Behaviors

Respondents were asked to select the three most important unhealthy behaviors in the community out of a total of 10 choices. The unhealthy behaviors that rated highest were drug abuse (illegal) (16%), poor eating habits (14%), alcohol abuse (14%), anger/violence (13%), smoking (12%), and lack of exercise (12%) (Figure 87).

Figure 87



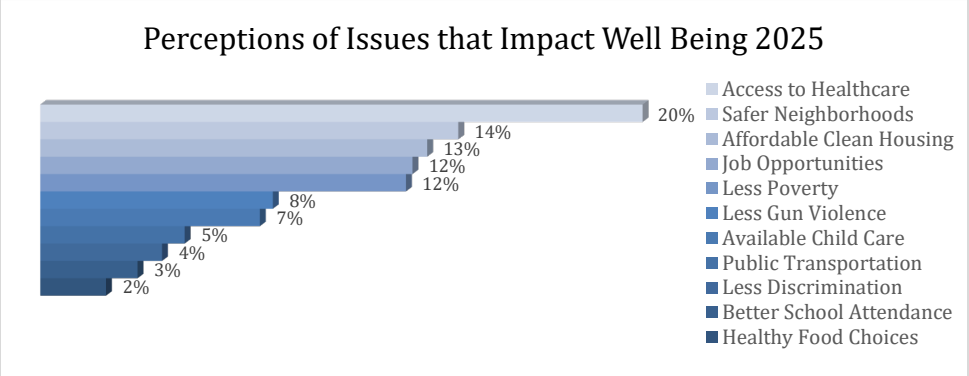
Source: CHNA Survey

5.3 Perceptions of Issues Impacting Well Being

Respondents were asked to select the three most important issues impacting well-being in the community from a total of 11 choices.

The issue impacting well-being that was rated the highest is access to healthcare (20%) (Figure 88).

Figure 88



Source: CHNA Survey

5.4 Summary of Community Health Issues

Based on findings from the previous analyses, a chapter-by-chapter summary of key takeaways is used to provide a foundation for identification of the most important health-related issues in the community. Considerations for identifying key takeaways include magnitude in the community, strategic importance to the community, existing community resources and potential for impact and trends and future forecasts.

Demographics (Chapter 1) – Four factors were identified as the most important areas of impact from the demographic analyses:

- Population decreased
- Population over age 65 increased
- Single female heads of house household represent a significant percentage of the population (21.5%, 27%, and 31.6%)
- Graduation rates are concerning in nearly half of the Tri-County high schools

Prevention Behaviors (Chapter 2) – Six factors were identified as the most important areas of impact from the chapter on prevention behaviors:

- Decreased utilization of doctors/clinics (increased urgent care and emergency department)
- Access to medical care, prescription medication, and dental care decreased
- Prostate screening is relatively low
- Exercise and healthy eating behaviors
- Depression and stress/anxiety affect approximately half of the population
- Prevalence of hunger has increased

Symptoms and Predictors (Chapter 3) – Five factors were identified as the most important areas of impact from the chapter on symptoms and predictors:

- Vaping rates increased
- Substance use among youth - Marijuana and inhalant use in Peoria County
- Obesity
- Predictors of heart disease
- Opioid use

Morbidity and Mortality (Chapter 4) – Five factors were identified as the most important areas of impact from the chapter on morbidity/mortality behaviors:

- Cancer rates
- Diabetes – Peoria County
- Suicide rates
- Cancer, heart disease, and accidents/Alzheimer's are the leading causes of mortality
- Sexually transmitted infections - Peoria County

Potential Health-Related Needs Considered for Prioritization

Before the prioritization of significant community health-related needs was performed, results were aggregated into potential categories. Based on similarities and duplication, the potential areas considered are:

- **Food insecurity among low-income populations due to high cost**
- **Access to healthy food and resources**
- **Food insecurity among youth**
- **Navigating the behavioral health system**
- **Suicide and self-harm among youth and young adolescents**
- **Access to behavioral health resources among youth and those with low-income**
- **Early and adequate prenatal care**
- **Emergency department use for medical care that is non-emergent**
- **Engagement with primary care providers for routine visits**
- **Navigating healthcare system and resources specifically among; AA/Black, males, rural residents, and individuals 65+ years old**

5.5 Community Resources

After summarizing potential categories for prioritization in the Community Health Needs Assessment, the PFHC CHNA steering committee reduced a list of 31 potential health needs to 10 potential health needs using the PEARL approach from the Hanlon Method. A comprehensive analysis of existing community resources was performed to identify the efficacy to which these 10 health-related areas were being addressed. A resource matrix can be seen in APPENDIX 6: RESOURCE MATRIX APPENDIX 5: CHARACTERISTICS OF SURVEY RESPONDENTS relating to the 10 health-related issues.

There are numerous forms of resources in the community. They are categorized as recreational facilities, county health departments, community agencies and area hospitals/clinics. A detailed list of community resources and descriptions appears in APPENDIX 7: DESCRIPTION OF COMMUNITY RESOURCES.

5.6 Significant Needs Identified and Prioritized

In order to prioritize the previously identified dimensions, the collaborative team considered health needs based on: (1) magnitude of the issues (e.g., what percentage of the population was impacted by the issue); (2) severity of the issues in terms of their relationship with morbidities and mortalities; (3) potential impact through collaboration. Using a modified version of the Hanlon Method (as seen in APPENDIX 8: PRIORITIZATION METHODOLOGY), and supplementary information on health needs (as seen in APPENDIX 9: ADDITIONAL INFORMATION FOR PRIORITIZATION), a group comprised of diverse representation from the community identified three significant health needs and considered them equal priorities:

- **Food Insecurity Among Youth**
- **Access to Behavioral Health**
- **Suicidal Thoughts and Behaviors**

FOOD INSECURITY AMONG YOUTH

FOOD INSECURITY—the limited or uncertain availability of nutritionally adequate and safe foods—continues to affect school-aged youth across the Tri-County area of Peoria, Tazewell, and Woodford Counties.

According to the Community Status Assessment (CSA), younger individuals with lower household incomes and unstable housing are significantly less likely to consume fruits and vegetables, often citing affordability, lack of importance, and dislike as barriers. The Community Context Assessment (CCA) further reveals that school-aged youth frequently skip meals or opt for unhealthy options due to time and financial constraints. Community Partner Assessment (CPA) data shows that about half of local organizations prioritize food insecurity, particularly through efforts targeting economic stability and the built environment.

In Peoria County, the food insecurity rate stands at 14.5%, while Tazewell County reports a child food insecurity rate of 15.5%. Although specific data for Woodford County is limited, regional trends suggest

similar challenges. These local rates exceed the Healthy People 2030 target of reducing household food insecurity to 6% and very low food security in children to 0.3%. This gap underscores the urgent need for coordinated, youth-focused interventions across the Tri-County area.

It is essential that everyone has access to food and drink necessary for living healthy lives. Food insecurity exists when people don't have physical and economic access to sufficient, safe and nutritious food that meets their dietary needs for a healthy life. In the Tri-County region, approximately 6% of residents go hungry at least 1-2 times per week, which is double the prior estimate in 2022 of 3%. Hunger was higher for Black residents and those reporting lower household income or unstable housing. Seniors, low income, and minority groups noted that limited access to healthy and fresh produce leads to a reliance on processed or fast foods.

ACCESS TO BEHAVIORAL HEALTH

ACCESS TO BEHAVIORAL HEALTH—defined as the ability to obtain timely, affordable, and culturally appropriate mental health and substance use services—is a critical determinant of overall well-being, particularly when navigating complex systems of care.

In the Tri-County area of Peoria, Tazewell, and Woodford Counties, improving access and resource navigation is essential, especially for underserved populations. According to the Community Status Assessment (CSA), only about 51% of residents reported speaking with someone about their mental health in the past year, with barriers including providers' not accepting insurance and a shortage of counselors, particularly in Tazewell County.

The Community Context Assessment (CCA) highlights long wait times—especially for Medicaid recipients—and a lack of providers in areas like Eureka. Minority and low-income residents face additional challenges, often relying on law enforcement rather than behavioral health professionals for crisis intervention. Community Partner Assessment (CPA) data shows that 72% of organizations are addressing healthcare access, with 67% specifically focused on mental and behavioral health. While Woodford County reports relatively better mental health outcomes, Peoria and Tazewell face more significant challenges, particularly among those with unstable housing or from minority backgrounds.

All three counties are designated Mental Health Professional Shortage Areas (HPSAs), reflecting a broader national trend. These local gaps stand in contrast to the Healthy People 2030 goal of increasing the proportion of adults with serious mental illness who receive treatment to 64.6% and reducing barriers to timely care. Addressing these disparities requires coordinated, community-based strategies that enhance provider availability and improve system navigation for all residents.

SUICIDAL AND SELF-HARM THOUGHTS AND BEHAVIORS

SUICIDAL AND SELF-HARM THOUGHTS AND BEHAVIORS—ranging from ideation to planning to attempt—are serious public health concerns that require both preventative and clinical interventions to reduce risk and promote mental well-being.

In the Tri-County area of Peoria, Tazewell, and Woodford Counties, addressing suicide risk is especially urgent given disparities in healthcare access and mental health support. While 87% of residents report having a primary care provider (PCP), Black and Latino/a/x individuals and those experiencing housing

instability are significantly less likely to have one, limiting early identification and intervention opportunities. Younger, higher-income, and more educated individuals more frequently use urgent care, which may not be equipped for sustained behavioral health support.

The Community Context Assessment (CCA) highlights that minority groups often need help navigating healthcare systems, a barrier echoed in the Community Partner Assessment (CPA), where 67% of organizations identified healthcare access and quality as a top priority. Suicide remains a leading cause of death nationally, with over 49,000 deaths in 2023—one every 11 minutes. Local data from Tazewell and Woodford Counties emphasize the importance of early intervention and community-based crisis services. These efforts align with the Healthy People 2030 goal of reducing the suicide rate to 12.8 per 100,000 population. To meet this target, the Tri-County region must expand culturally competent care, improve system navigation, and strengthen the integration of behavioral health into primary care and community settings.

III. APPENDICES

APPENDIX 1: MEMBERS OF COLLABORATIVE TEAM

Members of the **Collaborative Team** consisted of individuals with special knowledge of and expertise in the healthcare of the community. Individuals, affiliations, titles and expertise are as follows:

Phil Baer
Phil Baer, MBA, RRT, FACHE is vice president, Outpatient and Ancillary Services at OSF HealthCare Saint Francis Medical Center. Phil is accountable to plan, direct, evaluate and improve the operations of outpatient and ancillary services for OSF Saint Francis, including community outreach, ambulatory programs, behavioral health, wellness, diagnostic imaging, and laboratory functions. Phil will collaborate with hospital leadership, department management, medical staff, and governing bodies to establish quality and service standards and foster cooperative working relationships. He started his healthcare career as a Registered Respiratory Therapist and has gone on to hold multiple leadership positions at SFMC. Early in his career, Phil transitioned into the Performance Improvement department, holding roles as a Black Belt and later a Managing Master Black Belt. Phil has served at the Director level for the past 10 years, first as Director of Outpatient Diagnostic services, Director of Community Outreach, and his most recent position as Director of Medical Imaging. Phil is active with the Illinois Chapter of the American College of Healthcare Executives, serving on its board of directors, chairing its communication committee, and is a board certified fellow (FACHE). Phil also currently serves as Board Co Chair for the Partnership for a Healthy Community (PFHC) and is also on the Board of Directors for the OSF SFMC College of Nursing.

Rebecca Crumrine
As an Illinois Supplemental Nutrition Assistance Program-Education Educator in Peoria, Tazewell, Fulton & Mason Counties, Rebecca enjoys getting to make the healthier choice an easier choice for families. To accomplish her work, Rebecca collaborates with community partners to affect changes at organizational, community and policy levels. She serves as a leader in the local community by driving forward impactful multi-sector collaborative work and working to center community voice more into the process. Rebecca received her bachelor's degree from Bradley University in 2014, a master's degree from Illinois State University in 2016, and is currently working on a combined master's degree in public health and public administration from University of Illinois Springfield.

Jill Dodaro
Jill Dodaro assumed the role of Vice President, Chief Nursing Officer for Carle Health Greater Peoria in February 2024. Her career at Carle Health began as a Registered Nurse, and she steadily progressed through various clinical, educational, and leadership positions within the system. Jill earned her Bachelor of Science in Nursing and Master of Science in Nursing from Bradley University, and a Master of Business Administration from Benedictine University. She holds dual certifications from the American Nurses Credentialing Center in Medical-Surgical Nursing (MEDSURG-BC) and Nurse Executive Advanced (NEA-BC). Deeply committed to the community, Jill's involvement includes serving on the Partnership for a Healthy Community Board, the Junior Achievement of Central Illinois Board, the Methodist College Board, as an ex-officio member for Carle Health West Region Community Health Initiatives, and as a Heart of Illinois United Way grant reviewer.

Amy Dewald
Amy is the Community Health Education Specialist for the Woodford County Health Department. Prior to joining the Health Department, she was an Associate Professor of Biology at Eureka College and held

adjunct teaching positions at Illinois Central College and Heartland Community College. The courses she has taught are biology, microbiology, cell biology, immunology and anatomy and physiology. She brings a strong science background and knowledge of the etiology of infectious disease to her current role as Community Health Education Specialist. She strives to provide fact-based education, outreach and promotion of health-related topics to the community.

Sarah Donohue
Sarah Donohue received a B.A. in Neuroscience from Smith College and a PhD in Neurobiology from Duke University. She did her postdoctoral training in Magdeburg, Germany, where she studied addiction and attention. In 2023, she received a Master's in Public Health from Kent State University. She is the Director of Research Services, the Associate Director of Population Health and Community Engagement at the Center 4 Health Research, and a Research Assistant Professor in Psychiatry and Behavioral Medicine at the University of Illinois College of Medicine Peoria.

Amy Fox
Amy Fox is the Administrator of Tazewell County Health Department and has worked in public health for over 35 years in the areas of community health improvement planning, health promotion, substance abuse prevention, coalition development and emergency preparedness. Amy is active with several state level initiatives including Public Health Transformation and advisory committees for Emergency Preparedness, the Illinois Plan for Local Assessment of Need and a new committee member of the Illinois State Association of Counties (ISACo) Public Health Policy Committee.

Sally Gambacorta
Sally Gambacorta is the Community Health Director at Carle BroMenn Medical Center and Carle Eureka Hospital. Both hospitals are in central Illinois. She has worked for Carle BroMenn Medical Center for 30 years in Community Health. Sally holds a Bachelor of Science degree in Business Administration from Augustana College, a Master of Science degree in Industrial/Organizational Science from Illinois State University and a Master of Arts degree in Leisure Studies with a concentration in Corporate Fitness and Health Promotion from the University of Iowa. In her community health role, Ms. Gambacorta is responsible for the community health needs assessment and community benefits at both hospitals. She has extensive experience in collaborating with community partners to improve the health of the community. Ms. Gambacorta is a member of the McLean County Community Health Council Executive Steering Committee and facilitates the McLean County Behavioral Health Priority Action Team. She is also a member of the McLean County Mental Health First Aid Collaborative and serves on the board for the Partnership for a Healthy Community for Woodford, Tazewell and Peoria Counties.

Kate Green
Kate Green is the Executive Director of Home for All. Kate is focused on leveraging resources across the region to meet the ultimate goal of ending homelessness. Her approach to the work is informed by her experience in public administration and innovation. From strategic partnerships to capacity building, Kate works to enrich the network of organizations and individuals that touch the lives of those experiencing homelessness.

Megan Hanley
Megan Hanley, MPH, CIC has been the epidemiologist at TCHD since July 2022. She is passionate about using public health data and evidence-based strategies to drive positive change, improve quality of life, and reduce the morbidity and mortality of disease. In March 2025, Megan obtained her national

Certification in Infection Control (CIC) to better serve congregate settings during infectious disease outbreaks. In her spare time, Megan can be found serving her community on the village's Rescue Squad; she has been an Emergency Medical Technician for 9 years. She holds a Master of Public Health degree from Liberty University and a BS in Molecular and Cellular Biology from Cedarville University.

Monica Hendrickson
Monica Hendrickson has been the Public Health Administrator for the Peoria City/County Health Department since July 2017. She initially began working at Peoria City/County Health Department in 2009, as the Emergency Preparedness Planner until she left in 2010 to be the Director of Health Protection as Knox County Health Department. She returned to Peoria in 2013 as the agency's Epidemiologist until she transitioned into her new role. Monica received her MPH in 2008 from the University of Michigan School of Public Health and her BS in 2005 from the University of Illinois Urbana-Champaign. In addition to having served on the Heart of Illinois United Way as a grant reviewer and Solution Council member, Monica is on the Board of Directors, as well as a member of the Chair of the Trillium Place Board, a member of the Phoenix Community Development Services Board, a member of the State of Illinois Health Facilities and Services Review Board, and President for the Illinois Public Health Association. She is currently on the Partnership for a Healthy Community Board, the tri-county community health improvement initiative that aligns healthcare, health departments and other agencies towards improving outcomes.

Tricia Larson
Tricia is the Director of Outpatient Behavioral Health Outpatient for Trillium Place, an affiliate of Carle Health. She earned her Master of Arts in Human Development Counseling from the University of Illinois at Springfield and is a Licensed Clinical Professional Counselor. Tricia has been dedicated to the field of behavioral health for the past 19 years and has served in both clinical and leadership roles. Tricia has also served on numerous committees and Boards. She is dedicated to assisting individuals in achieving overall wellness through quality behavioral healthcare.

Leslie L. McKnight
Dr. Leslie L. McKnight is the Director of Community Health Policy and Planning at the Peoria City/County Health Department. She is responsible for the development and implementation of the Partnership for a Healthy Community Health Improvement Plan and health promotion and equity interventions throughout the Tri-County region. Dr. McKnight has over 20 years of experience in public policy and community development for local government agencies and has managed millions of dollars in grassroots and public-private partnership programs and activities related to housing, community, health, and economic development in Central IL. She holds a PhD in organization development from Benedictine University, Springfield IL and a Master of Science degree in Human Services Administration from Spertus College in Chicago, IL. She is published in many academic and leadership journals and is an adjunct professor in the Master of Business Administration (M.B.A) program at Bradley University and Master of Public Health (M.P.H) program at University of Illinois Springfield.

Andrea Parker
Andrea Parker, RN, MS, Executive Director for the Hult Center for Healthy Living – Carle Health Greater Peoria. Andrea Parker has 40 years of experience as a registered nurse with a background in pediatrics nursing, medical surgical nursing, community health and public health.

Andrea received her nursing degree from Methodist School of Nursing, later completing her Bachelor's degree from Bradley University and her master's in science from the University of IL at Chicago. Andrea jumped started her nursing career as a pediatric nurse with Methodist Medical Center and had the opportunity to work within home health and family practice which prepared her for community-based nursing roles such as overseeing Carle Health's Methodist Medical Center's School Health program. Prior to taking the helm at Hult Center for Healthy Living, she served as a Regional Health Officer for the Illinois Department of Public Health and before that held the Public Health Administrator position with the Peoria City/County Health Department overseeing multiple counties. Parker is a recognized health leader in the community serving on a variety of community agency boards. To list a few, she served as President for the Rotary Club of Peoria, President of the Crittenton Centers Board, Human Service Board member now Trillium and was a member of the UICOMP Dean's Community Council for many years.

Andrea has an extensive list of awards and achievements, among her most recent accomplishments are being inducted into the Bradley University's Centurion Society, receiving the "25 Women in Leadership" and the "Women of Influence" awards. Other professional recognitions include the Bradley University Mildred Pflederer Memorial Alumni Award for contributions to public health nursing; the Illinois Department of Public Health's Exceptional Achievement Award, induction into the Peoria African American Hall of Fame Museum, and "Those Who Excel" award from IL State Board of Education as well as recognized as a 40 Leader Under 40. Parker holds an adjunct faculty position with Carle Health's Methodist College teaching both undergraduate and graduate nursing. She has also held adjunct faculty positions with Bradley University College of Heath Science and the University of IL College of Nursing. She has published articles and has been featured in multiple local journals for a variety of health topics. Journals such as Peoria Medicine- the Official Journal of the Peoria Medical Society, Healthy Cells Magazine, IBI, and the Peoria Women.

Chris Setti
Chris Setti is the CEO of the Greater Peoria Economic Development Council, a public-private organization that helps drive economic success in a five-county region of Central Illinois. Chris joined the EDC in 2018 after a 12-year career with the City of Peoria where he served in a variety of roles including Director of Economic Development and Assistant City Manager. Prior to his work with the city, Chris spent 10 years working in social services in Chicago, Denver and Peoria. Chris has a bachelor's degree in political science from the University of Notre Dame and a master's degree in public administration from the University of Colorado-Denver. Chris grew up in Southern California but has called Peoria his home since 2003.

Amanda Sutphen
Amanda Sutphen is the Director of Community Outreach for OSF Healthcare Saint Francis Medical Center. In this position, Amanda is responsible for leading the coordination of services and activities that impact Community Outreach and Benefits, to include Community Gardens, Faith Community Nursing, Community Clinic, School Nursing, Dental Clinic and Community Health Needs Assessment as well as Community Initiatives. Amanda develops and shares the vision and strategic direction for community outreach while collaborating and driving the implementation of the strategy. Amanda received a Bachelor of Science in Health from the University of Iowa and holds a master's degree in Community Health from Western Illinois University.

Jennifer Zammuto
Jennifer Zammuto brings corporate processes and customer focus to her work today in leading the Heart of Illinois United Way, a unique, data-driven, collaborative nonprofit organization.

Fluent in French, Jennifer studied at Northern Illinois University and Universite d'Avignon, and worked in Europe during her early career. While at Caterpillar, she earned an Executive MBA from Bradley University. An active community member, she served on almost every committee at the Heart of Illinois United Way before accepting the leadership role as President in 2018. Previously, she was a member of Downtown Rotary, CEO Council and the Center for Prevention of Abuse Board. Currently, Jennifer serves on the Greater Peoria EDC Governing Board, Nominating Committee and serves as Secretary, on the LISC Central Illinois Board, Choose Greater Peoria, Regional Workforce Alliance, the Tri County Partnership for a Healthy Community, Al Hooks Black Leadership Initiative and Bradley University's Turner School for Entrepreneurship and Innovation Advisory Council, serves as a judge for their Social Impact Challenge and the Big Idea competition and more.

FACILITATORS

Michelle A. Carrothers (Coordinator) is currently the Vice President of Strategic Reimbursement for OSF Healthcare System, a position she has served in since 2014. She serves as a Business Leader for the Ministry Community Health Needs Assessment process. Michelle has over 35 years of health care experience. Michelle obtained both a Bachelor of Science Degree and Masters of Business Administration Degree from Bradley University in Peoria, IL. She attained her CPA in 1984 and has earned her Fellow of the Healthcare Financial Management Association Certification in 2011. Currently she serves on the National Board of Examiners for HFMA. Michelle serves on various Peoria Community Board of Directors and Illinois Hospital Association committees.

Sara Kelly
Sara Kelly, Ph.D., MPH is a psychiatric epidemiologist and public health expert with extensive experience conducting research using national databases including public health surveillance, electronic medical records, clinical trials and population-based surveys. She currently serves as a Research Assistant Professor at the University of Illinois College of Medicine in Peoria, where she leads collaborative research efforts focused on pediatric health and well-being. She also holds faculty appointments at the Institute for Research on Addictions and AI.Health4All at UIC. Dr. Kelly has a robust background in epidemiology, having completed her postdoctoral fellowship and PhD at West Virginia University, and her MPH at East Tennessee State University. Her research spans various domains, including substance use, mental health, and health disparities. Dr. Kelly has contributed significantly to the field through numerous peer-reviewed publications and presentations at national conferences. She is also dedicated to community service, volunteering with organizations such as the JOLT Foundation and serving as a grant reviewer for the Heart of Illinois United Way. Her commitment to public health and her contributions to research make her an asset to the academic and healthcare communities. She currently leads the Data Team for the Partnership for Healthy Communities.

Dawn Tuley (Coordinator) is a Strategic Reimbursement Senior Analyst at OSF Healthcare System. She has worked for OSF Healthcare System since 2004 and acts as the coordinator for 15 Hospital Community Health Need Assessments. In addition, she coordinates the submission of the Community Benefit Attorney General report and the filing of the IRS Form 990 Schedule H since 2008. Dawn holds a master's in healthcare administration from Purdue University and is certified in Community Benefit. Dawn has been a member of the McMahon-Illini Chapter of Healthcare Financial Management Association for over twelve years. She has served as the Vice President, President-Elect and two terms as the Chapter President on the board of Directors. She has earned a silver, bronze, gold and Metal of Honor from her work with the McMahon-Illini HFMA Chapter. She is currently serving as a director on the board.

Dr. Laurence G. Weinzimmer, Ph.D. (Principal Investigator) is the Caterpillar Inc. Professor of Strategic Management in the Foster College of Business at Bradley University in Peoria, IL. An internationally recognized thought leader in organizational strategy and leadership, he is a sought-after consultant to numerous *Fortune 100* companies and not-for-profit organizations. Dr. Weinzimmer has authored over 100 academic papers and four books, including two national bestsellers. His work appears in 15 languages, and he has been widely honored for his research accomplishments by many prestigious organizations, including the Academy of Management. Dr. Weinzimmer has served as principal investigator for numerous community assessments, including the United Way, Economic Development Council and numerous hospitals. His approach to Community Health Needs Assessments was identified by the Healthcare Financial Management Association (HFMA) as a Best-in-Practice methodology. Dr. Weinzimmer was contracted for assistance in conducting the CHNA.

APPENDIX 2: ACTIVITIES RELATED TO 2022 CHNA PRIORITIZED NEEDS

OSF Saint Francis Medical Center in Peoria

Peoria: Services Provided

OSF HealthCare Saint Francis Medical Center has fulfilled the Mission of our Sisters since 1877. OSF Saint Francis has grown into the fifth-largest medical center in Illinois, with nearly 5,000 employees and 600+ patient beds. A major teaching affiliate of the University of Illinois College of Medicine Peoria, OSF Saint Francis is the area's only Level 1 Trauma Center and tertiary care medical center. We are also home to OSF HealthCare Children's Hospital of Illinois, OSF HealthCare Cancer Institute and the OSF HealthCare Illinois Neurological Institute. OSF HealthCare is a Catholic, 16-hospital health system serving Illinois and Upper Peninsula of Michigan, driven by our Mission to "serve with the greatest care and love." Key services include: behavioral health; cancer; cardiovascular; diabetes; emergency services; lung & pulmonology; neurology; pediatrics; rehabilitation; specialty services; surgery; testing & diagnostics; transplant services; wellness services; weight management & women's health.

OSF Saint Francis employs a staff of highly experienced and exceptionally trained Mission Partners. These compassionate caregivers may be found throughout OSF Saint Francis in clinical and non-clinical roles, performing a variety of services. In addition to providing direct patient care, we coordinate patient care with other disciplines, including nutrition, pharmacy, social and insurance services, along with senior and weight management services.

This interdisciplinary team meets daily at the bedside with the patient and family to discuss the patient's goals for discharge, education and equipment needed and patient responsibilities upon discharge.

Peoria: Goals and Accomplishments

The Partnership for a Healthy Community led a collaborative approach in conducting a Community Health Needs Assessment (CHNA) for the Tri-County region. The Partnership for a Healthy Community is a multi-sector community partnership working to improve population health. The Partnership for a Healthy Community (PFHC) formed an ad-hoc committee creating a collaborative team to facilitate the CHNA. This collaborative team included members from: Bradley University, Carle Eureka Hospital, Heart of Illinois United Way, Heartland Health Services, Hopedale Medical Complex, OSF Saint Francis Medical Center, Peoria City/County Health Department, Tazewell County Health Department, UnityPoint Health – Central IL and Woodford County Health Department. They conducted the Tri-County CHNA to highlight the health needs and well-being of residents in the Tri-County region. Several themes are prevalent in the collaborative CHNA – the demographic composition of the Tri-County region, the predictors for and prevalence of diseases, leading causes of mortality, accessibility to health services and healthy behaviors. Results from this study can be used for strategic decision-making purposes as they directly relate to the health needs of the community. The study was designed to assess issues and trends impacting the communities served by PFHC stakeholders, as well as perceptions of targeted stakeholder groups.

The collaborative team identified three significant health needs and prioritized both to be addressed in the Community Health Needs Implementation Strategy.

1. **Healthy Eating/Active Living – defined as active living and healthy eating, and their impact on obesity, access to food, and food insecurity**
2. **Mental Health - defined as depression, anxiety, and suicide**
3. **Obesity - defined as overweight and obese**

Healthy Eating/Active Living (HEAL)

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

OSF Saint Francis Medical Center is collaborating with the PFHC in an effort to achieve this strategic goal. The PFHC is a multi-sector community initiative leading and supporting collaborative work within the community to drive health outcomes identified in the CHNA in the Tri-County area.

Goal 1: *Increase consumption of vegetables by individuals aged 2 years and older living in the Tri-County*

1. Outcome Measure 1: Decrease the number of CHNA survey respondents in the Tri-County reporting no consumption (0 servings per day) or low consumption (1-2 servings per day) of fruits and vegetables per day by 2%, from 67% to 65%.
2. Baseline Tri-County CHNA 2022: 67% of respondents reported low or no consumption of daily vegetables or fruits.

SFMC ACTIONS	IMPACT/PROGRESS for FY 2024
(1) Expand Gardens of Hope community outreach efforts Increase number of persons served 2% (FY22 Baseline: 16,879 Faith Community Nursing Encounters) Increase pounds of produce distributed 2% per year (FY22 Baseline: 12,629) Provide at least 4 community garden consults during 2023-2025 (2) Provide healthy eating education and awareness through community or social media outreach efforts	(1) 2024 total encounters increased to 24,934 encounters 2024 increased total pounds of produce distributed to 12,737 pounds 2024 - 2 community garden consults were provided (2) 33 outreach events provided contributing to increased community awareness concerning healthy eating

Goal 2: *Increase the proportion of individuals living in the Tri-County who participate in regular physical activity*

1. Outcome Measure 1: Increase the percentage of CHNA Survey respondents who report exercising 1-5 times per week from 60% to 61%
    a. Baseline Tri-County CHNA 2022: 60% of Residents report exercising 1-5 times per week)
2. Outcome Measure 2: Decrease the percentage of adults aged 18 and over reporting no leisure-time physical activity in the past month in each county
3. Baseline from County Health Rankings & Roadmaps: 27% Peoria, 24% Tazewell, & 23% Woodford

SFMC ACTIONS	IMPACT/PROGRESS for FY 2024
(1) Increase participation in SFMC Medical Exercise (2) Implement physical activity programs for older adults (Matter of Balance) (3) Increase the number of physical activity programs provided by Faith Community Nursing in a community setting	(1) Increased participation to 57,980 participants (2) Coaches trained and baseline established in 2023, paused due to retirement (3) Actions contributed to increased physical activity in the community with 1,186 persons served by such programs

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, 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.

OSF Saint Francis Medical Center is collaborating with the PFHC in an effort to achieve this strategic goal. The PFHC is a multi-sector community initiative leading and supporting collaborative work within the community to drive health outcomes identified in the CHNA in the Tri-County area.

Goal 1: *Reduce the proportion of individuals with obesity in the Tri-County*

1. Outcome Measure: Decrease the percentage of population with a body mass index considered obese in the Tri-County by 1%
    a. Baseline from County Health Rankings & Roadmaps: 39% Peoria, 33% Tazewell, & 32% Woodford
2. Outcome Measure 2: Decrease the number of children aged 3-17 years old who are considered obese at well child visits in the Tri-County by 1%
    a. Baseline from SFMC Internal Data: 20% Peoria, 20% Tazewell, & 16% Woodford

SFMC ACTIONS	IMPACT/PROGRESS for FY 2024
(1) Support PFHC's implementation of Strong People - Healthy Weight Program	(1) 13 participants, 18.9 pounds lost
(2) Increase number of persons served by SFMC Weight Management Clinic	(2) Increased number of persons served to 17,261
(3) Increase number of persons served by CHOI Healthy Kids U Clinic, including virtual clinical interactions	(3) Actions contributed to 2000 persons being served
(4) Collaborate with OSF Medical Group to increase the number of overweight or obese patients that receive weight management counseling during a provider visit and are referred to services	(4) Actions contributed to 2,447 individuals being referred for necessary weight loss services

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.

OSF Saint Francis Medical Center is collaborating with the PFHC in an effort to achieve this strategic goal. The PFHC is a multi-sector community initiative leading and supporting collaborative work within the community to drive health outcomes identified in the CHNA in the Tri-County area.

***Goal 1: Reduce** the percentage of individuals in the Tri-County who report poor overall mental health*

1. Outcome Measure 1: Decrease the percentage of CHNA survey respondents in the Tri-County who self-assessed their overall mental health status as "poor" from 16% to 15%
    a. Baseline Tri-County CHNA 2022: 16% of respondents reported "poor" self-assessed mental health
3. Outcome Measure 2: Decrease the percent of adults reporting frequent mental distress (14+ poor mental health days per month) in the Tri-County from 15% to 14% (Peoria) and 14% to 13% (Tazwell & Woodford)
    a. Baseline from County Health Rankings & Roadmaps: 15% Peoria, 14% Tazewell, & 14% Woodford

TACTICS	PROGRESS for FY 2024
(1) Implementation of behavioral health tele-medicine	(1) Implemented in October 2023, expanding access to available behavioral health services, including 409 consults provided in FY 2024
(2) Advance safe and consistent therapeutic care for behavioral health in ED	(2) ED Behavioral Health Checklist was developed and implemented with all Behavioral Health Patients - an assessment was performed of the checklist Two "Be Mindful" sensory carts implemented in Children's Hospital
(3) Advance cultural competency for behavioral health mission partners	(3) 1:1 observation behavioral health checklist was reviewed for cultural competency and optimized. Completed by all identified Mission Partners
(4) Increase outpatient Behavioral Health encounters	(4) Increased behavioral health encounters to 18,474
(5) Increase behavioral health screenings in outpatient settings	(5) Actions contributed to 73% of patients in the outpatient setting being screened within the last 365 days for depression and anxiety

Carle Greater Peoria

Evaluation of Prior Impact

Based on the Community Health Needs Assessment, which utilized both quantitative and qualitative research, Carle Health Greater Peoria prioritized the significant community health needs of the Tri-County area. Several criteria were considered in this prioritization, including alignment with the hospital's mission, existing programs, the potential to make an impact within a reasonable timeframe, the financial and resource requirements, and the ability to measure outcomes to gauge improvement.

The following health areas were selected as the top priorities:

1. **Mental Health**
2. **Healthy Eating Active Living**
3. **Obesity**
4. **Cancer**

As a result, Carle Health Greater Peoria inclusive of Methodist Medical Center, Pekin Community Hospital, and Proctor Hospital committed time and resources for each of these identified health priorities, as described below.

Mental Health

Evaluation of Prior Impact

In the 2022 Community Health Needs Assessment, as well as previous Community Health Needs Assessments, Mental Health was identified and prioritized as a significant health need.

In response, Carle Health Greater Peoria took the following actions:

1. Opened a new behavioral health facility, Young Minds Center, for youth and families. Young Minds Center increased inpatient beds for youth, added an assessment and intake center for crisis situations to reduce Emergency. Department visits, and expanded outpatient services.
2. Increased the number of prescribers by 6 since 2022.
3. Increased the number of psychiatric residents by 18 residents across 2025-2028 graduation years.
4. Implemented Mental Health First Aid and trained 225 individuals representing healthcare, first responders, and students.
5. Trained 76 staff on trauma-informed care through National Council training.
6. Implemented care coordination on inpatient units to assist patients in overcoming barriers to accessing care.
7. Implemented a multi-disciplinary team daily huddle to collaborate regarding patient care, improving access and streamlining transitions to lower levels of care.
8. Began a co-responder program in collaboration with the Peoria Police Department.
9. Expanded availability of Assertive Community Treatment (ACT) to Tazewell and Woodford County.
10. Increased efforts to engage the community through radio and billboard ads, service provision in community settings, and partnerships with other organizations.
11. Expanded operating hours of the Living Room program to 24/7 and outreach to individuals in Tazewell County to increase utilization and provide an alternative to crisis level services and emergency department visits.

Behavioral health needs continue to be an issue across the Tri-County. Lack of resources, funding, and stigma contribute to the issue in Peoria, Tazewell, and Woodford County. According to County Health Rankings the ratio of mental health providers per 100,000 has improved drastically over the past decade;

Peoria County: 2011 - 3,169:1 and 2025 - 320:1; Tazewell County: 2011 - 9,392:1 and 2025 - 430:1; Woodford County: 2011 - 38,516:1 and 2025 - 2,250:1.

According to the most recent data from the Illinois Department of Public Health, suicide deaths for all counties in the Tri-County are higher than the State of Illinois rate. From 2017-2021, the Illinois suicide incidence rate was 11 per 100,000 and Peoria County was 15, Tazewell County was 14, and Woodford County was 12. There is still work for Carle Health Greater Peoria to do in this space.

Carle Health Greater Peoria has contributed to the increase in mental health providers per 100,000 since the last Community Health Needs Assessment. Carle Health Greater Peoria's actions and financial commitments have supported improved access to care for behavioral health in Peoria, Tazewell, and Woodford County.

Healthy Behaviors – Active Living, Healthy Eating, and Obesity

Evaluation of Prior Impact

In the 2022 Community Health Needs Assessment, *Healthy Behaviors – Active Living, Healthy Eating, and Obesity* were identified as significant health priorities for the Tri County Region.

In response, Carle Health Greater Peoria implemented several community-based initiatives aimed at increasing access to nutritious foods, promoting physical activity, and addressing the social determinants that contribute to obesity:

1. Through health education provided by Hult Center for Healthy Living, 14,747 youth and adolescents in the Tri County area received evidence-based nutrition and physical activity education.
2. In 2023 and 2024, Family Medical Center collected 1,179 pounds of fresh food from their community garden. Almost 400 pounds were donated to food pantries and through a mobile food pantry event.
3. Through the grant-funded WELL Program, facilitated by the Hult Center for Healthy Living, 194 at-risk youth and adolescents received individualized one-on-one health coaching. Over 500 hours of coaching were delivered across seven schools, helping participants overcome barriers to health and empowering them with the skills and knowledge to lead healthier lives.

Despite these efforts, obesity remains a persistent public health challenge in the region. Like many communities across the country, Peoria is experiencing rising rates of obesity and related chronic conditions. Obesity is associated with a range of serious health issues, including heart disease, stroke, type 2 diabetes, certain cancers, and mental health challenges. These conditions not only reduce quality of life but also contribute significantly to healthcare costs and premature mortality.

According to the 2023 County Health Rankings & Roadmaps, 34.4% of adults in Peoria County are classified as obese. The economic and societal impact of obesity is profound, driving up healthcare expenditures and affecting workplace productivity through increased absenteeism and disability.

Improving nutrition and increasing opportunities for physical activity are essential strategies in reversing these trends. While Carle Health Greater Peoria is encouraged by the progress made, the organization recognizes that sustained, collaborative efforts are needed to make a lasting impact. Carle remains committed to advancing health equity and fostering healthier communities through ongoing investment, innovation, and partnership.

Cancer

Evaluation of Prior Impact

Cancer was identified as a priority concern during the previous Community Health Improvement Plan (CHIP) cycle. As part of ongoing performance management efforts, initiatives aimed at cancer prevention, screening, and early detection will continue to be monitored to ensure a positive impact on community health outcomes.

1. In response to the identified need, Carle Health Greater Peoria implemented several targeted actions during 2024. Two Cancer Screening Days were conducted to improve access to early detection services. The first event took place in May 2024 at Carle North Allen, resulting in a total of 65 cancer screenings completed. The second event was held in August 2024 in Pekin, with 61 screenings performed.
2. To further strengthen cancer intervention efforts, the Carle West Oncology Navigation Team expanded its services by adding a dedicated lung screening specialist role, enhancing the organization's capacity to support lung cancer early detection and patient navigation.

ANNUAL DATA REPORT

Q2 2025

DATA TEAM

TABLE OF CONTENTS

Partnership for a Healthy Community

EXECUTIVE SUMMARY

The 2025 Annual Data Report leverages a comprehensive array of public health surveillance systems to analyze trends in mortality, morbidity, and emerging health concerns, with a focused lens on the Tri-County region. The report provides a comprehensive review of mortality across multiple measures, including overall mortality rates (adult, youth, and infant), leading causes of death, and Years of Potential Life Lost (YPLL). Where necessary, data were suppressed to maintain confidentiality and ensure statistical reliability.

This year's data reports produced by the PFHC data team incorporate several newly analyzed data sources to enhance understanding of health indicators and vulnerable populations across the Tri-County region. These additions include updated community-level data from healthcare systems and measures that offer deeper insight into social and environmental determinants of health. Notably, the Point-in-Time Count (PITC), and Child Opportunity Index (COI) 3.0 have been integrated. The COI is a nationally recognized tool that evaluates the quality of resources and conditions essential for children's healthy development and long-term success, spanning domains such as education, health, environment, and socioeconomics. This index is particularly valuable for identifying disparities in opportunity among youth and informing targeted strategies to address youth-related challenges. Additionally, updated hospital data from OSF reflects priority health areas—obesity and mental health—based on 2024 encounter data. These data also include indicators related to social drivers of health documented in medical records for the Tri-County population, further enriching the understanding of community health needs.

KEY HIGHLIGHTS FROM SUBCOMMITTEES

HEALTHY EATING ACTIVE LIVING (HEAL)

- **Accomplishment:** The HEAL Food System Partners received another $10,000 grant to continue impactful work, demonstrating the team's ability to achieve results with limited funding.
- **Focus:** Actively planning outreach events for the 2025 Hunger Action Month and the September Walk, which will be held in Woodford County.

OBESITY

- **Accomplishment:** Continued work on a collaborative grant that examines the impact of social media on obesity among youth. Applied for an extension last month. Results and recommendations will be shared to partnership upon completion.
- **Focus:** Analysis will take place upon closing survey and plan will be developed for follow up (Practice Tool-kit).

MENTAL HEALTH

- **Accomplishment:** Finalized provider list for the community that encompasses providers that offer Telepsych in the Tri-County region.
- **Focus:** Provide future training opportunities will be offered by CAHC as well as additional efforts focused on distributing regional provider list to the community.

ADDITIONAL DETAILS

The Data team supports committees with data-driven insights and helps identify emerging health issues and disparities resulting in quarterly reports. Prior quarterly data reports produced by the PFHC data team are publicly available and can be accessed through the Partnership for a Healthy Community website at https://healthyhoi.org.

OUTPUTS & OUTCOMES

Partnership for a Healthy Community

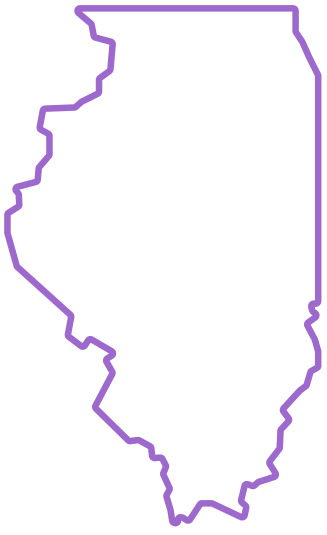
Recent committee reports from the HEAL (Healthy Eating Active Living), Obesity, and Mental Health teams underscore the continued dedication and impact of these groups in addressing priority health concerns across the Tri-County region.The HEAL team has advanced initiatives promoting access to nutritious foods and opportunities for physical activity, particularly in underserved neighborhoods. The Obesity team has focused on community-based interventions and data-informed strategies to reduce obesity rates, including efforts aligned with updated hospital encounter data. Meanwhile, the Mental Health team has prioritized expanding behavioral health resources, reducing stigma, and improving access to care through cross-sector collaboration. These accomplishments reflect the strategic alignment of committee efforts with identified community needs and reinforce the importance of sustained, coordinated action.

Further investigation for this report include updated mortality patterns using national and state-level data sources, including CDC WONDER, the Illinois Violent Death Reporting System (ILVDRS), and the State Unintentional Drug Overdose Reporting System (SUDORS). Suicide-related deaths were analyzed using ILVDRS and CDC WONDER, revealing that while rates remain highest among the Non-Hispanic White population, the rate of increase is substantially greater among the Non-Hispanic Black population. Additional insights are provided for suicide-related deaths in Peoria by race and age group; data for other counties are currently unavailable but efforts are underway to obtain additional local sources.

Overdose deaths were similarly examined using ILVDRS and CDC WONDER, with additional tables included for Peoria by race and age group. Due to suppression constraints related to low counts, comparable data for other counties could not be reported. In the following sections, we will highlight the overall strengths and challenges in Illinois, followed by a deeper examination of health factors and health outcomes specific to Peoria, Tazewell, and Woodford Counties. Additionally, we will provide a brief overview of mortality trends—including overall rates, youth-specific data, and emerging issues—based on insights from multiple public health surveillance systems.

ILLINOIS

In regards to Illinois, the following strengths and challenges have been identified when comparing to national estimates.



Top strengths	Top challenges
• Lower Prevalence of Non-Medical Drug Use • Lower Rates of Frequent Mental Distress • Fewer Adverse Childhood Experiences (ACEs) • Improved Water Quality and Fluoridation	• High Homicide Rate • High Prevalence of Excessive Drinking • Residential Segregation (Black/White) • Housing with Lead Risk • Premature Death

Illinois has seen improvement in several health indicators in recent years, including a **51% reduction in both unemployment and the uninsured population** between **2013 and 2023,** reflecting improved economic stability and access to healthcare. However, Illinois also faces significant challenges including a **76% increase in homicide rates and a 21% rise in adult diabetes prevalence** over the past decade. These trends, along with persistent issues like low fruit and vegetable consumption, housing with lead risk, and racial disparities, highlight the need for targeted public health interventions across the state.

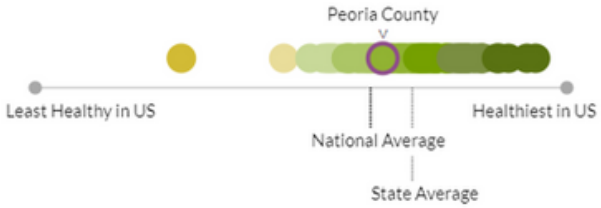
Data source:America's Health Rankings

HEALTH OUTCOMES BY COUNTY

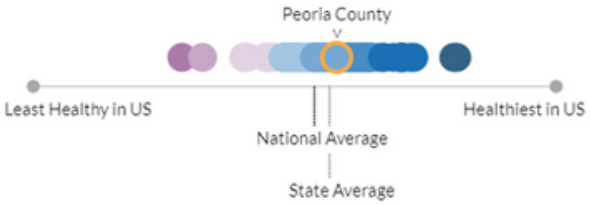
Partnership for a Healthy Community

PEORIA

Health Outcomes:
Peoria County is faring about the same as the average county in Illinois for health outcomes, and slightly better than the average county in the nation.

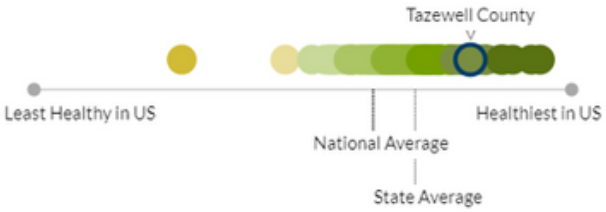


Health Factors:
Peoria County is faring about the same as the average county in Illinois for health factors, and about the same as the average county in the nation.

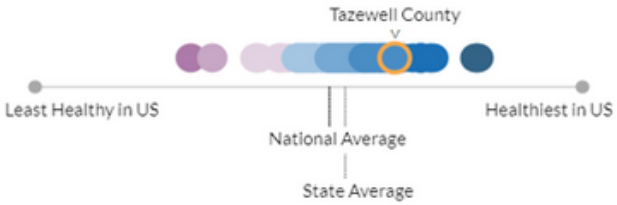


TAZEWELL

Health Outcomes:
Tazewell County is faring better than the average county in Illinois for health outcomes, and better than the average county in the nation.



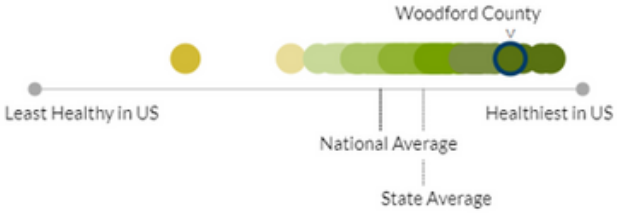
Health Factors:
Tazewell County is faring slightly better than average county in Illinois for health factors, and slightly better than the average county in the nation.



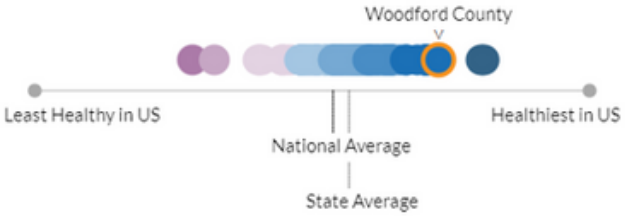
WOODFORD

WOODFORD COUNTY

Health Outcomes:
Woodford County is faring better than the average county in Illinois for health outcomes, and better than the average county in the nation

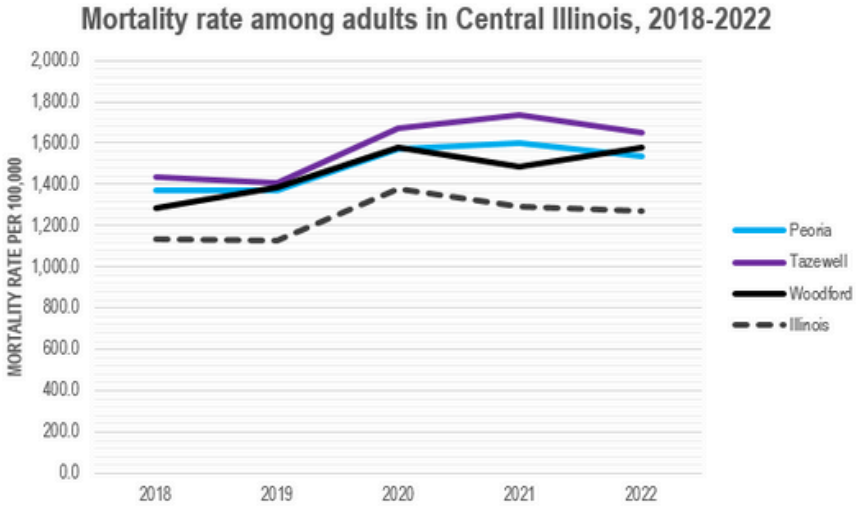


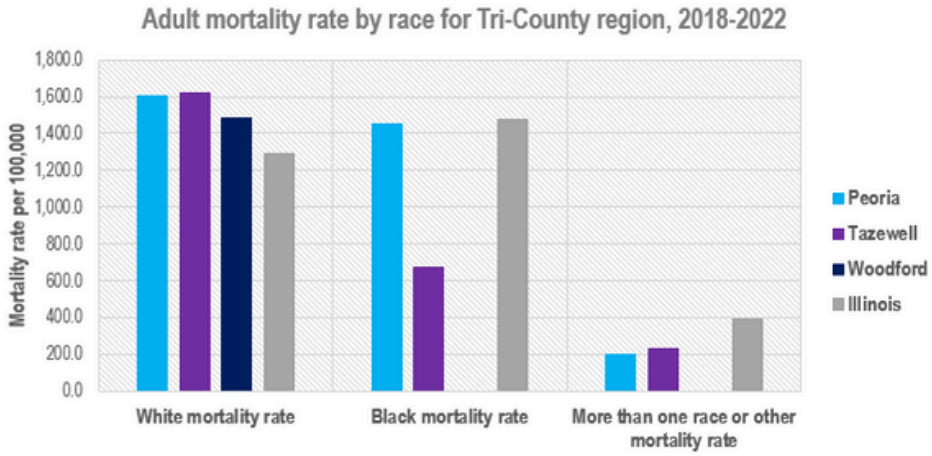
Health Factors:
Woodford County is faring better than the average county in Illinois for health factors, and better than the average county in the nation.



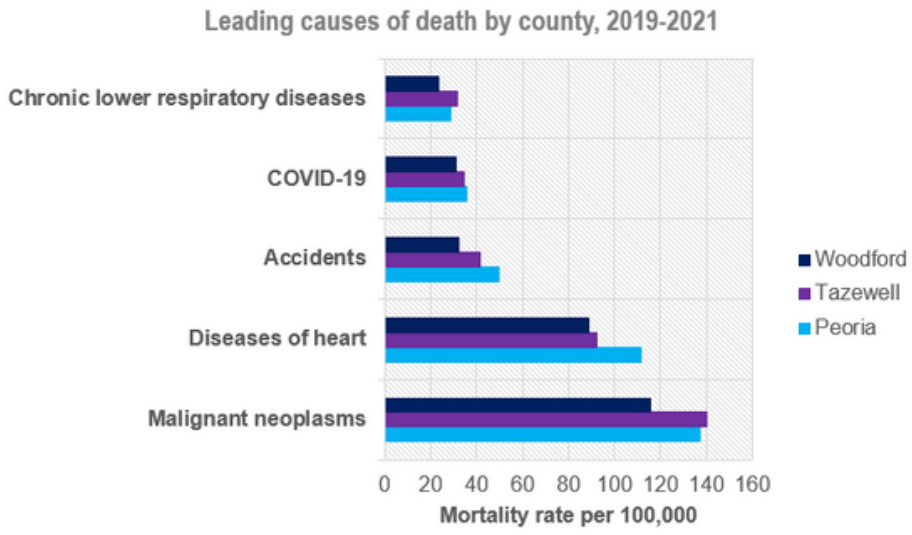
MORTALITY

ADULT





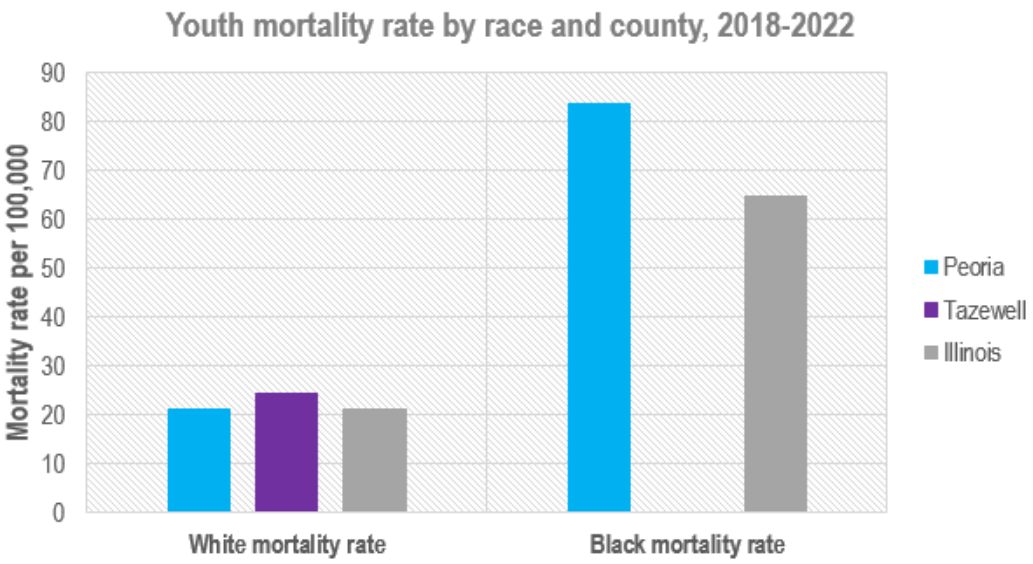
LEADING CAUSE OF DEATH



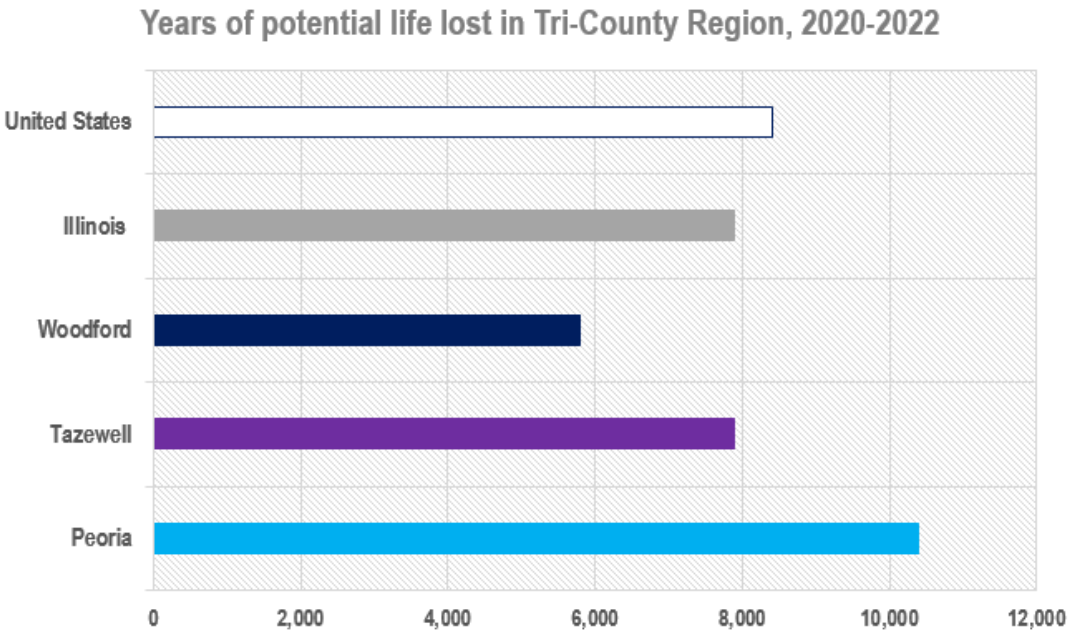
YOUTH MORTALITY

Partnership for a Healthy Community

YOUTH

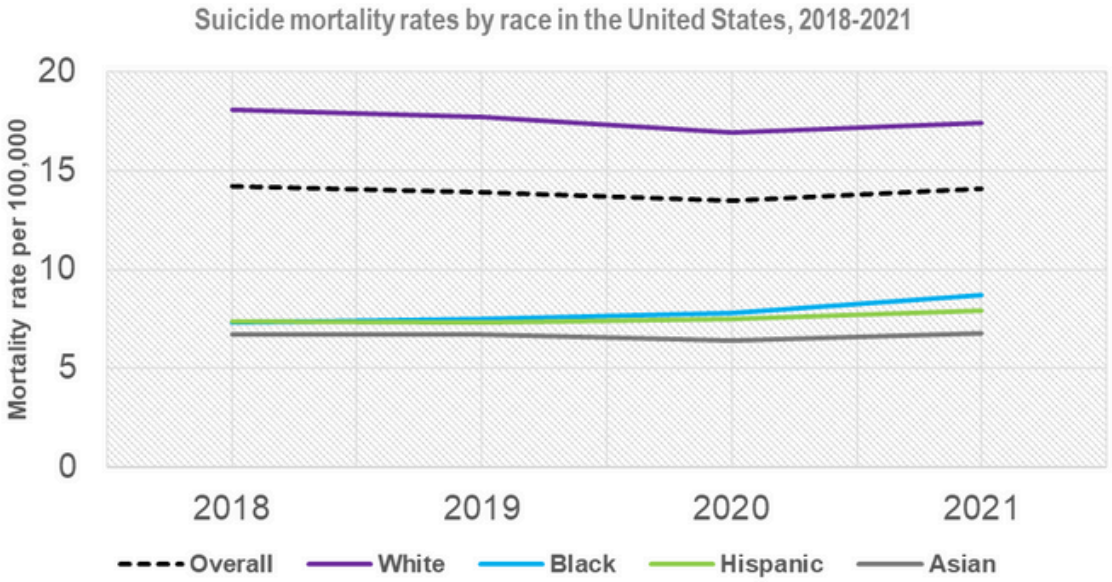


YEARS OF POTENTIAL LIFE LOST BEFORE THE AGE 75 PER 100,000

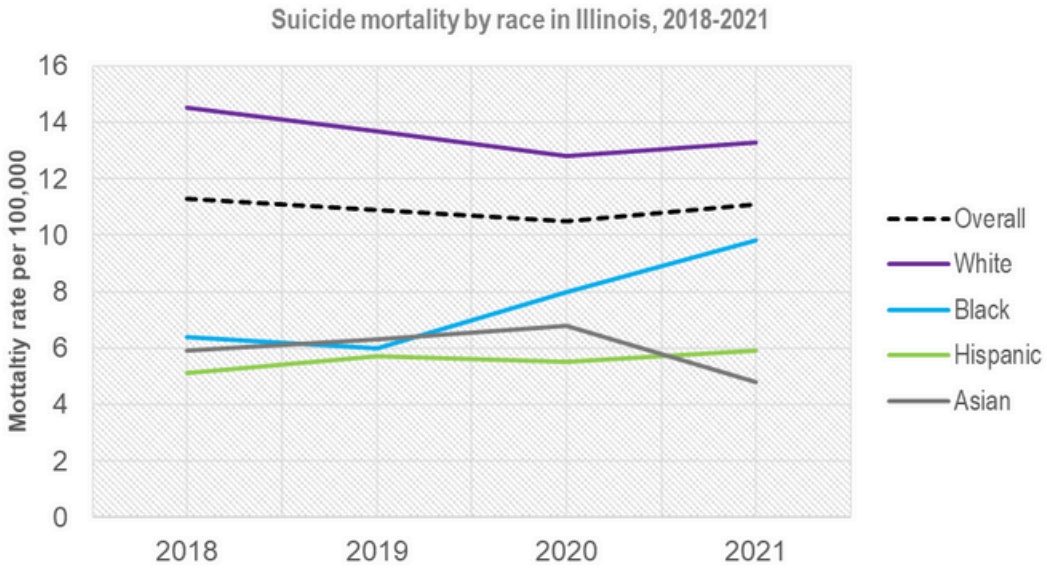


SUICIDE MORTALITY

NATIONAL

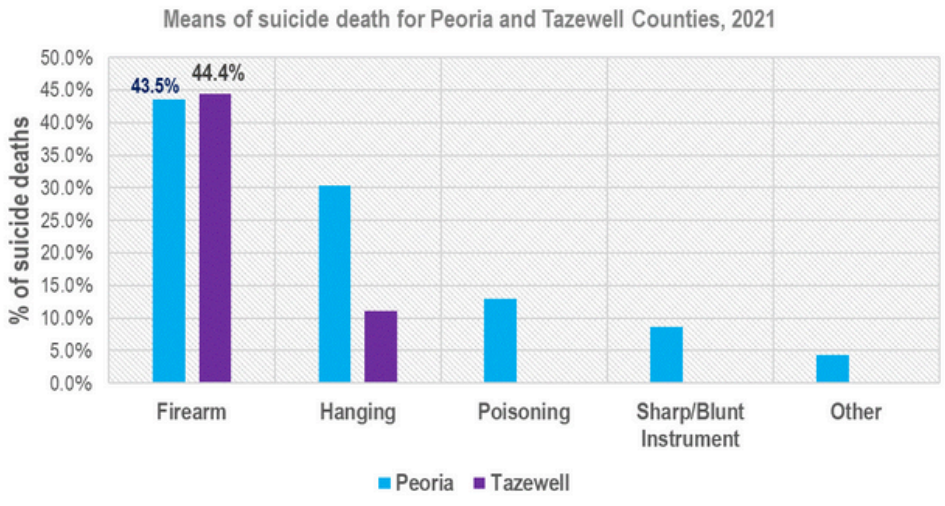


ILLINOIS



Data source: CDC WONDER, Suicide ICD-10 codes included: X60-X84, Y87.0,*U03

MEANS OF DEATH



EMERGING ISSUES BY COUNTY

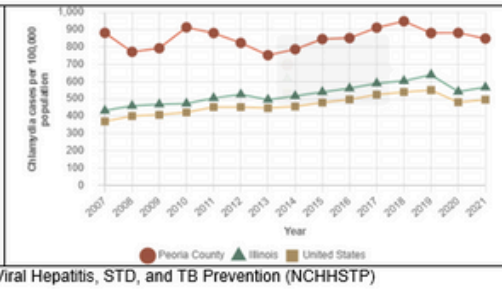
Partnership for a Healthy Community

PEORIA

SEXUALLY TRANSMITTED INFECTIONS

In Peoria County, Illinois, 849.3 new cases of chlamydia were diagnosed per 100,000 people. *(Peoria is getting worse for this measure.)*

Definition: Number of newly diagnosed chlamydia cases per 100,000 population.

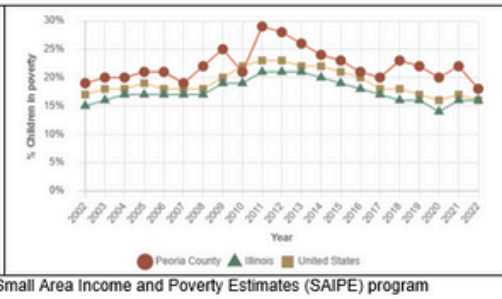


Data source: National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)

CHILDREN LIVING IN POVERTY

In Peoria County, Illinois, 18% of children lived in poverty.

Definition: Percent of people under 18 years in poverty. Prior to 2005, Children in poverty was based on the Current Population Survey; beginning in 2005, it was based on the American Community Survey



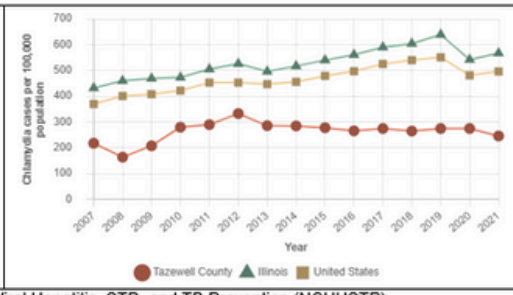
Data source: American Community Survey, Small Area Income and Poverty Estimates (SAIPE) program

TAZEWELL

SEXUALLY TRANSMITTED INFECTIONS

In Tazewell County, Illinois, 246.1 new cases of chlamydia were diagnosed per 100,000 people. *(Tazewell is getting worse for this measure.)*

Definition: Number of newly diagnosed chlamydia cases per 100,000 population.

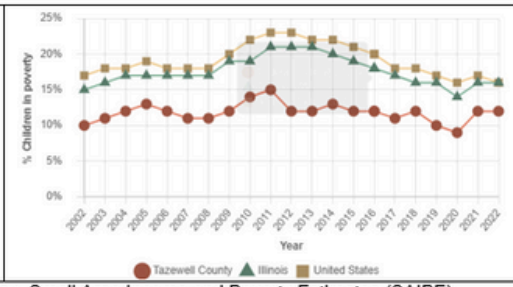


Data source: National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)

CHILDREN LIVING IN POVERTY

In Tazewell County, Illinois, 12% of children lived in poverty.

Definition: Percent of people under 18 years in poverty. Prior to 2005, Children in poverty was based on the Current Population Survey; beginning in 2005, it was based on the American Community Survey



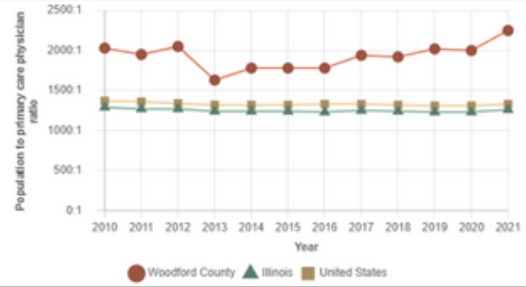
Data source: American Community Survey, Small Area Income and Poverty Estimates (SAIPE) program

WOODFORD

ACCESS TO PRIMARY CARE PHYSICIANS

There was one primary care physician per 2,250 people in Woodford County, Illinois.

Definition: Ratio of population to primary care physicians



Data source: Area Health Resource File/American Medical Association

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 of the HEAL team is to increase vegetable consumption among children and physical activity among adults. Additionally, they focus on increasing access, family stabilization, and supporting healthy food policies in the region.

Over the past year, the HEAL committee has been actively providing an array of community-based initiatives that focus on promote physical activity, gardening, and improved nutrition. Highlights include Hunger Action Month activities such as food drives, community walks, and educational campaigns. The Eatable Alphabet program reached **over 500 children** and families, and the Nutrition Security Summit brought together stakeholders to address food access and policy. The HEAL team also maintains a network of community gardens and food system partners.

Hunger Action Month

Hunger Action Month (HAM) was established nationally by the Feeding America network in 2008 to mobilize public action around the issue of hunger. Locally, the Partnership for a Healthy Community's HEAL (Healthy Eating Active Living) priority area has formed a dedicated HAM subcommittee in response to the estimated 42,000 individuals in the Tri-County region who lack access to sufficient nutritious food for an active, healthy life. This subcommittee works collaboratively to raise awareness, provide education, and promote actionable engagement around hunger and health needs in Peoria, Tazewell, and Woodford Counties. Key partners include Midwest Food Bank – Peoria, Peoria Area Food Bank, Tazewell County Health Department, Peoria City/County Health Department, Woodford County Health Department, Tri-County WIC, Oak Street Health, and University of Illinois Extension SNAP-Education teams in Peoria/Tazewell and Woodford.

HEAL's Hunger Action Month activities span a wide range of community engagement efforts, including social media campaigns, Wear Orange Day, Nourish Your Neighbor food drives in partnership with Kroger, the Tri-County Hunger Walk, and symbolic bridge lighting events. These efforts are supported by a comprehensive Hunger Action Month Community Toolkit and formal proclamations issued by local city and county governments.

Social media outreach resulted in 80 posts, 449 shares, and 1,023 likes, reaching over 51,000 individuals. The "Filling the Gap" video series further amplified educational efforts, generating over 5,300 online engagements. The Lulu & the Hunger Monster reading initiative reached more than 500 children across

36 classes, supported by donated books, trained volunteers, and coordinated reading sessions in pre-K classrooms throughout the region.

The Nourish Your Neighbor Food Drive engaged 10 Kroger stores and supported 12 local pantries (including 1 in Woodford, 7 in Peoria, 3 in Tazewell, and 1 in Fulton), resulting in nearly $800 in donations. The Tri-County Hunger Walk raised awareness and promoted physical activity, with 75 walkers covering a combined 37.5 miles and donating over 1,174 pounds of preferred food items to four local pantries, supported by 25 volunteers and six vendors.

Community Gardens

Food system partners across the Tri-County region have actively worked to improve access to community gardens, supporting a network of 36 gardens that collectively produced 17,858 pounds of healthy food for local residents. In addition to increasing food access, educational efforts reached 565 children and families through Eatable Alphabet classes, which promote nutrition literacy and healthy eating habits.

To further strengthen regional collaboration, the Nutrition Security Summit convened 75 attendees, featured six community tour stops, and offered 11 learning sessions focused on aligning and expanding food system partnerships. A Community Advisory Board (CAB) was established to ensure community voice and representation in planning efforts. The CAB includes 11 members from across the region—2 from Woodford, 2 from Tazewell, and 8 from Peoria—who provided valuable feedback that informed the Summit's content and direction.

Evaluation metrics for each intervention

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 (05/25)**	**Upcoming Work**
HE 1: Gather baseline data around community gardens and school-aged programming.	• Complete a comprehensive list establishing locations of community gardens and school aged gardening programs. • # of children/families accessing the community gardens	37 gardens By January 2024, recruit Woodford County community gardens. April 2023 – Identify # of children and families that accessed the garden	Mike – around 40 gardens – maybe some needs for Woodford county and what we are able to receive	Updated with all but some Woodford county gardens – check in with Emily Kelly about this
HE 2: HE 2: Implement garden-based learning sessions focused on gardening and healthy eating.	• # of children/families attending information sessions about gardening and healthy foods.	April 2023 – Identify # of children and families that attended garden-based learning	ONGOING Flyer for Toolkit: https://uofi.box.com/s/tb3yw0c7qylzypn374elqwn8ar89kdda Registration for Toolkit: https://go.illinois.edu/HEALgardentoolkit	Sharing of Toolkit – ongoing Garden classes – check in with dr kelly see if anything was turned in, dr. Amy – can we

	• 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.	Fresh from the Garden Friday's – Highlighting Produce grown in local gardens and utilizing in a recipe to feed families Emily enjoyed making the videos and it helped because the produce is something people want to know how to use. Miranda sees use too in the videos Springtime to start planning Timeline – June to shoot videos – July start airing the videos based on foods available Sprout & Share Saturdays – connecting Valerie & Mike to begin planning Jd – series was more time intensive. Could we	Planning for national nutrition month – Rebecca to follow up with HE team about wants and next steps/planning Mike – starting to look at gardens that were featured in last sprout and share and think about new gardens to feature

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**	**Upcoming Work**
PA 1: Increase data collection focusing on adult physical activity in the Tri-County Region.	# of establishments collecting adult physical activity data in the Tri-County Region			
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) 2023-14 partners 2024-16 partners	No updates	
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 – 2 campaign: Take A Walk Wednesdays. Move it Monday*	Talked about move-it Mondays and sending out updates about future campaigns on the days they are running to get people to share the info Interested in opportunities to promote/showcase Local Opal this Summer and highlight local parks/ways to be in nature and get PA	
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	Find more opportunities to promote events for physical activity partners are hosting Eg. Midweek Movers – TCHD Support created opportunities and help spread the word	

Current challenges or needs for selected interventions

Community Garden Intervention

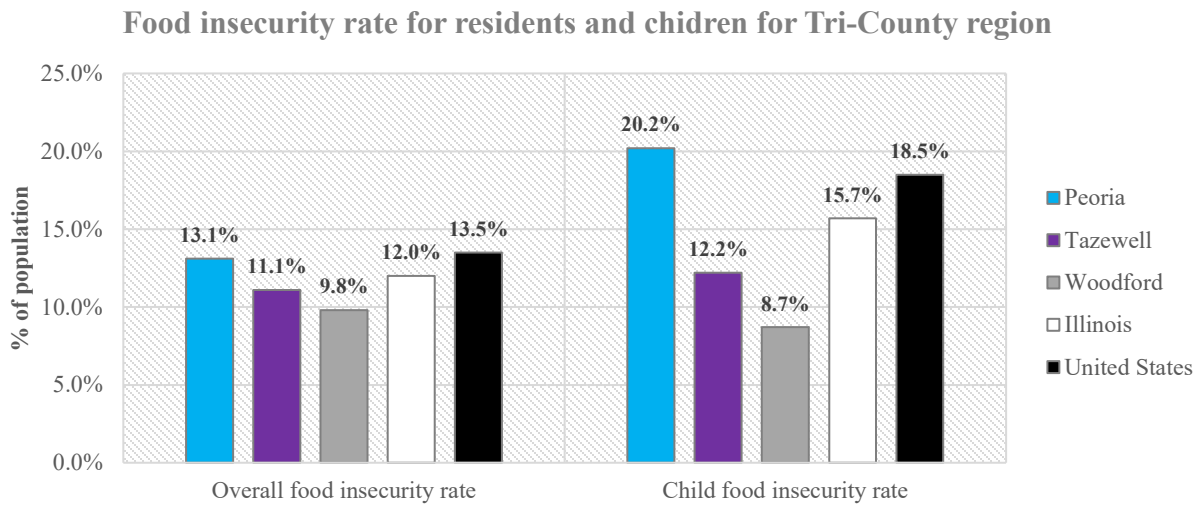
- *No education during winter.*

Physical Activity Intervention

- *No challenges noted at this time*

Public health surveillance data

Healthy Eating (HE)



Data sources:

1. 2022 Map the Meal Gap from Feeding America

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.

Change in Food Environment Index (FEI)	2020	2021	2022
Peoria	6.9	7.2	7.3
Tazewell	8.0	8.2	8.1
Woodford	8.9	9.1	8.9
Illinois	8.5	8.4	8.4
United States	7.0	7.7	7.4

FEI is based off of data from USDA Food Environment Atlas; Map the Meal Gap from Feeding America.

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

Physical activity (PA)

	Peoria	Tazewell	Woodford	Illinois	United States
Access to exercise opportunities[1]	80%	83%	75%	91%	84%
% physical inactivity[2]	25%	21%	22%	22%	23%

Data sources:

1. 2024, 2022 & 2020 ArcGIS Business Analyst and Living Atlas of the World; YMCA; US Census TIGER/Line Shapefiles
2. 2022 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.

Physical inactivity is defined as no leisure-time physical activity in the past month.

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.

Over the past year the Obesity Team efforts include the "Strong People Healthy Weight" program targeting adults in high-risk areas like Northeast Peoria County, with a 12-week curriculum combining nutrition education and physical activity. Pilot results showed improvements in weight, fitness, and blood pressure. For adolescents, digital interventions and health coaching programs like WELL and Healthy Kids U have reached hundreds of youth, with expanded services and partnerships with schools and universities.

Evaluation metrics

Strong People Healthy Weight

The selected intervention was an evidence-based program designed to promote physical activity and healthy dietary habits among middle-aged adults. The initial implementation site was Northeast Peoria County, identified as a priority area due to its notably high adult obesity rate of 47%. The program included comprehensive fitness assessments conducted at both Week 1 and Week 12, measuring lower body strength (chair stand), upper body strength (arm curl), lower body flexibility (sit-and-reach), agility and dynamic balance (8-foot up-and-go), and aerobic endurance (6-minute walk).

A total of 13 participants completed the program, with results indicating increased walking distance and improved blood pressure among participants. Below are the pilot outcomes from this cohort, demonstrating the program's effectiveness in promoting measurable health improvements.

Measure	Weight (lbs)	Hip (in)	Waist (in)
Average lost	1.72	1.70	1.35
Total lost	18.9	17	13.5

Digital Intervention for Adolescents with Obesity

The subcommittee was awarded a $50,000 Innovation for Health Grant to explore how adolescents in the Tri-County region respond to obesity-related health messaging, using insights gathered from social media data. In addition, the team developed and distributed a survey targeting Pediatric Primary Care Providers to better understand their experiences in managing adolescent obesity. This survey was disseminated

across all major health systems in the region, and the resulting data will inform the development of an evidence-based practice toolkit aimed at improving provider comfort, confidence, and effectiveness in treating adolescent obesity within primary care settings.

Complementing these efforts, the **Wellness Educational Lifestyle Learning (WELL) Program** offers a tailored, 12-session, evidence-based health coaching initiative for youth ages 8–18 who are at risk for type 2 diabetes. Each participant is paired with a dedicated Health and Wellness Coach to support improvements in nutrition, physical activity, and overall well-being. To date, over 200 youth have been referred to the program, which is now active in seven schools—including a new school-based health center at Richwoods High School—and has completed more than 500 hours of coaching. The WELL Program also serves as an internship rotation site for Bradley University's Master of Science in Nutrition and Dietetics program.

Additionally, the **Healthy Kids U (HKU) Clinic** continues to expand across the region. This program provides children and adolescents ages 2 to 18—referred by their primary care providers—with education on healthy eating habits, portion control, meal planning, and appropriate levels of physical activity. HKU now includes cooking classes hosted at the Cancer Center kitchen, In Motion fitness classes at the YMCA, and is actively recruiting additional registered dietitians to meet growing demand.

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**	**Upcoming Work**
DHIAO 1: Identify baseline data, definitions and programming for digital health interventions in the tri-county area.	• # of data points collected • Define "Digital Health Interventions" • Identify programming currently being offered		Adolescent obesity group discussed specifics of Needs assessment survey for providers. Goal is to bring awareness to barriers in treating Adolescents with Obesity from PCP's. Will finalize survey questions for survey. Tool kit to be based off results. Received grant from IFH, "*Understanding the Reactions of Adolescents to Obesity Related Health Messaging Residing in the Tri-county Area through Social Media Data"*	Distribute finalized survey to pediatric primary care physicians about adolescent obesity treatment to identify barriers and comfort related to this health issue
DHIAO 2: Promote through education and awareness utilizing social media communication.	• # of promotional campaigns performed through the Tri-County Region.		Social Media/Advertisement (Need Outside Source) Need page made to share links or QR codes (Place on Hult's Center or Partnership's website easily.) Collective Groups/ Branding *Keep doing whatever it is your doing, but we would like to share together on Partnership*	
DHIAO 3: Collaborate with healthcare providers for enrollment.	• % of individuals completing digital health program report improved weight related measures. • 10-15% improvement in BMI • % retention of registered		Ashley Fischer has a dot phrase that explains the medications at a patient level and the advantages and disadvantages of each- brought up during the child wellness visit stating guidelines changes for Adolescent obesity. Dr.Fischer has offered to teach a revised/ condensed evidence based format for having adolescent obesity conversation in around 10 minutes.- considering making a video for providers to model after.	**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

	individuals for one month of the program			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			
DHIAO 5: Personalize program with Text Messaging, Health coaching calls, or Tele Visits	Pre/ Post changes in Biometrics		Exploring further with Grant opportunity, will update further at end of January*	Further explore Epic Care Companion as option for digital component

Intervention Strategy: Strong People Healthy Weight (SPHW)

Objective : By December 31, 2025, reduce the proportion of adults (women) with obesity in the Tri-County Region by 2%.				
Tasks & Tactics	**Evaluation Plan**	**Target/Data**	**Monthly Recap (04/25)**	**Upcoming Work**
SPHW 1: Collect Baseline data / program information	• # of establishments collecting adult physical activity data in the Tri-County Region			
SPHW 2: Develop recruitment campaign in the tri-county area.	• Increase # of individuals registering for programs • # of promotional campaigns performed in the tri-county area		Adult Obesity Initiative: Strong People Living Well 12- week program started May 6th, out at the Louisville Slugger Dome. JoAn Grane has 13 community members attending 2 x each week. OSF Weight Management RDs, RNs, or EPs are supporting the 30-minute education portion. OSF has taught 3 cooking demos so far and several nutrition topics.	
SPHW 3: Provide a Leadership workshop to educate and inform about program.	• # of participants in the workshop			
SPHW4: Partner with community resources to establish class locations.	• % of retention of registered individuals through completion of program • # of individuals completing SPHW program report having improved weight related measures • Enrollment of 25 participants quarterly within the tri-county area			
SPHW5: Share success stories of the program within the tri-county program	• # of pre/post test changes in biometrics and behavior			

Current challenges or needs for selected interventions

Digital health intervention:

- Need support to distribute finalized survey to pediatric primary care physicians about adolescent obesity treatment to identify barriers and comfort related to this health issue

Strong People Healthy Weight (SPHW):

- None noted at this time.

Public health surveillance data

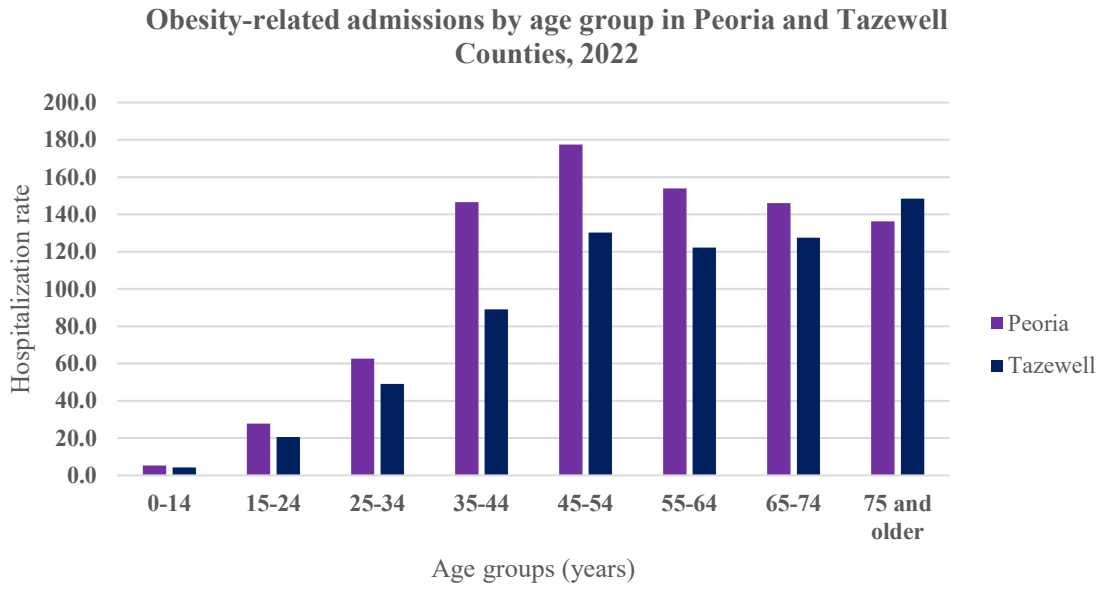
	Peoria	Tazewell	Woodford	Illinois	United States
Obesity among adults	36%	35%	34%	33%	34%

Data sources:

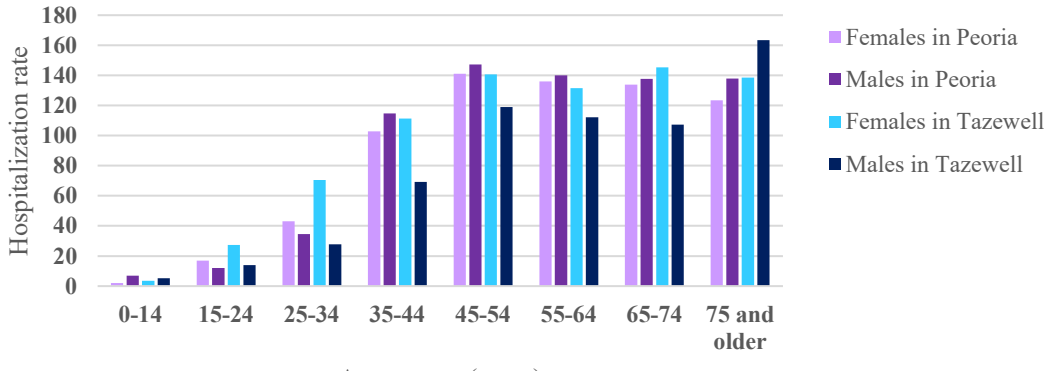
1. 2022 Behavior Risk Factor Surveillance System (BRFSS)

ESSENCE data

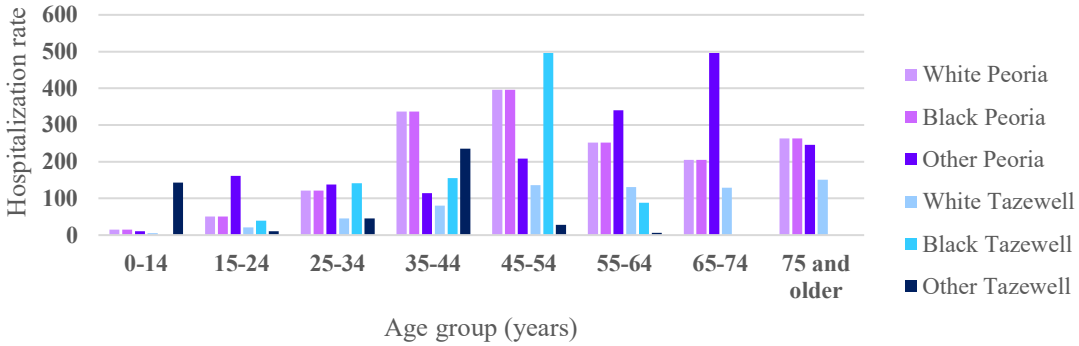
Obesity-related hospital admissions were pulled from the Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) for Peoria and Tazewell Counties during 2022. We identified age-adjusted obesity-related admission rates based on the International Statistical Classification of Disease and Related Health Problems, Tenth Revision codes X66. We further explored differences in hospitalization rates (per 100,000) by age, sex, and racial group to better understand the populations at highest risk for negative health outcomes related to each outcome. Hospitalization rate depicts the proportion of hospital visits for each population in 2022.



Obesity-related admissions by sex and age in Peoria and Tazewell Counties, 2022



Obesity-related admissoins by race and age in Peoria and Tazewell Counties, 2022



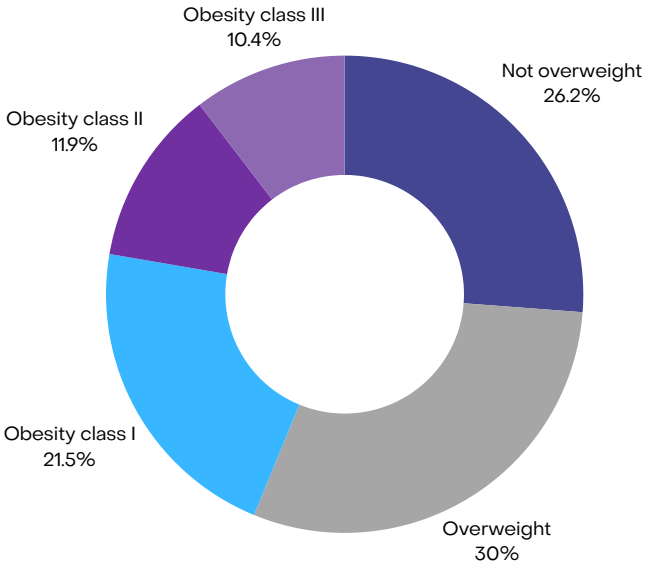
OSF COMMUNITY DATA: OBESITY

Data from OSF was aggregated among patients who received care in 2024 and collapsed into BMI classification. In particular, the data include patients aged 12-90 years old at the time of last encounter living in Peoria, Woodford, or Tazewell county who had some encounter with OSF Healthcare between 1/1/2024 and 1/1/2025. Each patient is only counted once.

For adolescents ages 12-17, obesity was based on the percentile of BMI for age and gender. They are not classified in Class 1, 2, or 3 for Obesity. For adolescents, a percentile <85 is not overweight, A percentile 85-95 is overweight, and a percentile over 95.00 is obese.

Of note, around 25% of patients did not have a documented BMI during this timeframe, so care should be taken when comparing counts of patients by BMI to the total population. BMI class groupings are listed as follows: BMI <25, not overweight.BMI 25-29.99 is overweight. BMI 30-34.99 is Obese class 1. BMI 35-39.99 is Obese class 2. BMI 40+ is Obese class 3. In cases of patients with changes in BMI over the course of the year, the highest recorded BMI was taken for this dataset.

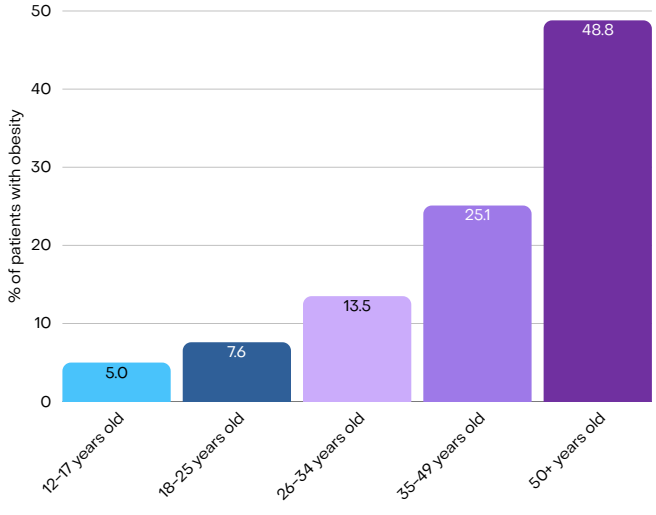
WEIGHT CLASSIFICATION BASED ON BMI AMONG TRI-COUNTY RESIDENTS



44% of adult patients in the Tri-County region had a BMI over 30

AGE-DISTRIBUTION AMONG PATIENTS WITH OBESITY

Approximately **half** of the patients in the Tri-County region with obesity are <u>over 50</u> years old



Demographic characteristics of adolescents with obesity in the Tri-County region, 2024 (n=3,436)

Demographic	Adolescents with obesity (n=3,436) n	%
Sex		
Female	1,681	48.9%
Male	1,755	51.1%
Race		
White	2,273	66.2%
Black or African American	738	21.5%
Asian	27	0.8%
AI, AN, or NH or other PI	4	0.1%
Two or more races or other	309	9.0%
Unknown	85	2.5%
Ethnicity		
Hispanic or Latino/a/x	341	9.9%
Not Hispanic or Latino/a/x	3,054	88.9%
Unknown	41	1.2%
Insurance status		
Uninsured	213	6.2%
Medicaid/Medicare	1,670	48.6%
Private health insurance	1,469	42.8%
Other or unknown	84	2.4%

Note: For adolescents (ages 12-17 years old) BMI class was determined using their BMI percentile score based on age and gender instead of exact BMI. A percentile <85 is not overweight, A percentile 85-95 is overweight, and a percentile over 95.00 is obese. They are not classified in Class 1, 2, or 3 for Obesity.

Demographic characteristics of OSF patients with obesity (n=69,146) in 2024

Demographic	Overall (n=69,146)		Peoria (n=36,990)		Tazewell (n=25,944)		Woodford (n=6,212)	
	n	%	n	%	n	%	n	%
Age								
12-17 years	3,436	5.0%	1,915	5.2%	1,200	4.6%	321	5.2%
18-25 years	5,259	7.6%	2,991	8.1%	1,856	7.2%	412	6.6%
26-34 years	9,351	13.5%	5,395	14.6%	3,311	12.8%	645	10.4%
35-49 years	17,355	25.1%	9,453	25.6%	6,338	24.4%	1,564	25.2%
50+ years	33,745	48.8%	17,236	46.6%	13,239	51.0%	3,270	52.6%
Sex								
Female	39,327	56.9%	21,623	58.5%	14,402	55.5%	3,302	53.2%
Male	29,813	43.1%	15,363	41.5%	11,540	44.5%	2,910	46.8%
Unknown	6	0.0%	4	0.0%	2	0.0%		0.0%
Race								
White	54,763	79.2%	24,300	65.7%	24,499	94.4%	5,964	96.0%
Black or African American	9,611	13.9%	9,136	24.7%	404	1.6%	71	1.1%
Asian	405	0.6%	319	0.9%	73	0.3%	13	0.2%
AI, AN, or NH or other PI	260	0.4%	168	0.5%	79	0.3%	13	0.2%
Two or more races or other	2,875	4.2%	2,391	6.5%	418	1.6%	66	1.1%
Unknown	1,232	1.8%	676	1.8%	471	1.8%	85	1.4%
Ethnicity								
Hispanic or Latino/a/x	3,454	5.0%	2,818	7.6%	544	2.1%	92	1.5%
Not Hispanic or Latino/a/x	64,856	93.8%	33,771	91.3%	25,026	96.5%	6,059	97.5%
Unknown	836	1.2%	401	1.1%	374	1.4%	61	1.0%
Insurance status								
Uninsured	4,462	6.5%	2,824	7.6%	1,308	5.0%	330	5.3%
Medicaid/Medicare	30,421	44.0%	17,517	47.4%	10,616	40.9%	2,288	36.8%
Private health insurance	33,595	48.6%	16,250	43.9%	13,807	53.2%	3,538	57.0%
Other or unknown	668	1.0%	399	1.1%	213	0.8%	56	0.9%

Abbreviations: AI: American Indian; AN: Alaskan Native; NH: Native Hawaiian; PI: Pacific Islander

Demographic characteristics based on obesity classification (n=65,710) among adult OSF patients in 2024

	Obesity class I (n=32,210)		Obesity class II (n=17,841)		Obesity class III (n=15,659)		Overall (n=65,710)	
Demographic	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Age								
18-25 years	2,400	7.5%	1,438	8.1%	1,421	9.1%	5,259	8.0%
26-34 years	4,054	12.6%	2,575	14.4%	2,722	17.4%	9,351	14.2%
35-49 years	7,868	24.4%	4,684	26.3%	4,803	30.7%	17,355	26.4%
50+ years	17,888	55.5%	9,144	51.3%	6,713	42.9%	33,745	51.4%
Sex								
Female	16,463	51.1%	10,508	58.9%	10,675	68.2%	37,646	57.3%
Male	15,746	48.9%	7,330	41.1%	4,982	31.8%	28,058	42.7%
Unknown	1	0.0%	3	0.0%	2	0.0%	6	0.0%
Race								
White	26,020	80.8%	14,292	80.1%	12,178	77.8%	52,490	79.9%
Black or African American	3,781	11.7%	2,415	13.5%	2,677	17.1%	8,873	13.5%
Asian	257	0.8%	84	0.5%	42	0.3%	383	0.6%
AI, AN, or NH or other PI	132	0.4%	67	0.4%	47	0.3%	246	0.4%
Two or more races or other	1,387	4.3%	691	3.9%	493	3.1%	2,571	3.9%
Unknown	633	2.0%	292	1.6%	222	1.4%	1,147	1.7%
Ethnicity								
Hispanic or Latino/a/x	1,572	4.9%	829	4.6%	712	4.5%	3,113	4.7%
Not Hispanic or Latino/a/x	30,222	93.8%	16,789	94.1%	14,791	94.5%	61,802	94.1%
Unknown	416	1.3%	223	1.2%	156	1.0%	795	1.2%
Insurance status								
Uninsured	2,143	6.7%	1,126	6.3%	980	6.3%	4,249	6.5%
Medicaid/Medicare	14,271	44.3%	7,699	43.2%	6,781	43.3%	28,751	43.8%
Private health insurance	15,483	48.1%	8,836	49.5%	7,807	49.9%	32,126	48.9%
Other or unknown	313	1.0%	180	1.0%	91	0.6%	584	0.9%

Abbreviations: AI: American Indian; AN: Alaskan Native; NH: Native Hawaiian; PI: Pacific Islander

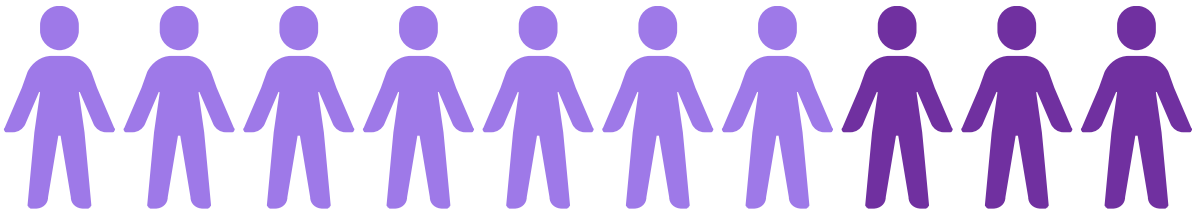
SOCIAL DRIVERS RELATED TO OBESITY

Data captures OSF patients aged 12-90 at the time of last encounter living in Peoria, Woodford, or Tazewell county who had some encounter with OSF Healthcare between 1/1/2024 and 1/1/2025. SDOH data is a relatively new and optional piece of documentation with a relatively low documentation rate.

FOOD & HOUSING INSECURITY

Approximately 4% of patients with obesity reported food insecurity and 3% reported housing insecurity

NUMBER OF CONCERNS RELATED TO SOCIAL DRIVERS



Approximately **70%** of patients with obesity reported at least one concern related to social determinants of health

Over **31%** of patients with obesity reported **2 or more** concerns related to social drivers

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%.*

Over the past year, the Mental Health committee expanded its membership and focused on culturally adapted healthcare (CAHC), inclusive care, and telemedicine. CAHC efforts include training, policy development, and the use of a cultural competence self-assessment tool. Telepsych services are being mapped and promoted, especially in underserved areas. The committee also supports Mental Health First Aid (MHFA) training through the CADRE initiative, with hundreds of participants across adult, youth, and population-specific sessions.

To date, the Mental Health Committee has grown to include 31 participating organizations—an increase of 30% from the previous year (n=24). The committee's work has been organized around two key subcommittees: **Culturally-Adapted Healthcare (CAHC)** and **Telemedicine**, both of which address critical gaps in mental health access and equity across the Tri-County region.

Culturally-Adapted Healthcare (CAHC)
The CAHC action team is committed to advancing personalized mental health services that reflect the diverse cultural needs, preferences, and lived experiences of residents in Peoria, Tazewell, and Woodford Counties. Their approach integrates culturally relevant practices and fosters collaboration with community organizations to ensure equitable access to care. Over the past year, the team has promoted awareness and education through CAHC training opportunities and ongoing dialogue with community partners. To support these efforts, the subcommittee adopted the *Cultural Competence Self-Assessment Checklist*, developed by the Central Vancouver Island Multicultural Society. This free tool uses a Likert scale to assess awareness, knowledge, and skills across cultural competence domains and is being implemented locally to guide improvements in inclusive care.

Telemedicine
The Telemedicine subcommittee has focused on expanding access to mental health services, particularly in underserved and rural areas. Over the past year, the team developed a comprehensive list of community

mental health resources, including providers offering counseling, telehealth, and telepsychiatry. In addition to disseminating this resource list, the subcommittee has supported structured partnerships and identified key access points to strengthen telemedicine infrastructure. Recognizing the shift in patient preferences post-COVID, the team continues to prioritize outreach and service delivery models that meet evolving community needs.

Future priorities for the Mental Health Committee include enhancing social media messaging to promote awareness of support services such as 2-1-1 and 9-8-8, expanding CAHC training opportunities, and increasing engagement across both subcommittees. These efforts aim to build a more inclusive, responsive, and accessible mental health system for all residents in the Tri-County region.

Programmatic outputs

Intervention Strategy: Culturally-Adapted Health Care (CAHC)

Tasks & Tactics	Evaluation Plan	Target/Data	Monthly Recap (04/25)	Upcoming Work
CAHC 1: Promote awareness and education trainings quarterly that are focused on improving cultural competence related to mental health care	60% of individuals who register for the event(s) will complete the training More than 50% of the individuals who attended the sessions will self-report improvement in behaviors after cultural competence training(s) More than 70% of the individuals who attended the session will self-report improvement in attitudes after cultural competence training(s)		OSF: Advance cultural competency for BH mission partners // 100% SFMC BH mission partners will complete Cultural Competency (D.Lockbaum)	What is Carle's plan (if any) for this? JG, I thought you said that you already had a plan in place. What kind of trainings? What are the outcomes? Who are you serving and by when? Can this be expanded/offered to others in the tri-county? What about other clinics? Heartland, etc? Do they have any trainings or CAHC work planned? Who else do we need to bring to the table for this initiative?
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%			Identify trainings and outcomes Explore if these can be expanded/offered to others in the tri-county? Identify other clinics? Heartland, etc? Do they have any trainings or CAHC work planned?
CAHC 3: Create policies to support matching patient race/ethnicity/cultural/sexual orientation backgrounds to provider	Increase # providers/systems that have policies to support cultural competence by 10%			What is Carle's plan (if any) for this? JG, I thought you said that you already had a plan in place. What kind of trainings? What are the outcomes? Who are you serving and by when? Can this be expanded/offered to others in the tri-county? What about other clinics? Heartland, etc? Do they have any trainings or CAHC work planned? In regard to improving the diversity of providers, we should remember that paraprofessionals can be used in some cases.
CAHC 4: Make culturally- and linguistically adapted materials and marketing available	Improve patient experience ratings (likelihood to recommend) by 1%			What is OSF's plan for this? What is Carle's plan (if any) for this? JG, I thought you said that you already had a plan in place. What kind of trainings? What are the outcomes? Who are you serving and by when? Can this be expanded/offered to others in the tri-county?

				What about other clinics? Heartland, etc? Do they have any trainings or CAHC work planned?

Intervention Strategy: Telemedicine (TELMED)

Tasks & Tactics	Evaluation Plan	Target/Data	Monthly Recap (04/25)	Upcoming Work
TELMED 1: Establish baseline, inventory available telemedicine among tri-county	Complete inventory list of all telemedicine access.	(MET) Inventory complete for telepsych providers.	OSF: Increase utilization of BH telemedicine from baseline by 2% (Baseline TBD) (D.Lockbaum and T.Bromley) See the list that Access Center provided in May 2023.	What is Carle's plan for telemedicine? What about other clinics? Heartland, etc? Do they have any trainings or CAHC work planned? Who else do we need to bring to the table for this initiative?
TELMED 2: Disseminate information through 10 promotional campaigns on how to access (mental health) telemedicine	Increase # patients engaged in mental health telemedicine by 10%	(IN PROGRESS) 10 promotional campaigns launched	See the list that Access Center provided in May 2023.	What is OSF's plan for telemedicine (if any) for this? What is Carle's plan for telemedicine? What about other clinics? Heartland, etc? Do they have any trainings or CAHC work planned?
TELMED 3: Support the development of structured partnerships for community healthcare organizations to provide telemedicine	Increase # new patients enrolled in telemedicine by 10%	(IN PROGRESS) Dr. Sara Kelly is waiting to receive data from OSF.	See the list that Access Center provided in May 2023.	What is OSF's plan for telemedicine (if any) for this? What is Carle's plan for telemedicine? What about other clinics? Heartland, etc? Do they have any trainings or CAHC work planned?
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%	(NOT STARTED)	See the list that Access Center provided in May 2023.	What is OSF's plan for telemedicine (if any) for this? What is Carle's plan for telemedicine? What about other clinics? Heartland, etc? Do they have any trainings or CAHC work planned?
TELMED 5: Provide more than 100 residents access to mental health telemedicine appointments who are either medically underserved or live in rural areas	Reduce # hospital readmissions among individuals who engage in telemedicine by 30%	IN PROGRESS		

Current challenges or needs for selected interventions

Culturally Adapted Health Care (CAHC)

- Not everyone has access to phone/internet and we need to be mindful of that with interventions.
- Organizations incorporate CAHC but do not assess for changes using standard evaluations.

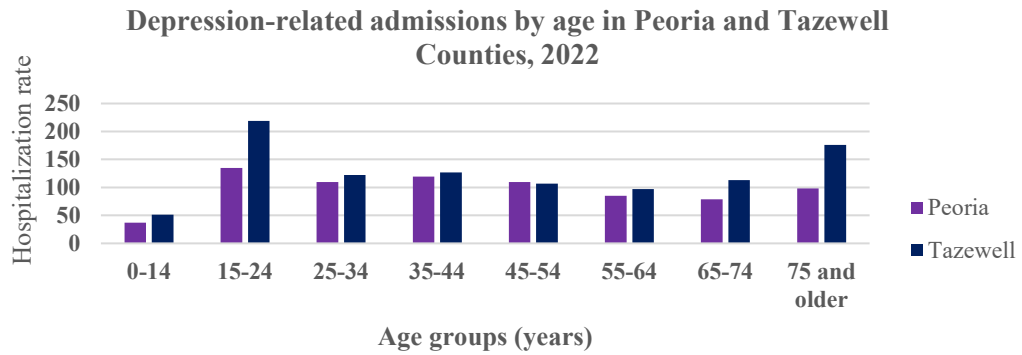
Telemedicine (TELMED)

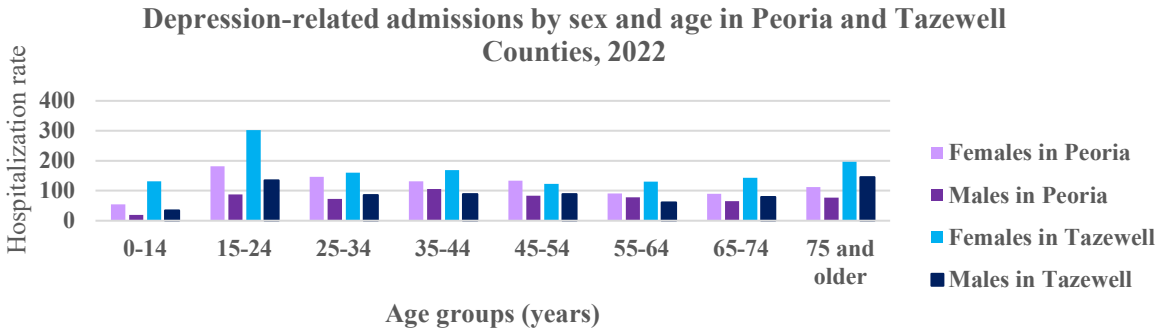
- Barriers to this include Medicare changes that will affect the hospitals providing telehealth. Private providers will be able to continue.
- Looking at this from a Tiered approach, where Tier 1 would be general awareness/campaign/education, Tier 2 would be those at risk, and Tier 3 would be those at the greatest risk/acute patients, we would like to enroll more people from Tier 1 into telehealth. Those with beginning or mild symptoms could avoid worsening problems if they are connected with care.

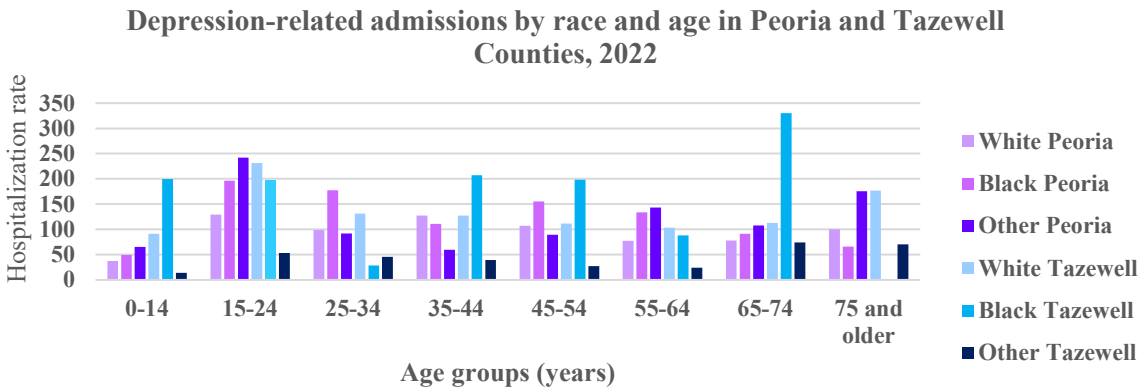
Public health surveillance

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 (per 100,000) 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. Hospitalization rate depicts the proportion of hospital visits for each population in 2022.

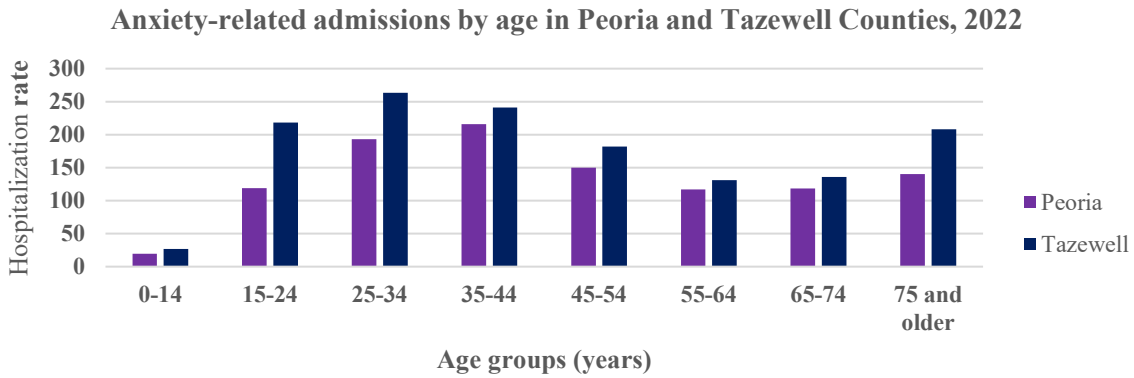
Depression

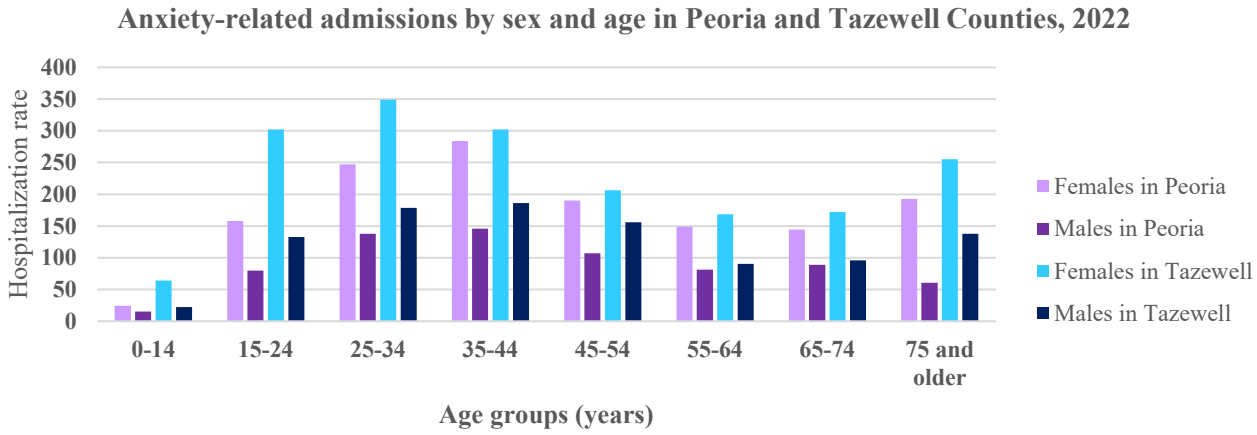


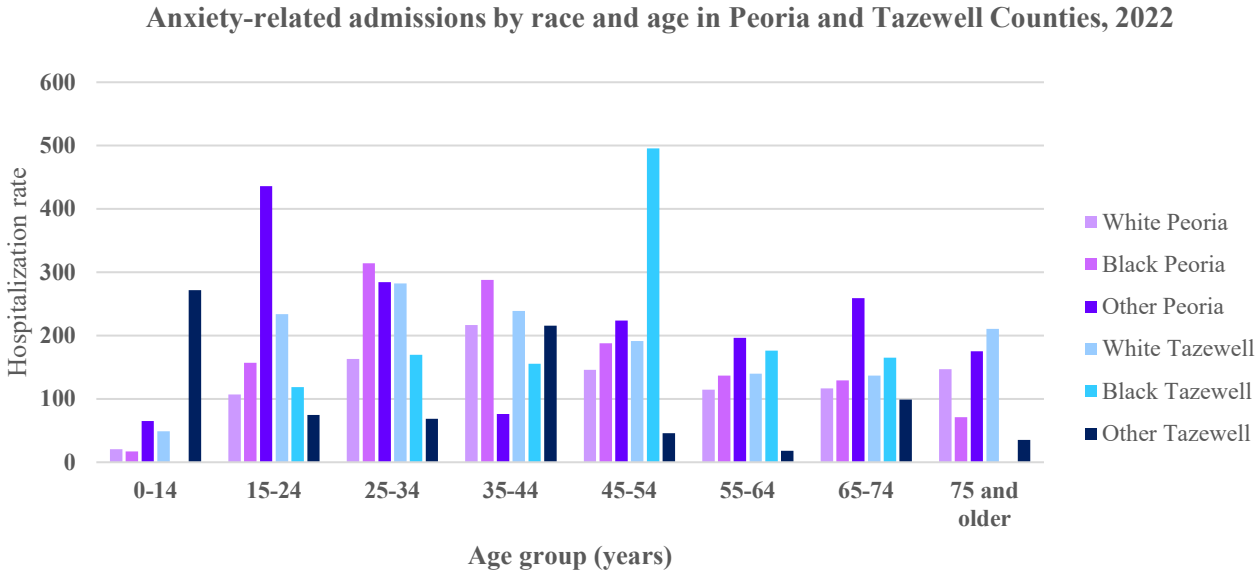




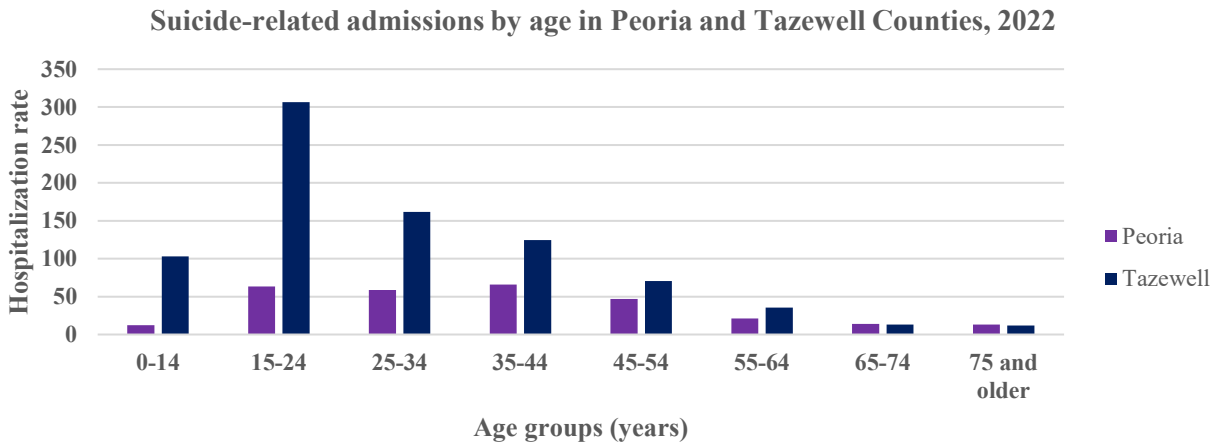
Anxiety

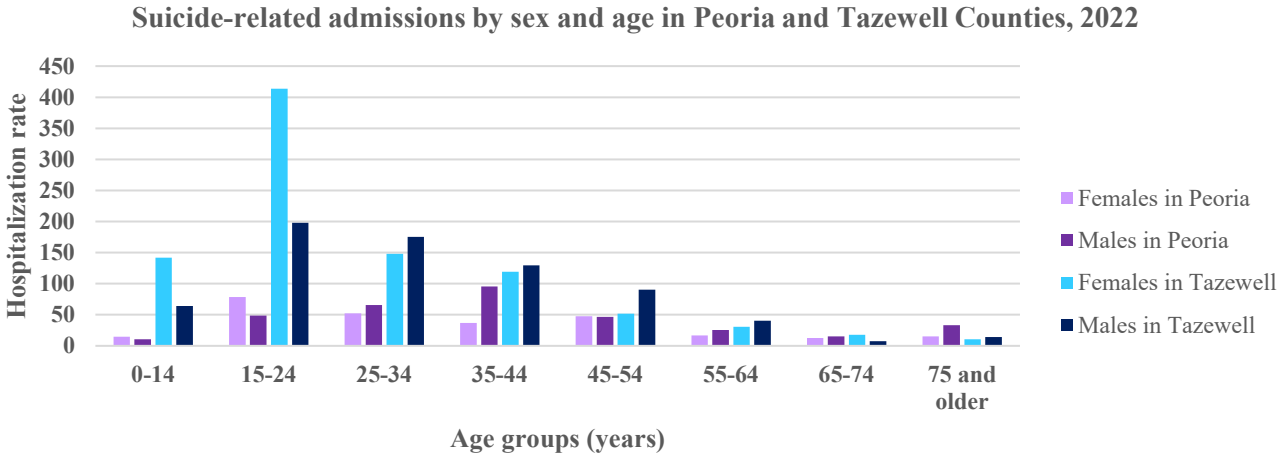

Anxiety-related admissions by age in Peoria and Tazewell Counties, 2022
Hospitalization rate
300
250
200
150
100
50
0
0-14
15-24
25-34
35-44
45-54
55-64
65-74
75 and older
Age groups (years)
Peoria
Tazewell

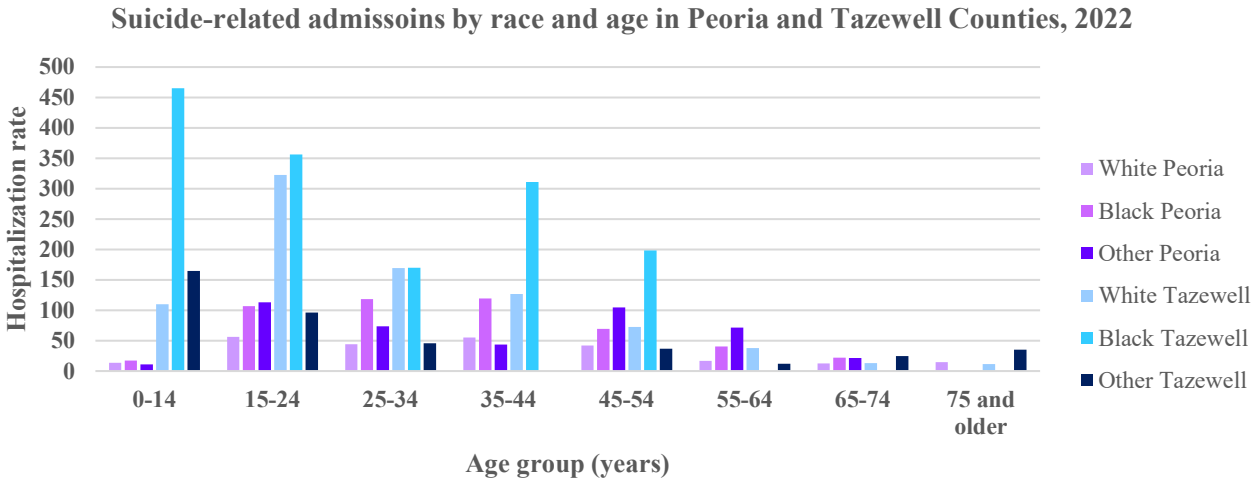

Anxiety-related admissions by sex and age in Peoria and Tazewell Counties, 2022
Hospitalization rate
400
350
300
250
200
150
100
50
0
0-14
15-24
25-34
35-44
45-54
55-64
65-74
75 and older
Age groups (years)
Females in Peoria
Males in Peoria
Females in Tazewell
Males in Tazewell


Anxiety-related admissions 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

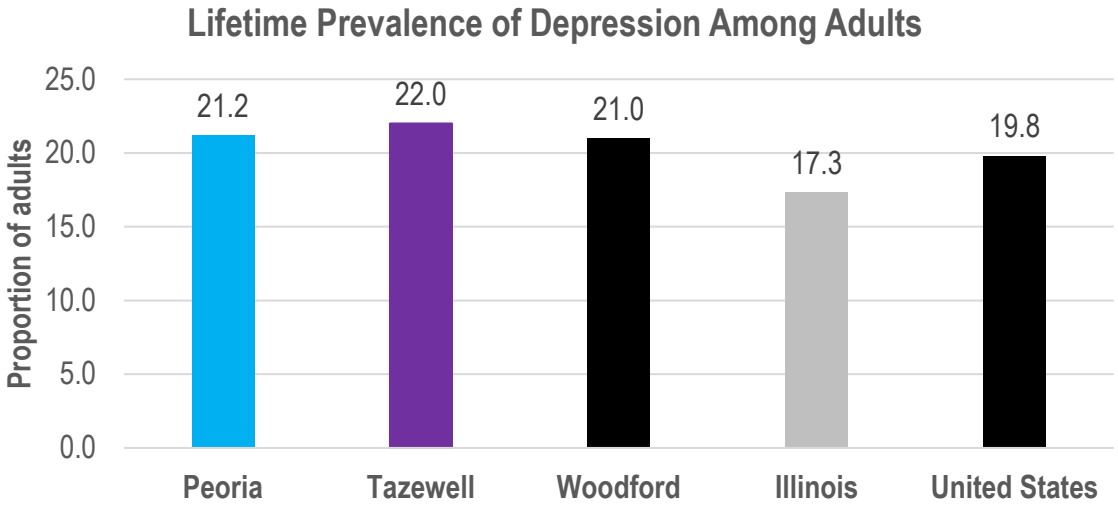
Suicide


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

Lifetime Depression



Data source: Behavioral Risk Factor Surveillance System

Additional health metrics related to mental health

	Peoria	Tazewell	Woodford	Illinois	United States
Additional measures of mental health (substance use)					
Binge drinking among adults[1]	20%	22%	24%	19%	19%
Alcohol-impaired Driving Deaths (% of driving deaths with alcohol involvement)[2]	33%	31%	36%	26%	26%

Data sources:

1. 2022 Behavior Risk Factor Surveillance System (BRFSS)
2. 2018-2022 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.

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.

Community resilience estimates

	Peoria % (95% CI)	Tazewell % (95% CI)	Woodford % (95% CI)	IL % (95% CI)	US % (95% CI)
Vulnerable population (%)	22.0% (±5.2%)	15.8% (±4.4%)	17.5% (±5.2%)	20.6% (±2.4%)	20.6% (±0.3%)

Community Resilience Estimates (CRE) provide a clear and accessible metric for assessing the social vulnerability of neighborhoods across the United States to the impacts of disasters, including public health emergencies like COVID-19. Derived from the 2022 American Community Survey (ACS), CRE incorporates multiple indicators that reflect underlying social and economic challenges. These components include income-to-poverty ratio, single or zero caregiver households, household crowding, communication barriers, lack of full-time year-round employment, disability status, absence of health insurance, age 65 and older, lack of vehicle access, and absence of broadband internet. Together, these measures offer valuable insight into the resilience and needs of communities, helping guide targeted interventions and resource allocation.

Source: https://www.census.gov/programs-surveys/community-resilience-estimates.html

Changes in mental health indicators using public health surveillance

Poor mental health days [1]	2020	2021	2022
Peoria	3.5	4.5	5.3
Tazewell	3.9	4.6	5.5
Woodford	3.7	4.5	5.0
Illinois	3.2	4.2	4.5

1. 2022 Behavior Risk Factor Surveillance System (BRFSS)

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

Across the United States, there was an increase in the number of poor mental health days reported by adults. In particular, Peoria experienced the highest increase over recent years going from 3.5 days (2020) to 5.3 days (2022), which equates to a 51% increase in over the past three years. Tazewell and Woodford Counties experienced an increase in poor mental health days by 41% and 35%, respectively.

Frequent mental distress [1]	2020	2021	2022
Peoria	13%	16%	18%
Tazewell	13%	16%	17%
Woodford	13%	15%	18%
Illinois	10%	14%	14%
United States	14%	15%	14%

1. Behavior Risk Factor Surveillance System (BRFSS)

Frequent mental distress is the percentage of adults that report their mental health is not good for 14+ days in the past month. The most recent public health surveillance data (2022), found that **18% of adults report frequent distress** which is higher than prior years for the Tri-County region.

Suicide mortality data for the Tri-County region

	Peoria	Tazewell	Woodford	Illinois	United States
Suicide mortality rate	15	14	11	11	14

Data sources:
1. 2018-2022 NCHS

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

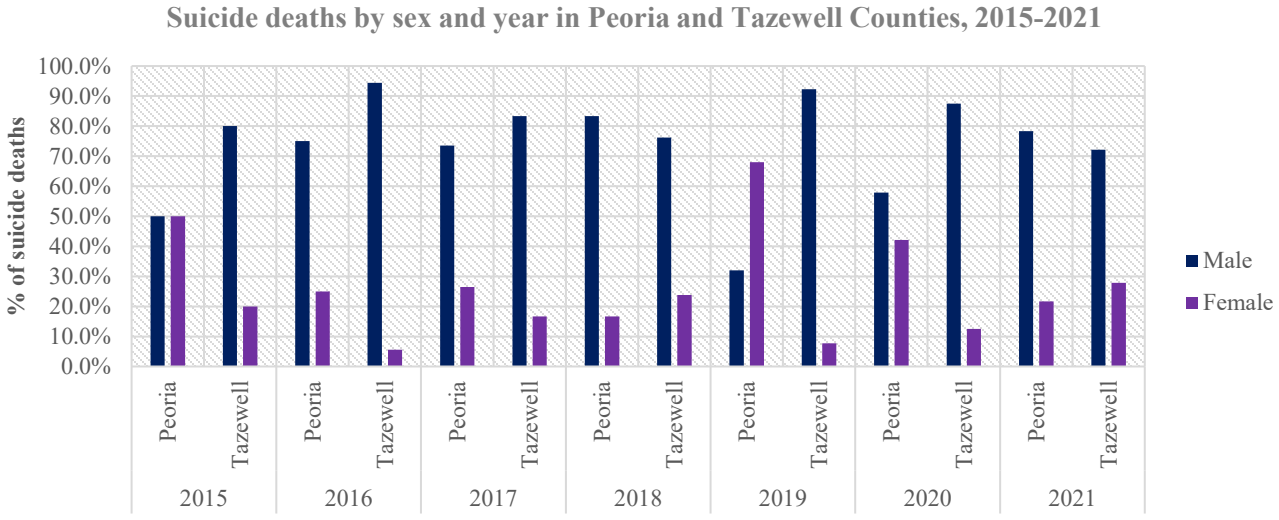
Further examination of national suicide data

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%).

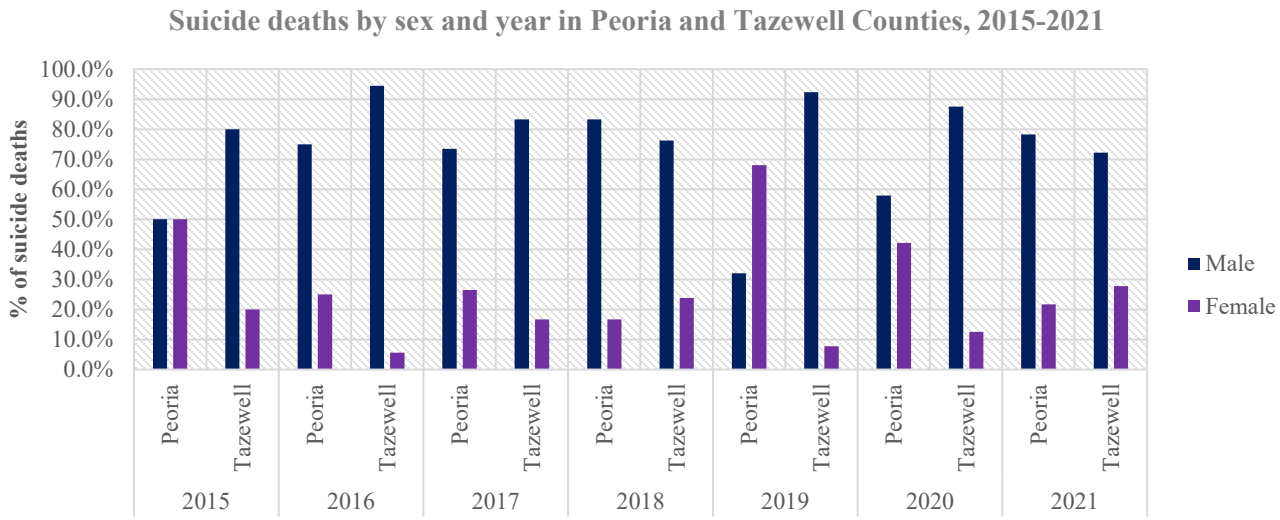
Although suicide related deaths rates were higher among the Non-Hispanic White population, the rate of suicide related deaths is increasing at a substantially higher rate among the Non-Hispanic Black population. Analysis of suicide deaths was done using CDC WONDER data or ILVDRS data. Additional information on suicide mortality can be found in the additional public health surveillance section of the data report.

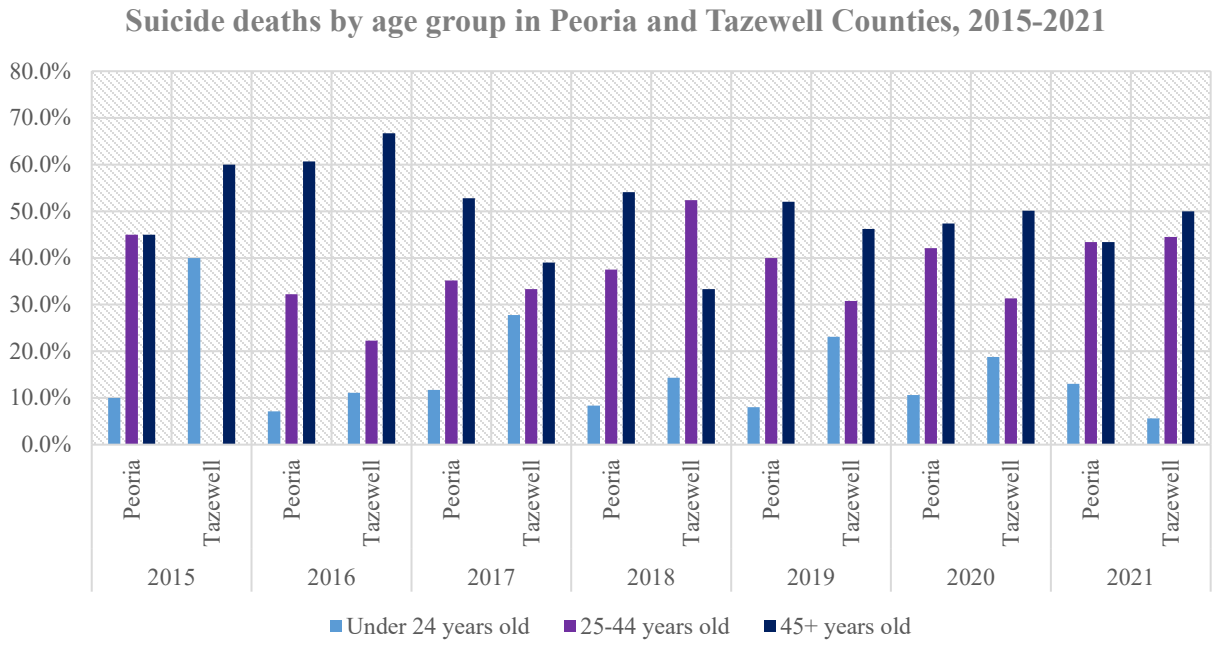
Regional violent death data

The following data was obtained from the state-based epidemiologic reporting system on violent deaths. More specifically, the goal of these data are to help inform, develop, and evaluate these violent deaths (e.g. suicides and homicides) that occur for each participating county and state. This data system is incident-based which captures information on victims and alleged perpetrators (deceased or alive), and has the capability to link events. Working in collaboration with the Illinois Violent Death Reporting



System (ILVDRS), we obtained regional data on violent deaths (i.e. suicides and homicides). Peoria and Tazewell Counties do participate in this program but Woodford County does not participate. Information is collected at the state level and sent to the National Center for Injury Prevention and Control within the Centers for Disease Control and Prevention (CDC) to be aggregated at the national-level (National Violent Death Reporting System). Information from NVDRS has been used to inform and support suicide and homicide prevention efforts.



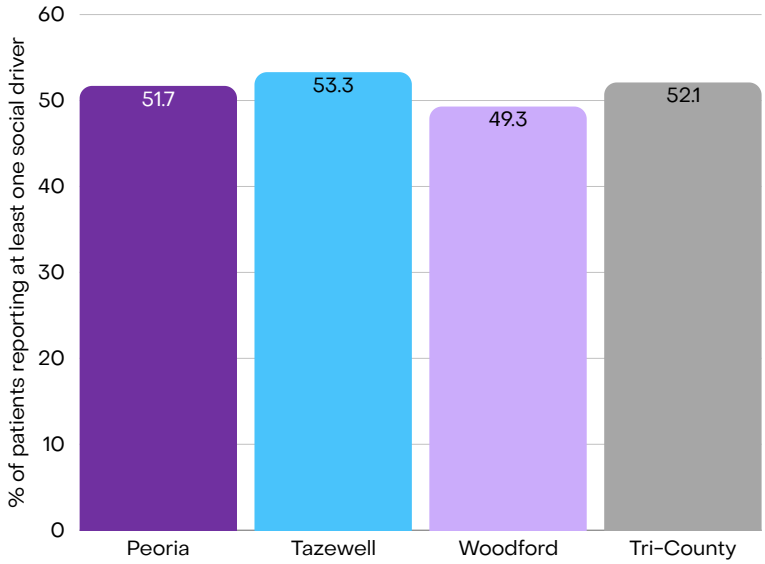


SOCIAL DRIVERS DOCUMENTED AMONG TRI-COUNTY RESIDENTS

Data captures OSF patients aged 12-90 at the time of last encounter living in Peoria, Woodford, or Tazewell county who had some encounter with OSF Healthcare between 1/1/2024 and 1/1/2025. SDOH data is a relatively new and optional piece of documentation with a relatively low documentation rate.

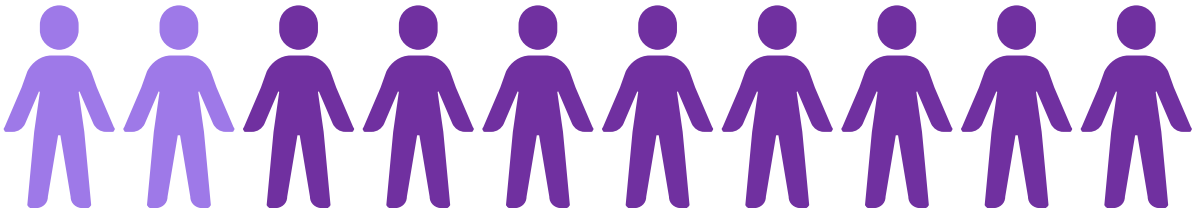
Among the Tri-County residents, the number of social drivers documented in their electronic medical records was assessed overall and by priority area. The possible options for social drivers include: food insecurity, housing insecurity, intimate partner violence (IPV), alcohol/tobacco use, or other social drivers documented.

DISTRIBUTION OF SOCIAL DRIVERS DOCUMENTED AMONG TRI-COUNTY



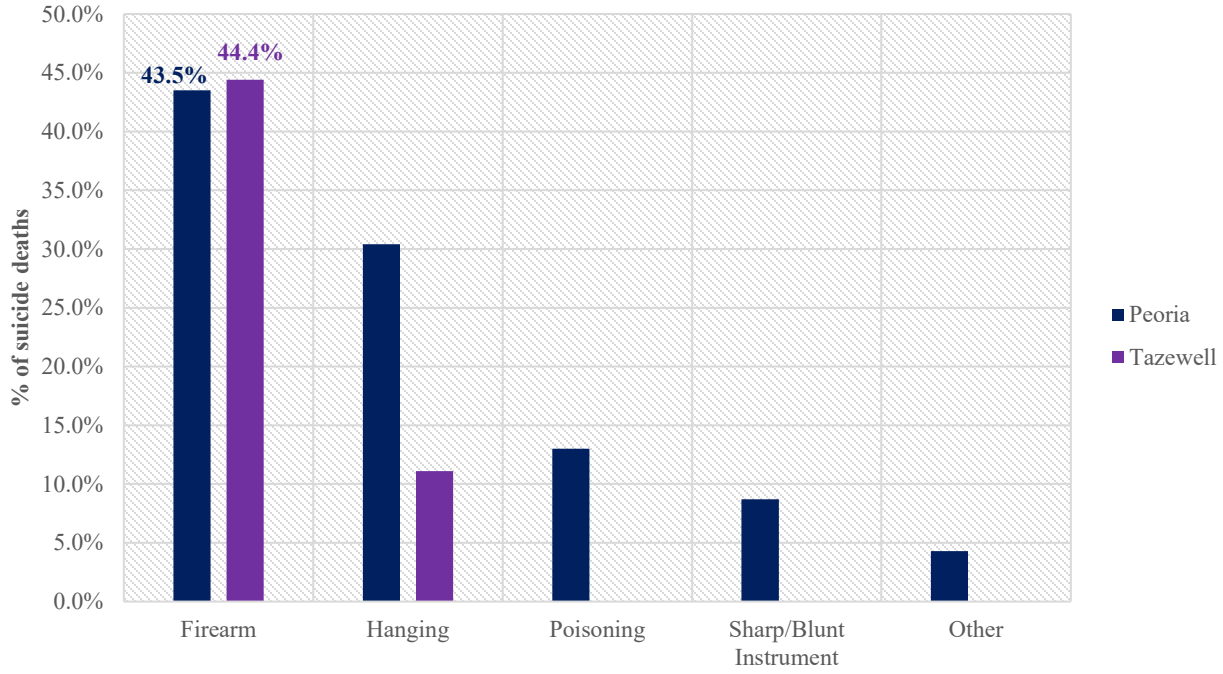
Approximately 52% of patients in the Tri-County region with social drivers documented in their chart reported at least one of these issues

NUMBER OF CONCERNS RELATED TO SOCIAL DRIVERS

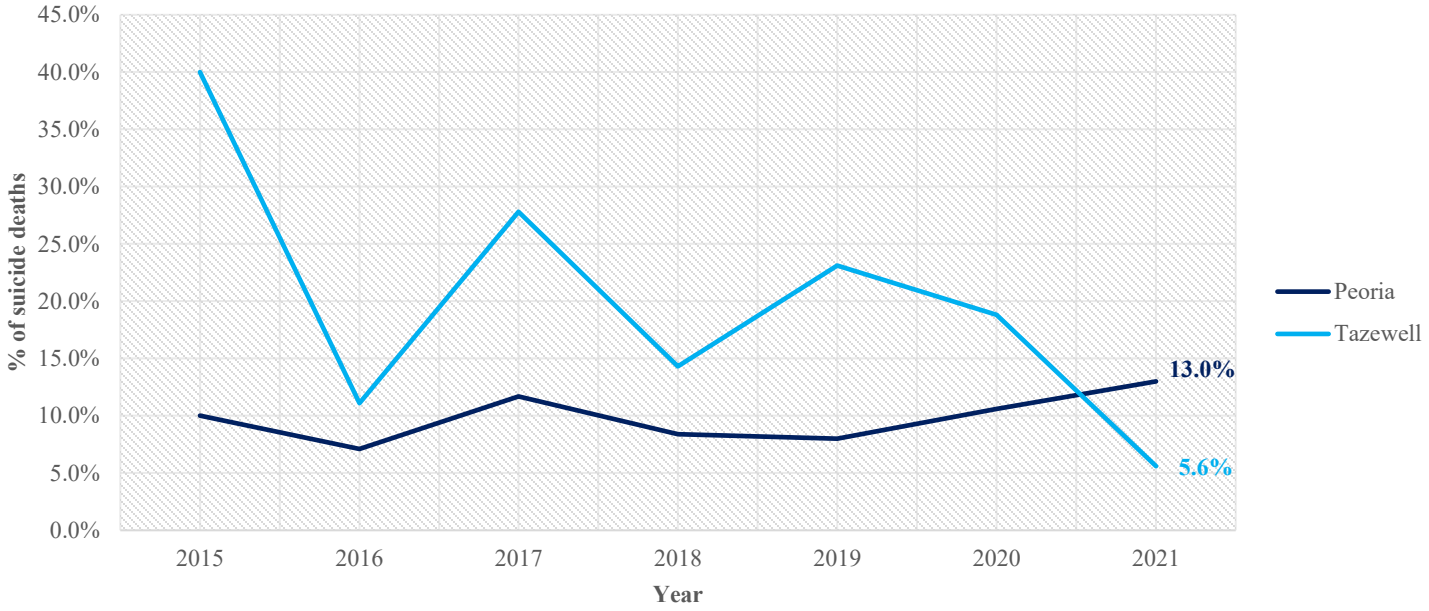


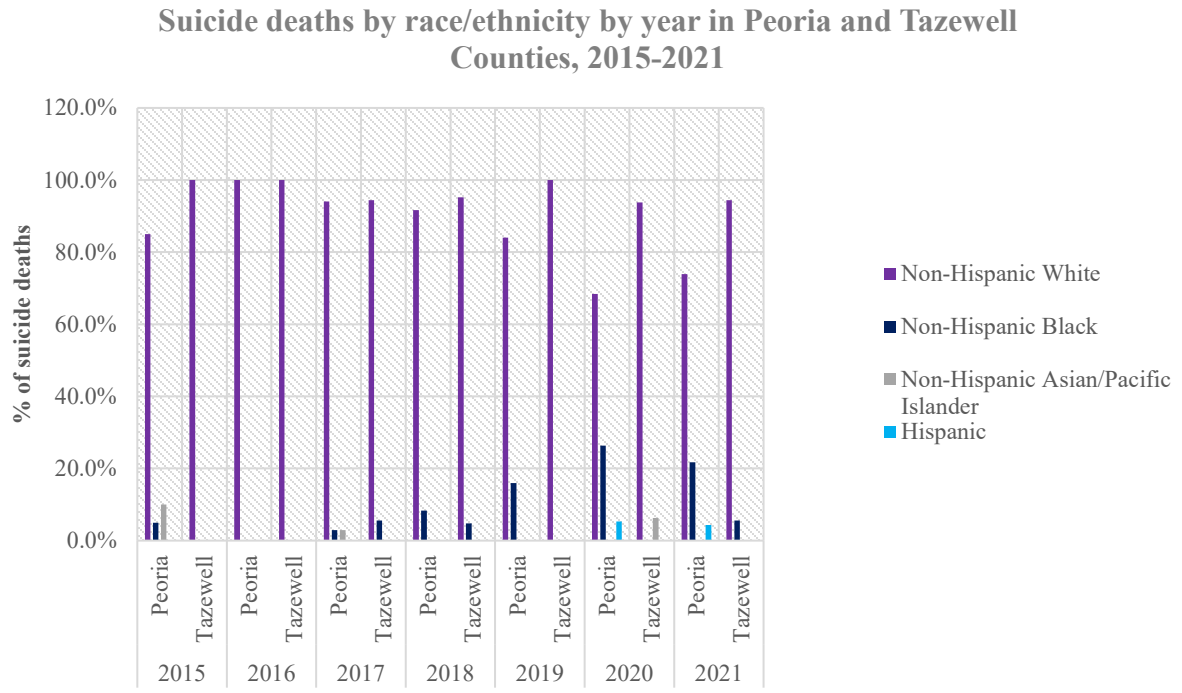
21% of patients in the Tri-County region with social drivers documented in their chart reported **2 or more** concerns

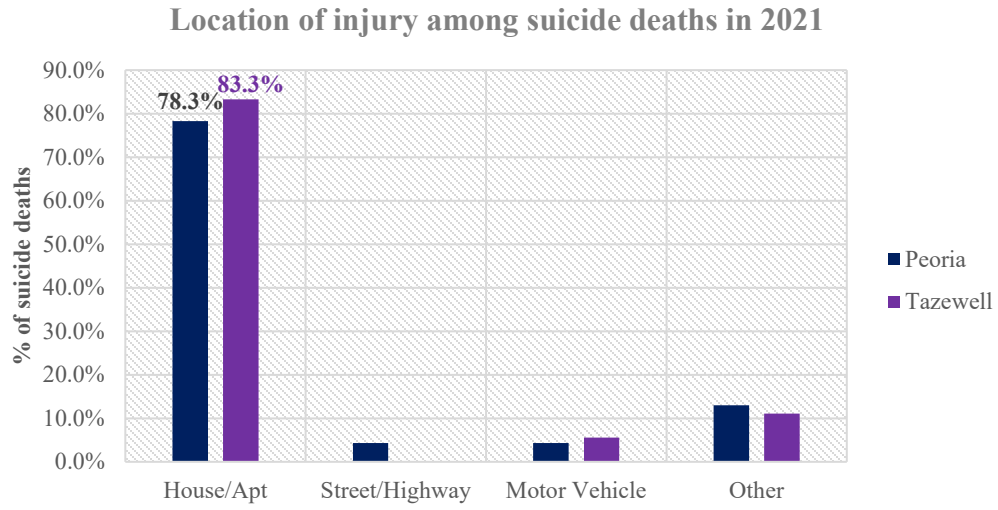
Means of suicide death for Peoria and Tazewell Counties, 2021



Suicide deaths among children and young adults (≤24 years old) in Peoria and Tazewell Counties, 2015-2021







OSF Community Data

Data from OSF was aggregated among patients who received care in 2024 and diagnosed with depression or anxiety. In particular, thee data include patients aged 12-90 years old at time of last encounter living in Peoria, Woodford, or Tazewell county who had some encounter with OSF Healthcare between 1/1/2024 and 1/1/2025. Each patient is only counted once. Of note, data is based on encounters with OSF Healthcare. If a patient received a diagnosis or treatment at a separate organization and never at OSF, that information will not show up here. There also may be overlap between those who have been diagnosed with depression and anxiety.

DEPRESSION

Demographic characteristics based on depression diagnosis (n=24,200) among OSF patients in 2024

Demographic	Overall		Peoria (n=12,903)		Tazewell (n=9,348)		Woodford (n=1,949)	
	n	%	n	%	n	%	n	%
Age								
12-17 years	1,141	4.7%	571	4.4%	466	5.0%	104	5.3%
18-25 years	2,598	10.7%	1,372	10.6%	1,026	11.0%	200	10.3%
26-34 years	3,538	14.6%	1,956	15.2%	1,364	14.6%	218	11.2%
35-49 years	5,650	23.3%	3,020	23.4%	2,183	23.4%	447	22.9%
50+ years	11,273	46.6%	5,984	46.4%	4,309	46.1%	980	50.3%
Sex								
Female	16,721	69.1%	8,761	67.9%	6,619	70.8%	1,341	68.8%
Male	7,476	30.9%	4,140	32.1%	2,728	29.2%	608	31.2%
Unknown	3	0.0%	2	0.0%	1	0.0%	0	0.0%
Race								
White	20,598	85.1%	9,738	75.5%	8,975	96.0%	1,885	96.7%
Black or African American	2,418	10.0%	2,288	17.7%	110	1.2%	20	1.0%
Asian	123	0.5%	87	0.7%	29	0.3%	7	0.4%
AI, AN, or NH or other PI	82	0.3%	47	0.4%	33	0.4%	2	0.1%
Two or more races or other	754	3.1%	612	4.7%	123	1.3%	19	1.0%
Unknown	225	0.9%	131	1.0%	78	0.8%	16	0.8%
Ethnicity								
Hispanic or Latino/a/x	926	3.8%	717	5.6%	183	2.0%	26	1.3%
Not Hispanic or Latino/a/x	23,182	95.8%	12,130	94.0%	9,136	97.7%	1,916	98.3%
Unknown	92	0.4%	56	0.4%	29	0.3%	7	0.4%
Insurance status								
Uninsured	1,303	5.4%	763	5.9%	436	4.7%	104	5.3%
Medicaid/Medicare	12,907	53.3%	7,231	56.0%	4,790	51.2%	886	45.5%
Private health insurance	9,782	40.4%	4,785	37.1%	4,056	43.4%	941	48.3%
Other or unknown	208	0.9%	124	1.0%	66	0.7%	18	0.9%

Abbreviations: AI: American Indian; AN: Alaskan Native; NH: Native Hawaiian; PI: Pacific Islander

ANXIETY

Demographic characteristics based on anxiety diagnosis (n=32,054) among OSF patients in 2024

Demographic	Overall		Peoria (n=16,193)		Tazewell (n=13,004)		Woodford (n=2,857)	
	n	%	n	%	n	%	n	%
Age								
12-17 years	1,816	5.7%	815	5.0%	799	6.1%	202	7.1%
18-25 years	3,683	11.5%	1,858	11.5%	1,484	11.4%	341	11.9%
26-34 years	5,007	15.6%	2,623	16.2%	2,014	15.5%	370	13.0%
35-49 years	8,126	25.4%	4,078	25.2%	3,332	25.6%	716	25.1%
50+ years	13,422	41.9%	6,819	42.1%	5,375	41.3%	1,228	43.0%
Sex								
Female	22,002	68.6%	10,995	67.9%	9,013	69.3%	1,994	69.8%
Male	10,049	31.4%	5,197	32.1%	3,989	30.7%	863	30.2%
Unknown	3	0.0%	1	0.0%	2	0.0%	0	0.0%
Race								
White	28,056	87.5%	12,795	79.0%	12,501	96.1%	2,760	96.6%
Black or African American	2,520	7.9%	2,361	14.6%	132	1.0%	27	0.9%
Asian	187	0.6%	126	0.8%	54	0.4%	7	0.2%
AI, AN, or NH or other PI	123	0.4%	68	0.4%	48	0.4%	7	0.2%
Two or more races or other	880	2.7%	686	4.2%	164	1.3%	30	1.1%
Unknown	288	0.9%	157	1.0%	97	0.7%	26	0.9%
Ethnicity								
Hispanic or Latino/a/x	1,111	3.5%	826	5.1%	245	1.9%	40	1.4%
Not Hispanic or Latino/a/x	30,842	96.2%	15,299	94.5%	12,734	97.9%	2,809	98.3%
Unknown	101	0.3%	68	0.4%	25	0.2%	8	0.3%
Insurance status								
Uninsured	1,669	5.2%	913	5.6%	623	4.8%	133	4.7%
Medicaid/Medicare	14,799	46.2%	7,989	49.3%	5,724	44.0%	1,086	38.0%
Private health insurance	15,326	47.8%	7,146	44.1%	6,566	50.5%	1,614	56.5%
Other or unknown	260	0.8%	145	0.9%	91	0.7%	24	0.8%

Abbreviations: AI: American Indian; AN: Alaskan Native; NH: Native Hawaiian; PI: Pacific Islander

SUICIDALITY

Demographic characteristics based on suicide diagnosis (n=635) among OSF patients in 2024

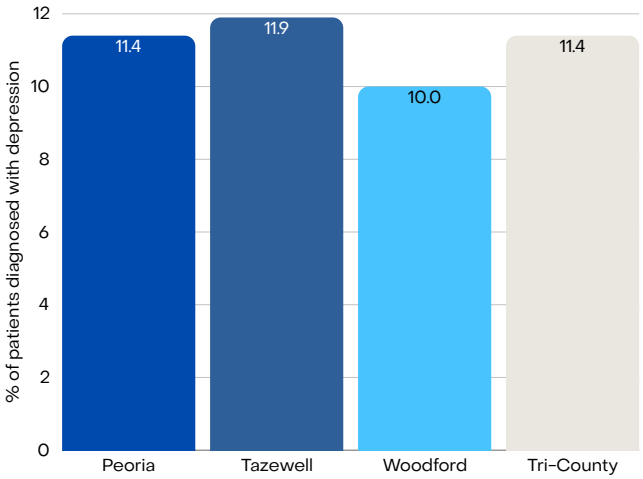
Demographic	Overall		Peoria (n=415)		Tazewell (n=181)		Woodford (n=39)	
	n	%	n	%	n	%	n	%
Age								
12-17 years	73	11.5%	34	8.2%	30	16.6%	9	23.1%
18-25 years	113	17.8%	76	18.3%	31	17.1%	6	15.4%
26-34 years	121	19.1%	87	21.0%	28	15.5%	6	15.4%
35-49 years	166	26.1%	108	26.0%	53	29.3%	5	12.8%
50+ years	162	25.5%	110	26.5%	39	21.5%	13	33.3%
Sex								
Female	290	45.7%	186	44.8%	84	46.4%	20	51.3%
Male	345	54.3%	229	55.2%	97	53.6%	19	48.7%
Unknown	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Race								
White	465	73.2%	261	62.9%	168	92.8%	36	92.3%
Black or African American	131	20.6%	124	29.9%	6	3.3%	1	2.6%
Asian	2	0.3%	2	0.5%	0	0.0%	0	0.0%
AI, AN, or NH or other PI	2	0.3%	2	0.5%	0	0.0%	0	0.0%
Two or more races or other	24	3.8%	19	4.6%	4	2.2%	1	2.6%
Unknown	11	1.7%	7	1.7%	3	1.7%	1	2.6%
Ethnicity								
Hispanic or Latino/a/x	30	4.7%	24	5.8%	5	2.8%	1	2.6%
Not Hispanic or Latino/a/x	601	94.6%	389	93.7%	175	96.7%	37	94.9%
Unknown	4	0.6%	2	0.5%	1	0.6%	1	2.6%
Insurance status								
Uninsured	42	6.6%	31	7.5%	10	5.5%	1	2.6%
Medicaid/Medicare	437	68.8%	314	75.7%	101	55.8%	22	56.4%
Private health insurance	146	23.0%	63	15.2%	67	37.0%	16	41.0%
Other or unknown	10	1.6%	7	1.7%	3	1.7%	0	0.0%

Abbreviations: AI: American Indian; AN: Alaskan Native; NH: Native Hawaiian; PI: Pacific Islander

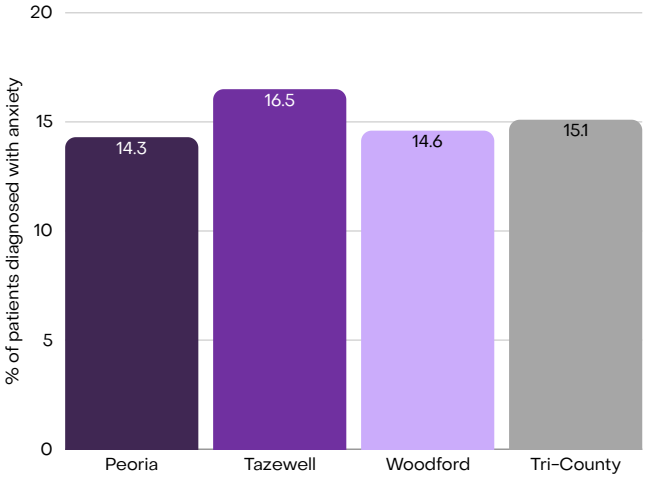
OSF COMMUNITY DATA: MENTAL HEALTH

Data from OSF was aggregated among patients who received care in 2024 and collapsed into BMI classification. In particular, the data include patients aged 12-90 years old at the time of last encounter living in Peoria, Woodford, or Tazewell county who had some encounter with OSF Healthcare between 1/1/2024 and 1/1/2025. Each patient is only counted once.

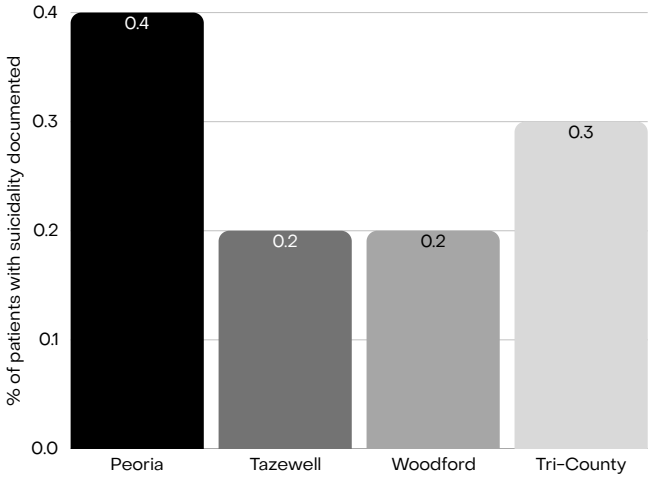
DIAGNOSED DEPRESSION AMONG TRI-COUNTY RESIDENTS



DIAGNOSED ANXIETY AMONG TRI-COUNTY RESIDENTS



SUICIDALITY DOCUMENTED AMONG TRI-COUNTY RESIDENTS



SOCIAL DRIVERS RELATED TO DEPRESSION

Data captures OSF patients aged 12-90 at the time of last encounter living in Peoria, Woodford, or Tazewell county who had some encounter with OSF Healthcare between 1/1/2024 and 1/1/2025. SDOH data is a relatively new and optional piece of documentation with a relatively low documentation rate.

FOOD & HOUSING INSECURITY

35-36% of patients diagnosed with depression reported food insecurity or housing insecurity

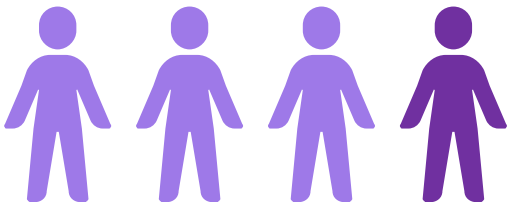
SUBSTANCE USE

Approximately 18% of patients diagnosed with depression reported alcohol or tobacco use

DOMESTIC VIOLENCE

One-third of patients diagnosed with depression reported domestic violence

NUMBER OF CONCERNS RELATED TO SOCIAL DRIVERS



Approximately **75%** of patients diagnosed with depression reported at least one concern related to social determinants of health

Over **30%** of patients diagnosed with depression reported **2 or more** concerns related to social drivers

SOCIAL DRIVERS RELATED TO ANXIETY

Data captures OSF patients aged 12-90 at the time of last encounter living in Peoria, Woodford, or Tazewell county who had some encounter with OSF Healthcare between 1/1/2024 and 1/1/2025. SDOH data is a relatively new and optional piece of documentation with a relatively low documentation rate.

FOOD & HOUSING INSECURITY

40-41% of patients diagnosed with anxiety reported food insecurity or housing insecurity

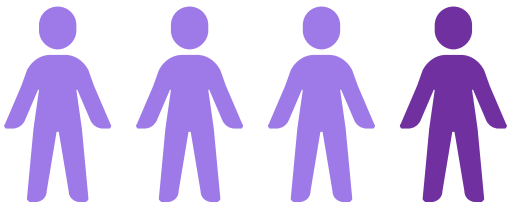
SUBSTANCE USE

Approximately 35% of patients diagnosed with anxiety reported alcohol or tobacco use

DOMESTIC VIOLENCE

22% of patients diagnosed with anxiety reported domestic violence

NUMBER OF CONCERNS RELATED TO SOCIAL DRIVERS



Approximately **73%** of patients diagnosed with anxiety reported at least one concern related to social determinants of health

Nearly **30%** of patients diagnosed with anxiety reported **2 or more** concerns related to social drivers

PERFORMANCE MANAGEMENT

Performance management efforts track progress in committees for the following topic areas: substance use and cancer

SUBSTANCE USE

Notable achievements for this subcommittee over the past year include the distribution of over 8,000 naloxone kits and community engagement through events like Overdose Awareness Day. Over the past cycle the Substance Use Performance Management team collaboratively worked towards the objectives below. Within this team, there are three work groups: healthcare provider/first responder education, naloxone distribution/outreach, and school-based education.

Objectives	Target	Baseline Data	Year 1
By December 31, 2025, reduce drug overdose deaths by 5% resulting in a Tri-County overdose death rate of 22.12 per 100,000.	Overdose Death Rate for Tri-County: 22.12 per 100,000	**Peoria:** 16.4 per 100,000 **Tazewell**: 20.6 per 100,000 **Woodford**: 13.1 per 100,000 **Tri-County**: 23.27 per 100,000 *Source: IDPH Opioid Data Dashboard, 2021*	**Peoria**: 33 per 100,000 **Tazewell**: 18.2 per 100,000 **Woodford**: 5.2 per 100,000 *Source: IDPH Opioid Data Dashboard, 2022*
By December 31, 2025, reduce the proportion of adolescents reporting using substances in the Tri-County area by 5%.	**Peoria:** 25% **Tazewell:** 35% **Woodford**: 7%	**Peoria**: 30% **Tazewell:** 40% **Woodford:** 11% *Source: 2022 Illinois Youth Survey*	Survey is conducted every other year.
By December 31, 2025, increase the proportion of people with a substance use disorder (SUD) in the Tri-County region who received treatment in the past year by 3%.	**Peoria**: 283.25 per 100,000 **Tazewell**: 279.6 per 100,000 **Woodford**: 135.5 per 100,000	Total Buprenorphine Patients per County (per 100,000 population): **Peoria**: 275.0 per 100,000 **Tazewell**: 271.5 per 100,000 **Woodford:** 131.6 per 100,000 *Source: Illinois Prescription Monitoring Program, 2020*	Data has not been updated since 2020.
Activities			
Units of Naloxone Distributed by County (Source: Sue Tisdale at Trillium Place)		**2022** **Peoria**: 6087 **Tazewell:** 430 **Woodford:** 122	**2023** (through September 2023) **Peoria**: 3818 **Tazewell**: 846 **Woodford**: 4
Fentanyl Test Strips Distributed		**2022** **Peoria:** 2300 **Tazewell:** 225	**2023** **Peoria:** 3140 **Tazewell:**
Xylazine Test Strips Distributed			

For more information on this priority areas in performance management, please visit: https://healthyhoi.wildapricot.org/2020-22-Substance-Use

CANCER

During the past cycle, the Cancer Action Performance Management team identified an opportunity to enhance community engagement through coordinated screening events. As a result, two community-wide screening days were held on May 19 and October 20, 2023, with participation from Carle Health and OSF HealthCare. Additionally, both organizations took part in National Lung Cancer Screening Day on November 11, 2023.

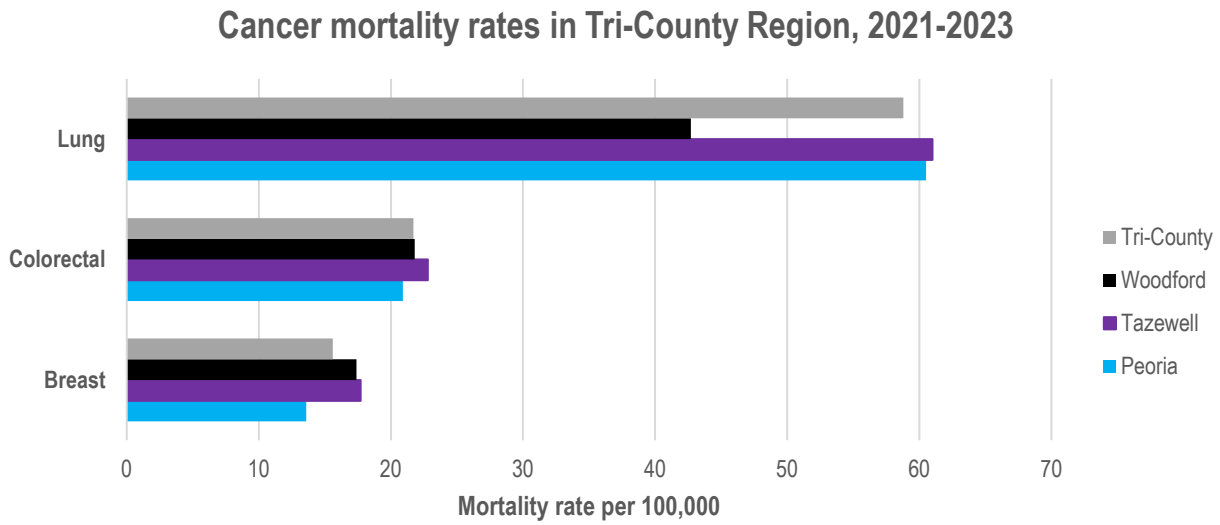
In collaboration with the American Cancer Society, grant funding was secured to help reduce transportation and lodging barriers for patients undergoing active treatment. Furthermore, two evidence-based screening initiatives were launched to improve lung and breast cancer screening rates among targeted populations in the Tri-County area.

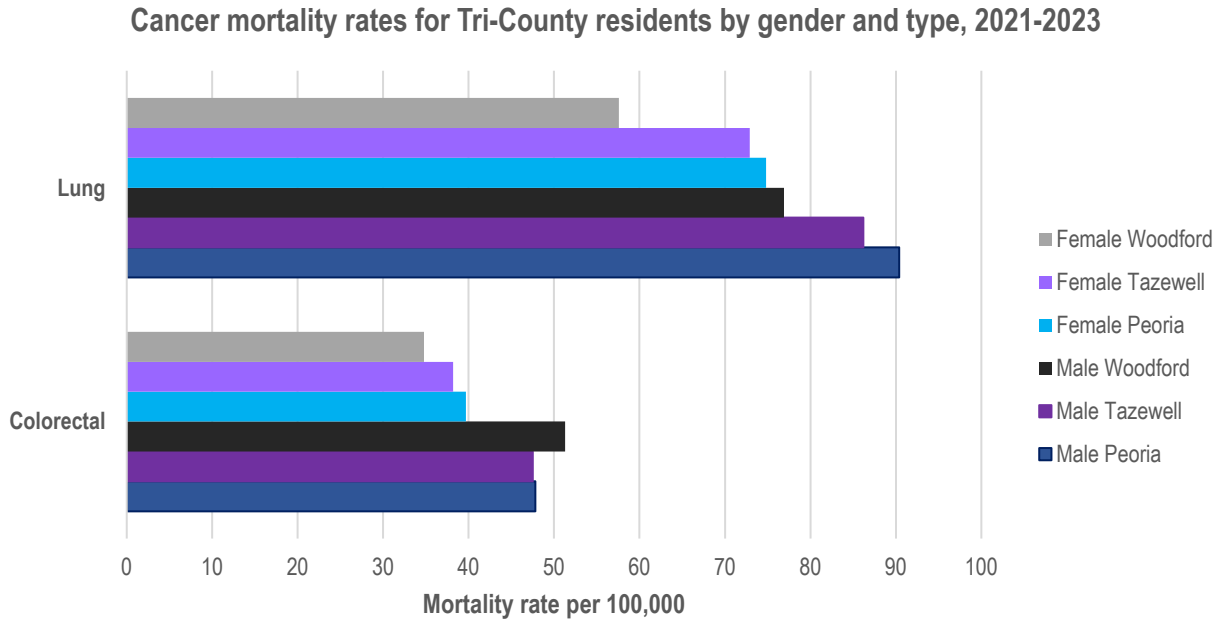
Additional Prevention Activities Completed:

- **Community-Wide Screening Days:** Held twice annually (Spring and Fall)

- *May 19, 2023:* Carle Pekin, OSF Saint Francis Medical Center (SFMC)
- *October 20, 2023:* Carle North Allen Family Medicine, OSF Route 91

- **National Lung Cancer Screening Day:**
  - *November 11, 2023:* OSF SFMC, Carle Proctor





Data source: CDC WONDER

Cancer mortality was extracted from CDC WONDER using the following ICD-10 codes for breast (C50, D05), colorectal (C18,C19, C20, C21, D01), and lung cancer (C34, C78).

Objectives	Target	Baseline Data	Baseline	Recent
Breast cancer *Long*: Reduce female **breast** cancer death rate by **1%** *Short*: Increase the number of breast cancer screenings in women over age 40	15.3 per 100,000	19.7 per 100,000 females (2018)	Mortality rate 2018-2020: **Peoria:** 16.4 **Tazewell:** 12.2 **Woodford:** SUPP	Mortality rate 2021-2023: **Peoria:** 13.6 **Tazewell:** 17.7 **Woodford:** 17.4
Colorectal cancer *Long*: Reduce **colorectal** cancer death rate by 1% *Short*: Increase the number of colorectal cancer screenings for men and women over age 45 (colonoscopy, Cologuard, FIT, FOBT)	8.9 per 100,000	13.4 per 100,000 (2018)	Mortality rate 2018-2020: **Peoria:** 21.6 **Tazewell:** 22.8 **Woodford:** 17.4	Mortality rate 2021-2023: **Peoria:** 20.9 **Tazewell:** 22.8 **Woodford:** 21.8
Lung cancer *Long*: Reduce **lung** cancer death rate by 1% *Short*: Increase the number of LDCTs completed by eligible patients ages 50-77	25.1 per 100,000	34.8 per 100,000	Mortality rate 2018-2020: **Peoria:** 62.3 **Tazewell:** 67.1 **Woodford:** 60.9	Mortality rate 2021-2023: **Peoria:** 60.5 **Tazewell:** 61.0 **Woodford:** 42.7
Prevention Increase genetic screening to identify high risk patients	Evaluation plan: 3 cancer high risk assessments completed (consulted and completed)			

In **Peoria County**, all three cancer types showed a modest decline in mortality rates over the two time periods with the most significant improvement observed in breast cancer outcomes. The mortality rate for breast cancer decreased by 17.1%. Colorectal cancer mortality rates in Peoria reduced by 3.2% between the two time periods and lung cancer rates decreased by 2.9%.

Between the periods of 2018–2020 and 2021–2023, **Tazewell County** experienced a notable increase in breast cancer mortality, rising by 45.1%. Colorectal cancer mortality remained stable across both time periods. Lung cancer mortality showed a modest decline, decreasing from 67.1 to 61.0 deaths per 100,000.

Between 2018–2020 and 2021–2023, colorectal cancer mortality in **Woodford County** increased by 25.3. Lung cancer mortality showed a significant 29.9% decrease between the two time periods. Of note, data for breast cancer mortality was only available for the 2021–2023 period due to suppression constraints.

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 drivers of health

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

SDOH measures related to children

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

Data sources:
1.2021 Small Area Income and Poverty Estimates
2. 2017-2021 American Community Survey, 5-year estimates
3. 2019 Easy Access to State and County Juvenile Court Case Counts
4. 2018 Stanford Education Data Archive
Note: SUPP: Data are suppressed when there is not sufficient data and/or do not meet the criteria for confidentiality constraints.

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

SDOH measures related to children by race

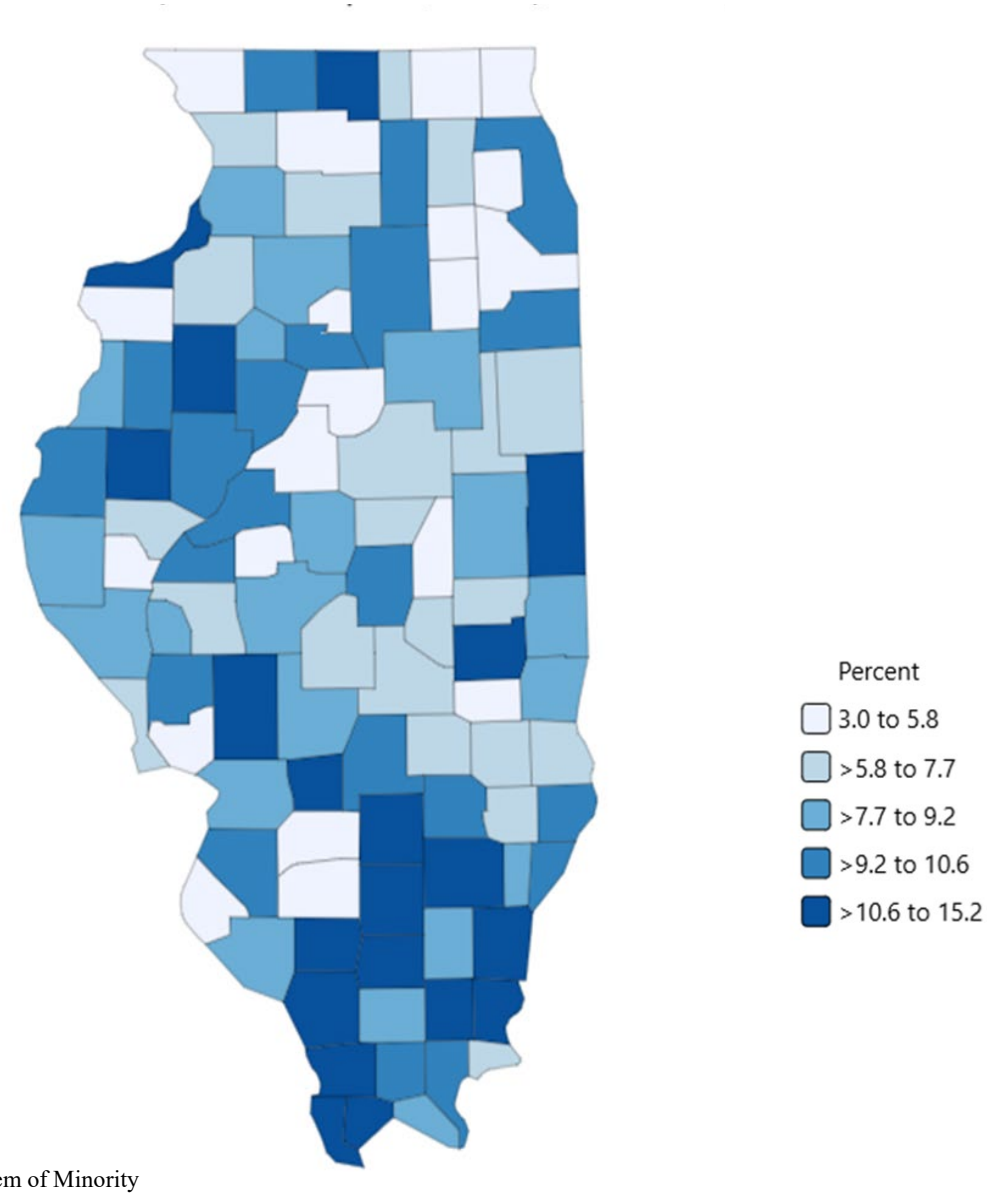
	Peoria	Tazewell	Woodford	Illinois
% children in poverty[1]				
Black	44.0	52.5	5.6	35.5
Hispanic	20.9	4.2	6.2	19.2
White	9.2	10.0	5.5	9.1
Average reading score/grade performance[2]				
Black	2.0	2.5	SUPP	2.5
Hispanic	2.3	2.9	SUPP	2.7

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

Data sources:
1.2021 Small Area Income and Poverty Estimates
2. 2018 Stanford Education Data Archive
Note: SUPP: Data are suppressed when there is not sufficient data and/or do not meet the criteria for confidentiality constraints.

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

FAMILIES LIVING IN POVERTY, ALL RACES & AGES, 2018-2022



Data source: HD*Pulse*: An Ecosystem of Minority Health and Health Disparities Resources. National Institute on Minority Health and Health Disparities

Additional measures related to health status

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

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

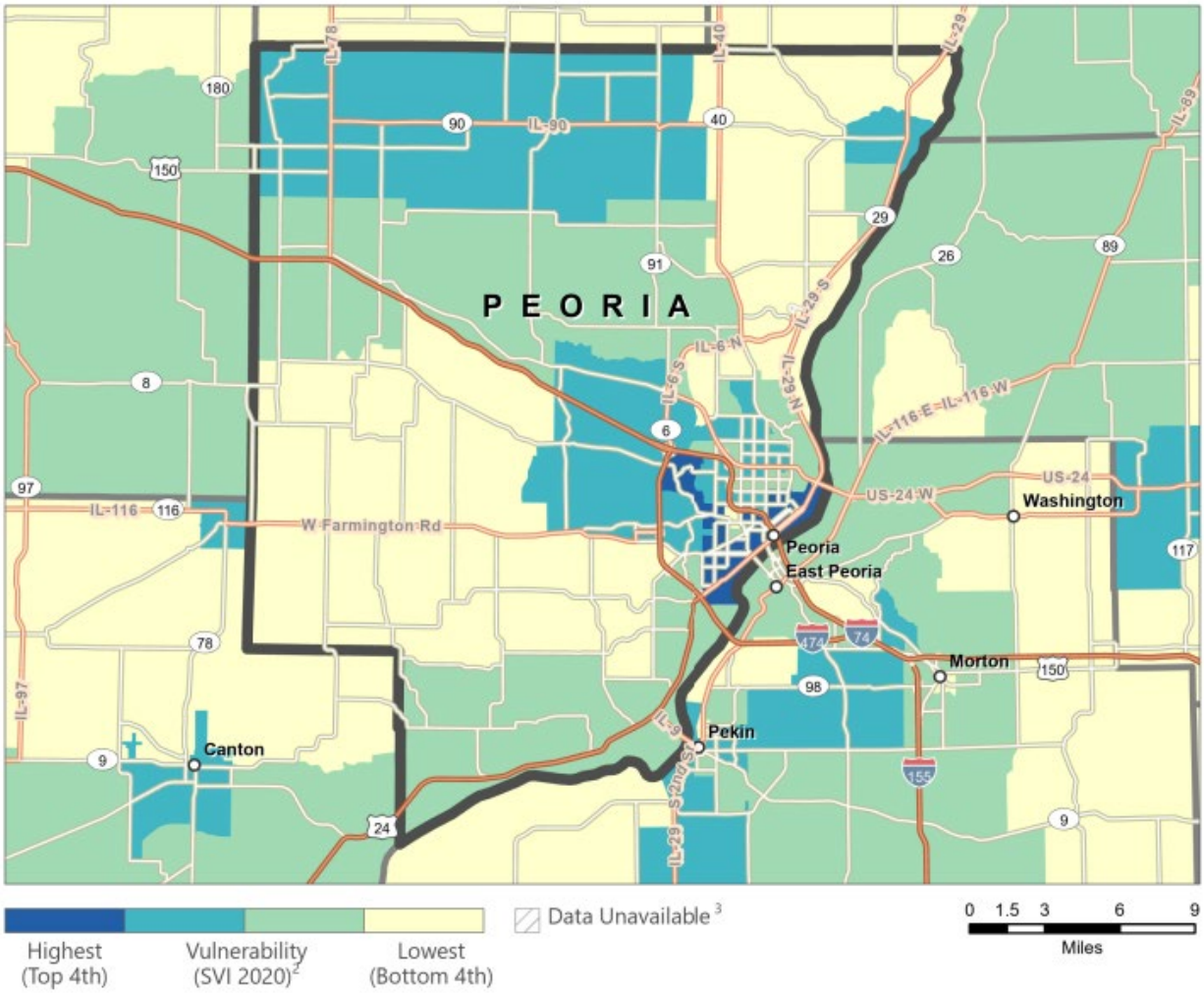
The data in the table above depicts the age-adjusted percentage of adults for the Tri-County region in comparison to Illinois and the US.

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

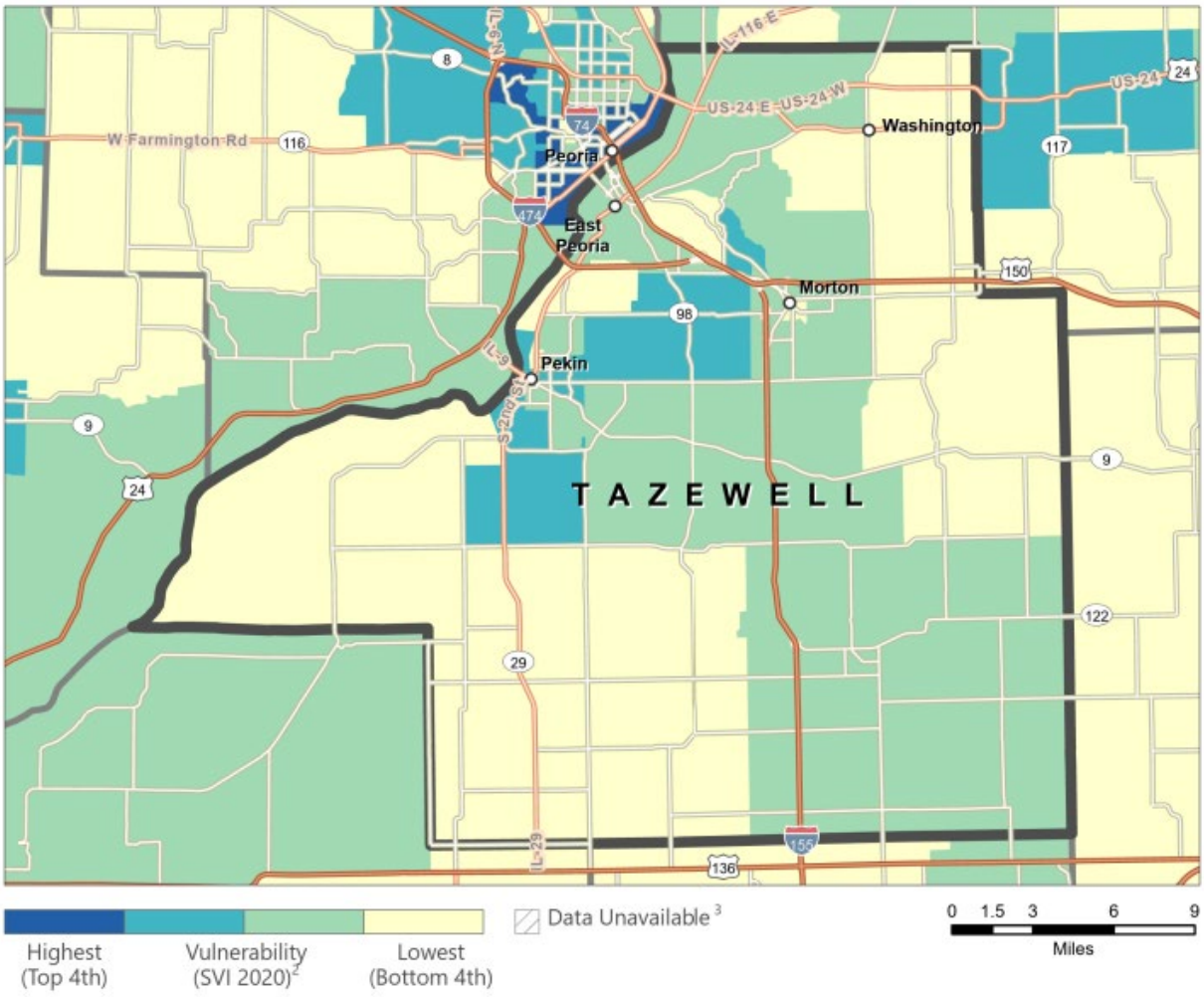
Social Vulnerability Index

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

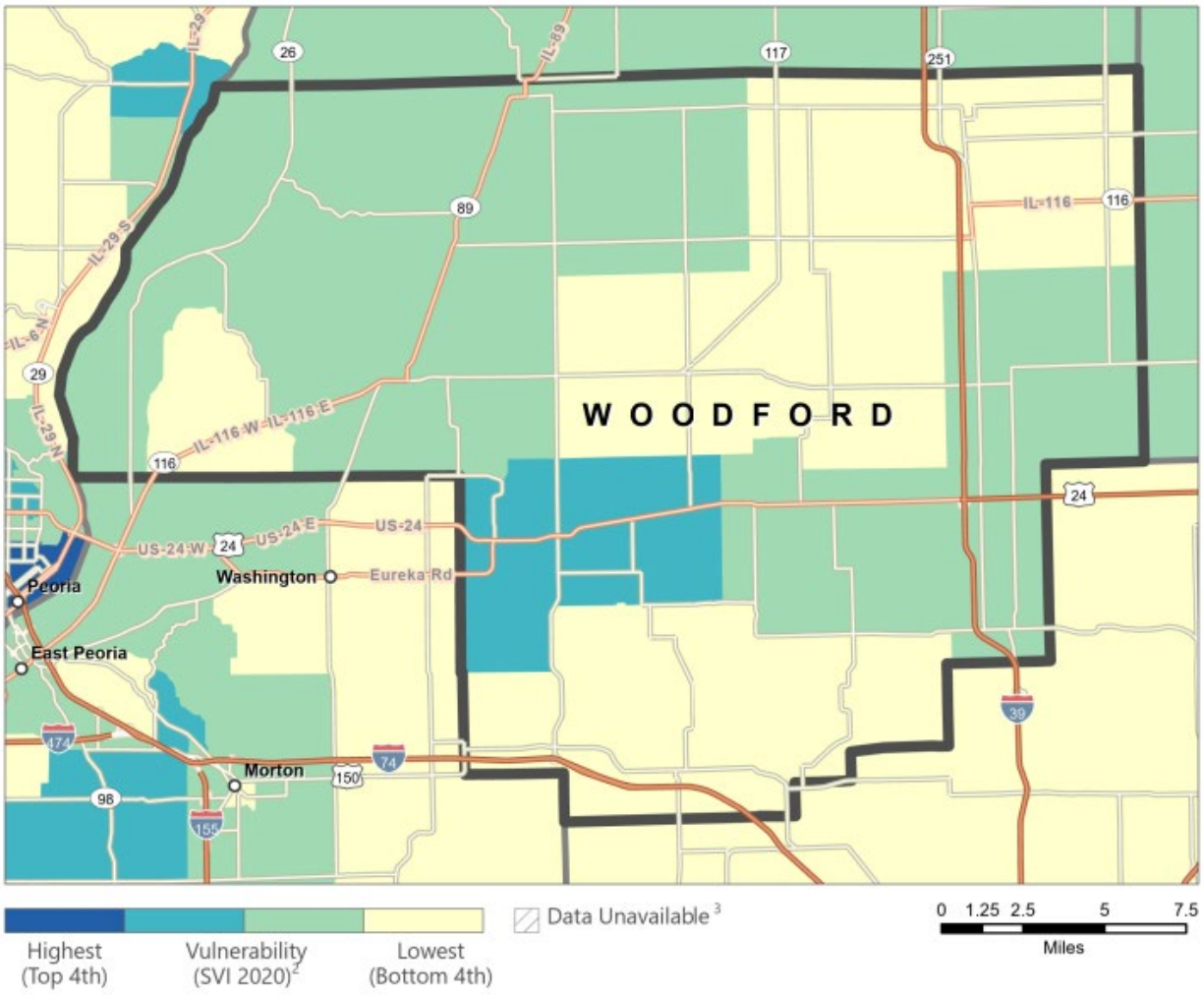
Peoria County, 2020



Tazewell County, 2020



Woodford County, 2020

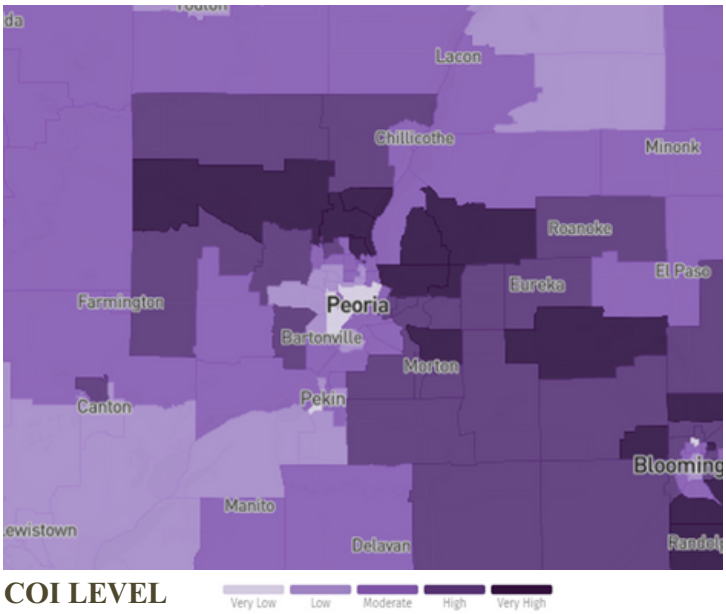


CHILD OPPORTUNITY INDEX

The Child Opportunity Index (COI) 3.0 is a nationally recognized measure that captures the quality of resources and conditions that children need to grow up healthy and achieve long-term success. It includes indicators across education, health, environment, and social and economic domains. This tool is especially valuable in identifying disparities in opportunity among youth populations and can help guide strategies to address youth-related challenges.

The COI is a complement to the Social Vulnerability Index (SVI). While the SVI is often more reflective of adult or general population vulnerabilities, the COI offers a youth-focused lens that can help us better understand and support at-risk populations.

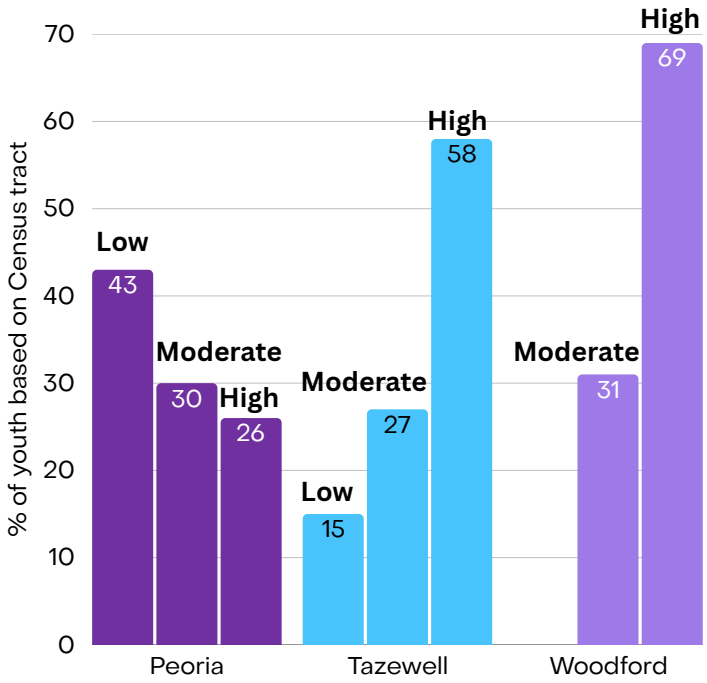
MAP OF CHILD OPPORTUNITY INDEX BY CENSUS TRACT FOR TRI-COUNTY REGION



<u>Meaning</u>: A low COI for a county means that children living there have limited access to the resources and conditions—like quality schools, safe neighborhoods, and healthy environments—that are important for their healthy development and future success.

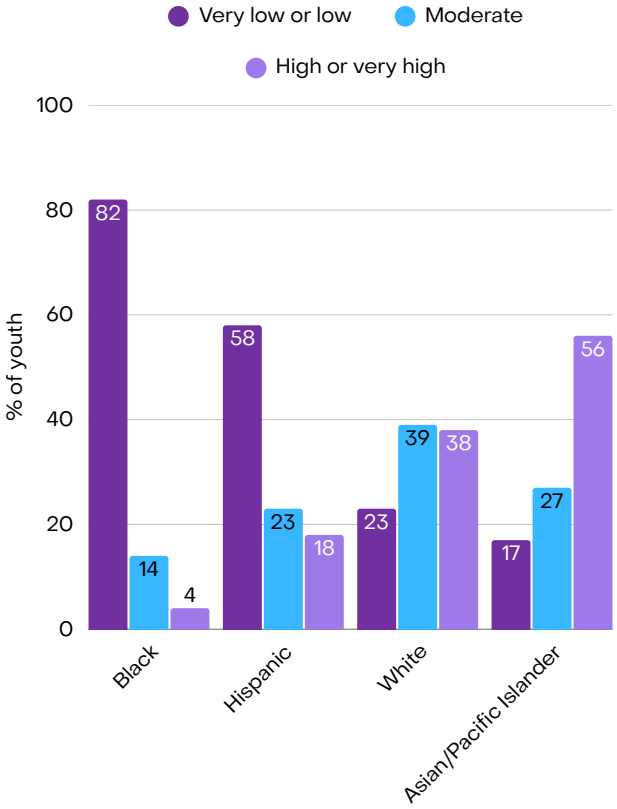
- **Peoria County** overall ranks <u>low</u> on COI levels. Approximately 82% of children in Peoria County reside in Census tracts with a different COI, resulting in racial/ethnic variability.
- **Tazewell County** overall ranks <u>high</u> on COI levels. Approximately 58% of children in Tazewell County reside in Census tracts with a different COI, resulting in racial/ethnic variability.
- **Woodford County** overall ranks <u>very high</u> on COI levels. Approximately 51% of children in Woodford County reside in Census tracts with a different COI, resulting in racial/ethnic variability.

COI IN TRI-COUNTY BASED ON CENSUS TRACT

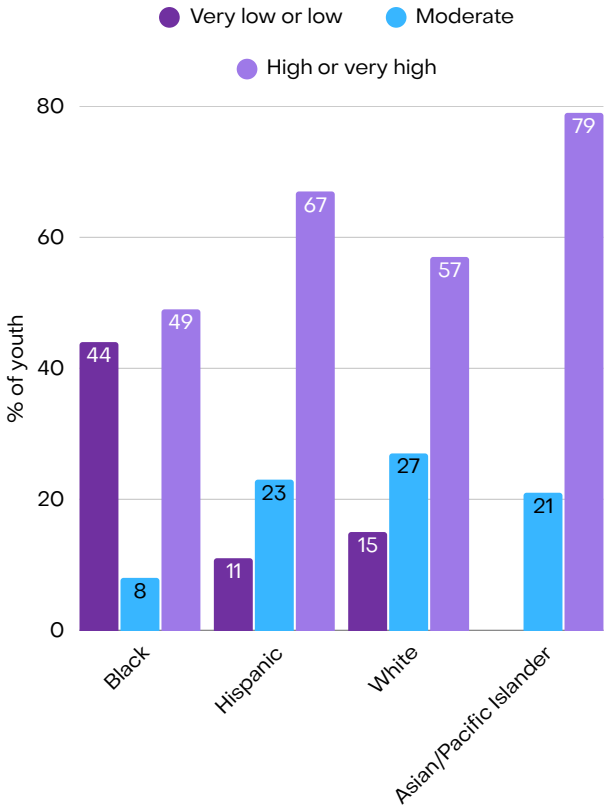


CHILD OPPORTUNITY INDEX

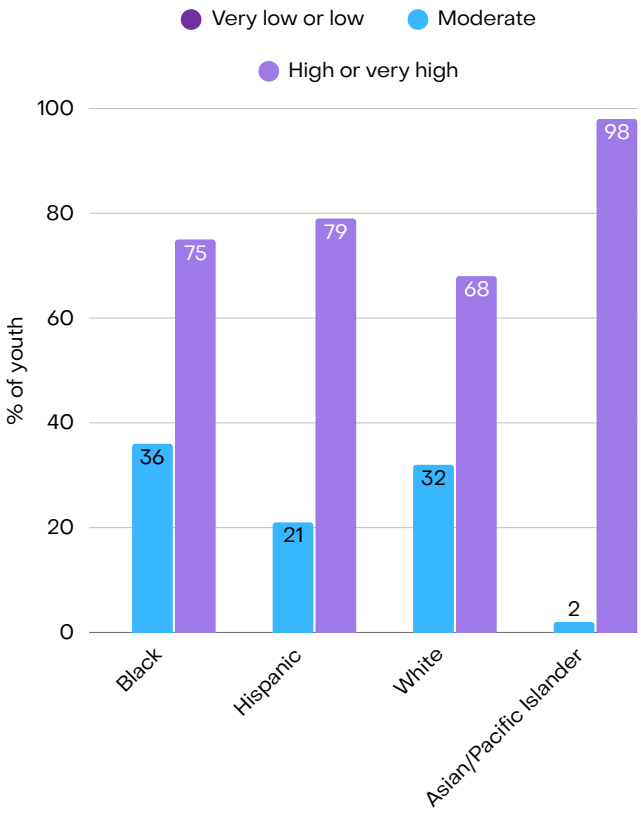
RACIAL/ETHNIC DISPARITIES FOR COI IN PEORIA COUNTY



RACIAL/ETHNIC DISPARITIES FOR COI IN TAZEWELL COUNTY



RACIAL/ETHNIC DISPARITIES FOR COI IN WOODFORD COUNTY



Larger disparities among youth are present in Peoria County, although racial/ethnic disparities appear across the Central Illinois region

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

Cancer

	Peoria	Tazewell	Woodford	Illinois	United States
Medical encounters					
Cancer diagnosis (excluding skin)[1]	6.2	6.5	6.5	6.9	6.0
Cancer screening					
Up-to-date on colon cancer screening[2]	68.9	67.5	69.5		70.6
Up-to-date on cervical cancer screening[2]	81.4	82.2	82.8	72.1	83.7
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

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

Health risk behaviors

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

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

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

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

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

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

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

Maternal and child health

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

Data sources:
1. 2014-2020 NCHS
Note The data in the table above 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
Note: SUPP: Data are suppressed when there is not sufficient data and/or do not meet the criteria for confidentiality constraints.

Dental

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

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

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

Disability

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

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

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

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

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

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

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

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

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

Mortality

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

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

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

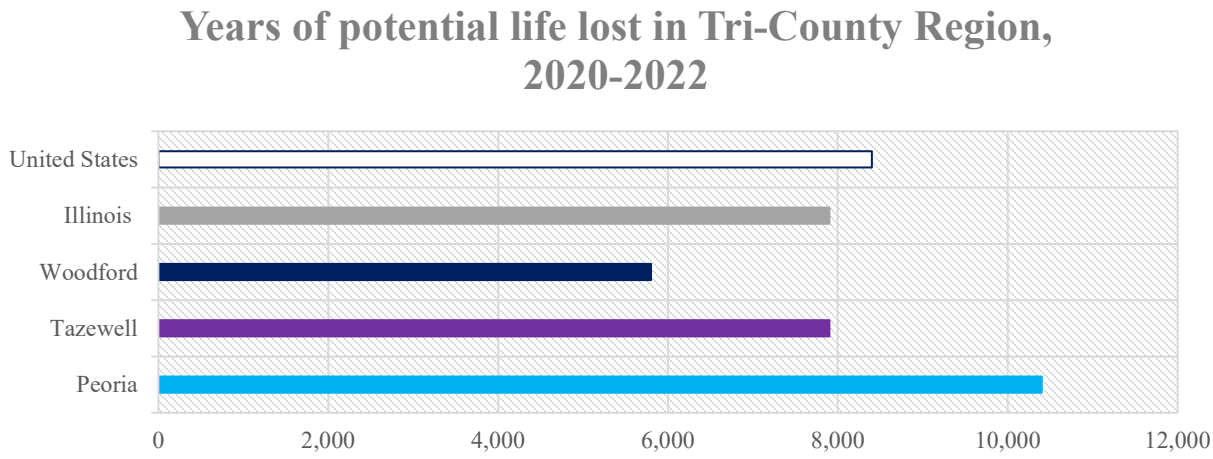
Leading causes of death for the Tri-County region

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

Data sources:
1. 2018-2020 CDC WONDER

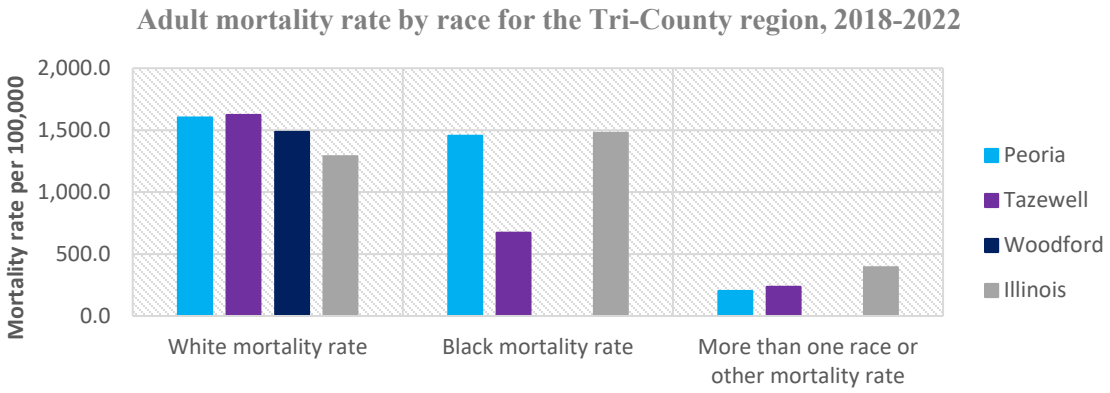
In the Tri-County region, Peoria County had higher death rates associated with diseases of the heart and malignant neoplasms. Tazewell County had the highest death rate related to chronic lower respiratory disease, and diabetes. Woodford County had higher death rates related to accidents than Tazewell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

Years of Potential Life Lost & Life expectancy

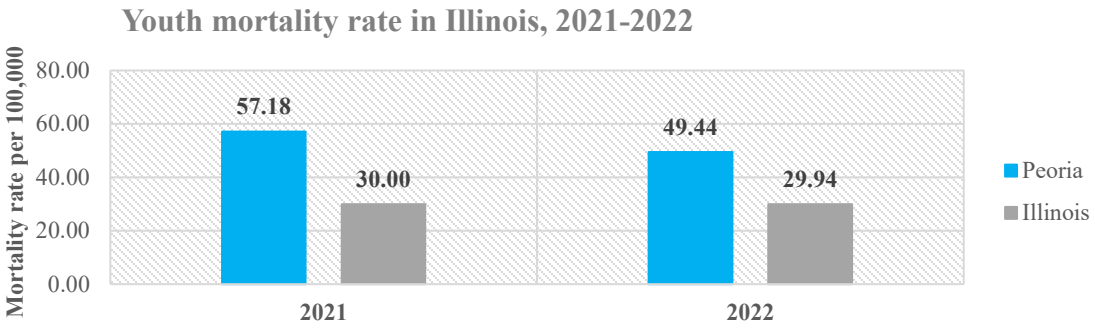


Years of Potential Life Lost (YPLL) depicts the number of years of life that were lost to deaths of people under the age of 75, per 100,000 people. For instance, in Peoria County, 10,400 years of life were lost to deaths of people under the age of 75, per 100,000 people. This is up from 9,700 estimated in the 2024 Annual Data Report.

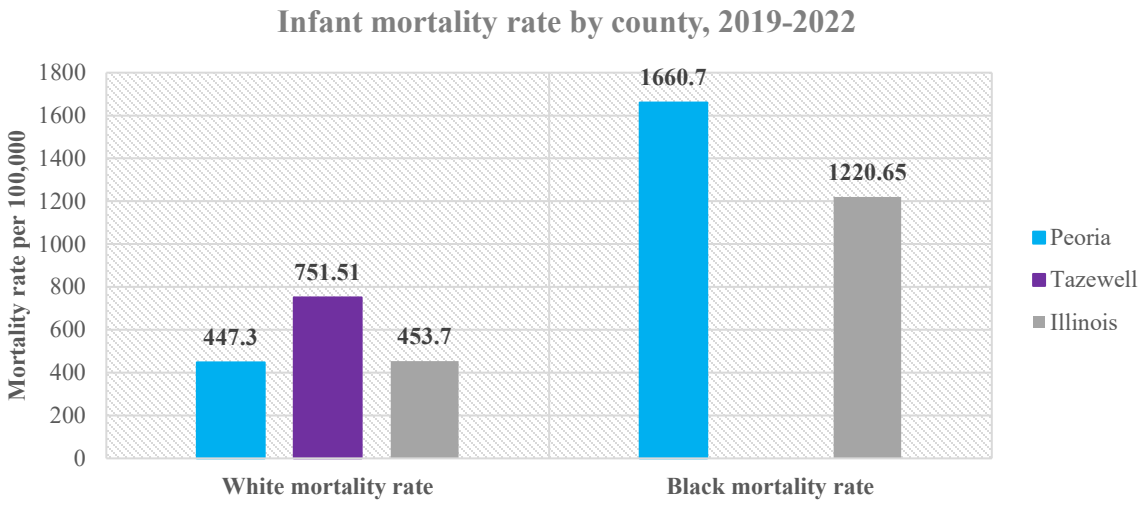
MORTALITY ESTIMATES



Adult mortality is not substantially different across the Tri-County region. However, youth and infant mortality rates are markedly different.



Similar to youth mortality rates, infant mortality rates are significantly higher among the Black populations compared to White populations in Illinois, including Peoria County. Due to small numbers, the other counties in the Tri-County region were suppressed. Data source: CDC WONDER



Age-adjusted death rate by race/ethnicity

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

Data sources:
1. 2018-2020 NCHS

Violent death data

The following data was obtained from the state-based epidemiologic reporting system on violent deaths. More specifically, the goal of these data are to help inform, develop, and evaluate these violent deaths (e.g. suicides and homicides) that occur for each participating county and state. This data system is incident-based which captures information on victims and alleged perpetrators (deceased or alive), and has the capability to link events. Information is collected at the state level and sent to the National Center for Injury Prevention and Control within the Centers for Disease Control and Prevention (CDC) to be aggregated at the national-level (National Violent Death Reporting System). Of note, data were suppressed for homicides in Tazewell County.

Characteristics (%) of suicide deaths by race in Peoria County, 2015-2021

	NH White	NH Black	NH Other	Hispanic or LatinX
Sex				
Male	64.0	72.2	66.7	100.0
Female	36.0	27.8	33.0	-
Age Groups				
<15 years old	1.3	5.6	33.3	-
15-24 years old	5.3	16.7	33.3	100.0
25-34 years old	15.3	27.8	-	-
35-44 years old	22.0	27.8	33.3	-
45-54 years old	20.0	5.6	33.3	-
55-64 years old	15.3	11.1	-	-
65+ years old	20.7	5.6	-	-
Educational attainment				
Below high school	12.1	16.7	-	-
High school graduate	39.6	38.9	-	-
Some College or Associate's Degree	24.2	33.3	33.3	50.0
Bachelor's or more	23.5	11.1	66.7	-
Unknown	0.7	-	-	-
Marital Status				
Married	28.7	22.2	66.7	-
Single	34.0	66.7	33.3	100.0
Widowed	8.0	-	-	-
Divorced	29.3	11.1	-	-
Weapon Type				
Firearm	34.7	55.6	66.7	-
Hanging	35.3	16.7	-	-
Poisoning	24.7	22.2	33.3	50.0
Sharp/Blunt Instrument	0.7	5.6	-	-
Other	4.7	-	-	-

Notes: Additional data from ILVDRS will be assessed to identify other contextual differences surrounding these deaths to inform prevention efforts by the PFHC. Please note that these are based on known information that likely results in underestimates

Abbreviations: NH, Non-Hispanic

Characteristics (%) of suicide deaths by age group in Peoria County, 2015-2021

	<15 years old	15-24 years old	25-34 years old	35-44 years old	45-54 years old	55-64 years old	65+ years old
Sex							
Male	66.7	78.6	71.4	56.4	62.5	60.0	71.9
Female	33.3	21.4	28.6	43.6	37.5	40.0	28.1
Educational attainment							
Below high school	100.0	21.4	14.3	7.7	6.5	12.0	9.4
High school graduate	-	28.6	39.3	43.6	54.8	28.0	34.4
Some College or Associate's Degree	-	42.9	21.4	25.6	19.4	36.0	21.9
Bachelor's or more	-	7.1	25.0	20.5	19.4	24.0	34.4
Unknown	-	-	-	2.6	-	-	-
Weapon Type							
Firearm	-	28.6	39.3	23.1	28.1	44.0	62.5
Hanging	66.7	35.7	39.3	33.3	40.6	28.0	18.6
Poisoning	33.3	21.4	14.3	41.0	21.9	28.0	15.6
Sharp/Blunt Instrument	-	7.1	-	2.6	-	-	-
Other	-	7.1	7.1	-	9.4	-	3.1

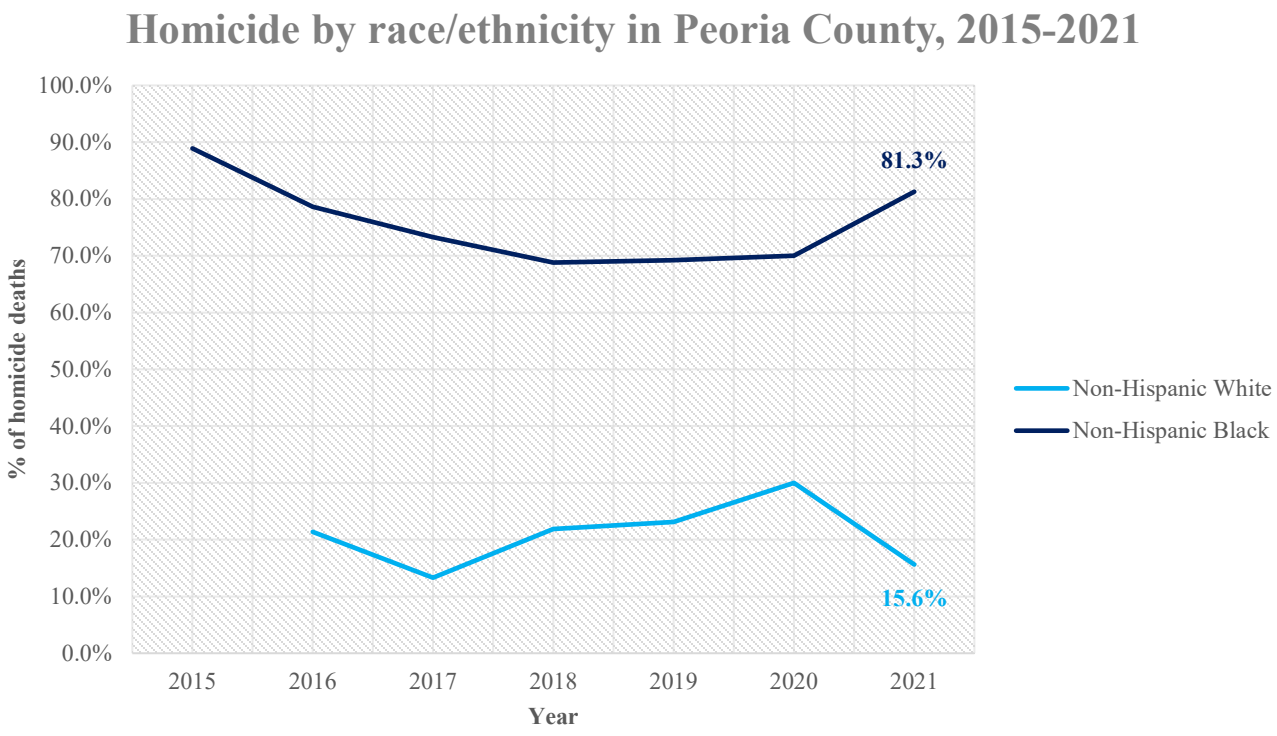
Notes: Additional data from ILVDRS will be assessed to identify other contextual differences surrounding these deaths to inform prevention efforts by the PFHC. Please note that these are based on known information that likely results in underestimates

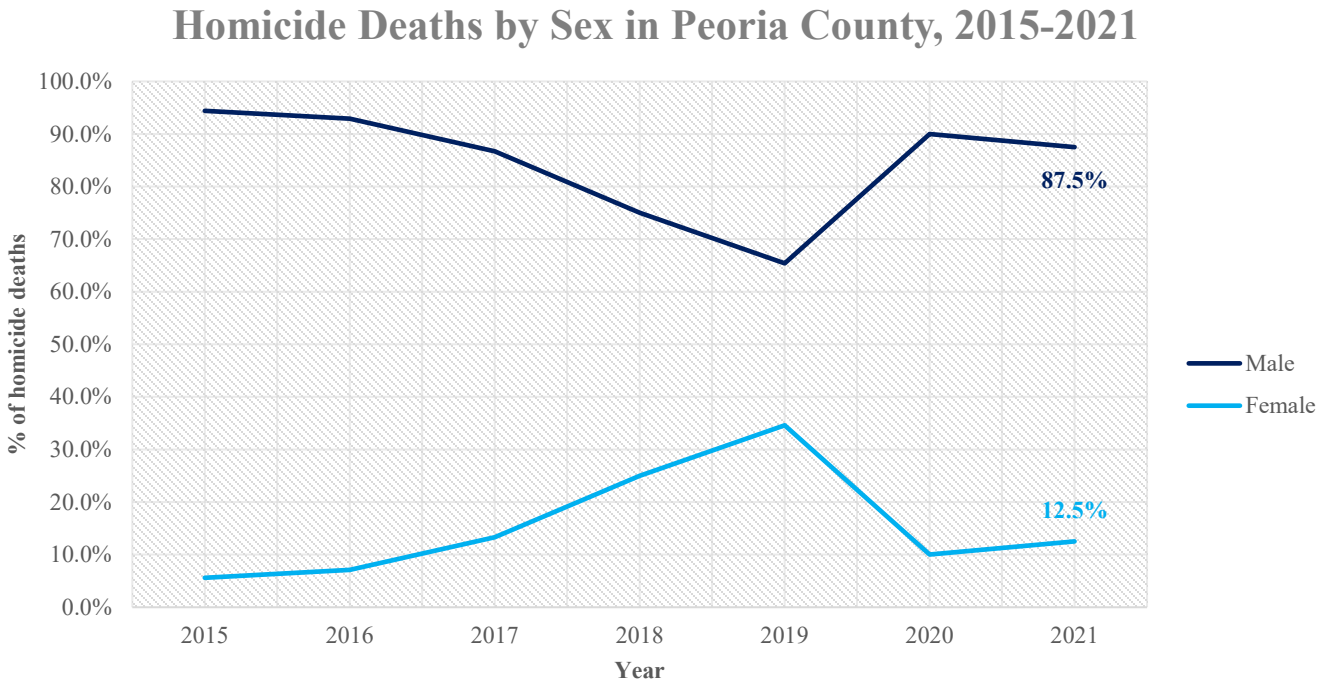
Characteristics of suicide deaths (%) for Peoria and Tazewell Counties by year, 2015-2021

	2015		2016		2017		2018		2019		2020		2021	
	Peoria	Tazewell	Peoria	Tazewell	Peoria	Tazewell	Peoria	Tazewell	Peoria	Tazewell	Peoria	Tazewell	Peoria	Tazewell
Sex														
Male	50.0	80.0	75.0	94.4	73.5	83.3	83.3	76.2	32.0	92.3	57.9	87.5	78.3	72.2
Female	50.0	20.0	25.0	5.6	26.5	16.7	16.7	23.8	68.0	7.7	42.1	12.5	21.7	27.8
Age group														
<15 years old	0.0	20.0	0.0	0.0	2.9	0.0	4.2	4.8	0.0	0.0	5.3	0.0	0.0	0.0
15-24 years old	10.0	20.0	7.1	11.1	8.8	27.8	4.2	9.5	8.0	23.1	5.3	18.8	13.0	5.6
25-34 years old	20.0	0.0	14.3	5.6	17.6	11.1	16.7	14.3	8.0	0.0	36.8	12.5	4.3	27.8
35-44 years old	25.0	0.0	17.9	16.7	17.6	22.2	20.8	38.1	32.0	30.8	5.3	18.8	39.1	16.7
45-54 years old	30.0	0.0	21.4	16.7	17.6	16.7	20.8	19.0	16.0	15.4	15.8	12.5	8.7	16.7
55-64 years old	10.0	60.0	10.7	27.8	17.6	16.7	20.8	4.8	12.0	23.1	15.8	6.3	13.0	11.1
65+ years old	5.0	0.0	28.6	22.2	17.6	5.6	12.5	9.5	24.0	7.7	15.8	31.3	21.7	22.2
Race/ethnicity														
Non-Hispanic White	85.0	100.0	100.0	100.0	94.1	94.4	91.7	95.2	84.0	100.0	68.4	93.8	73.9	94.4
Non-Hispanic Black	5.0	0.0	0.0	0.0	2.9	5.6	8.3	4.8	16.0	0.0	26.3	0.0	21.7	5.6
Non-Hispanic Asian/Pacific Islander	10.0	0.0	0.0	0.0	2.9	0.0	0.0	0.0	0.0	0.0	0.0	6.3	0.0	0.0
Hispanic	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.3	0.0	4.3	0.0
Weapon type														
Firearm	30.0	20.0	46.4	33.3	35.3	33.3	29.2	52.4	32.0	30.8	42.1	43.8	43.5	44.4
Hanging	35.0	0.0	35.7	5.6	32.4	11.1	45.8	9.5	20.0	15.4	31.6	0.0	30.4	11.1
Poisoning	30.0	0.0	10.7	5.6	32.4	0.0	25.0	0.0	40.0	0.0	21.1	0.0	13.0	0.0
Sharp/Blunt Instrument	0.0	40.0	0.0	5.6	0.0	0.0	0.0	4.8	0.0	7.7	0.0	6.3	8.7	0.0
Other	5.0	0.0	7.1	0.0	0.0	0.0	0.0	0.0	8.0	0.0	5.3	0.0	4.3	0.0
Marital status														
Married	25.0	20.0	39.3	50.0	23.5	33.3	25.0	38.1	32.0	53.8	26.3	37.5	26.1	38.9
Single	35.0	40.0	35.7	33.3	38.2	44.4	37.5	42.9	32.0	46.2	42.1	31.3	47.8	33.3
Widowed	0.0	0.0	7.1	0.0	8.8	0.0	8.3	4.8	8.0	0.0	10.5	12.5	4.3	5.6
Divorced	40.0	40.0	17.9	16.7	29.4	22.2	29.2	14.3	28.0	0.0	21.1	18.8	21.7	22.2

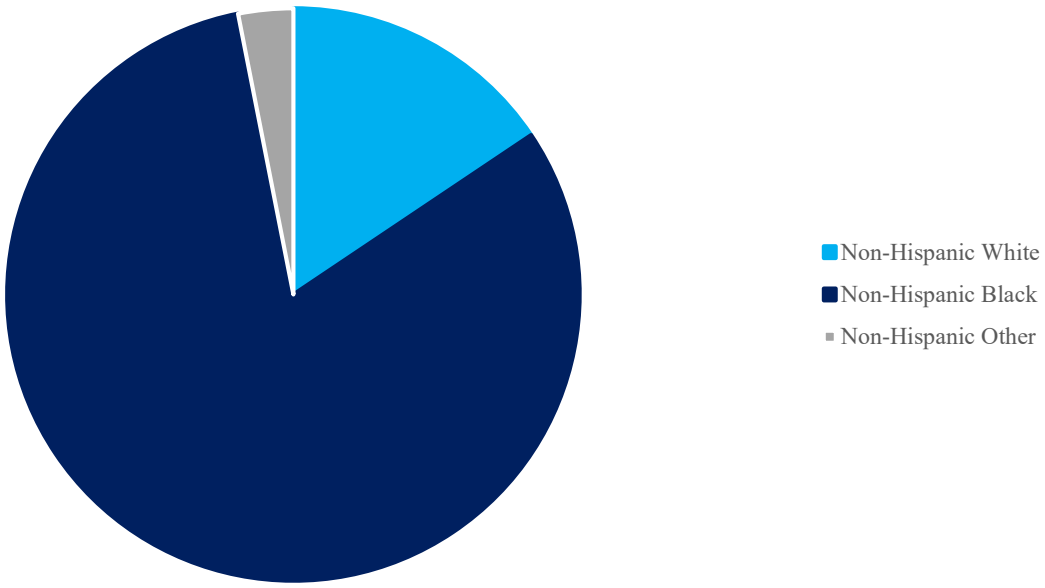
Notes: Additional data from ILVDRS will be assessed to identify other contextual differences surrounding these deaths to inform prevention efforts by the PFHC. Please note that these are based on known information that likely results in underestimates

Homicide deaths (ILVDRS)

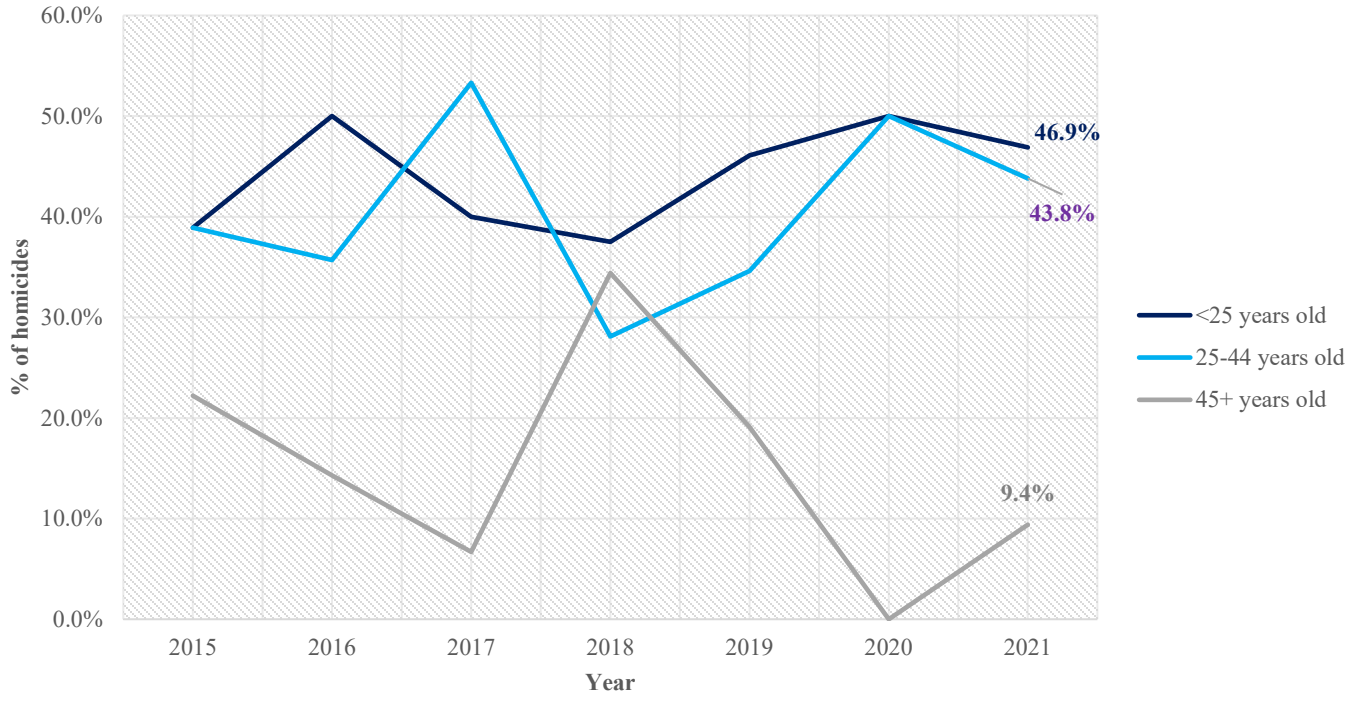




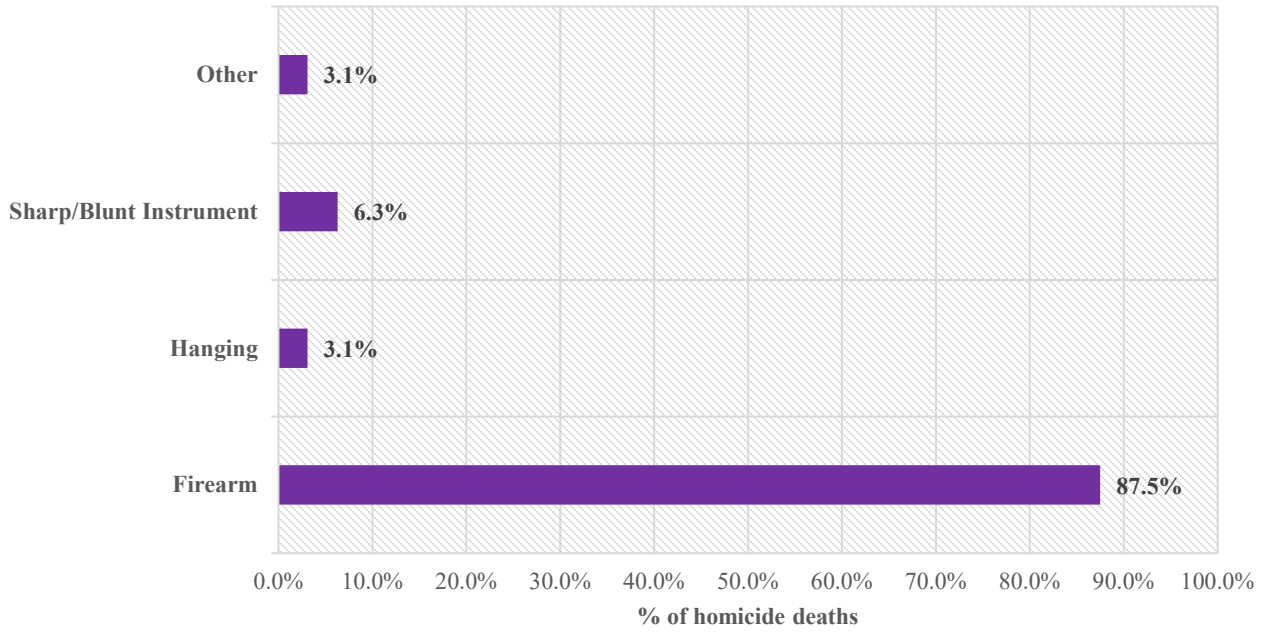
Homicide deaths in Peoria County by race/ethnicity in 2021



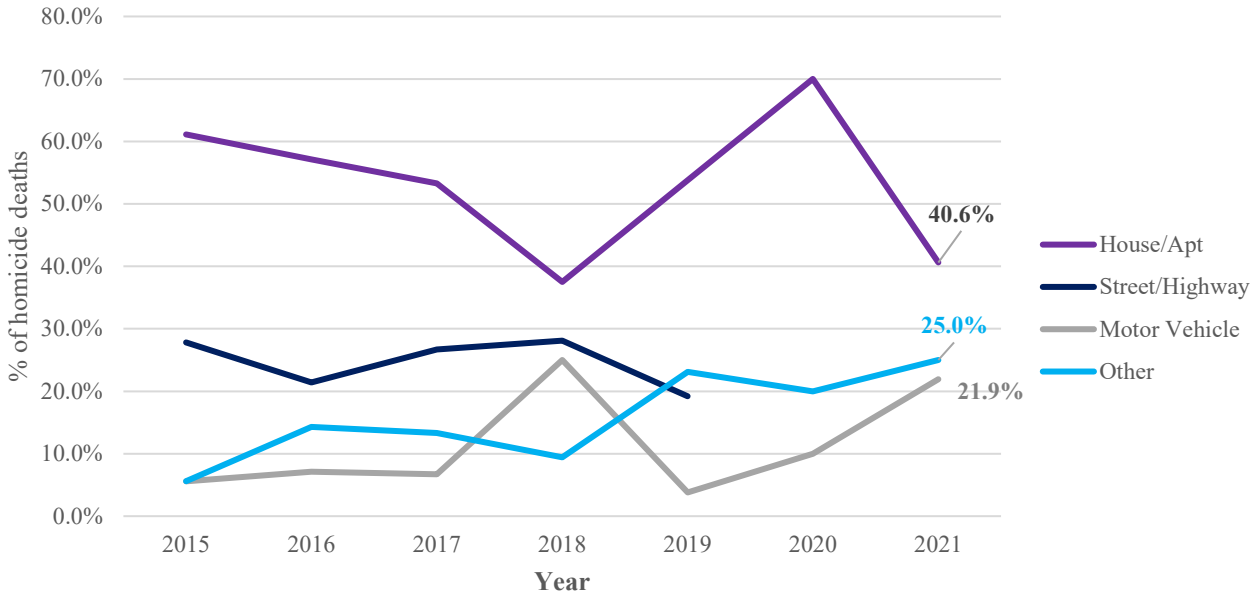
Homicide deaths by age group in Peoria County, 2015-2021



Weapon type involved in homicide deaths in Peoria County, 2021



Location of injury for homicide deaths in Peoria County, 2015-2021



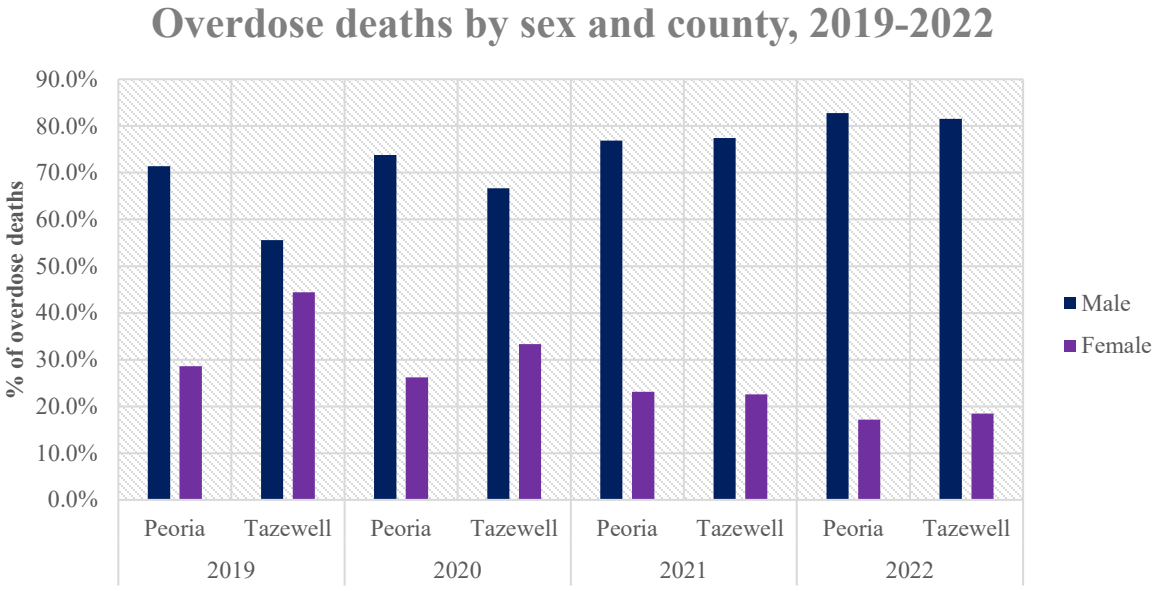
Characteristics (%) of homicide deaths in Peoria County, 2015-2021

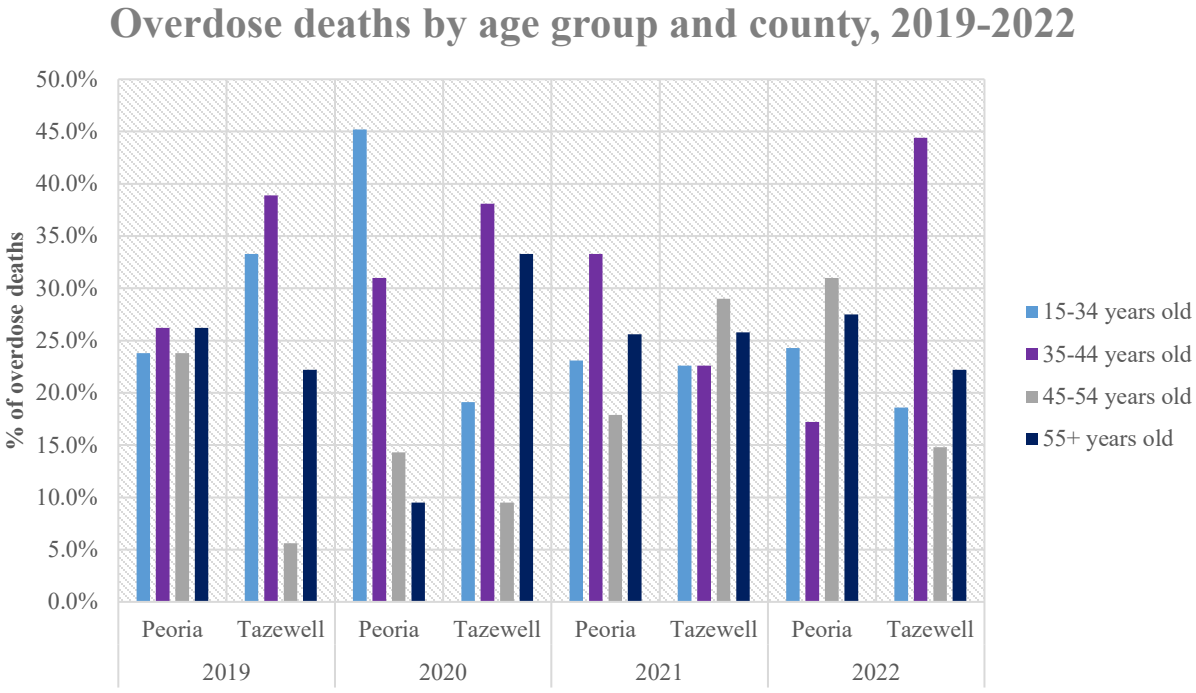
	2015	2016	2017	2018	2019	2020	2021
Sex							
Male	94.4	92.9	86.7	75.0	65.4	90.0	87.5
Female	5.6	7.1	13.3	25.0	34.6	10.0	12.5
Age Groups							
<15 years old	16.7	7.1	6.7	3.1	11.5	10.0	6.3
15-24 years old	22.2	42.9	33.3	34.4	34.6	40.0	40.6
25-34 years old	33.3	35.7	33.3	12.5	23.1	40.0	34.4
35-44 years old	5.6		20.0	15.6	11.5	10.0	9.4
45-54 years old	16.7			15.6	3.8		3.1
55-64 years old	5.6	14.3	6.7	9.4	11.5		
65+ years old				9.4	3.8		6.3
Race/Ethnicity							
Non-Hispanic White		21.4	13.3	21.9	23.1	30.0	15.6
Non-Hispanic Black	88.9	78.6	73.3	68.8	69.2	70.0	81.3
Non-Hispanic Asian/Pacific Islander	5.6			3.1			
Non-Hispanic Other			13.3		3.8		3.1
Hispanic	5.6			6.3	3.8		
Weapon Type							
Firearm	72.2	50.0	80.0	59.4	69.2	90.0	87.5
Hanging			6.7	6.3	7.7	10.0	3.1
Poisoning		7.1					
Sharp/Blunt Instrument	16.7	35.7		31.3	11.5		6.3
Other	11.1	7.1	13.3	3.1	11.5		3.1
Marital Status							
Married	5.6	14.3	6.7	18.8	11.5	10.0	3.1
Single	88.9	78.6	86.7	68.8	76.9	90.0	93.8
Widowed				3.1	3.8		
Divorced	5.6	7.1	6.7	9.4	7.7		3.1
Injury Location							
House/Apt	61.1%	57.1%	53.3	37.5	53.8%	70.0%	40.6
Street/Highway	27.8%	21.4%	26.7	28.1	19.2%		12.5
Motor Vehicle	5.6%	7.1%	6.7	25.0	3.8%	10.0%	21.9
Other (e.g. building, outdoors)	5.6%	14.3%	13.3	9.4	23.1%	20.0%	25.0

Notes: Additional data from ILVDRS will be assessed to identify other contextual differences surrounding these deaths to inform prevention efforts by the PFHC. Please note that these are based on known information that likely results in underestimates

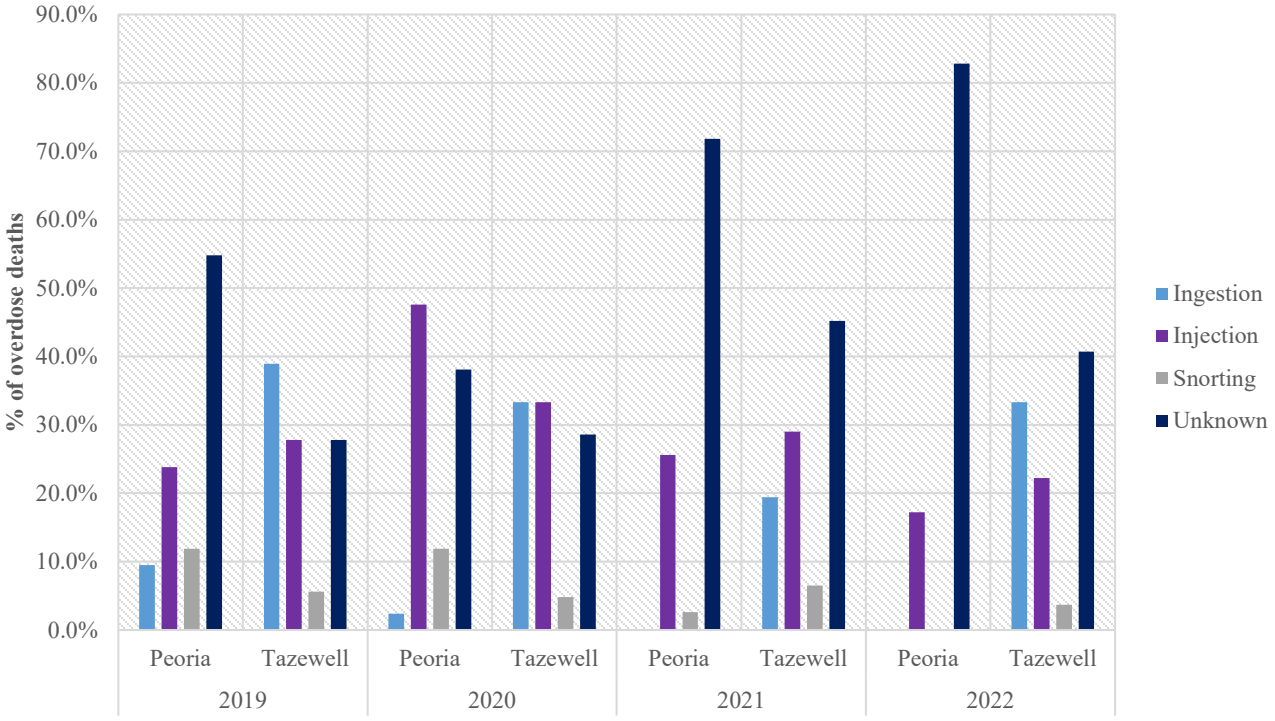
Overdose death data

Similar to ILVDRS, this statewide epidemiologic dataset was used to identify overdose deaths in the region. These data are collected from coroner reports which help disseminate surveillance findings related for fatal overdoses to stakeholders around the state in a dashboard called State Unintentional Drug Overdose Reporting System (SUDORS). These datasets have information that can provide additional contextual evidence that surrounds these deaths. Similar to the collaborative approach with ILVDRS data, the data team will be obtaining additional contextual indicators associated with overdose deaths with hopes to inform the community and prevention efforts.

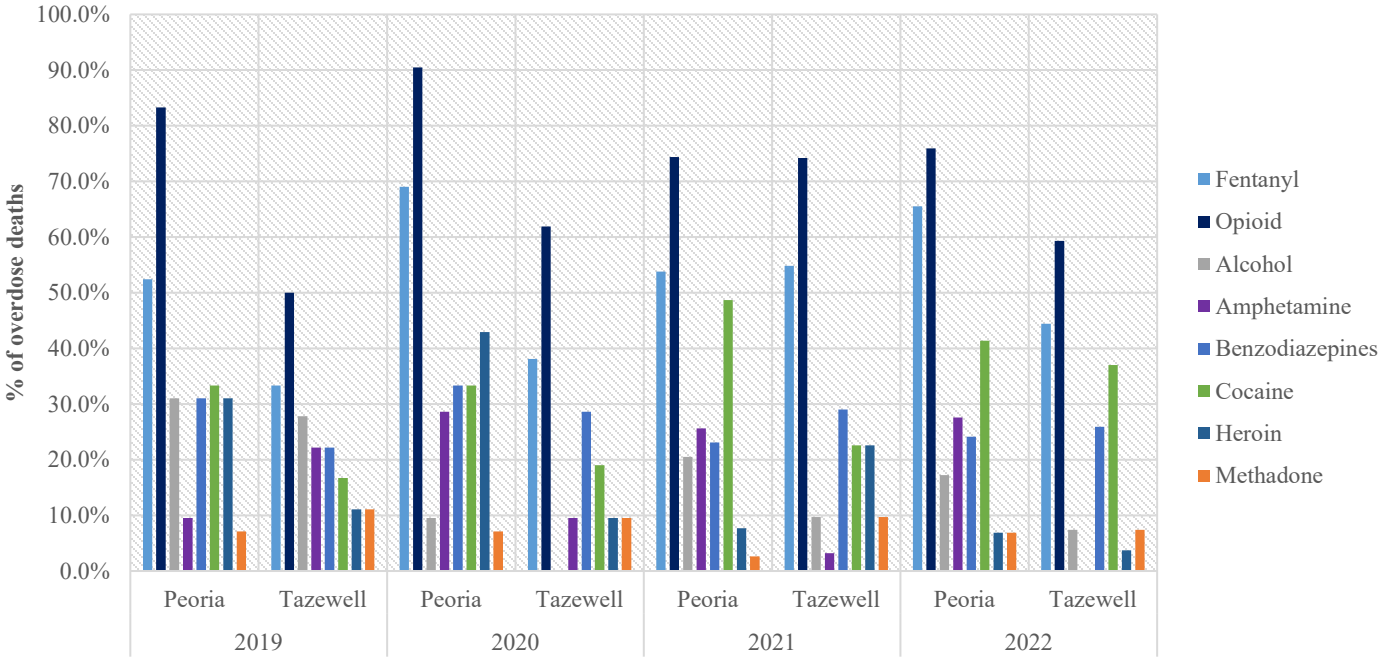




Overdose deaths by route of administration and county, 2019-2022



Substances attributed to overdose death by county, 2019-2022



Characteristics of overdose deaths (%) in Peoria and Tazewell Counties, 2019-2022

	2019		2020		2021		2022	
	Peoria	Tazewell	Peoria	Tazewell	Peoria	Tazewell	Peoria	Tazewell
Sex								
Male	71.4	55.6	73.8	66.7	76.9	77.4	82.8	81.5
Female	28.6	44.4	26.2	33.3	23.1	22.6	17.2	18.5
Age group								
15-24 years old	2.4	11.1	4.8	4.8	5.1		10.3	
25-34 years old	21.4	22.2	40.5	14.3	17.9	22.6	13.8	18.5
35-44 years old	26.2	38.9	31.0	38.1	33.3	22.6	17.2	44.4
45-54 years old	23.8	5.6	14.3	9.5	17.9	29.0	31.0	14.8
55-64 years old	21.4	11.1	7.1	23.8	20.5	25.8	24.1	18.5
65+ years old	4.8	11.1	2.4	9.5	5.1		3.4	3.7
Race/ Ethnicity								
Non-Hispanic White	71.4	94.4	81.0	100.0	71.8	93.5	75.9	96.3
Non-Hispanic Black	26.2		19.0		20.5	6.5	24.1	3.7
Non-Hispanic Asian/Pacific Islander	2.4	5.6			2.6			
Hispanic					5.1			
Marital Status								
Married	16.7	16.7	16.7	33.3	15.4	16.1	10.3	18.5
Single	42.9	72.2	57.1	42.9	56.4	38.7	44.8	55.6
Widowed	4.8		4.8			6.5		
Divorced	33.3	11.1	19.0	23.8	23.1	38.7	44.8	25.9
Unknown	2.4		2.4		5.1			
Naloxone Administered								
No	71.4	66.7	57.1	66.7	48.7	80.6	93.1	77.8
Yes	28.6	33.3	42.9	33.3	51.3	19.4	6.9	22.2
Route of Administration								
Ingestion	9.5	38.9	2.4	33.3		19.4		33.3
Injection	23.8	27.8	47.6	33.3	25.6	29.0	17.2	22.2
Snorting	11.9	5.6	11.9	4.8	2.6	6.5		3.7
Unknown	54.8	27.8	38.1	28.6	71.8	45.2	82.8	40.7
Physical Health Problem								
No	78.6	77.8	81.0	33.3	84.6	80.6	86.2	74.1
Yes	21.4	22.2	19.0	66.7	15.4	19.4	13.8	25.9
Recent Opioid Use								
No	90.5	100.0	85.7	90.5	89.7	96.8	100.0	88.9
Yes	9.5		14.3	9.5	10.3	3.2		11.1

Notes: Additional data from SUDORS will be assessed to identify other contextual differences surrounding these overdose deaths to inform prevention efforts by the PFHC. Please note that these are based on known information that likely results in underestimates.

Substances attributed to overdose deaths (%) in Peoria and Tazewell Counties, 2019-2022

	2019		2020		2021		2022	
	Peoria	Tazewell	Peoria	Tazewell	Peoria	Tazewell	Peoria	Tazewell
Fentanyl								
No	47.6	66.7	31.0	61.9	46.2	45.2	34.5	55.6
Yes	52.4	33.3	69.0	38.1	53.8	54.8	65.5	44.4
Opioid								
No	16.7	50.0	9.5	38.1	25.6	25.8	24.1	40.7
Yes	83.3	50.0	90.5	61.9	74.4	74.2	75.9	59.3
Alcohol								
No	69.0	72.2	90.5	100.0	79.5	90.3	82.8	92.6
Yes	31.0	27.8	9.5	-	20.5	9.7	17.2	7.4
Amphetamine								
No	90.5	77.8	71.4	90.5	74.4	96.8	72.4	100.0
Yes	9.5	22.2	28.6	9.5	25.6	3.2	27.6	-
Benzodiazepine								
No	69.0	77.8	66.7	71.4	76.9	71.0	75.9	74.1
Yes	31.0	22.2	33.3	28.6	23.1	29.0	24.1	25.9
Cocaine								
No	66.7	83.3	66.7	81.0	51.3	77.4	58.6	63.0
Yes	33.3	16.7	33.3	19.0	48.7	22.6	41.4	37.0
Heroin								
No	69.0	88.9	57.1	90.5	92.3	77.4	93.1	96.3
Yes	31.0	11.1	42.9	9.5	7.7	22.6	6.9	3.7
Methadone								
No	92.9	88.9	92.9	90.5	97.4	90.3	93.1	92.6
Yes	7.1	11.1	7.1	9.5	2.6	9.7	6.9	7.4

Notes: Additional data from SUDORS will be assessed to identify other contextual differences surrounding these overdose deaths to inform prevention efforts by the PFHC. Please note that these are based on known information that likely results in underestimates.

Characteristics (%) of overdose deaths by race in Peoria County, 2019-2022

	NH White	NH Black	NH Other	Hispanic or LatinX
Sex				
Male	72.8	82.4	100.0	100.0
Female	27.2	17.6	-	-
Age Groups				
<15 years old	6.1	2.9	-	-
15-24 years old	29.8	8.8	-	-
25-34 years old	33.3	8.8	50.0	-
35-44 years old	20.2	23.5	-	50.0
45-54 years old	10.5	41.2	-	50.0
55-64 years old	-	14.7	50.0	-
65+ years old	6.1	2.9	-	-
Educational attainment				
Below high school	16.7	14.7	-	-
High school graduate	54.4	58.8	-	-
Some College or Associate's Degree	23.7	17.6	-	50.0
Bachelor's or more	4.4	5.9	-	-
Unknown	0.9	2.9	100.0	50.0
Marital Status				
Married	13.2	23.5	-	-
Single	55.3	41.2	-	-
Widowed	2.6	2.9	-	-
Divorced	28.1	32.4	-	50.0
Unknown	0.9	-	100.0	50.0

Notes: Additional data from ILVDRS will be assessed to identify other contextual differences surrounding these deaths to inform prevention efforts by the PFHC. Please note that these are based on known information that likely results in underestimates
Abbreviations: NH, Non-Hispanic

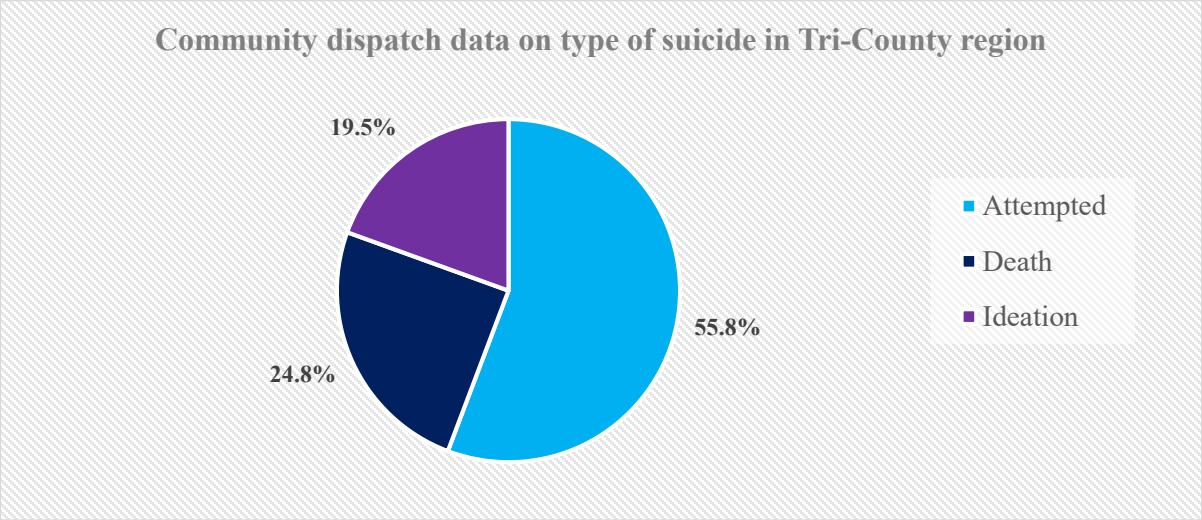
Characteristics (%) of overdose deaths by age group in Peoria County, 2019-2022

	<15 years old	15-24 years old	25-34 years old	35-44 years old	45-54 years old	55-64 years old	65+ years old
Sex							
Male	50.0	78.4	78.6	71.9	74.1	100.0	50.0
Female	50.0	21.6	21.4	28.1	25.9	-	50.0
Educational attainment							
Below high school	37.5	21.6	4.8	21.9	11.1	16.7	37.5
High school graduate	50.0	54.1	59.5	46.9	59.3	33.3	50.0
Some College or Associate's Degree	12.5	21.6	26.2	25.0	18.5	16.7	12.5
Bachelor's or more	-	2.7	4.8	3.1	7.4	16.7	-
Unknown	-	-	4.8	3.1	3.7	16.7	-

Notes: Additional data from ILVDRS will be assessed to identify other contextual differences surrounding these deaths to inform prevention efforts by the PFHC. Please note that these are based on known information that likely results in underestimates

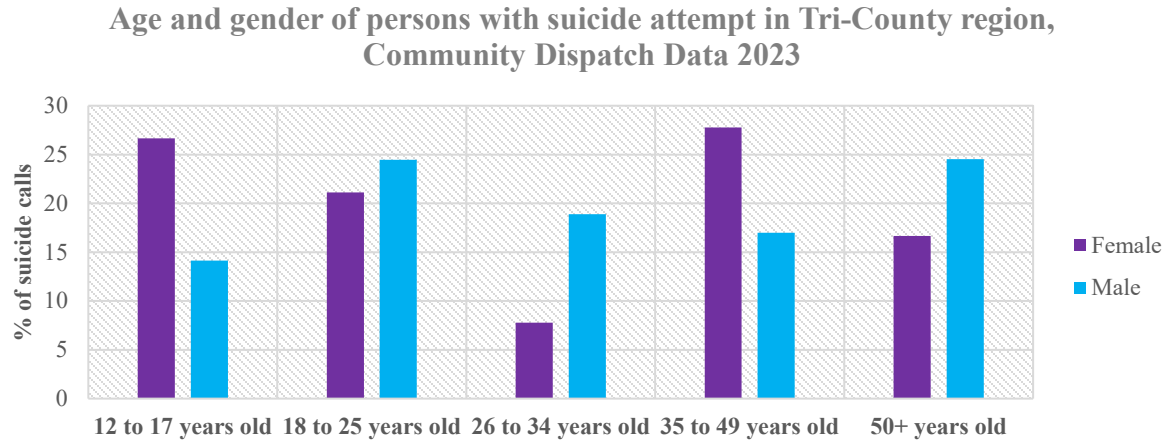
Community dispatch data on suicide

Data was aggregated from the community dispatch officials for the Tri-County region to describe the calls related to suicide. Below are the demographic characteristics from these data to better understanding these non-fatal and fatal incidents.



Demographic characteristics of those with suicide calls to community dispatch in Tri-County region

	Overall		Female		Male	
Age (years)	**Frequency**	**% Frequency**		**% Frequency**		**%**
12 to 17 years old	39	19.8	24	26.67	15	14.15
18 to 25 years old	47	23.86	19	21.11	28	24.46
26 to 34 years old	27	13.71	7	7.78	20	18.88
35 to 49 years old	43	21.83	25	27.78	18	16.98
50+ years old	41	20.81	15	16.67	26	24.53



Youth adversity data

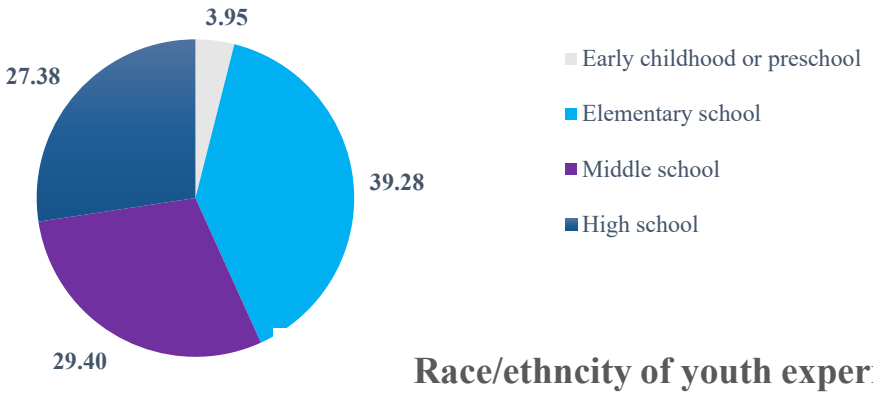
Using data completed by law enforcement when they are at the scene of a crime, violence, and/or abuse and identify a child who is at the scene who have been exposed a potentially traumatic incident. These data are provided by law enforcement to the school system before the next day in order for them to respond to these potential needs. To date, Peoria and Tazewell counties are participating in this partnership program. Aggregate data from August 2023- June 2024 is characterized below:

Description	Overall		Peoria		Tazewell		p-value
	N	%	n	%	n	%	
Type of school							**<0.0001**
Early childhood or preschool	133	3.95	107	3.83	26	4.50	
Elementary school	1,324	39.28	1,074	38.45	250	43.25	
Middle school	991	29.40	798	28.57	193	33.39	
High school	923	27.38	814	29.14	109	18.86	
Gender							0.22
Female	1,615	47.60	1,343	48.08	272	45.33	
Male	1,778	52.40	1,450	51.92	328	54.67	
Race/ethnicity							**<0.0001**
Non-Hispanic White	615	19.85	361	12.93	254	83.01	
Non-Hispanic Black	1,923	62.05	1,907	68.28	16	5.23	
Hispanic or LatinX	261	8.42	256	9.17	5	1.63	
Multi-racial, other race or unassigned	300	9.68	269	9.63	31	10.13	
Number of adversities over a year							**<0.0001**
One documented adversity	2,295	67.64	1,838	65.81	457	76.17	
Two to three documented adversities	880	25.94	765	27.39	115	19.17	
Four or more documented adversities	218	6.42	190	6.80	28	0.67	

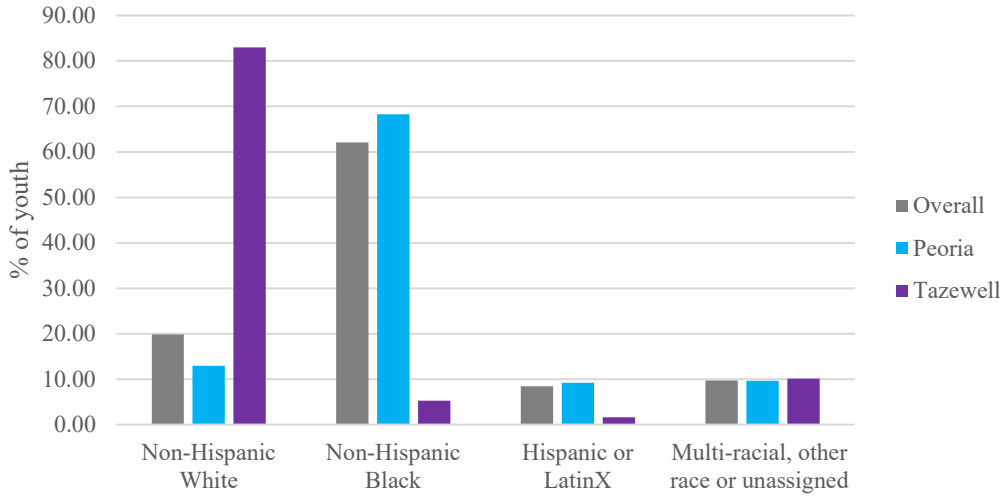
p-value depicts significant difference between Peoria and Tazewell counties based on X^2 test.

Peoria had a higher proportion of older children experiencing this type of adversity who were more often Non-Hispanic Black whereas Tazewell youth were more often younger and Non-Hispanic White. Moreover, Peoria youth more often had multiple adversities reported over the course of the year compared to Tazewell.

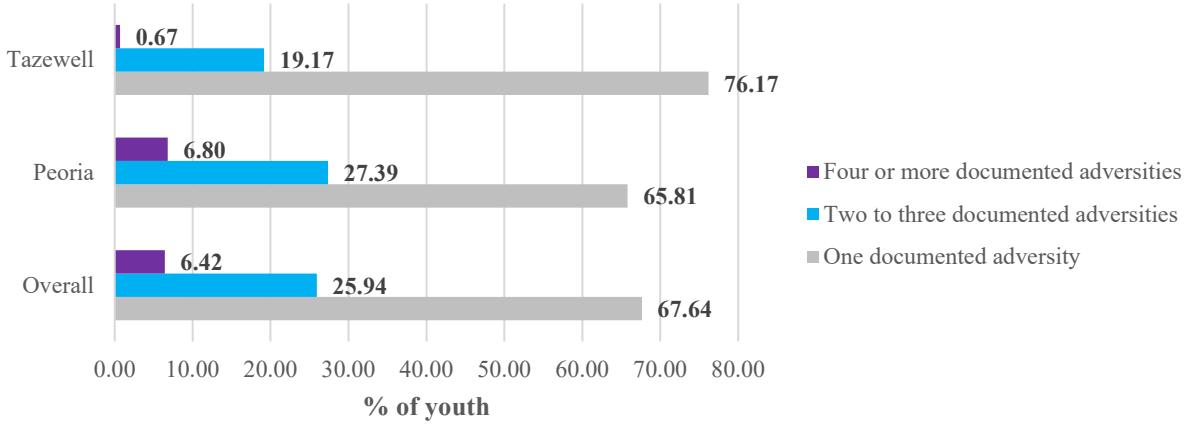
School age for youth experiencing adversity in Peoria and Tazewell Counties

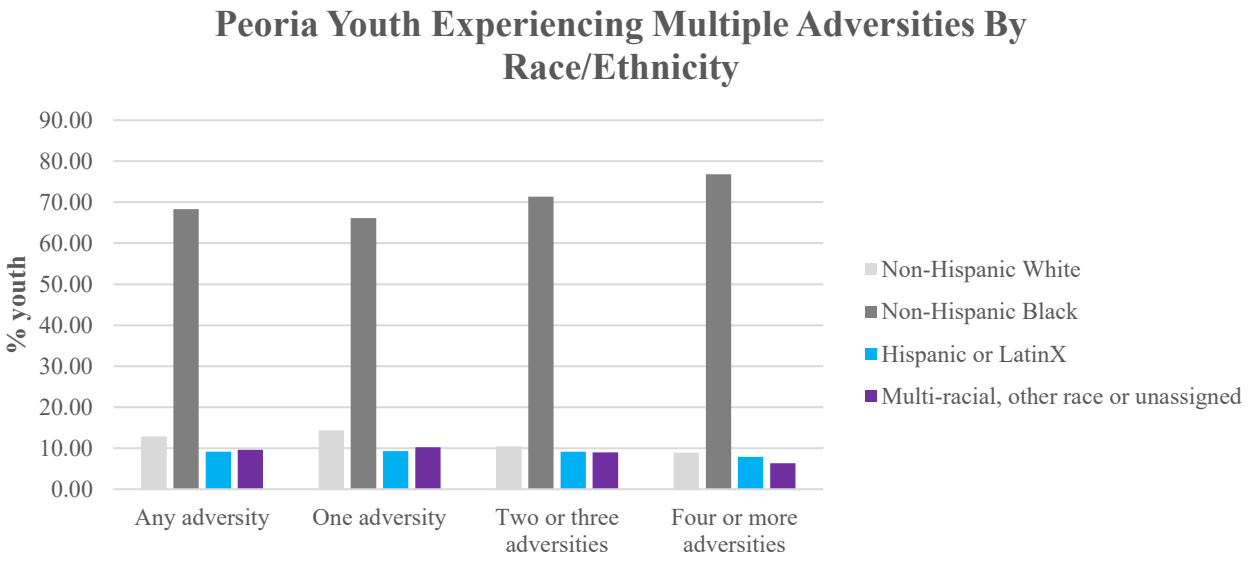


Race/ethncity of youth experiencing adveristy by county



Number of adversities youth experience in one year by location





Characteristic	aOR	Lower 95% CI	Upper 95% CI
Race/ethnicity			
Non-Hispanic White	Ref	Ref	Ref
Non-Hispanic Black	**1.56**	**1.23**	**1.98**
Hispanic or LatinX	1.40	0.99	1.96
Multi-racial, other race or unassigned	1.14	0.82	1.58
County			
Peoria	Ref	Ref	Ref
Tazewell	**1.61**	**1.15**	**2.25**

HEALTH AMONG RESIDENTS EXPERIENCING HOMELESSNESS

***Sources**: Illinois Department of Public Health: Illinois Homelessness Mortality and Morbidity Report, 2017-2022*
2025 Point In Time Count (PITC)

MORTALITY AMONG PEOPLE EXPERIENCING HOMELESSNESS

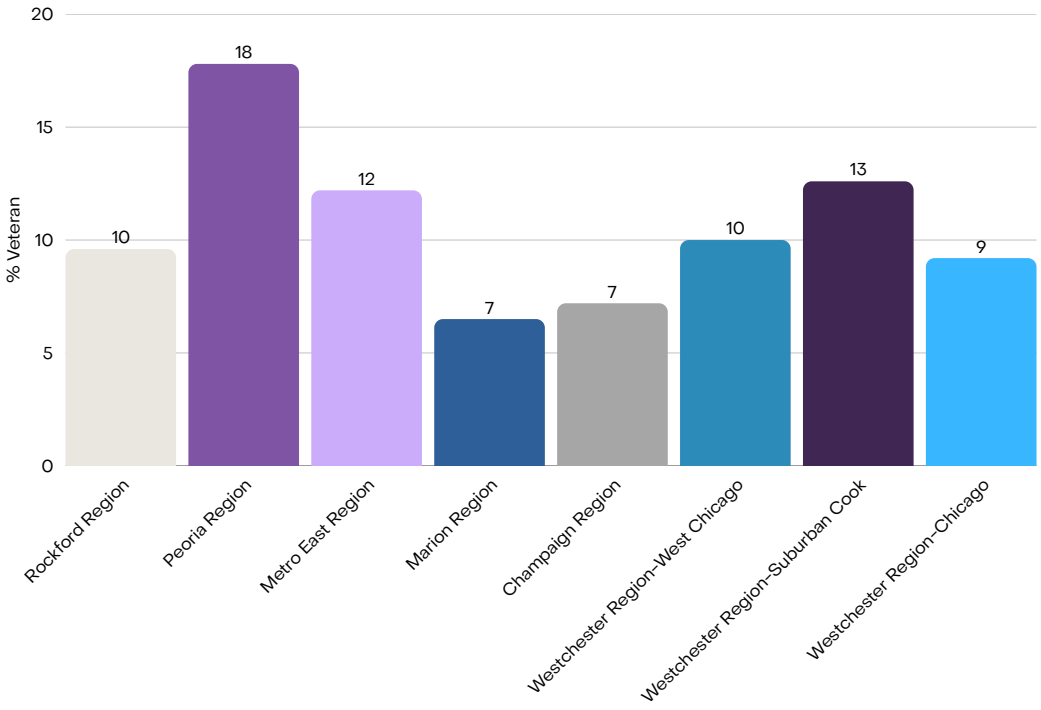
4% of the total deaths in the Peoria region were among people experiencing homelessness. Among those deaths in the Peoria region for people experiencing homelessness, it was higher among males (72%) compared to females (28%) between 2017 and 2022. These deaths were higher among non-Hispanic Whites and those with a high school diploma or less educational attainment. Moreover, the Peoria region had the highest proportion of Veteran decedents experiencing homelessness compared to the rest of the state.

INSIGHTS FROM THE 2025 PITC

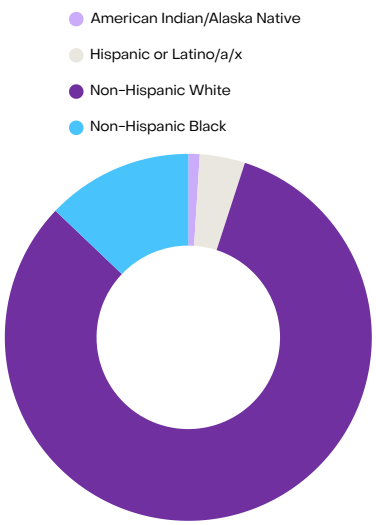
The 2025 PITC recorded the highest number of individuals experiencing homelessness between 2009–2015, with a total of 635 people counted. This figure is nearly double the expected rate for this timeframe. While a significant portion of those counted were identified as chronically unhoused, there is a notable increase in the number of families, particularly individuals experiencing chronic homelessness with at least one child. Historically, chronic homelessness has been more prevalent among males; however, the gender gap is narrowing, with a growing proportion of females now experiencing homelessness.

Additional concerning trends include a rise in individuals facing domestic violence and a recent uptick in the number of unhoused Veterans, reversing a previously declining trend. Furthermore, the prevalence of complex health conditions, such as HIV/AIDS, serious mental illness, and substance use disorders, is increasing among this population. These findings highlight the multifaceted and evolving challenges faced by people experiencing homelessness.

VETERAN DECEDENTS AMONG PEOPLE EXPERIENCING HOMELESSNESS IN ILLINOIS



RACE/ETHNICITY AMONG DECEDENTS EXPERIENCING HOMELESSNESS IN THE PEORIA REGION



NEXT STEPS

The next major deliverable from the PFHC Data Team will be the Q3 data report, which will feature updated ESSENCE surveillance data focused on mental health and obesity across the Tri-County region. This report will analyze emergency department visit trends and present visual insights to inform the Partnership's ongoing prevention strategies aimed at addressing these critical health concerns.

In parallel, the Data Team is collaborating with Carle Health to identify and analyze aggregate-level data aligned with PFHC's priority areas. This initiative will specifically explore the population-level impact of obesity and mental health conditions, providing a clearer understanding of their scope and implications within the community.

Additionally, the Data Team will support PFHC in the next CHNA cycle by helping to identify, define, and develop metrics for the selected issue statements. This effort will ensure a data-driven and feasible approach to monitoring progress throughout the implementation period.

Through continuous evaluation of health outcomes and program outputs, the Data Team will ensure that future reports reflect evolving community needs, emerging trends, and evidence-based insights—ultimately supporting strategic action and informed decision-making.

MEMBERS OF THE DATA TEAM

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Sally Gambacorta, MA, MS	Carle Health
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APPENDIX 3: REGIONAL ANALYSES & HEALTH DISPARITIES

REGION (Zip Codes)	NAME
PEORIA COUNTY	
Region 1 (61602, 61603, 61604, 61605, 61606, 61625)	Peoria/West Peoria
Region 2 (61612, 61614, 61615, 61616)	North Peoria/Peoria Heights
Region 3 (61607, 61547)	Bartonville/Limestone
Region 4 (61569,61533, 61536)	South West Peoria County
Region 5 (61529, 61517, 61559)	North West Peoria County
Region 6 (61528, 61525, 61626, 61523, 61552)	North East Peoria County
TAZEWELL COUNTY	
Region 1 (61611, 61571, 61610)	North Tazewell County
Region 2 (61534, 61734, 61747, 61759, 61721)	South Tazewell County
Region 3 (61550, 61755, 61568)	East Tazewell County
Region 4 (61564, 61554)	West Tazewell County
WOODFORD COUNTY	
Region 1 (61738, 61760, 61771, 61561, 61516)	East Woodford County
Region 2 (61570, 61545, 61530, 61729, 61742)	Central Woodford County
Region 3 (61548, 61611)	West Woodford County

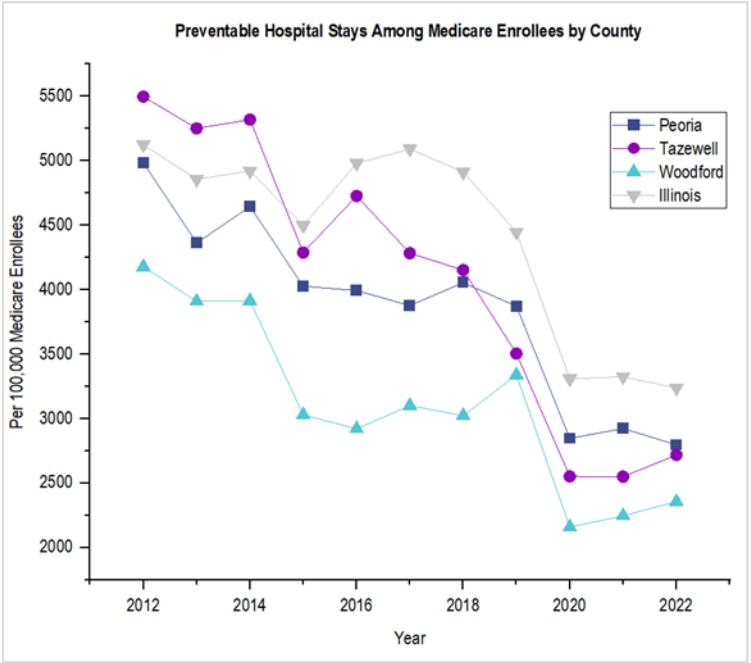
HEALTH DISPARITIES

Indicators related to health status are assessed based on national surveillance for the Tri-County region. In particular, measures such as poor or fair health, poor physical health days, frequent physical distress, poor mental health days, and frequent mental distress are crucial for understanding the health and well-being of the Tri-County region in Illinois. These indicators provide valuable insights into the prevalence of physical and mental health challenges faced by residents. By analyzing these measures, public health officials can identify disparities, allocate resources effectively, and implement targeted interventions to improve overall community health and address specific needs.

These analyses were guided by the Wheel of Power and Privilege, a framework that considers how intersecting identities—such as race, ethnicity, income, and housing stability—shape individuals' experiences with healthcare systems and health outcomes. This approach allowed for a more nuanced examination of how systemic inequities contribute to elevated suicide risk and barriers to care among marginalized groups.

Additionally, this section examines preventable hospital stays by county, utilizing surveillance data. By analyzing these metrics, we can identify areas where improved outpatient care could reduce unnecessary hospitalizations and enhance overall community health (Figure 89 and Figure 90).

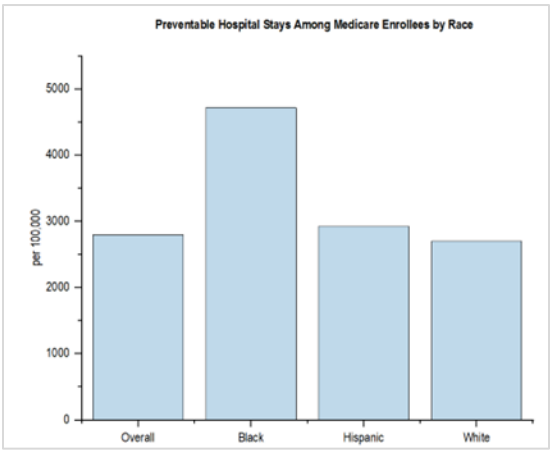
Figure 89



Source: 2022 Mapping Medicare Disparities (MMD) Tool

Importantly, the rate of preventable hospital stays is higher among certain subpopulations as well. Black Medicare Enrollees have substantially higher rates compared to all other races.

Figure 90



Source: 2022 Mapping Medicare Disparities (MMD) Tool

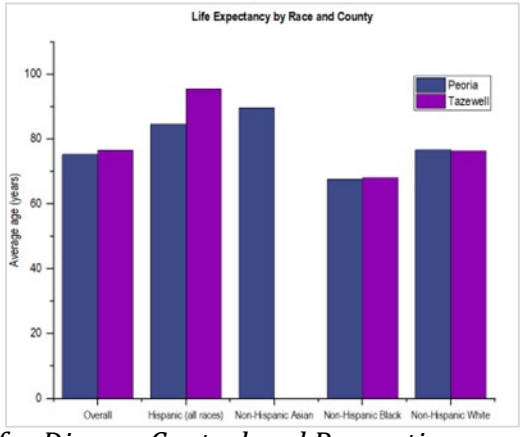
Health Outcomes in Focus

Health insights previously discussed represented factors that can improve to live longer and healthier lives. Health outcomes on the other hand tell us how long people live in a community. These mortality outcomes are specifically broken up by subpopulations such as age and race/ethnicity.

Premature death

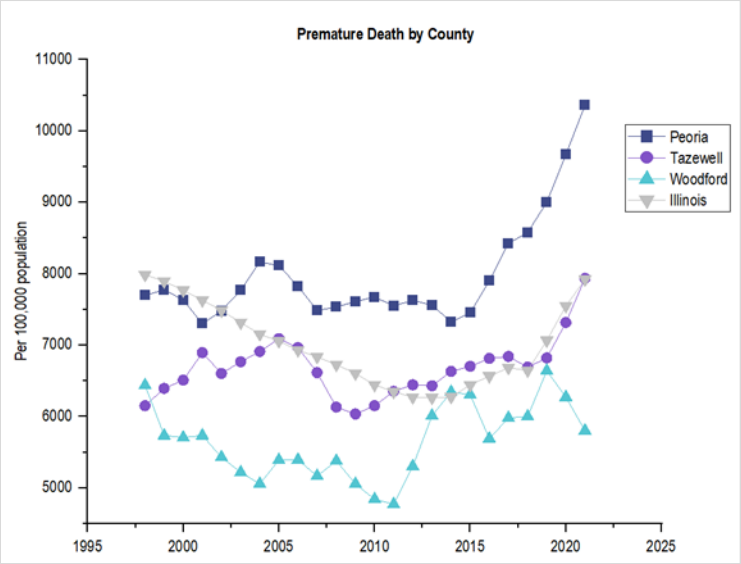
Premature death is measured using Years of Potential Life Lost (YPLL), which are illustrated for each county in the Tri-County region. The data shows a continued rise in YPLL for Peoria and Tazewell counties, with Peoria experiencing a particularly significant increase. Additionally, another figure highlights differences in life expectancy by race for Peoria and Tazewell counties, providing further insight into health disparities in the region.

Figure 91



Source: Centers for Disease Control and Prevention

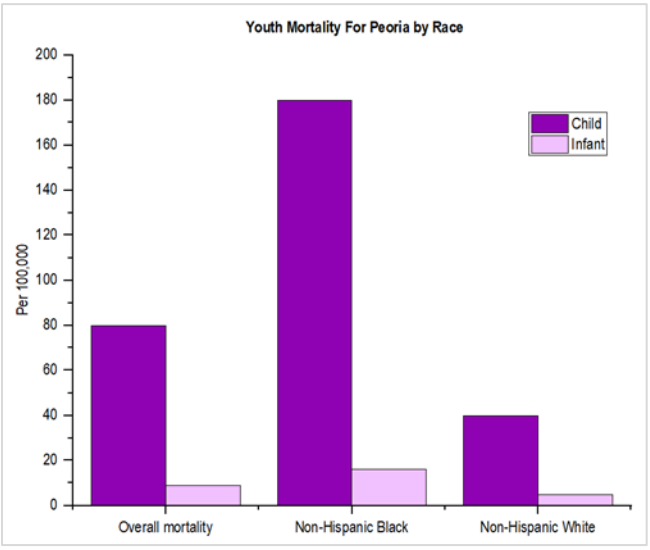
Figure 92



Source: Centers for Disease Control and Prevention

Given the differences in premature death among youth in Peoria County, additional analyses assessed the specific age groups impacted. Child mortality includes ages 1-18 and infant mortality includes those under 1 year old. Infant mortality was measured by race using 2016-2022 data and child mortality was measured by race using 2019-2022 data.

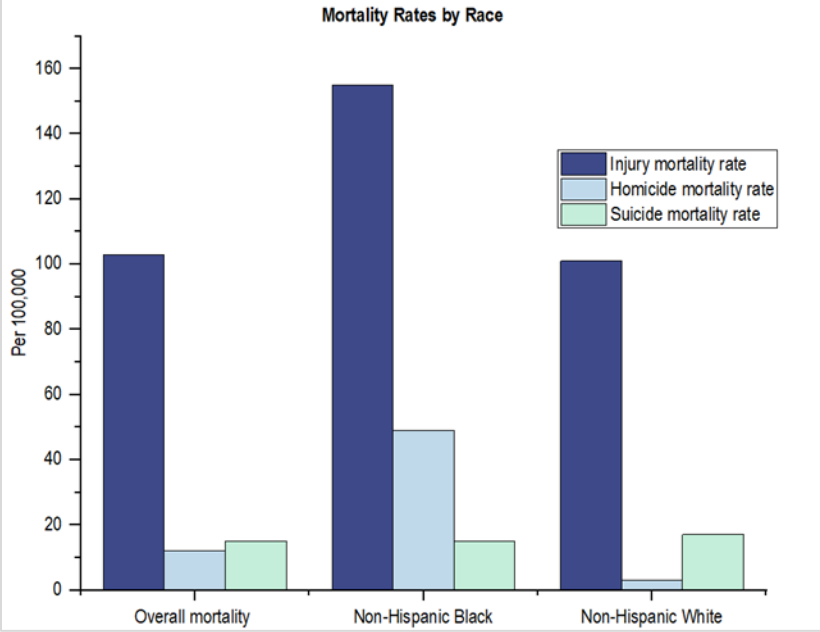
Figure 93



Source: Centers for Disease Control and Prevention

In addition to examining youth mortality, specific type of mortality commonly influencing premature death were assessed for the Tri-County region by race/ethnicity (Figure 94).

Figure 94



Source: 2020-2022 National Vital Statistics System (NVSS)

Populations Disproportionately Impacted

This section assesses differences in health outcomes and identifies populations that are disproportionately impacted. Unlike the subsections listed above, this section uses survey data collected from community members. In particular, responses were categorized by zip code and county of residence. Differences in various health outcomes by county and region are highlighted to provide a comprehensive understanding of the health landscape. Understanding which populations are disproportionately affected by certain health issues is crucial for developing targeted interventions and ensuring equitable healthcare access and resources.

To measure health issues among the most vulnerable populations, survey data was used to identify indicators of vulnerability. These indicators included reporting a household income of less than $20,000, identifying as any race other than white, identifying as non-binary, transgender, lesbian, gay, bisexual, or queer, and being uninsured. Among survey respondents, approximately 30% reported at least one indicator of vulnerability, while around 9% reported two or more indicators. This measure helps to highlight the health challenges faced by these vulnerable groups, enabling targeted interventions to address their specific needs.

Vulnerable populations

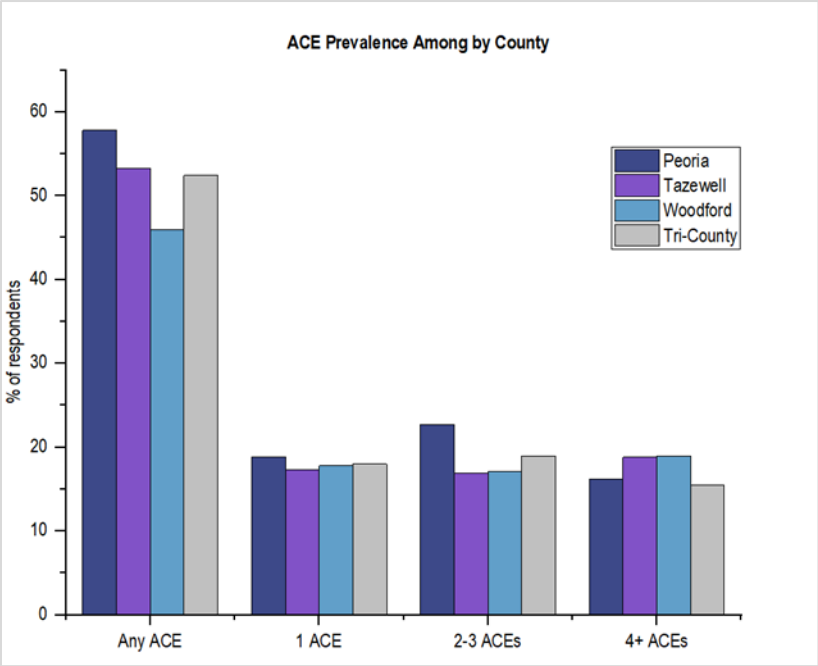
Those who were vulnerable more often reported below average physical and mental health ($p<0.0001$). Moreover, vulnerable respondents more often reported not seeking medical care compared to those with no indicator of vulnerability ($p<0.0001$). The most common reason for not seeking medical care among this population was wait time for appointment, followed by lack of insurance, and overall cost.

Mental health measures were also higher among those with at least one indicator of vulnerability. In particular, those who were vulnerable more often reported feeling depressed or anxiety/stress in the

past month. Similarly, this population more often reported recent substance use as well. In particular, smoking cigarettes, vaping, excessive drinking, and other drug use was more often reported among this population suggesting a need for substance use related resources.

Examining adverse childhood experiences (ACEs) among respondents reveals the significant impact these adversities can have on an individual's lifelong health. Experiencing ACEs increases the risk of developing chronic physical and mental health issues, such as heart disease, depression, and anxiety. The risk is further amplified with the number of adverse experiences; the more ACEs an individual encounters, the greater their vulnerability to these health problems. The figure below illustrates the number of ACEs reported by respondents in the Tri-County region, highlighting the prevalence and severity of these experiences within the community. No significant differences are reported by county and are comparable to state and national estimates among the general population.

Figure 95



Source: 2025 CHNA Survey

Regional Differences

Short summary: Peoria County reported below average mental health issues compared to other counties, with regions 1 (Peoria/West Peoria) and 4 (South West Peoria) showing significantly higher rates. Cost and lack of health insurance were major barriers to seeking medical care, particularly in regions 4, 1, and 5 (North West Peoria). Access to care was also a concern, with Peoria and Tazewell respondents more often reporting transportation issues compared to Woodford County. Depression and stress/anxiety were prevalent, impacting daily activities for multiple days in the past month, especially in specific regions of Peoria and Tazewell. Mental health care access was hindered by counselors refusing to take insurance, and Tazewell respondents struggled to find counselors. Smoking and marijuana use were more common in Peoria compared to Tazewell and Woodford, with higher rates in regions 4, 1, and 5.

Potential implications: These findings highlight significant disparities in mental health, access to care, and substance use across different regions. Addressing these issues requires targeted interventions to improve mental health services, reduce barriers to medical care, and provide better support for those struggling with depression, anxiety, and substance use. Enhanced transportation options and insurance acceptance by counselors could also help mitigate these challenges. *Of note, due to sample size limitations differences found for regions 3-6 in Peoria and Region 2 in Tazewell should be used with caution.*

- *Peoria more often reported below average mental health issues compared to other counties (p=0.003).*
    - *In Peoria, these were significantly higher in regions 1 and 4, respectively*
- *Peoria respondents more often reported cost as a reason for not seeking medical care compared to other counties (p=0.01) and more often reported no health insurance as a reason they did not seek medical care (p=0.003) compared to other counties.*
    - *Regions 4, 1, and 5 in Peoria had more respondents report cost and lack of insurance was more often reported as a reason for not seeking medical care*
- *Peoria and Tazewell respondents more often reported not having a way to get to the doctor as a reason to not seeking medical care compared to Woodford County (p=0.04).*
    - *Among Peoria County respondents, regions 4, 1, and 6 more often reported not having a way to get to the doctor.*
    - *Among Tazewell County respondents, regions 1 (North Tazewell) and 4 (West Tazewell), respectively, had a higher proportion of respondents report no way of getting to the doctor*
- *Peoria and Tazewell respondents more often reported feeling depressed 3+ days in the past month (p<0.0001).*
    - *Among Peoria respondents, regions 1, 3 (Bartonville/Limestone), and 6 more often reported feeling depressed multiple days in the past month.*
    - *Among Tazewell respondents, region 4 and 2 (South Tazewell) more often reported feeling depressed multiple days in the past month.*
- *Peoria and Tazewell respondents more often reported stress and/or anxiety that impacted their daily activities at least 3 days in the past month (p=0.0088).*
    - *Among Peoria respondents, regions 1 and 3 more often reported stress/anxiety multiple days in the past month.*
    - *Among Tazewell respondents, regions 1 and 4 more often reported stress/anxiety multiple days in the past month.*
- *Peoria and Tazewell respondents more often reported not receiving mental health care because the counselor refused to take insurance (p=0.02).*
    - *Among Peoria respondents, this was more often reported in regions 1 and 2*

    - *Among Tazewell respondents, this was more often reported in regions 1 and 2.*
- *Tazewell respondents more often reported not being able to find a counselor as a reason for not getting mental health care (p=0.022).*
    - *Among Tazewell residents, this was more often reported among respondents in region 1.*
- *Peoria respondents (18%) more often reported smoking compared to Tazewell (12%) and Woodford (14%) Counties (p=0.009).*
    - *Among Peoria residents, this was more often reported among respondents in regions 4, 1, and 5.*
- *Peoria respondents (10%) more often reported using marijuana compared to Tazewell (7%) and Woodford (5%) respondents (p=0.001).*

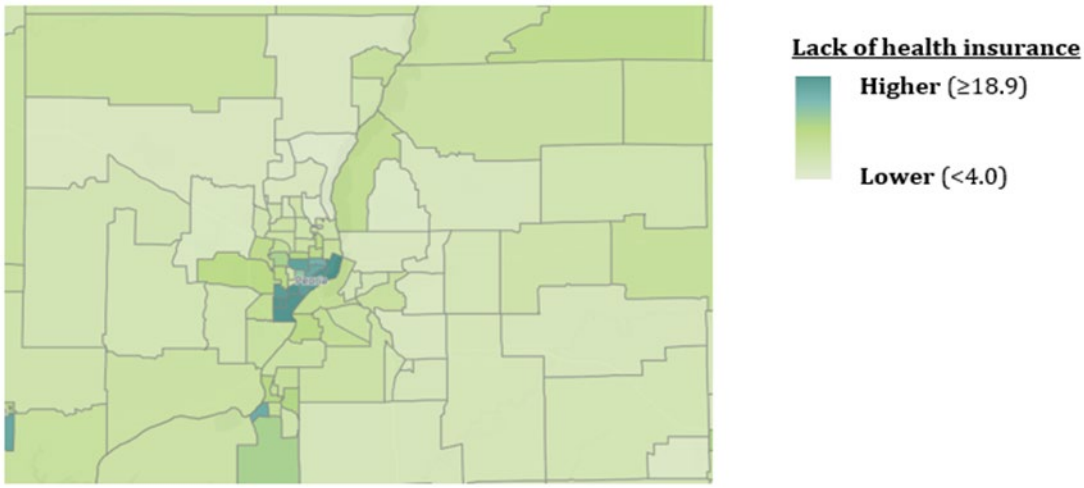
Among Peoria residents, this was more often reported among respondents in regions 4 and 1, respectively.

Geographic Health Metrics: A Visual Exploration

The following sections provide a detailed visualization of the distribution of health issues in the Tri-County region of Central Illinois, utilizing data from public health surveillance sources such as the Behavioral Risk Factor Surveillance System (BRFSS) 2020-2022 and the American Community Survey (ACS) 2017-2021. These visualizations illustrate the prevalence of various health behaviors, health outcomes, and disparities in health issues by race/ethnicity. By mapping these metrics, we aim to highlight critical areas of concern and identify trends that can inform targeted interventions and policy decisions to improve community health.

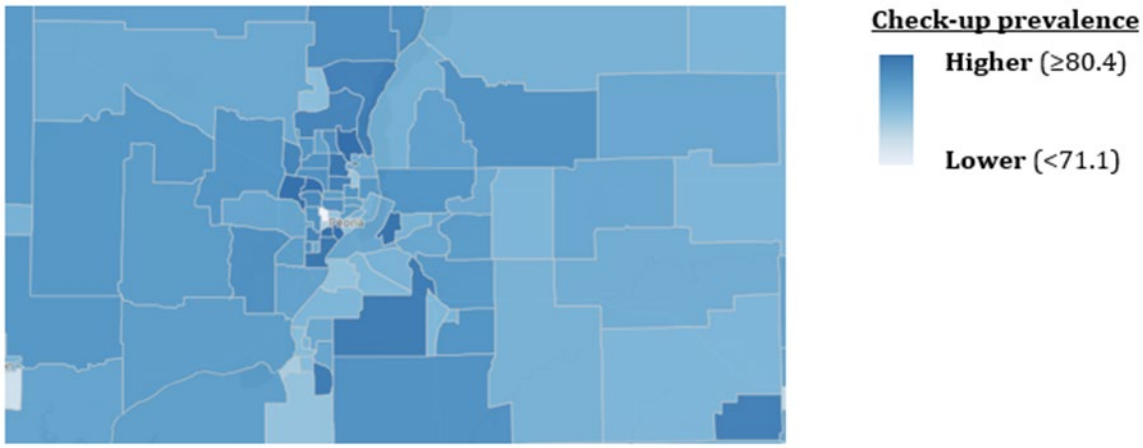
Additional health metrics are mapped out using Census Tract data to identify populations with greater need. These measures are crucial for achieving health equity as they highlight areas where interventions can be most impactful. The Social Vulnerability Index (SVI) helps identify communities that may be more susceptible to health issues, guiding resource allocation to those with higher vulnerability. Monitoring the percentage of the population current on preventive services and educational attainment provides insight into access to healthcare and socioeconomic factors that influence health outcomes. Environmental measures, such as Particulate Matter (PM2.5), are essential for understanding air quality and its impact on public health, ensuring that communities meet both EPA and WHO standards for cleaner air. By addressing these metrics, we can work towards reducing health disparities and promoting equitable health for all populations.

Figure 96 Prevalence of residents with no insurance



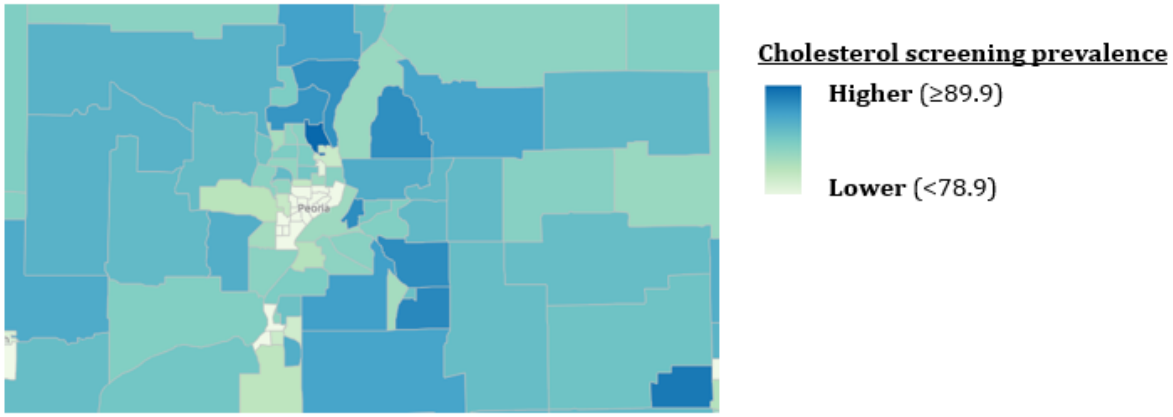
Source: CDC PLACES

Figure 97 Prevalence of annual check-up



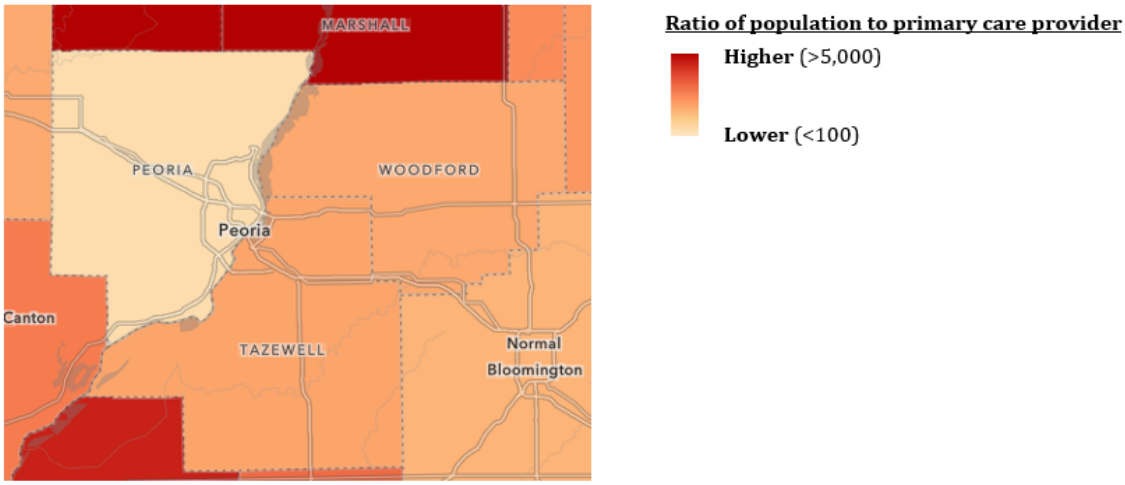
Source: CDC PLACES

Figure 98 Prevalence of cholesterol screening



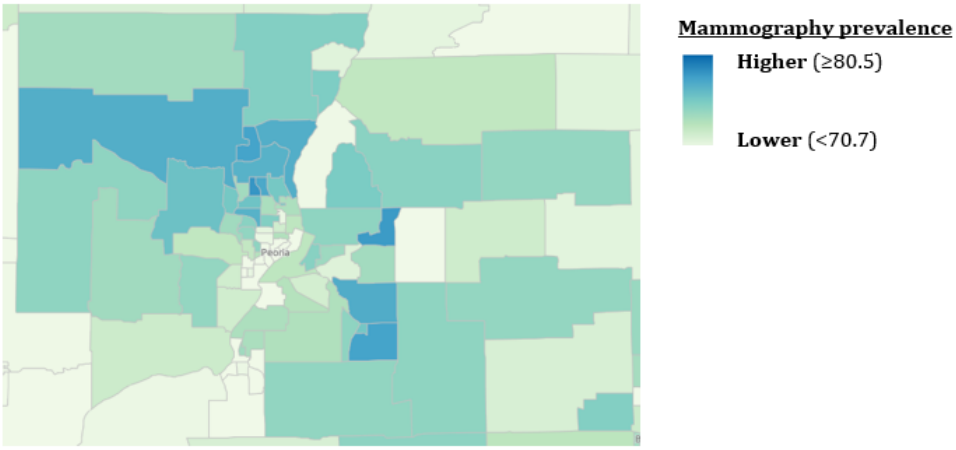
Source: CDC PLACES

Figure 99 Ratio of population to primary care provider



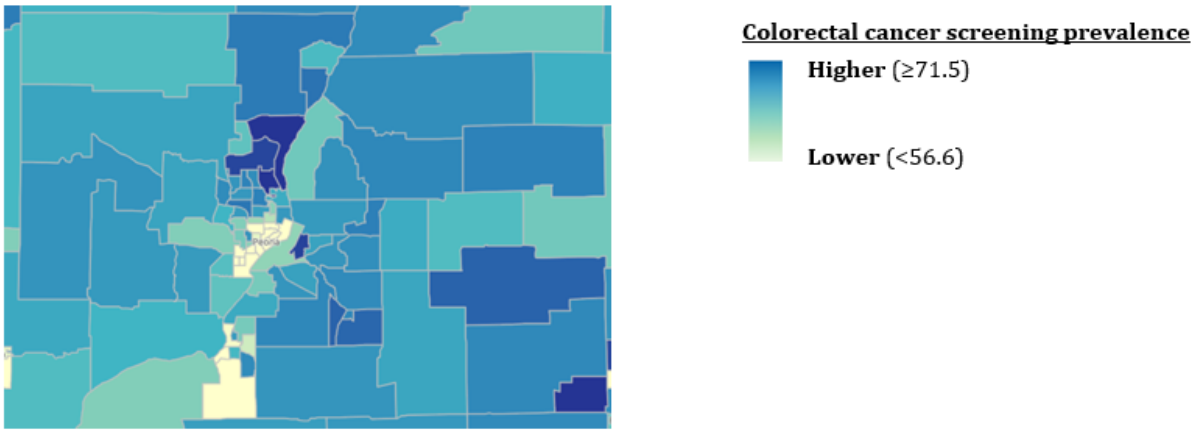
Source: CDC PLACES

Figure 100 Prevalence of mammography



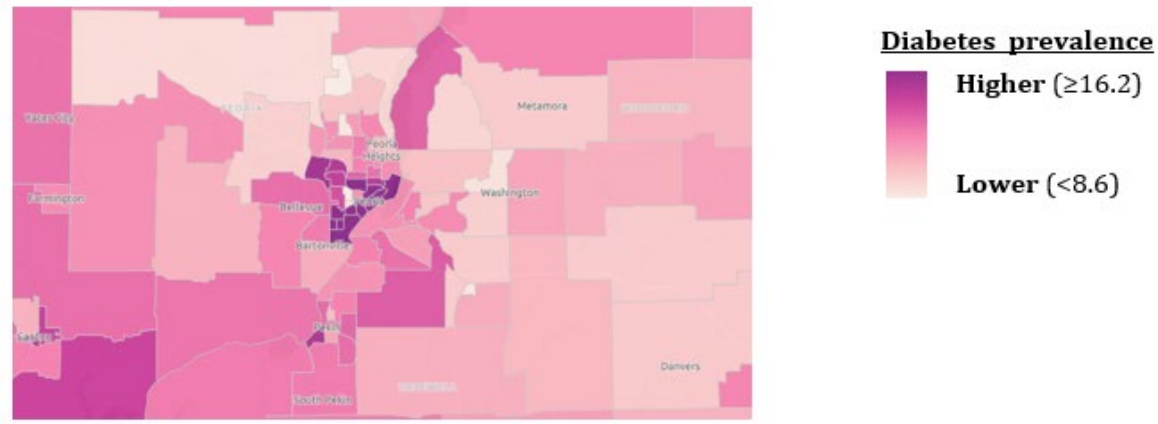
Source: CDC PLACES

Figure 101 Prevalence of colorectal cancer screening



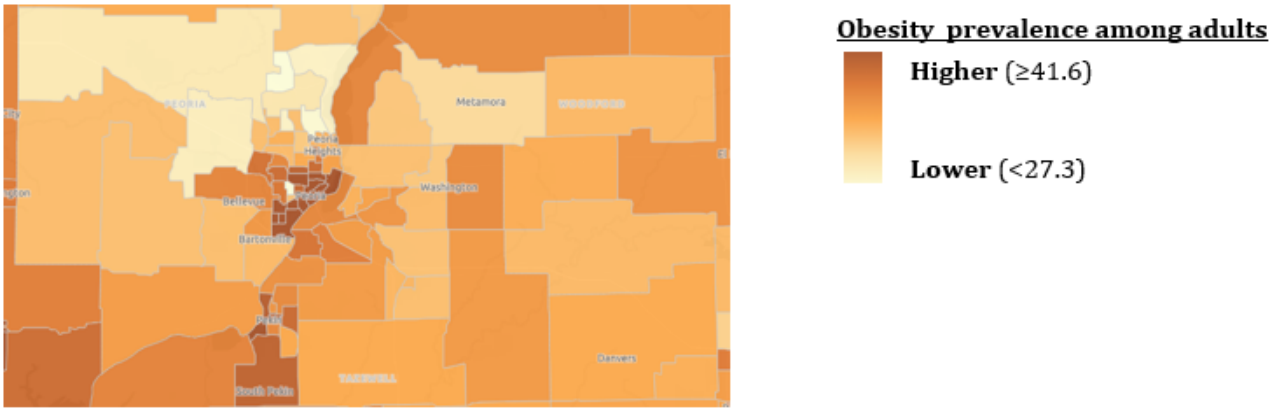
Source: CDC PLACES

Figure 102 Prevalence of diabetes



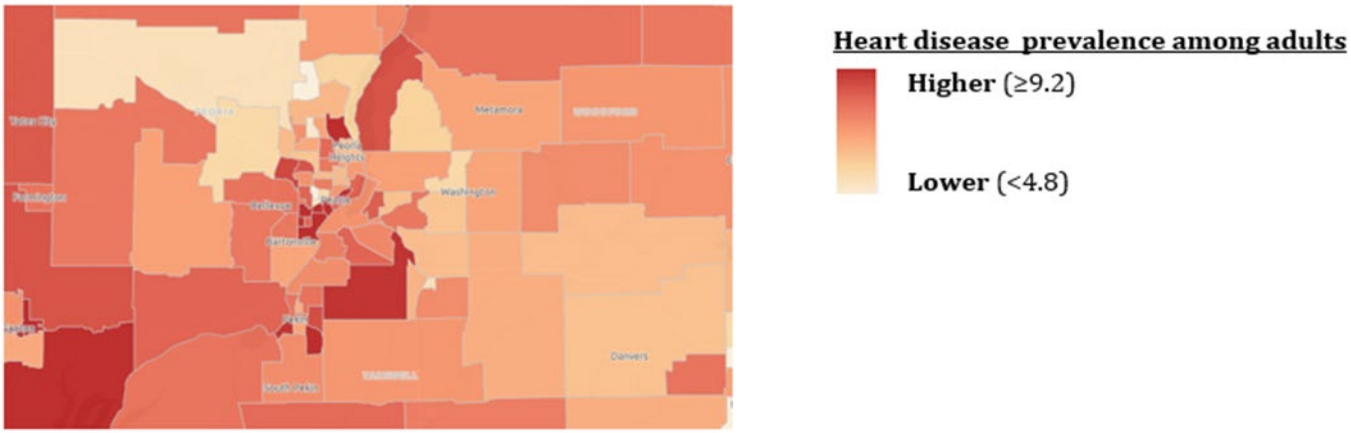
Source: CDC PLACES

Figure 103 Prevalence of obesity among adults



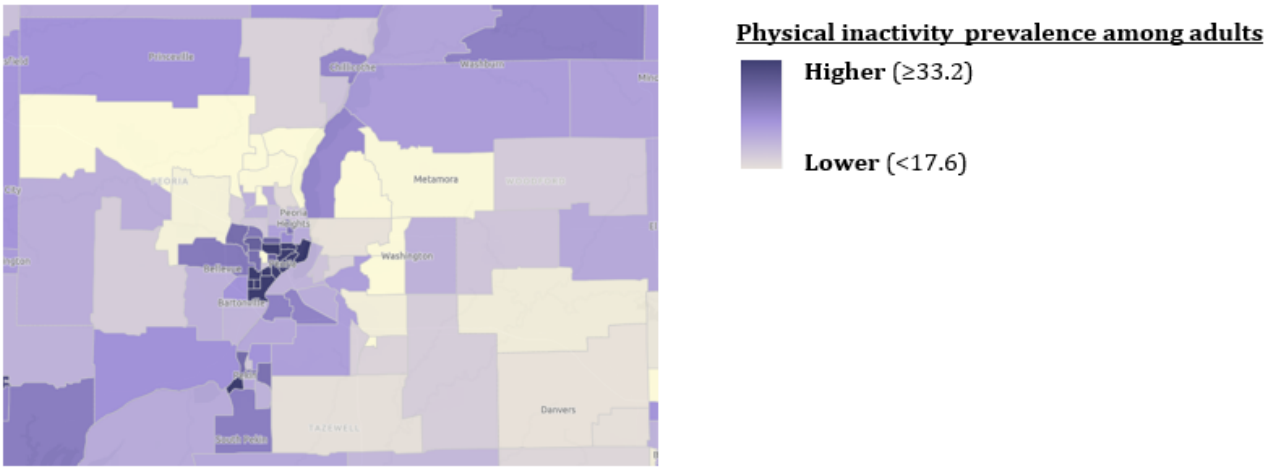
Source: CDC PLACES

Figure 104 Prevalence of heart disease among adults



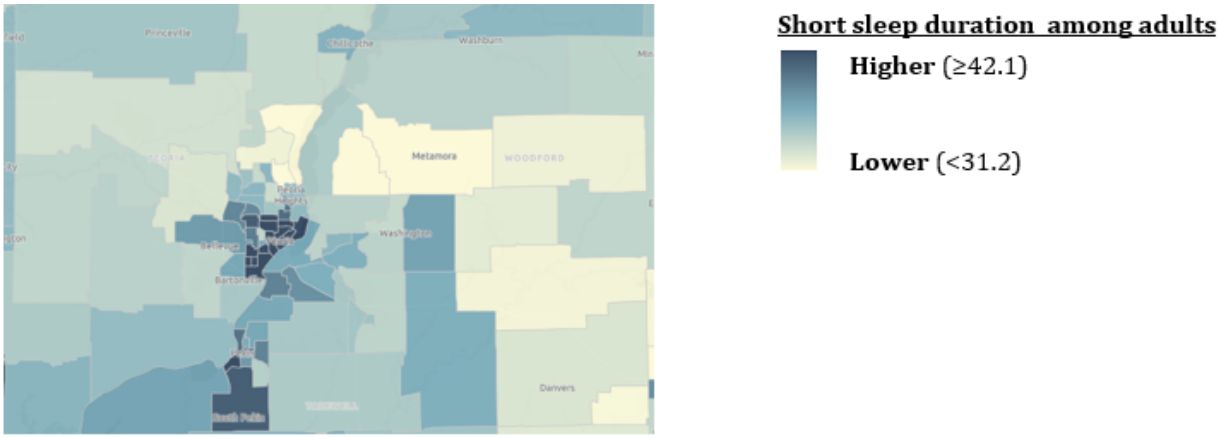
Source: CDC PLACES

Figure 105 Prevalence of inactivity among adults



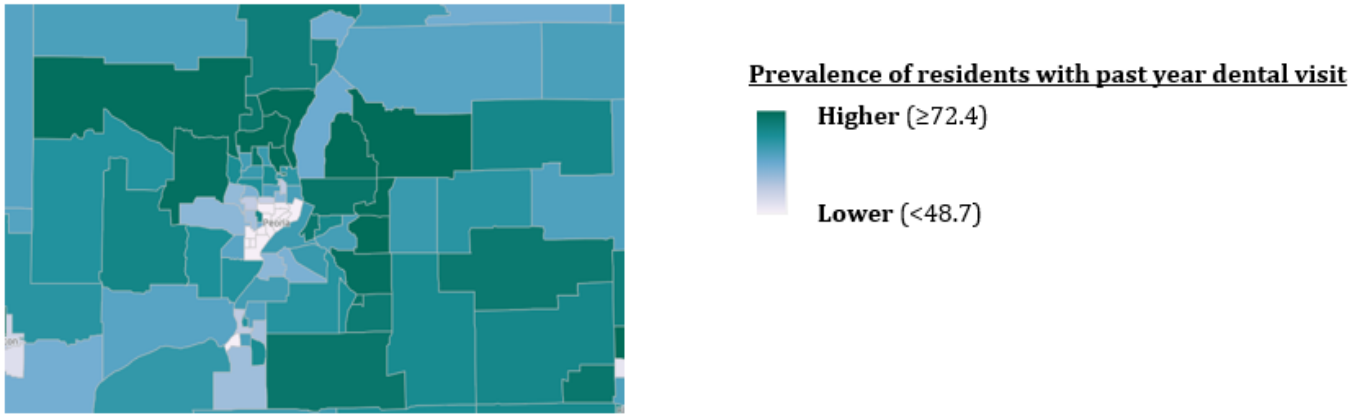
Source: CDC PLACES

Figure 106 Prevalence of short sleep duration



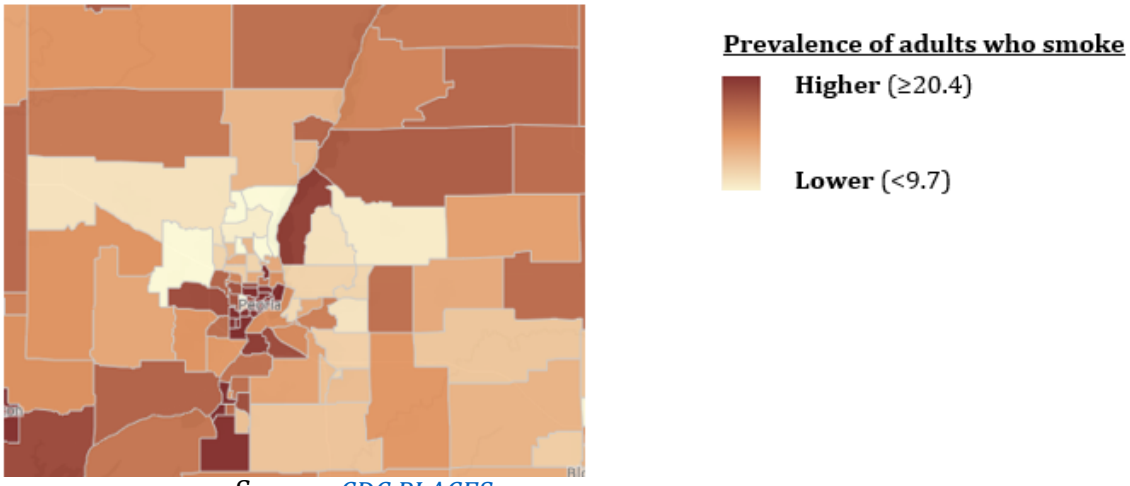
Source: CDC PLACES

Figure 107 Prevalence of residents with past year dental visit



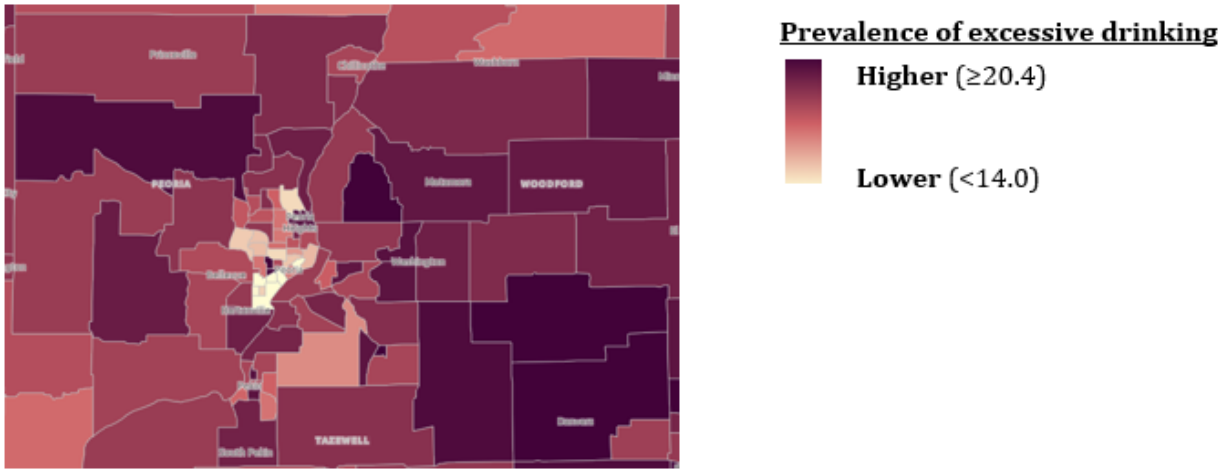
Source: CDC PLACES

Figure 108 Prevalence of adults who smoke



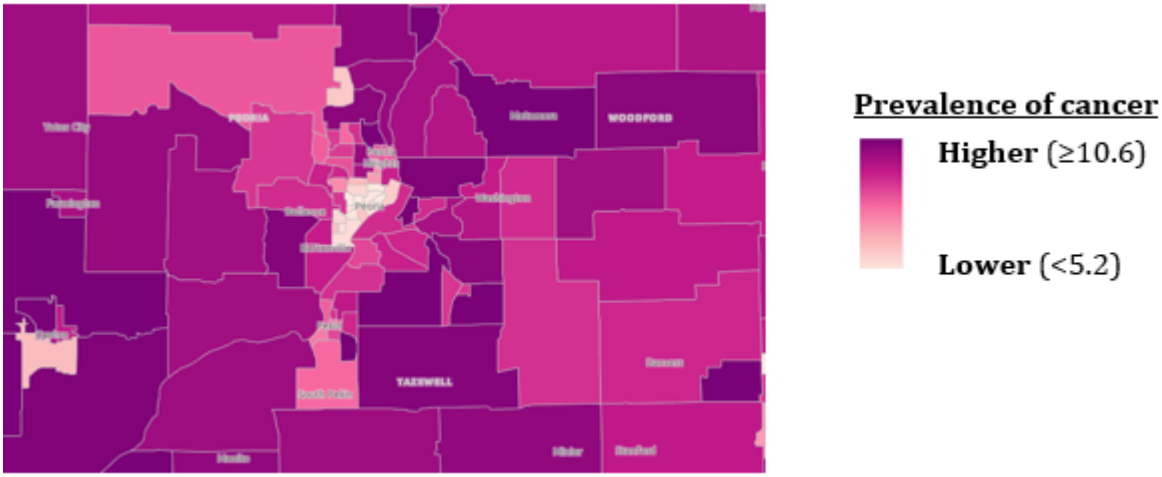
Source: CDC PLACES

Figure 109 Prevalence of excessive drinking among adults



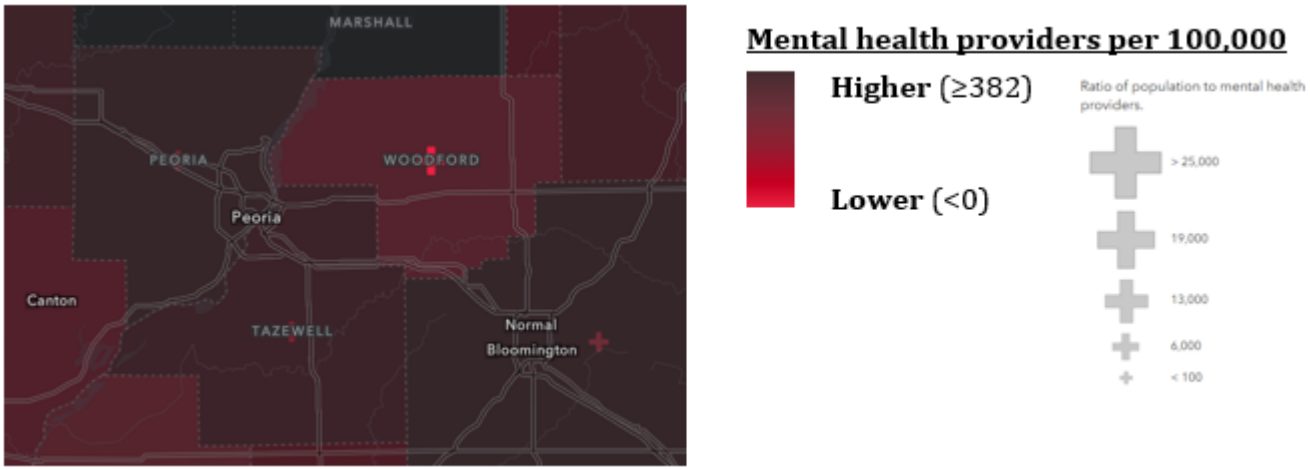
Source: CDC PLACES

Fiaure 110 Prevalence of cancer (excludina skin)



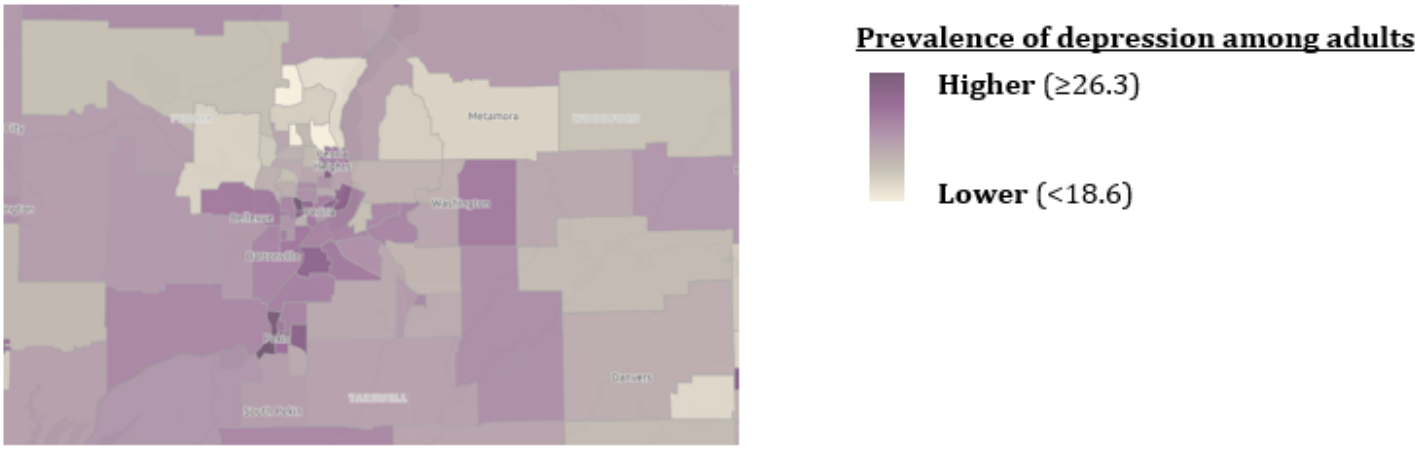
Source: CDC PLACES

Figure 111 Need for additional mental health providers



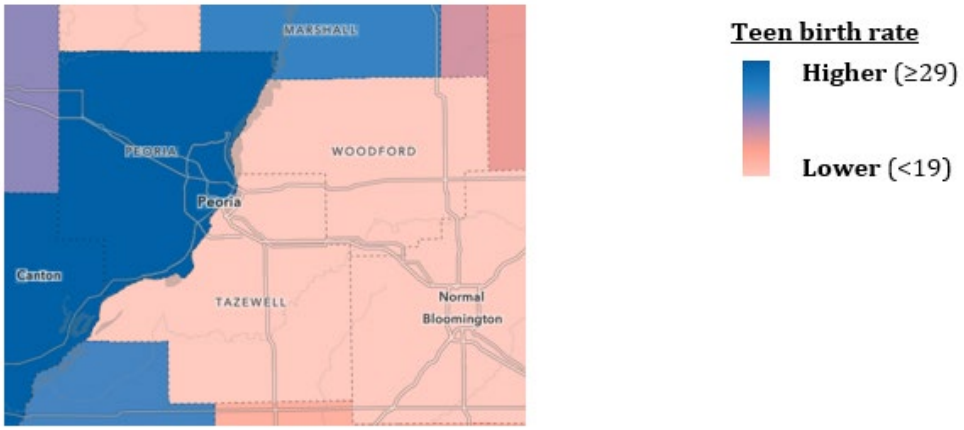
Source: CDC PLACES

Figure 112 Prevalence of depression among adults



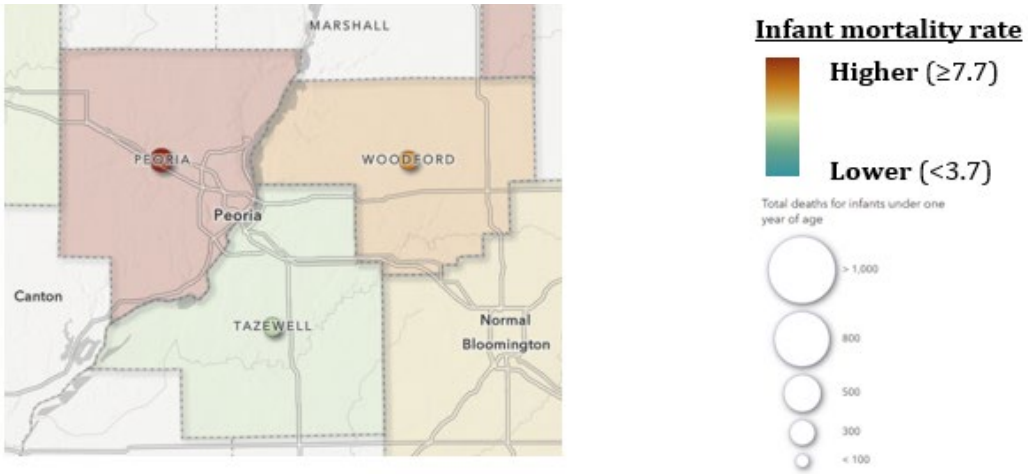
Source: CDC PLACES

Figure 113 Teen birth rate per 1,000



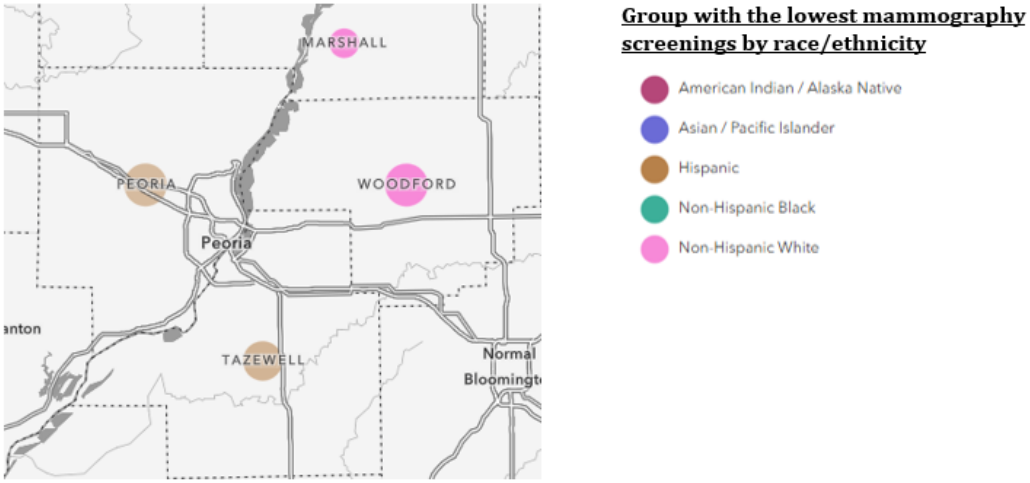
Source: CDC PLACES

Figure 114 Infant mortality rate per 1,000



Source: CDC PLACES

Figure 115 Lowest mammogram screenings among female Medicare



Source: CDC PLACES

Health Disparities by Race/Ethnicity

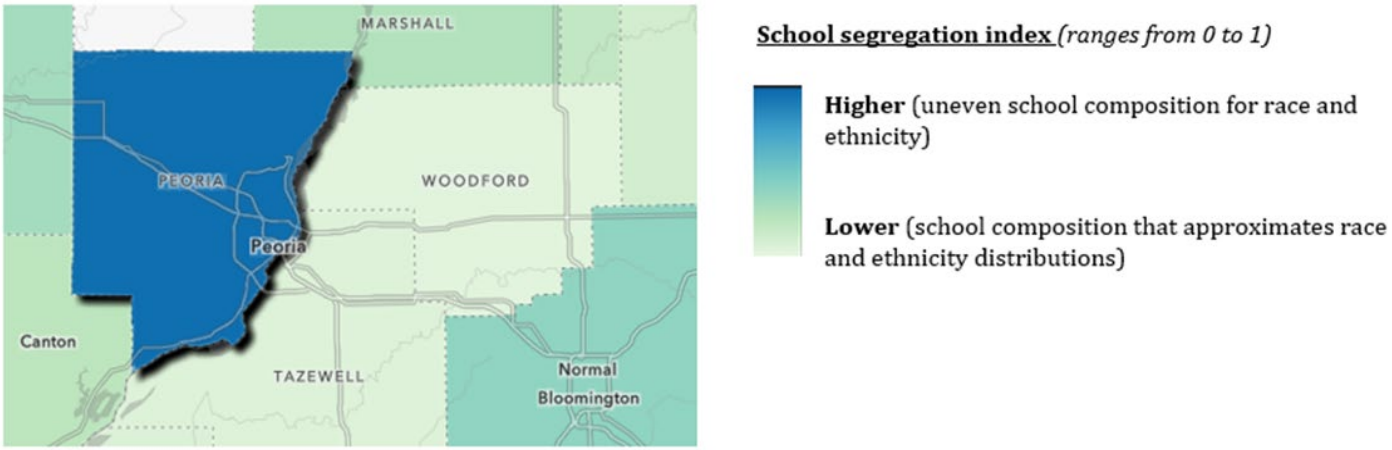
Additional indicators of health disparities in Tri-County region in regards to the health and well-being of children.

Table 5

Health Issue	**Race/ethnicity that experiences higher rates of health issue/outcome**
Teen birth rate	
Peoria	Black
Tazewell	Black
Woodford	White
Child Poverty	
Peoria	Black
Tazewell	Black
Woodford	Hispanic

Source: CDC PLACES

Figure 116 Social segregation index



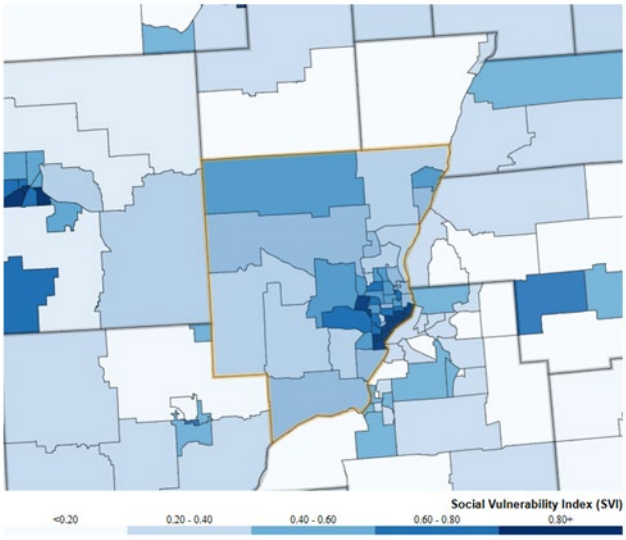
Source: CDC PLACES, USC and Stanford University

Additional Health Metrics Mapped Out

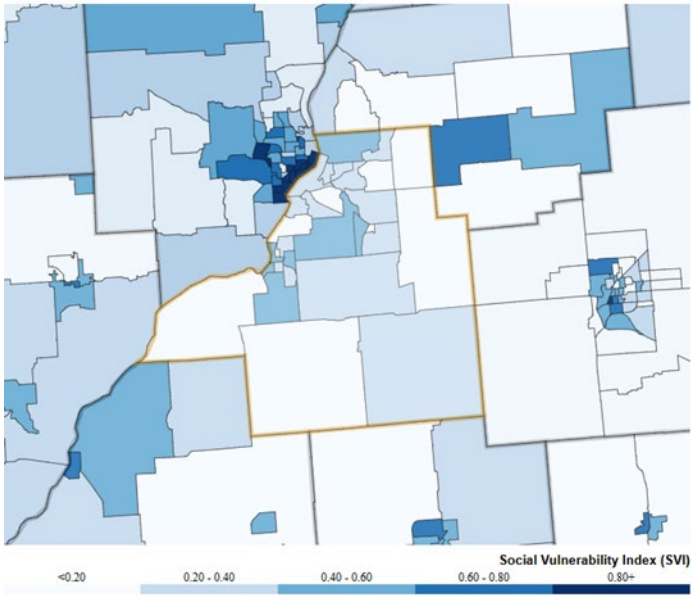
Description

Social Vulnerability Index (SVI) is a measure used to identify communities that may be more vulnerable to health issues. A lower score (0) indicates lowest vulnerability whereas a higher score (1) indicates highest vulnerability.

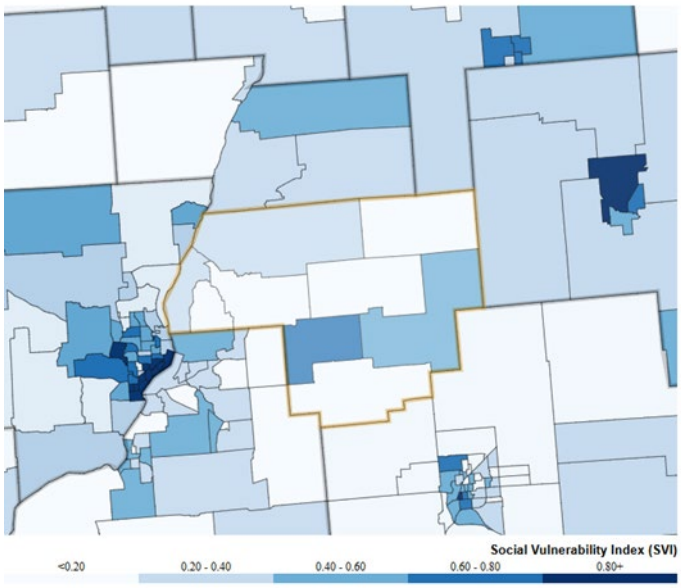
Peoria



Tazewell



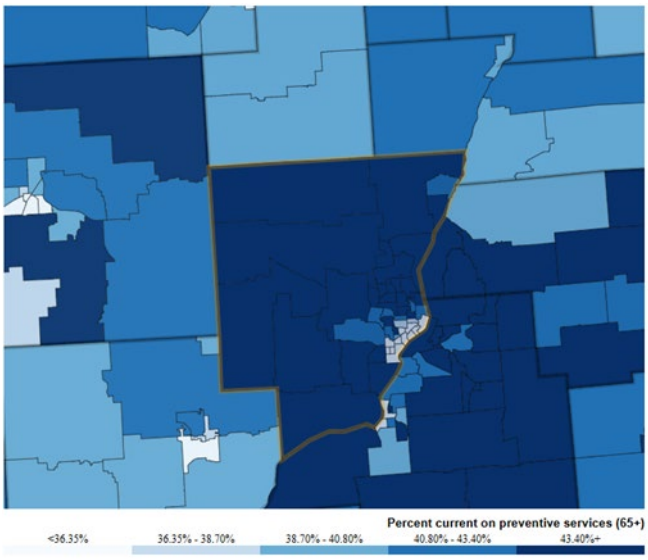
Woodford



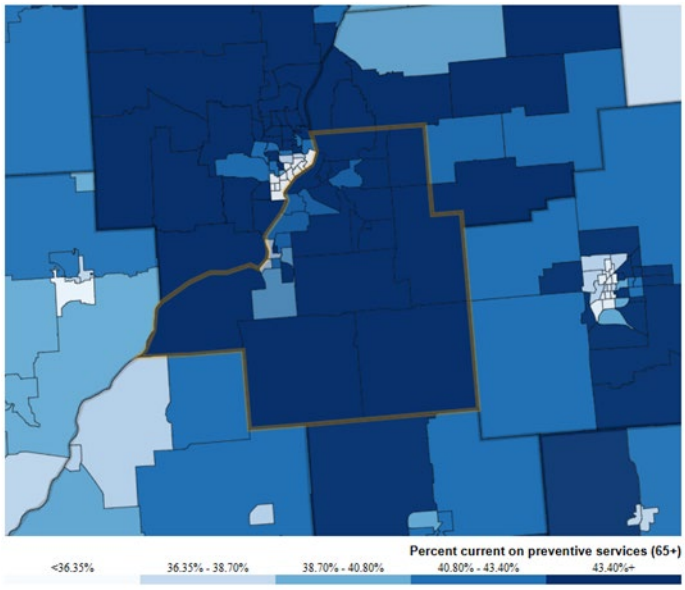
Description

Percent of the population current on preventive services.

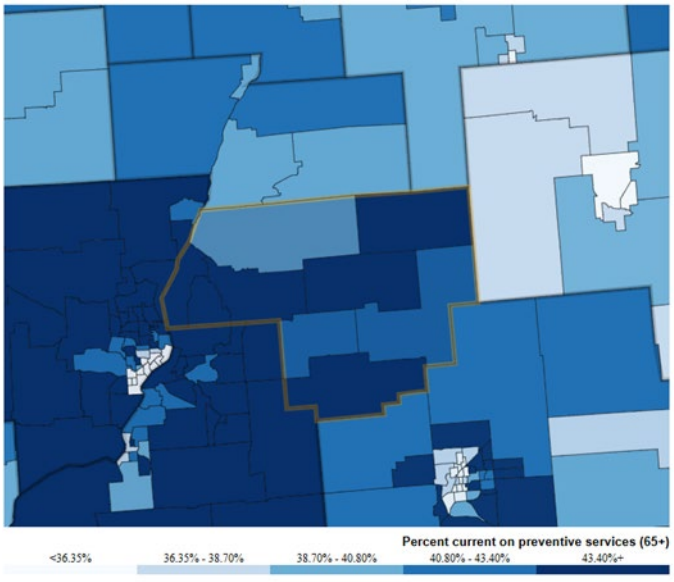
Peoria



Tazewell



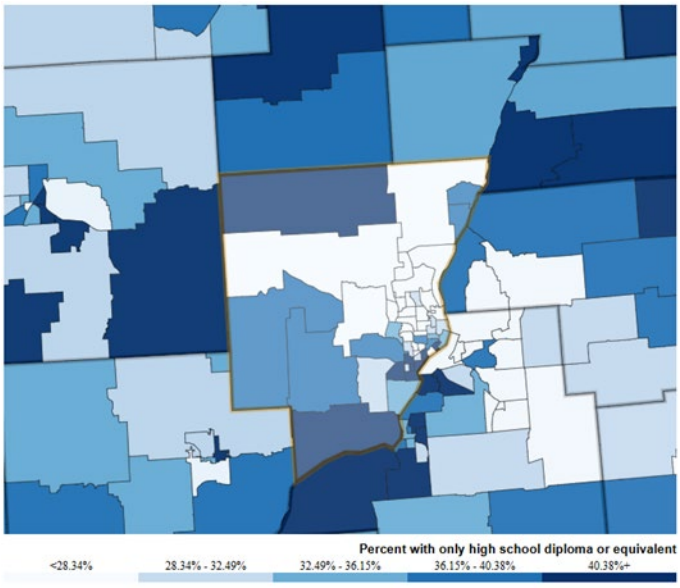
Woodford



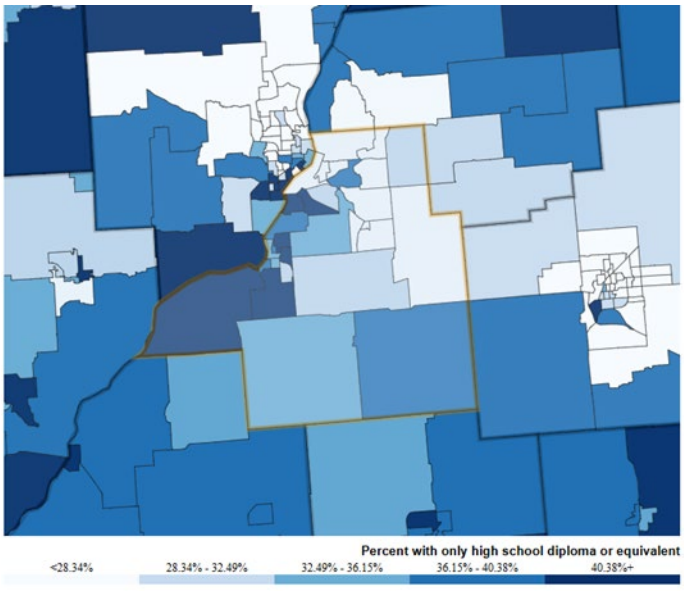
Description

Percent of the population with only high school diploma or equivalent.

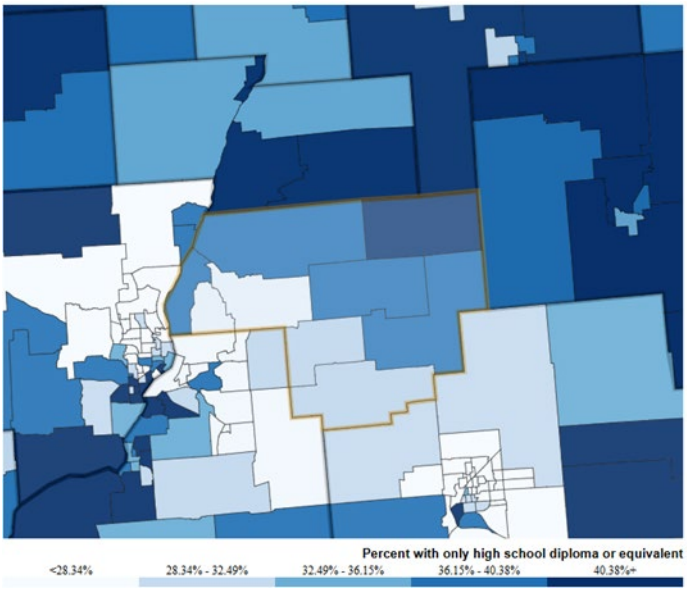
Peoria



Tazewell



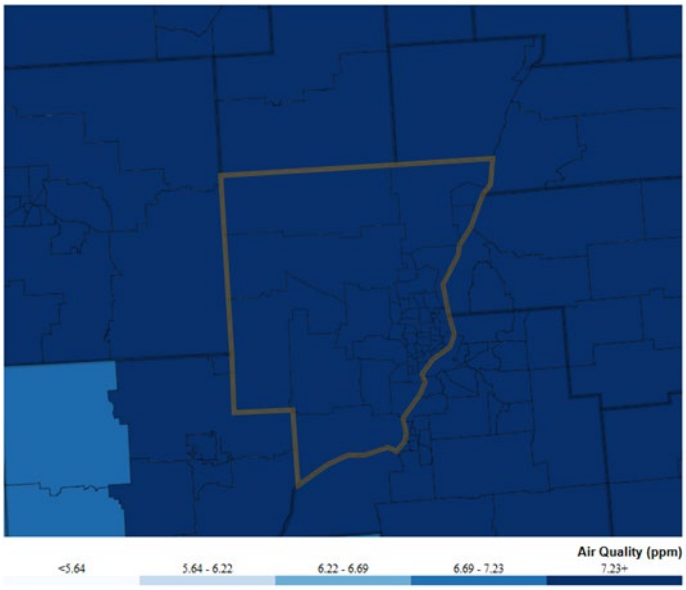
Woodford



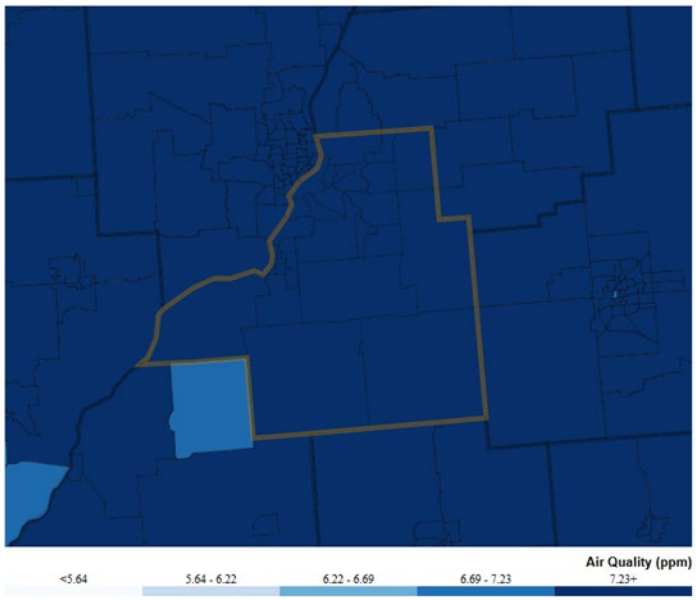
Description

Environment: Particulate Matter (PM2.5) measures air quality annual average for fine particular matter. The EPA sets standards of 9.0 micrograms per cubic meter µg/m³. The WHO has more stringent guidelines for air quality set at of 5 µg/m³.

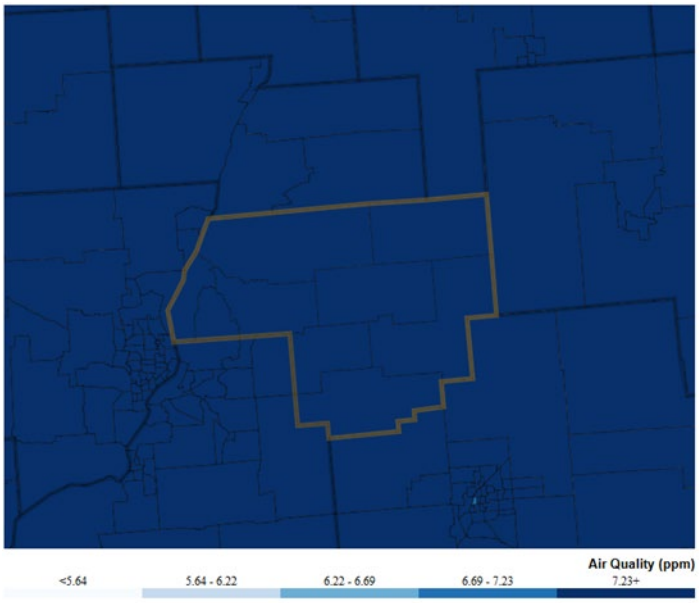
Peoria



Tazewell



Woodford



APPENDIX 4: SURVEY

2024 COMMUNITY HEALTH-NEEDS ASSESSMENT SURVEY

INSTRUCTIONS

We want to know how you view our community, and other factors that may impact your health. We are inviting you to participate in a research study about community health needs. Your opinions are important! This survey will take about 12 minutes to complete. All of your individual responses are anonymous and confidential. We will use the survey results to better understand and address health needs in our community.

COMMUNITY PERCEPTIONS

1. What would you say are the three (3) biggest **HEALTH ISSUES** in our community?

- ☐ Aging issues, such as Alzheimer's disease, hearing loss, memory loss, arthritis, falls
- ☐ Cancer
- ☐ Chronic pain
- ☐ Dental health (including tooth pain)
- ☐ Diabetes
- ☐ Heart disease/heart attack
- ☐ Mental health issues, such as depression, anxiety
- ☐ Obesity/overweight
- ☐ Sexually transmitted infections
- ☐ Viruses, such as COVID-19 or flu
- ☐ Women's health, such as pregnancy, menopause

2. What would you say are the three (3) most **UNHEALTHY BEHAVIORS** in our community?

- ☐ Angry behavior/violence
- ☐ Alcohol abuse
- ☐ Child abuse
- ☐ Domestic violence
- ☐ Drug use
- ☐ Lack of exercise
- ☐ Poor eating habits
- ☐ Risky sexual behavior
- ☐ Self harm/suicide
- ☐ Smoking/vaping (tobacco use)

3. What would you say are the three (3) most important factors that would improve your **WELL-BEING**?

- ☐ Access to health services
- ☐ Affordable healthy housing
- ☐ Availability of child care
- ☐ Better school attendance
- ☐ Good public transportation
- ☐ Less gun violence
- ☐ Job opportunities
- ☐ Less poverty
- ☐ Less race/ethnic discrimination
- ☐ Safer neighborhoods/schools

ACCESS TO CARE

The following questions ask about your own health and health choices. Remember, this survey will not be linked to you in any way.

Medical Care

1. When you get sick, where do you go most often? (Please choose only one answer).

- ☐ Clinic/Doctor's office
- ☐ Urgent Care Center
- ☐ Emergency Department
- ☐ I don't seek medical care

If you don't seek medical care, why not?

☐ Fear of Discrimination ☐ Lack of trust ☐ Cost ☐ I have experienced bias ☐ Do not need

2. In the last YEAR, was there a time when you needed medical care but were not able to get it?

- ☐ Yes (please answer #3)
- ☐ No (please go to #4: Prescription Medicine)

3. If you were not able to get medical care, why not? (Please choose all that apply).

- ☐ Didn't have health insurance.
- ☐ Cannot afford
- ☐ Fear of discrimination
- ☐ Too long to wait for appointment.
- ☐ Didn't have a way to get to the doctor
- ☐ Lack of trust

Prescription Medicine

4. In the last YEAR, was there a time when you needed prescription medicine but were not able to get it?

- ☐ Yes (please answer #5)
- ☐ No (please go to #6: Dental Care)

5. If you were not able to get prescription medicine, why not? (Please choose all that apply).

- ☐ Didn't have health insurance
- ☐ Cannot afford
- ☐ Fear of discrimination
- ☐ Pharmacy refused to take my insurance or Medicaid
- ☐ Didn't have a way to get to the pharmacy
- ☐ Lack of trust

Dental Care

6. In the last YEAR, was there a time when you needed dental care but were not able to get it?

- ☐ Yes (please answer #7)
- ☐ No (please go to #8: Mental-Health Counseling)

7. If you were not able to get dental care, why not? (Please choose all that apply).

- ☐ Didn't have dental insurance
- ☐ Cannot afford
- ☐ Fear of discrimination
- ☐ Not sure where to find available dentist
- ☐ The dentist refused my insurance/Medicaid
- ☐ Didn't have a way to get to the dentist
- ☐ Lack of trust

Mental-Health Counseling

8. In the last YEAR, was there a time when you needed mental-health counseling but could not get it?

- ☐ Yes (please answer #9)
- ☐ No (please go to next section – HEALTHY BEHAVIORS)

9. If you were not able to get mental-health counseling, why not? (Please choose all that apply).

- ☐ Didn't have insurance
- ☐ Cannot afford
- ☐ Didn't have a way to get to a counselor
- ☐ Fear of discrimination
- ☐ Long wait time.
- ☐ The counselor refused to take insurance/Medicaid
- ☐ Embarrassment
- ☐ Cannot find counselor
- ☐ Lack of trust

HEALTHY BEHAVIORS

The following questions ask about your own health and health choices. Remember, this survey will not be linked to you in any way.

Exercise

1. In a typical WEEK how many times do you participate in exercise, (such as jogging, walking, weight-lifting, fitness classes) that lasts for at least 30 minutes?

☐ None (please answer #2) ☐ 1 – 2 times ☐ 3 - 5 times ☐ More than 5 times

2. If you answered "none" to the question about exercise, why didn't you exercise in the past week? (Please choose all that apply).

☐ Don't have any time to exercise
☐ Don't like to exercise
☐ Can't afford the fees to exercise
☐ Don't have child care while I exercise
☐ Don't have access to an exercise facility
☐ Too tired
☐ Safety issues

Healthy Eating

3. On a typical DAY, how many **servings/separate portions** of fruits and/or vegetables did you have? An example would be a banana (but not banana flavored pudding).

☐ None (please answer #4) ☐ 1 - 2 servings ☐ 3 - 4 servings ☐ 5 servings or more

4. If you answered "none" to the questions about fruits and vegetables, why didn't you eat fruits/vegetables? (Please choose all that apply).

☐ Don't have transportation to get fruits/vegetables
☐ Don't like fruits/vegetables
☐ It is not important to me
☐ Can't afford fruits/vegetables
☐ Don't know how to prepare fruits/vegetables
☐ Don't have a refrigerator/stove
☐ Don't know where to buy fruits/vegetables

5. Please check the box next to any health conditions that you have. (Please choose all that apply).
If you don't have any health conditions, please check the first box and go to question #6: Smoking.

☐ I do not have any health conditions
☐ Diabetes
☐ Depression/anxiety
☐ Allergy
☐ Heart problems
☐ Stroke
☐ Asthma/COPD
☐ Overweight
☐ Cancer
☐ Memory problems

Smoking

6. On a typical DAY, how many cigarettes do you smoke?

☐ None ☐ 1 - 4 ☐ 5 - 8 ☐ 9 - 12 ☐ More than 12

Vaping

7. On a typical DAY, how many times do you use electronic vaping?

☐ None ☐ 1 - 4 ☐ 5 - 8 ☐ 9 - 12 ☐ More than 12

GENERAL HEALTH

8. Where do you get most of your health information and how would you like to get health information in the future? (For example, do you get health information from your doctor, from the Internet, etc.). _____

_____

9. Do you have a personal physician/doctor? ☐ Yes ☐ No

10. How many days a week do you or your family members go hungry?

☐ None ☐ 1–2 days ☐ 3-5 days ☐ More than 5 days

11. In the last 30 DAYS, how many days have you felt depressed, down, hopeless?

☐ None ☐ 1–2 days ☐ 3 – 5 days ☐ More than 5 days

12. In the last 30 DAYS, how often has your stress and/or anxiety stopped you from your normal daily activities?
☐ None ☐ 1–2 days ☐ 3 - 5 days ☐ More than 5 days

13. In the last YEAR have you talked with anyone about your mental health?
☐ No ☐ Doctor/nurse ☐ Counselor ☐ Family/friend

14. How often do you use prescription pain medications not prescribed to you or use differently than how the doctor instructed on a typical DAY?
☐ None ☐ 1–2 times ☐ 3-5 times ☐ More than 5 times

15. How many alcoholic drinks do you have on a typical DAY?
☐ None ☐ 1–2 drinks ☐ 3-5 drinks ☐ More than 5 drinks

16. How often do you use marijaunia on a typical DAY?
☐ None ☐ 1–2 times ☐ 3-5 times ☐ More than 5 times

17. How often do you use substances such as inhalants, ecstasy, cocaine, meth or heroin on a typical DAY?
☐ None ☐ 1–2 times ☐ 3-5 times ☐ More than 5 times

18. Do you feel safe in your home? ☐ Yes ☐ No

19. Do you feel safe in your neighborhood? ☐ Yes ☐ No

20. In the past 5 years, have you had a:

Breast cancer screening/mammogram	☐ Yes	☐ No	☐ Not applicable
Prostate exam	☐ Yes	☐ No	☐ Not applicable
Colon cancer screening	☐ Yes	☐ No	☐ Not applicable
Cervical cancer screening/pap smear	☐ Yes	☐ No	☐ Not applicable

Overall Health Ratings

21. My overall physical health is: ☐ Below average ☐ Average ☐ Above average
22. My overall mental health is: ☐ Below average ☐ Average ☐ Above average

INTERNET

1. Do you have Internet at home? For example, can you watch Youtube at home?

☐ Yes (please go to next section – BACKGROUND INFORMATION) ☐ No (please answer #2)

2. If don't have Internet, why not? ☐ Cost ☐ No available Internet provider ☐ I don't know how ☐ Data limits ☐ Poor Internet service ☐ No phone or computer

BACKGROUND INFORMATION

1. What county do you live in?

☐ Peoria ☐ Tazewell ☐ Woodford ☐ Other

2. What is your Zip Code? _____

3. What type of health insurance do you have? (Please choose all that apply).

☐ Medicare ☐ Medicaid/State insurance ☐ Commercial/Employer

☐ Don't have (Please answer #4)

4. If you answered "don't have" to the question about health insurance, why **don't** you have insurance? (Please choose all that apply).

☐ Can't afford health insurance ☐ Don't need health insurance

☐ Don't know how to get health insurance

5. What is your gender? ☐ Male ☐ Female ☐ Non-binary ☐ Transgender ☐ Prefer not to answer

6. What is your sexual orientation? ☐ Heterosexual ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Queer ☐ Prefer not to answer

7. What is your age? ☐ Under 20 ☐ 21-35 ☐ 36-50 ☐ 51-65 ☐ Over 65

8. What is your racial or ethnic identification? (Please choose only one answer).

☐ White/Caucasian ☐ Black/African American ☐ Hispanic/LatinX

☐ Pacific Islander ☐ Native American ☐ Asian/South Asian

☐ Multiracial

9. What is your highest level of education? (Please choose only one answer).

☐ Grade/Junior high school ☐ Some high school ☐ High school degree (or GED)

☐ Some college (no degree) ☐ Associate's degree ☐ Certificate/technical degree

☐ Bachelor's degree ☐ Graduate degree

10. What was your household/total income last year, before taxes? (Please choose only one answer).

☐ Less than $20,000 ☐ $20,001 to $40,000 ☐ $40,001 to $60,000

☐ $60,001 to $80,000 ☐ $80,001 to $100,000 ☐ More than $100,000

11. What is your housing status?

☐ Do not have ☐ Have housing, but worried about losing it ☐ Have housing, **NOT** worried about losing it

12. How many people live with you? _____

13. Prior to the age of 18, which of the following did you experience (check all that apply):

☐ Emotional abuse ☐ Physical abuse ☐ Sexual abuse

☐ Substance use in household ☐ Mental illness in household ☐ Parental separation or divorce

☐ Emotional neglect ☐ Physical neglect ☐ Incarcerated household member

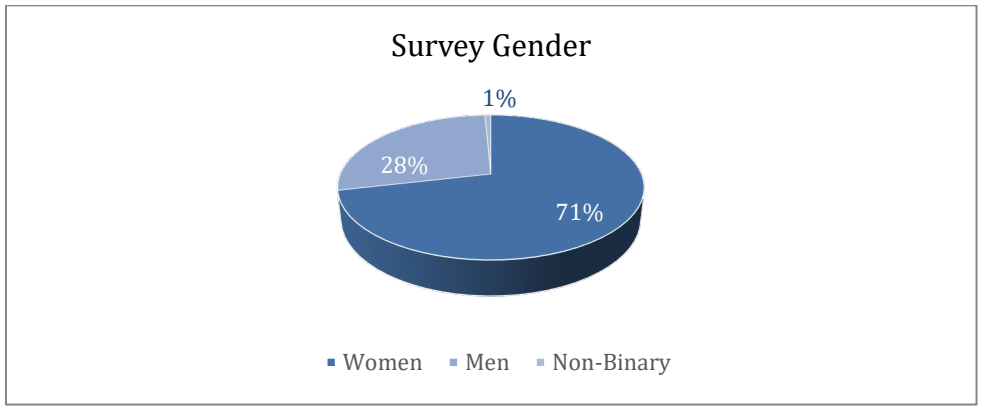
☐ Mother treated violently

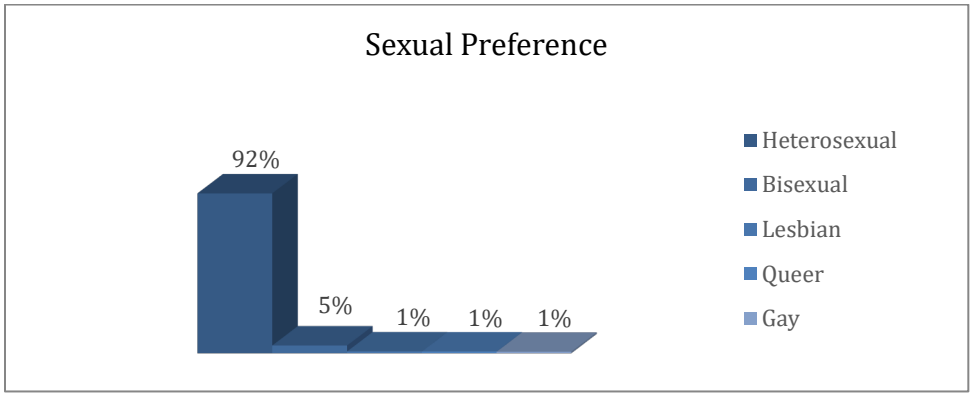
Is there anything else you'd like to share about your own health goals or health issues in our community?

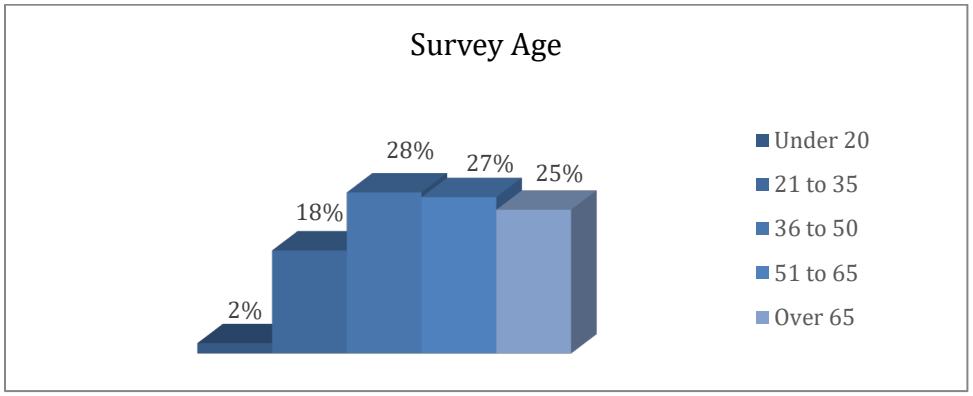
_____

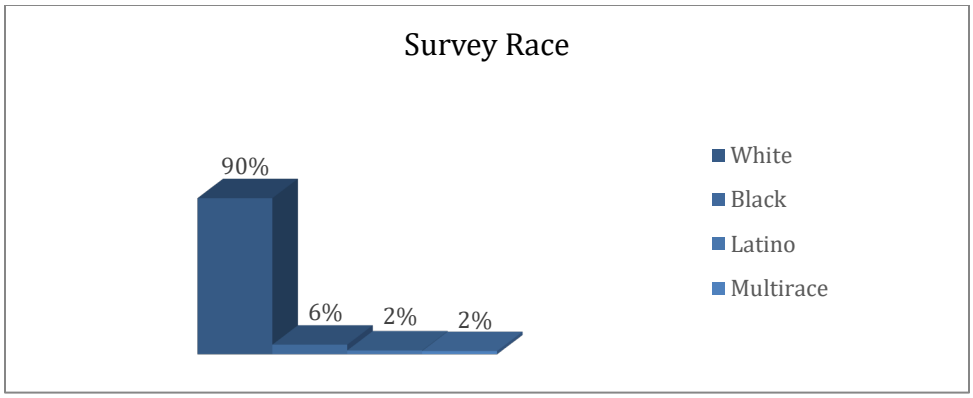
Thank you very much for sharing your views with us!

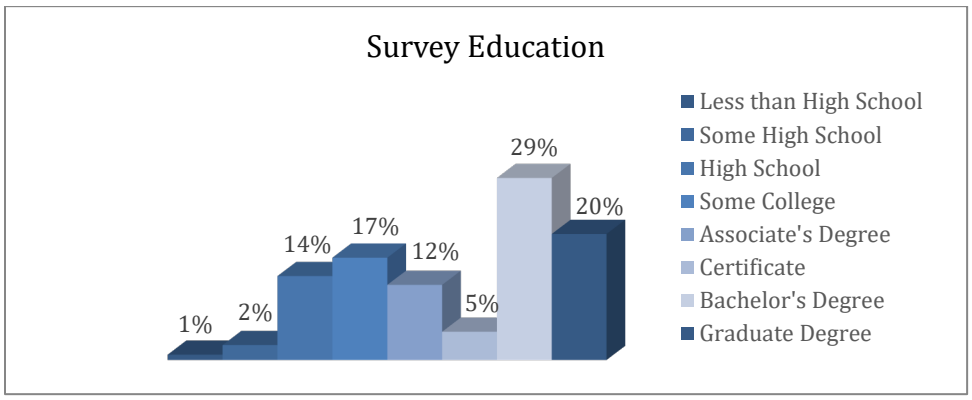
APPENDIX 5: CHARACTERISTICS OF SURVEY RESPONDENTS 2025

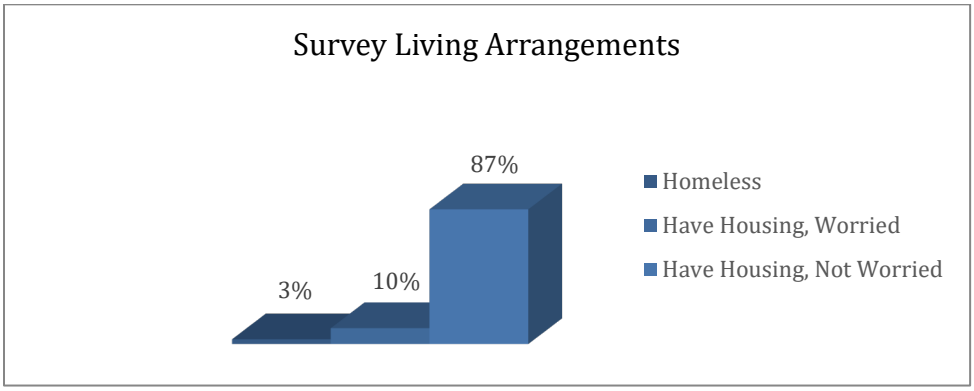


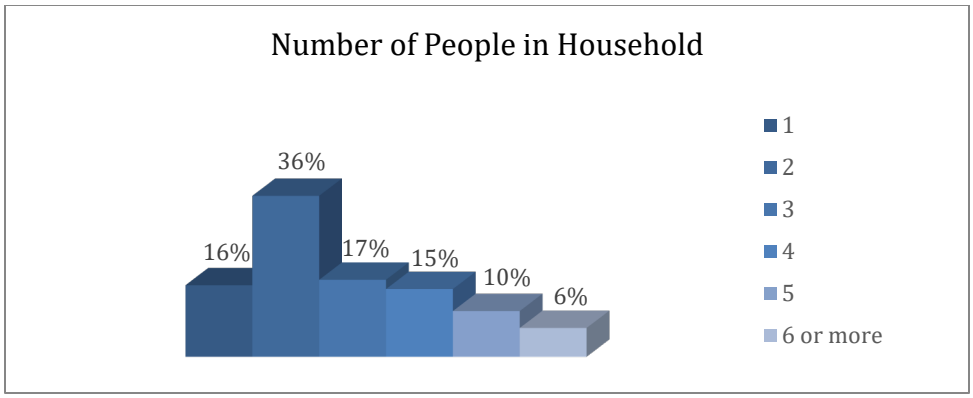


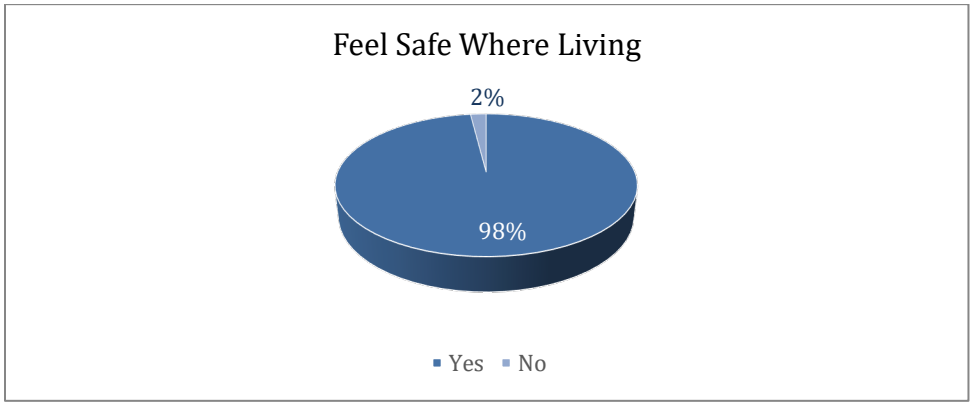


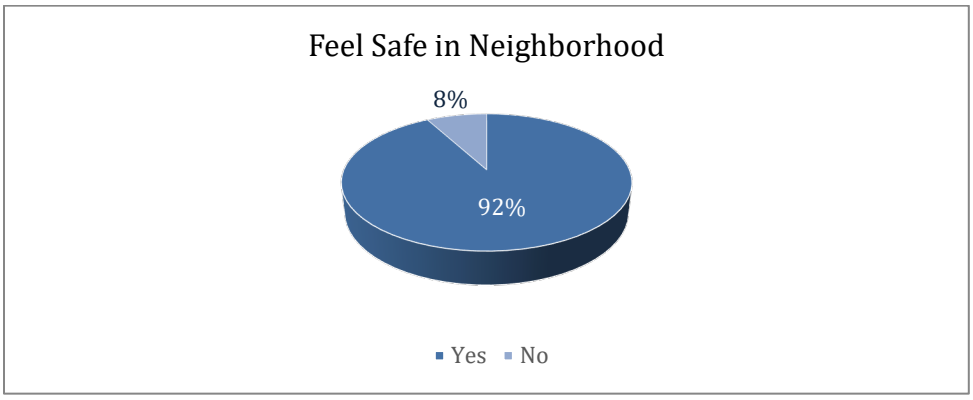

Survey Race
90%
6%
2%
2%
White
Black
Latino
Multirace

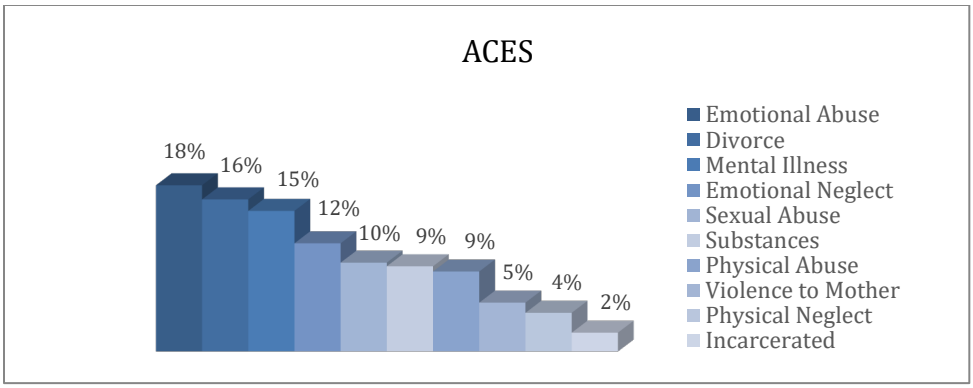

Survey Education
1%
2%
14%
17%
12%
5%
29%
20%
Less than High School
Some High School
High School
Some College
Associate's Degree
Certificate
Bachelor's Degree
Graduate Degree


Survey Living Arrangements
3%
10%
87%
Homeless
Have Housing, Worried
Have Housing, Not Worried


Number of People in Household
36%
16%
17%
15%
10%
6%
1
2
3
4
5
6 or more


Feel Safe Where Living
2%
98%
Yes
No


Feel Safe in Neighborhood
8%
92%
Yes
No


ACES
18%
16%
15%
12%
10%
9%
9%
5%
4%
2%
Emotional Abuse
Divorce
Mental Illness
Emotional Neglect
Sexual Abuse
Substances
Physical Abuse
Violence to Mother
Physical Neglect
Incarcerated

APPENDIX 6: RESOURCE MATRIX

	Health Departments			Education	Health Care Organizations					Community Organizations
Issue Statements	Peoria County	Tazewell County	Woodford County	UICOMP	Carle Eureka Hospital	OSF Saint Francis Medical Center	Carle Health Pekin Hospital	Carle Health Methodist Hospital	Carle Health Proctor Hospital	Heart of Illinois United Way
The high cost of nutritious food limits consumption and contributes to food insecurity among low-income populations	S3, T3	S3, T3	S2, T2	S2, T2	S1, T1	S3, T3	S2, T2	S2, T2	S2, T2	S3, T1
Increased availability of nutritious foods through strengthening & aligning of resources & services across the Tri-County food system	S3, T3	S3, T3	S3, T3	S2, T2	S2, T1	S3, T3	S2, T2	S2, T2	S2, T2	S3, T1
During school closures, youth experience significant food insecurity, with over 2 million meals missed, highlighting the critical role of school-based nutrition programs	S3, T3	S3, T3	S3, T3	S1, T2	S1, T1	S3, T3	S2, T2	S2, T2	S2, T2	S3, T1
Improve knowledge to navigate the behavioral health system	S3 T3	S2, T2	S2, T3	S3, T2	S2, T2	S3, T3	S3, T3	S3, T3	S3, T3	S3, T1
Decrease suicidal thoughts/behaviors and self-harm related admissions for adolescents and young adults	S3, T3	S2, T2	S2, T3	S3, T1	S3, T3	S3, T3	S3, T3	S3, T3	S3, T3	S3, T1

*Note: S - indicates strategic focus, T- indicates tactical focus
(1) = low; (2) = moderate; (3) = high, in terms of degree to which the need is being addressed

	Health Departments			Education	Health Care Organizations					Community Organizations
Issue Statements	Peoria County	Tazewell County	Woodford County	UICOMP	Carle Eureka Hospital	OSF Saint Francis Medical Center	Carle Health Pekin Hospital	Carle Health Methodist Hospital	Carle Health Proctor Hospital	Heart of Illinois United Way
Increase access to behavioral health care for youth and those with low income	S3, T3	S2, T2	S2, T2	S3, T2	S2, T2	S3, T3	S3, T3	S3, T3	S3, T3	S3, T1
Increase the proportion of pregnant women who receive early and adequate prenatal care	S2, T2	S2, T2	S2, T2	S3, T3	S1, T1	S3, T3	S3, T3	S3, T3	S3, T3	S3, T1
Reduce emergency department as choice of medical care for non-emergent issues	S2, T2	S2, T2	S2, T1	S1, T1	S3, T3	S3, T3	S3, T2	S3, T2	S3, T2	S3, T1
Increase the proportion of people that routinely engage with primary care provider/services	S2, T2	S2, T2	S2, T1	S1, T1	S3, T3	S3, T3	S3, T3	S3, T3	S3, T3	S3, T1
Navigation of healthcare system and resources specifically among; AA/Black, Males, Rural Residents, and Individuals 65+ years old	S2, T2	S2, T2	S2, T2	S2, T3	S3, T3	S3, T3	S3, T2	S3, T2	S3, T2	S3, T1

APPENDIX 7: DESCRIPTION OF COMMUNITY RESOURCES

HEALTH DEPARTMENTS

Peoria City/County Health Department

The goal of the Peoria City/County Health Department is to protect and promote health and prevent disease, illness and injury. Public health interventions range from preventing diseases to promoting healthy lifestyles and from providing sanitary conditions to ensuring safe food and water.

Tazewell County Health Department:

The Tazewell County Health Department promotes and protects the public's health and wellbeing through programs targeting the following concerns: dental, emergency planning, environmental, health promotion, MCH/WIC, nursing, and concerns for the 21st century.

Woodford County Health Department

The Woodford County Health Department sponsors programs in the following areas: maternal and child health, infectious diseases, environmental health, health education, and emergency preparedness.

EDUCATIONAL INSTITUTIONS

University of Illinois College of Medicine Peoria

The University of Illinois College of Medicine Peoria (UICOMP) is one of three campuses that make up the nation's largest public medical school. The Peoria campus is known among students for its small class sizes, rigorous curriculum and faculty mentorship. Residents and fellows know us for our large referral base and exceptional facilities. Physicians come to the Peoria campus seeking the ideal combination of teaching and clinical practice in a research-based university setting.

HOSPITAL/CLINICS

Carle Eureka Hospital

Carle Eureka Hospital has served and cared for the people of central Illinois for over 120 years. A 25-bed, Critical Access hospital located in Eureka, IL, we've set new standards for what a rural hospital can achieve. With many awards for quality and patient satisfaction, our skilled staff provides emergency care, inpatient and outpatient surgeries, rehabilitation, advanced radiology and more.

Carle Health Pekin Hospital

Carle Health Pekin Hospital, an 85-bed facility in Pekin, IL, is part of Carle Health, a vertically integrated system with a bold but simple mission: to be the trusted partner in all healthcare decisions for everyone who depends on it. Always focused on its North Star – providing the best care possible for patients – Carle Health Pekin is driven by a deep philanthropic spirit to solve real-world health issues now and into the future. The hospital and its campus are home to an emergency department, physical rehabilitation services, state-of-the-art radiology imaging, the Women's Diagnostic Center and surgery services. Carle Health Pekin holds a Magnet® designation, the nation's highest nursing honor.

Carle Health Methodist Hospital
Carle Health Methodist Hospital, a 310-bed facility in Peoria, IL, is part of Carle Health, a vertically integrated system with a bold but simple mission: to be the trusted partner in all healthcare decisions for everyone who depends on it. Always focused on its North Star – providing the best care possible for patients – Carle Health Methodist is driven by a deep philanthropic spirit to solve real-world health issues now and into the future. It's the only hospital in central Illinois to be certified a Baby Friendly Hospital. It's also the regional leader in behavioral health services through its Trillium Place affiliate and is a Level II Trauma Center. Carle Health Methodist holds a Magnet® designation, the nation's highest nursing honor.

Carle Health Proctor Hospital
Carle Health Proctor Hospital, a 205-bed facility in Peoria, IL, is part of Carle Health, a vertically integrated system with a bold but simple mission: to be the trusted partner in all healthcare decisions for everyone who depends on it. Always focused on its North Star – providing the best care possible for patients – Carle Health Proctor is driven by a deep philanthropic spirit to solve real-world health issues now and into the future. It offers the only behavioral health facility in the region designed for older adults and has the state-of-the-art Outpatient Dialysis Center and Burklund Cardiopulmonary Rehabilitation Center. Carle Health Proctor holds a Magnet® designation, the nation's highest nursing honor

OSF Healthcare Saint Francis Medical Center
OSF HealthCare Saint Francis Medical Center, with 642 beds, is the fifth-largest medical center in Illinois. A major teaching affiliate of the University of Illinois College of Medicine at Peoria, it is the area's only Level I Trauma Center, the highest level designated in trauma care. It serves as the resource hospital for emergency medical services for northcentral Illinois. It is home to OSF Children's Hospital of Illinois and the OSF Illinois Neurological Institute. OSF Saint Francis Medical Center and Children's Hospital have been designated Magnet Status for excellence in nursing care since 2004.

COMMUNITY AGENCIES

Heart of Illinois United Way
The Heart of Illinois United Way brings together people from business, labor, government, health and human services to address community's needs. Money raised through the Heart of Illinois United Way campaign stays in community funding programs and services in Marshall, Peoria, Putnam, Stark, Tazewell and Woodford Counties.

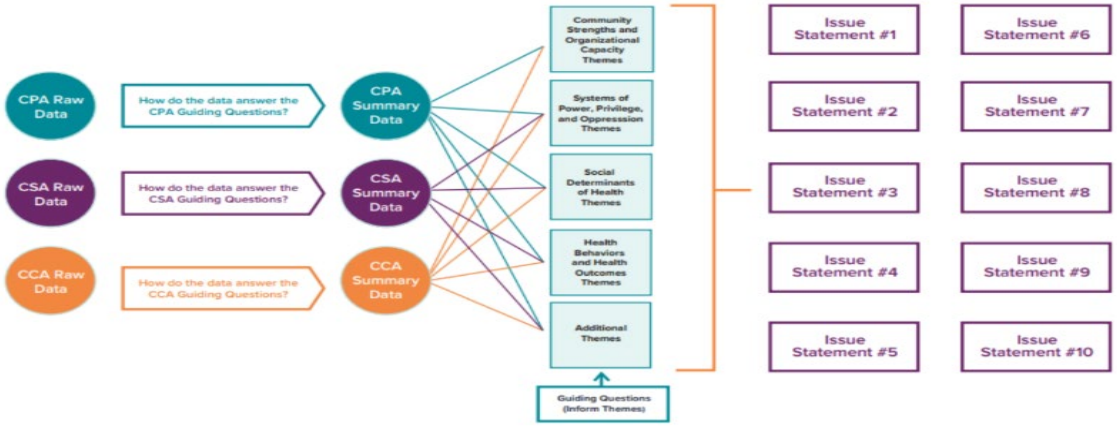
APPENDIX 8: PRIORITIZATION METHODOLOGY

MAPP 2.0 Community Context Assessment

Background and Framework

The Partnership for a Healthy Community (PFHC) utilized the MAPP 2.0 (Mobilizing for Action through Planning and Partnerships) framework to guide its community health needs assessment and prioritization process. Developed by the National Association of County and City Health Officials (NACCHO), MAPP 2.0 is a community-driven strategic planning tool designed to achieve health equity by addressing the most pressing population health issues. It emphasizes inclusive stakeholder engagement, policy and systems change, and the alignment of community resources toward shared goals.

Figure 117 MAPP 2.0 process developed by NACCHO



To inform this process, the PFHC conducted three core assessments: Community Status Assessment (CSA), Community Context Assessment (CCA), and Community Partner Assessment (CPA). These assessments were supplemented with a variety of public health surveillance data to identify emerging

trends and issues impacting community health and well-being. The data encompassed health behaviors, chronic disease prevalence, social determinants of health, and health inequities, as well as systemic factors such as power, privilege, and oppression that influence health outcomes in the Tri-County region of Central Illinois.

Purpose of the Prioritization Process

The MAPP 2.0 framework provided a structured approach for the PFHC to:
- Assess Health Issues: Identify the most pressing health concerns using both quantitative and qualitative data.
- **Align Resources**: Discuss efforts and resources across sectors that could be used to address these concerns.
- **Strategic Action**: Discuss relationships among these issues and identify programs where capacity to address these issues is possible in the Tri-County region. Develop and implement effective strategies to improve community health outcomes.

Identifying Issue Statements

The PFHC Board led the process of identifying issue statements through a series of structured sessions. These sessions involved reviewing raw data and summarizing key health issues affecting the Tri-County region. The Hanlon Method for Prioritizing Health Problems was used to guide this process. This method is widely recognized in public health for its systematic approach to evaluating and ranking health issues.

A critical component of the Hanlon Method is the PEARL criteria, which serve as a preliminary screening tool. Each potential issue was evaluated based on the following:

- ***Propriety*** *– Is the issue appropriate for public health intervention?*
- ***Economics*** *– Are there significant economic consequences if the issue is not addressed?*
- ***Acceptability*** *– Will the community and stakeholders support addressing the issue?*
- ***Resources –*** *Are sufficient resources available to address the issue?*
- ***Legality –*** *Is it legally feasible to address the issue?*
- *Issues that did not meet all PEARL criteria were excluded from further consideration.*

As part of the comprehensive prioritization process, the PFHC applied the PEARL method, a key component of the Hanlon Method for Prioritizing Health Problems, to systematically evaluate a broad list of community health issues. The PEARL criteria—Propriety, Economics, Acceptability, Resources, and Legality—served as a screening tool to determine whether each issue was appropriate and feasible for public health intervention. This method was used to assess issues across four primary domains: food insecurity, behavioral health, healthcare access and quality, and preventative care. Each potential issue was reviewed to ensure it met all five PEARL criteria; those that did not were excluded from further consideration. Through this structured and evidence-based approach, the PFHC narrowed the comprehensive list to a final set of 10 issue statements that were deemed both impactful and actionable. (See APPENDIX 9: ADDITIONAL INFORMATION FOR PRIORITIZATION for the full list of issues considered.)

Community Engagement and Voting Process

Following the identification of 10 issue statements across three emerging domains. Seven key entities participated in a series of meetings to review and provide feedback. During these sessions, attendees were able to score and rate these issues using Hanlon method. The following table describes the voting entities and meeting dates for this voting process.

Table 6

Name of entity	**Date of meeting(s)**
Carle Health	June 12
Community Conversations Group	May 22
OSF	June 2
PFHC Board/Action Teams	June 12
Peoria City/County Health Department	May 20, June 2, June 5
Tazewell County Health Department	June 3, June 11
Woodford County Health Department	May 20, June 3

Scoring and Final Prioritization

Each of these entities (n=7) voted on each of the 10 issue statements. The Hanlon scoring method was applied to each of the 10 issue statements. This method evaluates issues based on:

- *Size of the problem*
- *Seriousness of the problem*
- *Effectiveness of the intervention*

Each category was scored on a scale from 1 to 10. The average scores were calculated, and standard deviations were analyzed to ensure that outliers did not disproportionately influence the results. These scores were compiled from all seven participating entities, each of which independently evaluated the issue statements. The collective scoring allowed for a balanced and representative assessment of community priorities. Based on this analysis, the issues that ranked as the **highest priority** and **lowest priority** were determined by the aggregated scores across all entities, ensuring that the final prioritization reflected a consensus-driven and data-informed process.

Scores for the 10 Issue Statements for Each Voting Entity

Scores for the Tri-County region are provided in the table below which also depicts the average score using Hanlon method to calculate these scores for each of the issue statements. The following table provides the calculations for the voting entities across each of the 10 issue statements.

	ISSUE 1	ISSUE 2	ISSUE 3	ISSUE 4	ISSUE 5	ISSUE 6	ISSUE 7	ISSUE 8	ISSUE 9	ISSUE 10	AVERAGE	SD
PEORIA	129.3	126	146.4	128.5	143.8	137.2	129.2	96.3	100.8	129.5	126.7	16.4
TAZEWELL	130	136.5	167.4	141.6	162.5	161	104.3	94.3	116.3	112.3	132.62	25.7
WOODFORD	87.9	103	111.6	99.6	114.7	105.2	89.2	96.9	81.2	95.9	98.52	10.6
OSF SFMC	112	150	156	138	125	161	160	154	147	105	140.8	20.2
CARLE WEST	37.1	61.7	53.1	300	183.6	289.1	143.2	160.9	242.5	196.6	166.78	94.9
PARTNERSHIP	126.3	121.4	141.3	166.4	171	177.7	131.7	109.7	113.6	132.1	139.12	24.4
CCG	115.4	144.6	161.4	105.8	182.4	168.8	110.8	116.4	91.6	111.4	130.86	30.9
AVERAGE FOR EACH ISSUE STATEMENT	105.4	120.5	133.9	154.3	154.7	171.4	124.1	118.4	127.6	126.1	126.7	16.4

Abbreviations: CCG: Community Conversation Group, SD: standard deviation

Of note, OSF Saint Francis Medical Center requested that Mission Partners rank each issue statement for size of problem, seriousness, and effectiveness of interventions. Mission Partner rankings were collected and averaged. Any outlying ranking was removed from the average. On June 2, the issue statements and average rankings were reviewed at OSF Social Drivers of Health Steering Committee Meeting. Final rankings for submission were determined by the Committee.

Following discussion among all seven voting entities, Issue Statements 4 and 6 were merged into a single issue due to their strong interconnectedness and the consistently high scores they received across the partnership. This decision reflects a shared understanding that addressing these issues together would lead to more effective and coordinated community health strategies.

Final Priority Areas

Through group discussion and analysis of the scoring data, the PFHC identified the following top three priority areas:
Issue 1. Reduce food insecurity among youth
Issue 2. Increasing access to behavioral health services by improving navigation of services
Issue 3. Decreasing suicidal thoughts and behaviors among adolescents and young adults

These priorities will guide the next phase of strategic planning and intervention development for the Tri-County region.

National Target Data

Issue 1: Healthy People 2030 aims to increase the proportion of primary care visits where adolescents and adults are screened for depression. In addition, Healthy People 2030 aims to increase the proportion

of people with serious mental illness who receive treatment as well. The objectives aim to improve navigation and reduce barriers in order to improve early identification and access to services.

Issue 2: Healthy People 2030 aims to reduce the suicide mortality rate to 12.8 per 100,000. Of note, this is a *Leading Health Indicator*, reflecting the importance in national health priorities as well.

Issue 3: Healthy People 2030 aims to reduce household food insecurity and huger and eliminate very low food security in children. These objectives aims to ensure children and adolescents have consistent access to nutritious food, which is essential for growth, development, and academic performance.

APPENDIX 9: ADDITIONAL INFORMATION FOR PRIORITIZATION

As part of the MAPP 2.0 process, data were analyzed to identify key areas of concern using five guiding elements: (1) community strengths and organizational capacity, (2) systems of power, privilege, and oppression, (3) social drivers of health, (4) health behaviors and outcomes, and (5) additional themes such as health literacy. Each area of concern was evaluated across these elements to ensure a comprehensive and equity-informed assessment.

Following a series of structured data analysis sessions conducted by the Partnership for a Healthy Community (PFHC), ten priority issue statements were identified. These issues reflect key health and social challenges across the Tri-County area, including food insecurity, behavioral health access, prenatal care, and healthcare system navigation.

The following pages are summary documents developed for each issue and distributed to PFHC member entities, who then scored them using the Hanlon method to guide prioritization and strategic planning.

- *Food insecurity among low-income populations due to high cost*
- *Access to healthy food and resources*
- *Food insecurity among youth*
- *Navigating the behavioral health system*
- *Suicide and self-harm among youth and young adolescents*
- *Access to behavioral health resources among youth and those with low-income*
- *Early and adequate prenatal care*
- *Emergency department use for medical care that is non-emergent*
- *Engagement with primary care providers for routine visits*
- *Navigating healthcare system and resources specifically among; AA/Black, males, rural residents, and individuals 65+ years old*

PARTNERSHIP FOR HEALTHY COMMUNITIES ISSUE STATEMENTS 2025

SCORING HEALTH ISSUE STATEMENTS

To evaluate health issues systematically, score each issue statement across three categories: Size, Seriousness, and Effectiveness of Intervention. Assign a score from 1 to 10 for each category based on the criteria provided.

Size of the Problem: assess the proportion of the population affected:

- Score 1: Less than 1% affected, Score 10: More than 50% affected

Seriousness of the Problem: evaluate the severity of the issue based on the impact on quality of life, mortality or morbidity rates, economic or social burden

- Score 1: Minimal impact (e.g., mild symptoms, low cost), Score 10: Severe disability, high mortality, or economic burden

Effectiveness of Intervention: consider the strength and feasibility of available interventions

- Score 1: Little or no evidence of effectiveness, Score 10: Strong evidence from systematic reviews or randomized controlled trials, with high feasibility and community acceptance

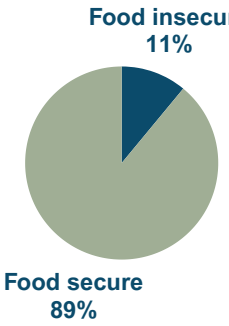
Health Issue Statements Matrix

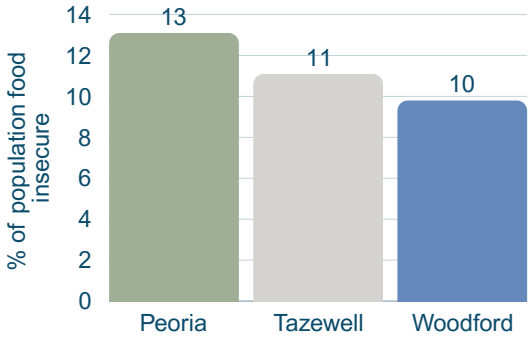
Issue statement	Size (1-10)	Seriousness (1-10)	Effectiveness (1-10)
The high cost of nutritious food limits consumption and contributes to food insecurity among low-income populations			
Increased availability of nutritious foods through strengthening & aligning of resources & services across the Tri-County food system			
During school closures, youth experience significant food insecurity, with over 2 million meals missed, highlighting the critical role of school-based nutrition programs			
Improve knowledge to navigate the behavioral health system			
Decrease suicidal thoughts/behaviors and self-harm related admissions for adolescents and young adults			
Increase access to behavioral health care for youth and those with low income			
Increase the proportion of pregnant women who receive early and adequate prenatal care			
Reduce emergency department as choice of medical care for non-emergent issues			
Increase the proportion of people that routinely engage with primary care provider/services			
Navigation of healthcare system and resources specifically among; AA/Black, Males, Rural Residents, and Individuals 65+ years old			

THE HIGH COST OF NUTRITIOUS FOOD LIMITS CONSUMPTION AND CONTRIBUTES TO FOOD INSECURITY AMONG LOW-INCOME POPULATIONS

Partnership for a Healthy Community

41,387 TRI-COUNTY RESIDENTS ARE FOOD INSECURE





Community Status Assessment

- The most common reasons for not eating more fruits/vegetables were the lack of importance, dislike, and affordability of them.
- Those who were younger, had lower household income, and unstable housing less often reported consumption of healthy fruits/vegetables.
- Increase in people who experience hunger 1-2 days per week (3% to 6% between 2022-2025).
- Hunger was higher for Black residents and those reporting lower household income or unstable housing.

Community Context Assessment

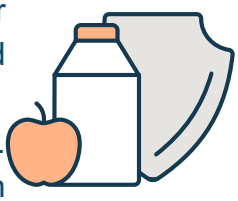
- Unhealthy eating is often due to cost/convenience/lack of access
- LGBTQ+, men, maternal health, youth, and minority groups cited that poor eating is driven by poverty and living in food deserts.
- Low-income population would like more places to get a good, hot meal
- Seniors, low-income, and minority groups noted that limited access to healthy and fresh produce leads to a reliance on processed or fast foods

Community Partner Assessment

- Food access and affordability are one of the main issues addressed by the organizations in the community (67%).

Programs that improve access to healthy food among low-income populations:

Fresh fruit and vegetable programs: focus on providing fresh produce at discounted rates or through subsidies, which include farmers' markets that accept food assistance benefits and mobile markets that bring fresh produce to low-income neighborhoods. [1]



Community food stores: focus on increasing access to healthy food has been effective. These stores often provide affordable, nutritious options and are strategically located in underserved areas.[2]

Education and behavioral prevention programs: focus on educating individuals about nutrition and healthy eating habits, which include cooking classes and nutrition workshops. [1]

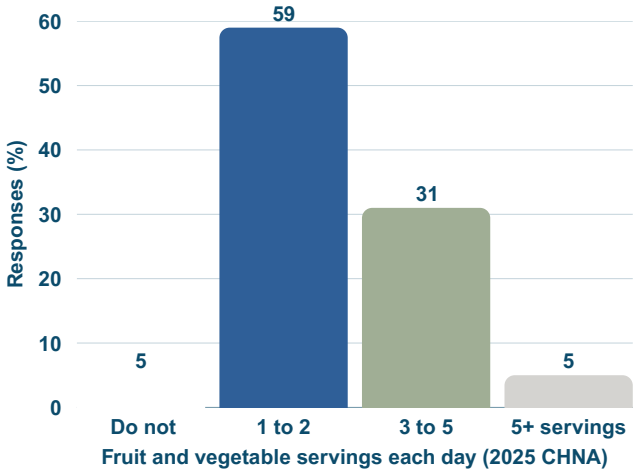
REFERENCES:

1. Emmanuel Ezekekwu, Sonali S. Salunkhe, J'Aime C. Jennings & Brandy N. Kelly Pryor (2021): Community-Based and System-Level Interventions for Improving Food Security and Nutritious Food Consumption: A Systematic Review, Journal of Hunger & Environmental Nutrition, DOI: 10.1080/19320248.2021.2021120
2. Gittelsohn, J., Kasprzak, C. M., Hill, A. B., Sundermeir, S. M., Laska, M. N., Dombrowski, R. D., ... & Leone, L. A. (2022). Increasing healthy food access for low-income communities: Protocol of the Healthy Community Stores Case Study project. International journal of environmental research and public health, 19(2), 690.
3. Feed America. (2024, January 15). The 2024 USDA food security report: An alarming rise in hunger. Feed America. https://www.feedam.org/blog-posts/the-2024-usda-food-security-report-an-alarming-rise-in-hunger
4. Economic Research Service. (2025, January 8). Food security in the U.S. - Key statistics & graphics. U.S. Department of Agriculture. https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/key-statistics-graphics

INCREASED AVAILABILITY OF NUTRITIOUS FOODS THROUGH STRENGTHENING & ALIGNING OF RESOURCES ACROSS THE TRI-COUNTY FOOD SYSTEM

Partnership for a Healthy Community

64% OF RESIDENTS REPORT LOW OR NO CONSUMPTION OF FRUIT OR VEGETABLES EACH DAY



Community Status Assessment

- The most common reasons for not eating more fruits/vegetables were the lack of importance, dislike, and affordability of them.

Community Context Assessment

- LGBTQ+, men, maternal health, youth, and minority groups cited that poor eating is driven by poverty and living in food deserts.
- Unhealthy eating often due to cost/convenience/lack of access.
- Low-income populations would like more places to get a good hot meal.

Community Partner Assessment

- Food access and affordability are one of the main issues addressed by the organizations in the community (67%).

Consumption of fruits and vegetables tends to be more likely for women, older people, those with higher education, and those with higher income. Consumption of fruits and vegetables tends to be less likely for those with an unstable housing environment.

Providing comprehensive resources in the community through partnership and alignment of resources can reduce food insecurity in a variety of ways. Examples of strategies that work in communities include food pharmacies, partnerships with local stores, vouchers for healthy foods, as well as upstream factors such as affordable housing or reliable transportation. [1-2]

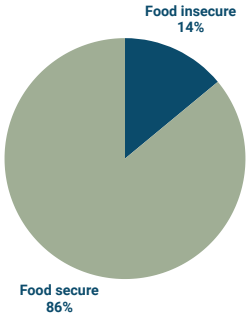
REFERENCES:

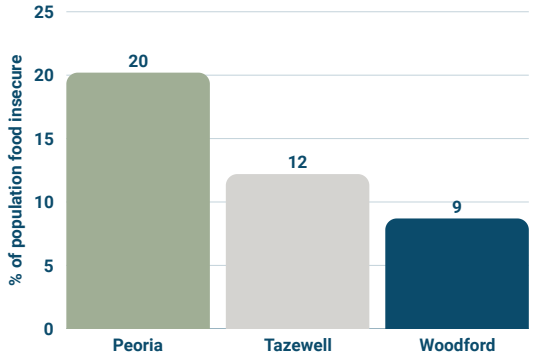
1. 1.O'Connor, E. A., Webber, E. M., Martin, A. M., Henninger, M. L., Eder, M. L., & Lin, J. S. (2025). Preventive services for food insecurity: evidence report and systematic review for the US Preventive Services Task Force. JAMA.
2. 2.De Marchis, E. H., Torres, J. M., Benesch, T., Fichtenberg, C., Allen, I. E., Whitaker, E. M., & Gottlieb, L. M. (2019). Interventions addressing food insecurity in health care settings: a systematic review. The Annals of Family Medicine, 17(5), 436-447.

DURING SCHOOL CLOSURES, YOUTH EXPERIENCE SIGNIFICANT FOOD INSECURITY, HIGHLIGHTING THE CRITICAL ROLE OF SCHOOL-BASED NUTRITION PROGRAMS

Partnership for a Healthy Community

12,751 TRI-COUNTY YOUTH ARE FOOD INSECURE





Community Status Assessment

- Those who were younger, had lower household income, and unstable housing less often reported consumption of healthy fruits/vegetables..
- The most common reasons for not eating more fruits/vegetables were the lack of importance, dislike, and affordability of them

Community Context Assessment

- Youth report skipping meals or choose unhealthy options due to lack of time and money

Community Partner Assessment

- Approximately half of the organizations reported food insecurity (through economic stability and built environment) as an issue that they focus much of their effort.

Programs that improve food insecurity among youth:

Food banks and pantries: providing immediate food assistance to families in need is essential in reducing food insecurity among youth, especially when they collaborate with schools and local agencies to reach food-insecure youth

Mobile markets: these types of community interventions focus on bringing fresh produce to underserved areas, which improves food insecurity among youth

Universal free meals: policy interventions that provide free meals in schools reduce stigma and ensure all children have access to nutritious meals, which have been shown to have positive impacts on food outcomes, along with academic outcomes

Partnerships with local stores: focus on building capacity among corner stores to include healthy foods can improve food insecurity among youth

REFERENCES:

1. Holley, C. E., & Mason, C. (2019). A systematic review of the evaluation of interventions to tackle children's food insecurity. Current nutrition reports, 8, 11-27.
2. Engelhard E, Hake M. Food Security Evidence Review. Feeding America. August 2020. Available at: https://www.feedingamerica.org/sites/default/files/2020-12/Food%20Security%20Evidence%20Review%20August%202020.pdf. Accessed May 9, 2025.

IMPROVE KNOWLEDGE TO NAVIGATE THE MENTAL AND BEHAVIORAL HEALTH SYSTEM

Partnership for a Healthy Community

61,111 ADULTS IN THE TRI-COUNTY REGION HAD A MENTAL HEALTH ISSUE IN PAST YEAR

23% of adults have experienced a mental health issue in the past year (2023 NSDUH)

Community Status Assessment

- Only ~51% of respondents talked with someone about their mental health in the past year.
- Mental healthcare access limited by counselors refusing to take insurance and in Tazewell difficulty to find counselors.
- Mental health providers are in greater need in the Tri-County region compared to state and national estimates.

Community Context Assessment

- Extremely long wait times for mental healthcare, especially with Medicaid.
- Minority groups reported a need for support navigating healthcare systems and resources in the community.

Community Partner Assessment

- Healthcare access/utilization are top issues addressed by organization in the community (72%).
- Communication and education are one of the most common activities reported by organizations in the PFHC (78%).

Programs that improve knowledge to navigate the mental and behavioral health system:[1]

Community outreach programs: focus on engaging community members by raising awareness about behavioral health services and how to access them, leveraging partnerships and local organizations.

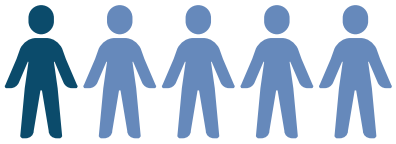
Patient navigation programs: focus on utilizing trained navigators who assist individuals in understanding and accessing health services needed

Integrated care models: focus on integrating behavioral health in primary care settings to support comprehensive care

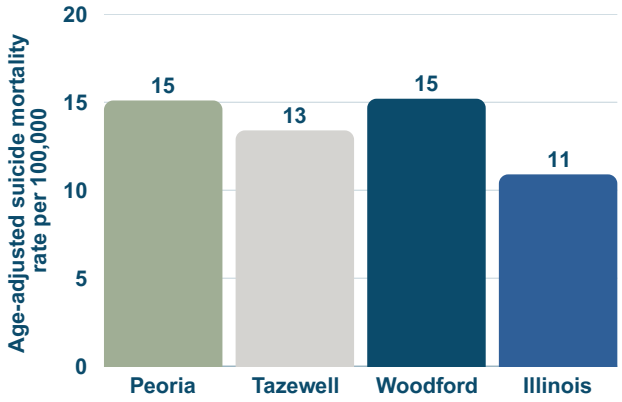
REFERENCES:
1. Mullen, J. N., Levitt, A., & Markoulakis, R. (2023). Supporting individuals with mental health and/or addictions issues through patient navigation: a scoping review. Community Mental Health Journal, 59(1), 35-56.

DECREASE SUICIDAL THOUGHTS/BEHAVIORS AND SELF-HARM RELATED ADMISSIONS FOR ADOLESCENTS AND YOUNG ADULTS

Partnership for a Healthy Community



20% OF HIGH SCHOOL STUDENTS HAVE SERIOUSLY CONSIDERED ATTEMPTING SUICIDE IN THE PAST YEAR (2023 YRBSS)



Community Status Assessment

- Suicide mortality rate in the Tri-County region is higher than state.

Community Context Assessment

- Low-income population and youth cited self-medication as a treatment for unmanaged mental health issues.
- Low-income population reported high levels of stigma and an overall lack of mental health treatment which contributes to accessing preventive care and other issues (i.e. substance use).

Community Partner Assessment

- Mental/behavioral health was one of the top topics that organizations specifically stated they were working on in the region (67%).

Programs that decrease suicidal thoughts/behaviors and self-harm behaviors among adolescents and young adults:[1-4]

Community awareness campaigns: focus on raising awareness about mental health and suicide prevention by focusing on reducing stigma and encouraging help-seeking. These campaigns can be done through community events, social media campaigns, and public service announcements (PSAs)

Cognitive-Behavioral Therapy (CBT): providing CBT which is a structured, evidence-based therapy that helps individuals identify and change negative thought patterns and behaviors. CBT can help underlying issues such as depression and/or anxiety that are often linked to suicide/self-harm

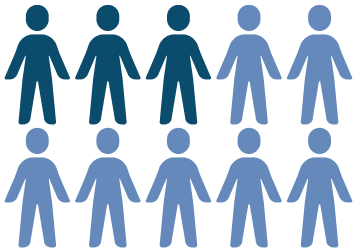
Peer support programs: focus on the influence of peers to provide support and promote positive coping strategies, resulting in a sense of belonging and understanding

REFERENCES:

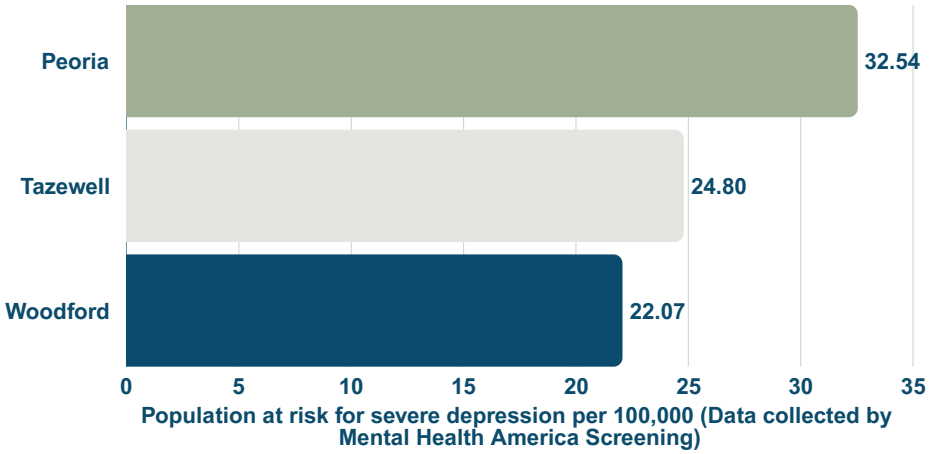
1. Aoun, J., Spodenkiewicz, M., & Marimoutou, C. (2024). Scoping review on prevention of suicidal thoughts and behaviors in adolescents: methods, effectiveness and future directions. Frontiers in child and adolescent psychiatry, 3, 1367075.
2. Schlichthorst, M., Ozols, I., Reifels, L., & Morgan, A. (2020). Lived experience peer support programs for suicide prevention: A systematic scoping review. International journal of mental health systems, 14, 1-12.
3. Büscher, R., Torok, M., Terhorst, Y., & Sander, L. (2020). Internet-based cognitive behavioral therapy to reduce suicidal ideation: a systematic review and meta-analysis. JAMA network open, 3(4), e203933-e203933.
4. Tarrier, N., Taylor, K., & Gooding, P. (2008). Cognitive-behavioral interventions to reduce suicide behavior: a systematic review and meta-analysis. Behavior modification, 32(1), 77-108

INCREASE ACCESS TO BEHAVIORAL HEALTH CARE FOR YOUTH AND THOSE WITH LOW INCOME

Partnership for a Healthy Community



30% of adults had unmet mental health treatment in the past year (2023 NSDUH)



Community Status Assessment

- Worse mental health was more common among those with unstable housing environments and minority populations.
- The most common barriers for seeking mental health treatment include cost, or no coverage under insurance, limited awareness of available treatment, and transportation

Community Context Assessment

- Shortage of mental health providers
- Lack of diverse providers and overall stigma around mental health among community members

Community Partner Assessment

- Mental/behavioral health was one of the top topics that organizations specifically stated they were working on in the region (67%).
- Healthcare access/utilization are top issues addressed by organization in the community (72%).

Programs that improve access to behavioral health care for youth and those with low income:[1-2]

Awareness and anti-stigma campaigns: Interventions that focus on reducing stigma and increasing mental health literacy can improve help-seeking behavior and reduce misconceptions surrounding mental and behavioral health

Community health worker programs: utilizing trained laypersons to provide outreach and navigation for mental health services in the community can improve engagement in treatment for low-income communities

School-based programs: focus on programs that are grounded in social and emotional learning can improve emotional regulation among youth. Specific programs noted in the literature include: Positive behavioral interventions and supports (PBIS) and Cognitive Behavioral Intervention for Trauma in School (CBITS)

Integrated health care: co-locating mental health services within primary care offices can improve access to those with low-income, including families and youth in need

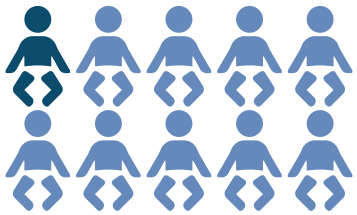
REFERENCES

1.Petersen, I., Evans-Lacko, S., Semrau, M., Barry, M. M., Chisholm, D., Gronholm, P., Egbe, C. O., & Thornicroft, G. (2016). Population and community platform interventions. In V. Patel, D. Chisholm, T. Dua, R. Laxminarayan, & M. E. Medina-Mora (Eds.), Mental, neurological, and substance use disorders: Disease control priorities (3rd ed., Vol. 4, pp. 247–263). The International Bank for Reconstruction and Development / The World Bank. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4904839/

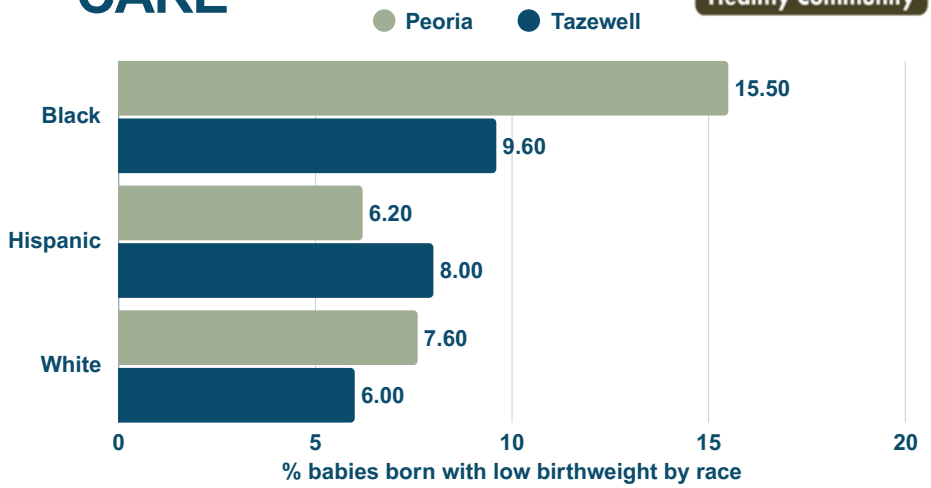
2. Mullen, J. N., Levitt, A., & Markoulakis, R. (2023). Supporting individuals with mental health and/or addictions issues through patient navigation: a scoping review. Community Mental Health Journal, 59(1), 35-56.

INCREASE THE PROPORTION OF PREGNANT WOMEN WHO RECEIVE EARLY AND ADEQUATE PRENATAL CARE

Partnership for a Healthy Community



Approximately 1 in 10 babies are born with low birth weight (2014-2020 NCHS)



Community Status Assessment

- Black youth experience higher rates of teen births in Peoria and Tazewell Counties.

Community Context Assessment

- Postpartum support was mentioned as a way to improve preventive care for maternal health (for children and adults).
- Minority populations reported perceived disparities in treatment, especially surrounding maternal health and well-being.
- Postpartum support was mentioned as a way to improve preventive care for maternal health (for children and adults).
- Maternal health populations noted not feeling comfortable talking with doctors about health issues because they give the perception of not being interested.

Community Partner Assessment

- Communication and education are one of the most common activities reported by organizations in the PFHC (78%).

Programs that improve the proportion of pregnant women who receive early and adequate prenatal care:[1-3]

Educational campaigns: focusing on campaigns that raise awareness on the importance of early and adequate prenatal care can motivate pregnant women to seek care, which can be delivered through social media, community events, and healthcare settings

Incentive programs: providing incentives for attending prenatal care can encourage pregnant women to seek early and consistent care including: transportation vouchers, childcare support, or direct financial incentives

Community health worker programs: utilizing community health workers to provide education, support, and navigation for prenatal care can improve consistent care for pregnant women

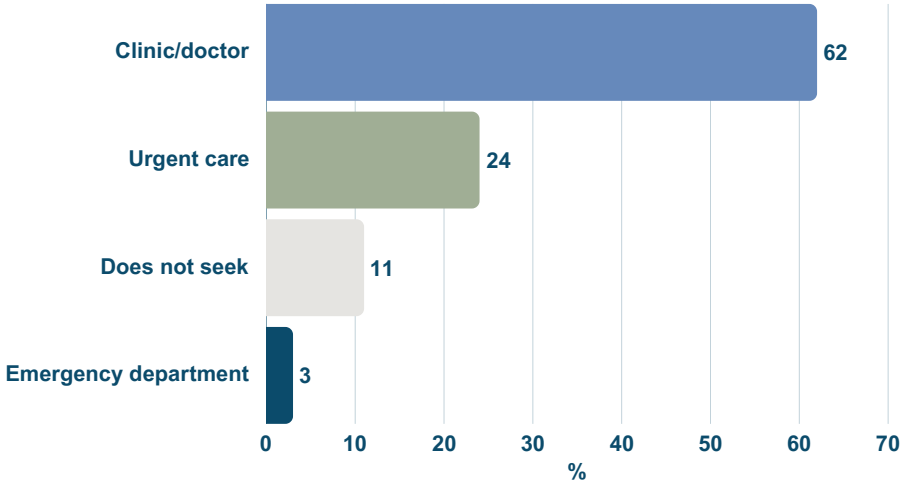
REFERENCES

1. Mzembe, T., Chikwapulo, V., Kamninga, T. M., Chikowe, I., Mamba, K. C., & Luhanga, T. (2023). Interventions to enhance healthcare utilisation among pregnant women to reduce maternal mortality in low- and middle-income countries: A review of systematic reviews. BMC Public Health, 23, 1734. https://doi.org/10.1186/s12889-023-16558-y
2. Petersen, I, S Evans-Lacko, M Semrau, M Barry, D Chisholm, and others. 2015. Population and Community Platform Interventions. In: Patel, V, D Chisholm, T Dua, R Laxminarayan, and ME Medina-Mora, editors. 2015. Mental, Neurological, and Substance Use Disorders. Disease Control Priorities, third edition, volume 4. Washington, DC: World Bank.
3. National Conference of State Legislatures. (2025, April 10). State approaches to ensuring healthy pregnancies through prenatal care. https://www.ncsl.org/health/state-approaches-to-ensuring-healthy-pregnancies-through-prenatal-care

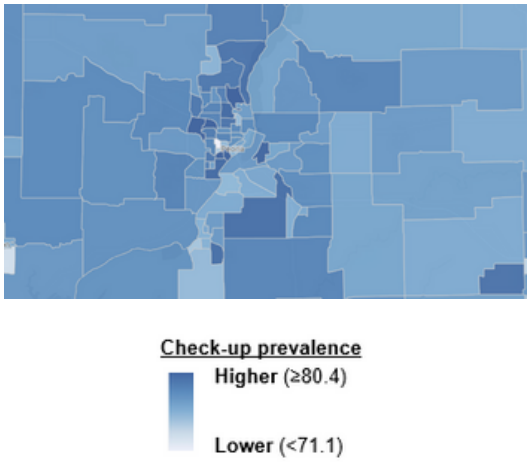
REDUCE EMERGENCY DEPARTMENT AS CHOICE OF MEDICAL CARE FOR NON-EMERGENT ISSUES

Partnership for a Healthy Community

CHOICE OF MEDICAL CARE AMONG CHNA RESPONDENTS



PREVALENCE OF ANNUAL CHECK-UP



Community Status Assessment

- Use of clinics/doctor's office decreased 5% from 2022-2025; comparatively, use of urgent care facilities and emergency departments increased by 4% and 1%, respectively.
- Black and Latino/a/x respondents along with those who experience unstable housing less often report having a personal primary care physician (PCP).

Community Context Assessment

- Lack of primary care providers was commonly reported as a reason for using emergency rooms rather than other types of healthcare access

Community Partner Assessment

- Healthcare access/utilization are top issues addressed by organizations in the community (72%).

Programs that reduce emergency department use as the choice of medical care for non-emergent issues:[1-2]

Care management partnerships: supporting partnerships that help patients who are uninsured or underinsured through community-based care management programs that connect them to primary care providers and offer personalized care plans

Transitional care programs: supporting individuals who transition from hospital to home, which provide follow-up calls and care coordination, can help reduce emergency department utilization for non-emergent issues

Hot spotting/Super-Utilizer programs: focus on targeting individuals who frequently use EDs to provide intensive case management that often addresses underlying social drivers, leading to improved care coordination

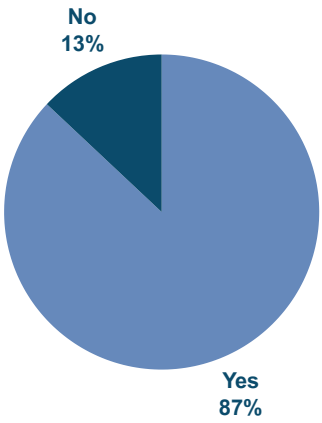
REFERENCES

1. Gurewich, D., Cabral, H. J., & McWilliams, J. M. (2024). Association of a care management program with emergency department visits and hospitalizations among Medicaid enrollees. JAMA Health Forum, 5(4), e240157. https://doi.org/10.1001/jamahealthforum.2024.0157
2. Gurewich, D., Cabral, H. J., Jones, C., & McWilliams, J. M. (2022). Association of primary care use with timely follow-up care after emergency department visits among Medicaid enrollees. JAMA Health Forum, 3(8), 222712. https://doi.org/10.1001/jamahealthforum.2022.2712

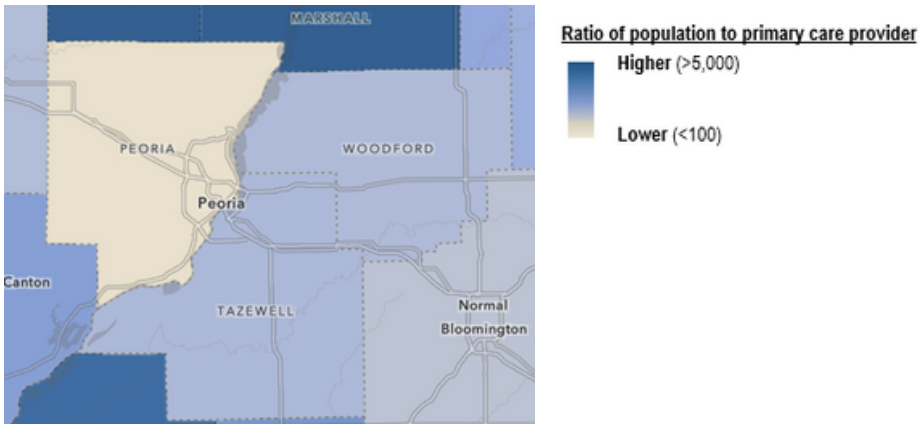
INCREASE THE PROPORTION OF PEOPLE THAT ROUTINELY ENGAGE WITH PRIMARY CARE PROVIDERS/SERVICES

Partnership for a Healthy Community

PROPORTION OF TRI-COUNTY RESPONDENTS WITH PRIMARY CARE PROVIDER



RATIO OF POPULATION TO PRIMARY CARE PROVIDER



Community Status Assessment

- 87% of residents report having a primary care provider (PCP).
- Black and Latino/a/x respondents along with those who experience unstable housing less often report having a primary care physician (PCP).
- Urgent care use is more common among younger people, those with higher education, and higher income.

Community Context Assessment

- Minority groups reported a need for support navigating healthcare systems and resources in the community.

Community Partner Assessment

- Healthcare access and quality are a main focus reported by two-thirds of the organizations in the community (67%).

Programs that increase the proportion of people who routinely engage with primary care providers/services: [1-2]

Mobile and telehealth clinics: supporting different modes for healthcare encounters, such as mobile units or virtual visits, can reduce logistical barriers

Integrated health care: co-locating mental health services within primary care offices can improve access to those with low-income, including families and youth in need

Community health worker programs: utilizing community health workers to provide education, support, and navigation for prenatal care can improve consistent care

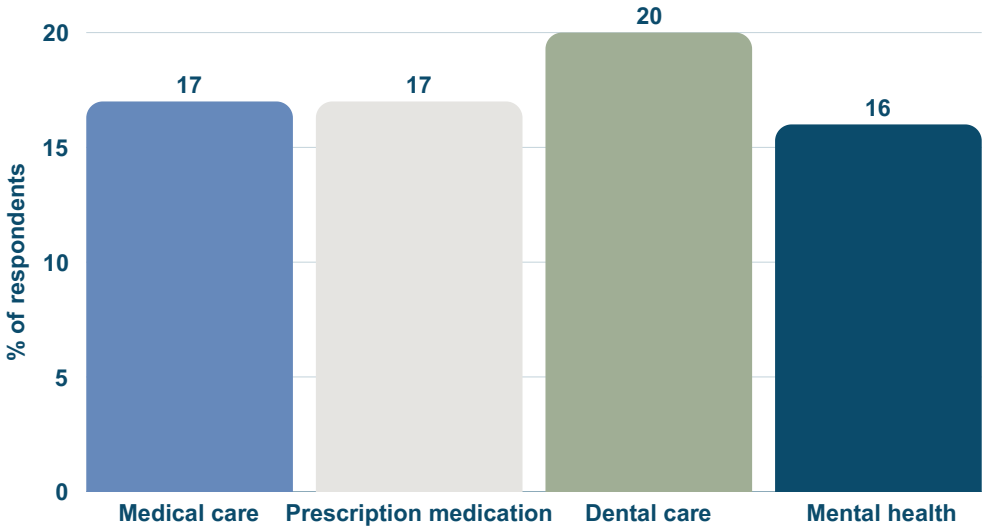
REFERENCES

1. Sommers, B. D., Blendon, R. J., Orav, E. J., & Epstein, A. M. (2023). Association of hospital incentive care management partnerships for uninsured patients with emergency department utilization. JAMA Network Open, 6(7), e2319456. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2807135
2. Verhaegh, K. J., MacNeil-Vroomen, J. L., Eslami, S., Geerlings, S. E., de Rooij, S. E., & Buurman, B. M. (2014). Transitional care interventions prevent hospital readmissions for adults with chronic illnesses. Health Affairs, 33(9), 1531–1539. https://doi.org/10.1377/hlthaff.2014.0160

NAVIGATION OF HEALTHCARE SYSTEM AND RESOURCES SPECIFICALLY AMONG; AA/BLACK, MALES, RURAL RESIDENTS, AND INDIVIDUALS 65+ YEARS OLD

Partnership for a Healthy Community

DID NOT HAVE ACCESS TO CARE IN THE PAST YEAR AMONG TRI-COUNTY RESPONENTS



Community Status Assessment

- Urgent care use is more common among younger people, those with higher education, and higher income.

Community Context Assessment

- Seniors, low income, and cancer patients often reported difficulty navigating health care coverage (e.g. providers who accept Medicaid).
- Minority groups reported a need for support navigating healthcare systems and resources in the community.

Community Partner Assessment

- Healthcare access/utilization are top issues addressed by organizations in the community (72%).

Programs that enhance navigation of healthcare system and resources: [1-2]

Community health workers and patient navigators: enhancing CHWs has been shown to improve access and navigation, particularly when tailored to address disparities

Mobile and telehealth clinics: supporting different modes for healthcare encounters, such as mobile units or virtual visits, can reduce logistical barriers

Bridge personnel: using social workers, nurses, or other trained laypersons to assist with appointment scheduling, transportation, and follow-up care can improve continuity of care, especially among those with complex health and social needs

REFERENCES

1. Sommers, B. D., Blendon, R. J., Orav, E. J., & Epstein, A. M. (2023). Association of hospital incentive care management partnerships for uninsured patients with emergency department utilization. JAMA Network Open, 6(7), e2319456. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2807135
2. Verhaegh, K. J., MacNeil-Vroomen, J. L., Eslami, S., Geerlings, S. E., de Rooij, S. E., & Buurman, B. M. (2014). Transitional care interventions prevent hospital readmissions for adults with chronic illnesses. Health Affairs, 33(9), 1531–1539. https://doi.org/10.1377/hlthaff.2014.0160
3. Alsan, M., Garrick, O., Graziani, G., & Eichmeyer, S. (2023). Disparities in health care follow-up after the emergency department visit among Black and White patients. JAMA Network Open, 6(2), e2255712. https://doi.org/10.1001/jamanetworkopen.2022.55712

PEORIA COUNTY

Partnership for a Healthy Community

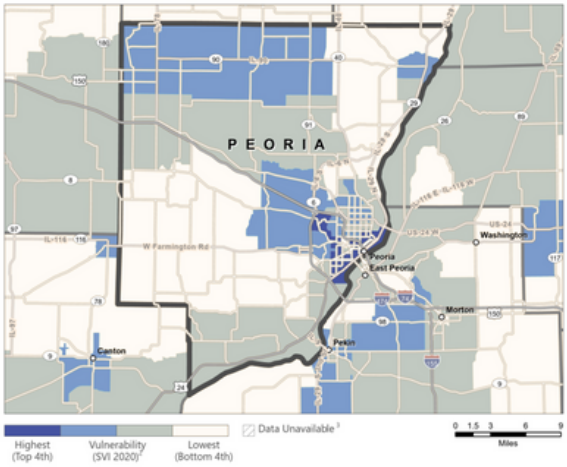
Demographic Profile

Demographic	Census	CSA respondents
Age		
Under 20 years	10.0%	1.0%
21-35 years	20.0%	21.5%
36-50 years	29.0%	28.4%
51-65 years	18.0%	27.4%
Over 65 years	23.0%	21.7%
Gender		
Male	47.2%	34.9%
Female	51.2%	63.1%
Non-binary, transgender, or other	1.6%	2.0%
Race/ethnicity		
White/Caucasian	70.1%	73.9%
Black/African American	17.6%	15.3%
Hispanic/LatinX	3.2%	4.3%
Pacific Islander	0.1%	0.6%
Native American	0.1%	0.4%
Asian/South Asian	4.5%	2.9%
Multiracial	4.4%	2.6%
Household income		
Below median household income	50.0%	46.3%
Above median household income	50.0%	53.7%
Housing instability		
% population housing problems	13.6%	14.9%

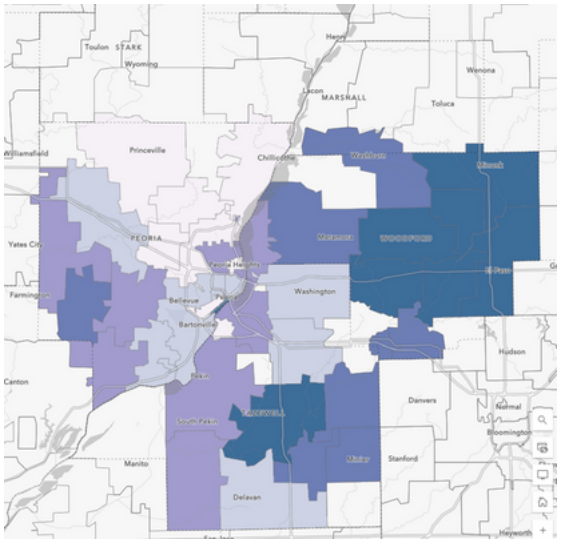
Data source: 2025 CHNA and 2022 ACS 5-Year Estimates Data Profiles,
Abbreviations: CSA; Community status assessment

Social Vulnerability Index

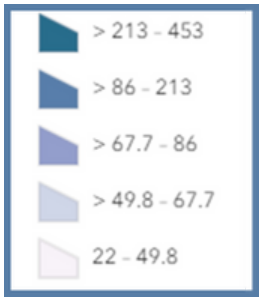
The Social Vulnerability Index (SVI) refers to the community's capacity to prepare and respond to stressful or hazardous events such as natural disasters or disease outbreaks. This comprehensive measure was developed by the CDC and is derived from 16 factors related to poverty, lack of access to transportation, and housing environment.



CSA Response Rate



RESPONSE RATE (PER 10,000)



TAZEWELL COUNTY

Partnership for a Healthy Community

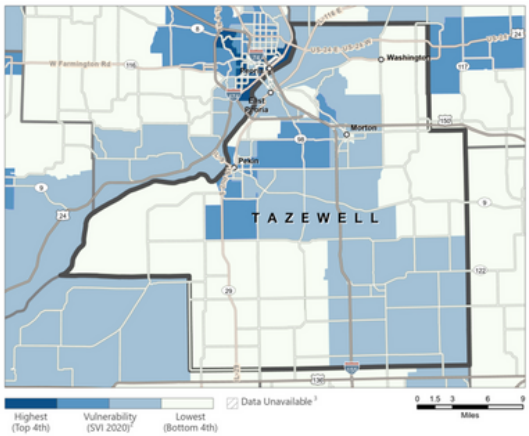
Demographic Profile

Demographic	Census	CSA respondents
Age		
Under 20 years	10.0%	1.1%
21-35 years	17.0%	18.9%
36-50 years	30.6%	33.2%
51-65 years	17.1%	25.8%
Over 65 years	25.3%	20.9%
Gender		
Male	43.0%	22.1%
Female	55.4%	75.9%
Non-binary, transgender, or other	1.6%	2.0%
Race/ethnicity		
White/Caucasian	94.4%	95.9%
Black/African American	1.2%	0.1%
Hispanic/LatinX	1.7%	1.8%
Native American	0.1%	0.5%
Asian/South Asian	1.1%	0.2%
Multiracial	1.5%	1.5%
Household income		
Below median household income	50.0%	32.9%
Above median household income	50.0%	67.1%
Housing instability		
% population housing problems	9.1%	11.1%

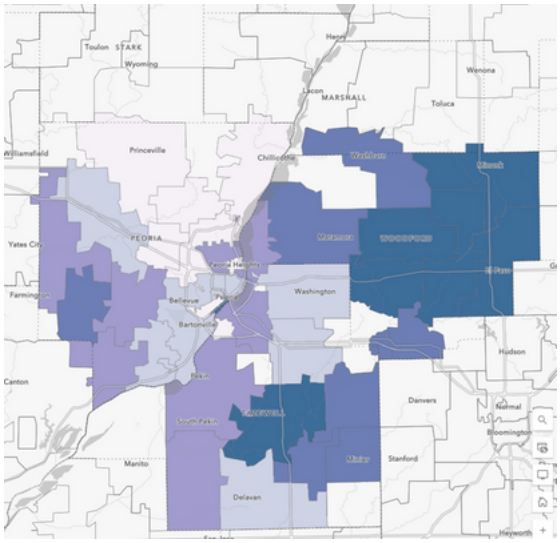
Data source: 2025 CHNA and 2022 ACS 5-Year Estimates Data Profiles,
Abbreviations: CSA; Community status assessment

Social Vulnerability Index

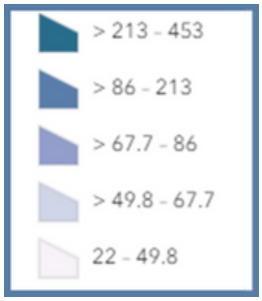
The Social Vulnerability Index (SVI) refers to the community's capacity to prepare and respond to stressful or hazardous events such as natural disasters or disease outbreaks. This comprehensive measure was developed by the CDC and is derived from 16 factors related to poverty, lack of access to transportation, and housing environment.



CSA Response Rate



RESPONSE RATE (PER 10,000)



WOODFORD COUNTY

Partnership for a Healthy Community

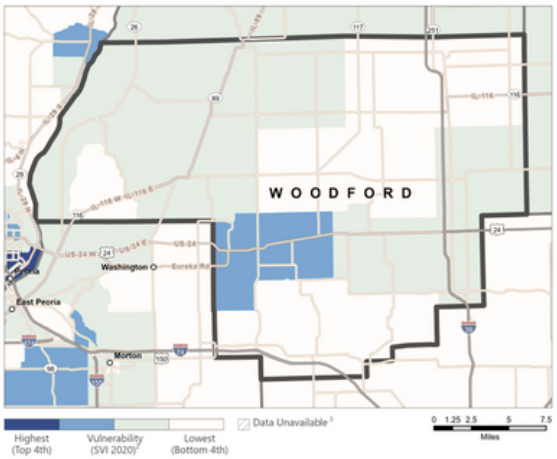
Demographic Profile

Demographic	Census	CSA respondents
Age		
Under 20 years	10.0%	3.2%
21-35 years	16.2%	13.6%
36-50 years	19.7%	23.2%
51-65 years	30.7%	27.5%
Over 65 years	23.4%	32.5%
Gender		
Male	49.4%	25.4%
Female	49.0%	72.8%
Non-binary, transgender, or other	1.6%	1.8%
Race/ethnicity		
White/Caucasian	95.6%	96.4%
Black/African American	0.6%	0.4%
Hispanic/LatinX	1.7%	0.7%
Pacific Islander	0.1%	0.3%
Native American	0.1%	0.7%
Asian/South Asian	0.5%	0.3%
Multiracial	1.4%	1.2%
Household income		
Below median household income	50.0%	44.5%
Above median household income	50.0%	55.5%
Housing instability		
% population housing problems	9.2%	14.0%

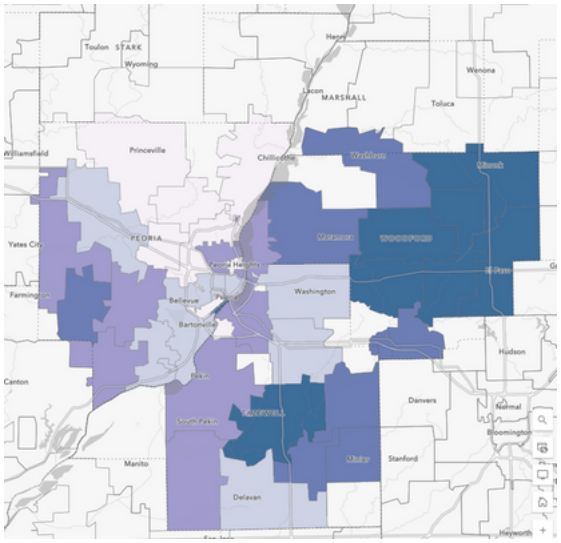
Data source: 2025 CHNA and 2022 ACS 5-Year Estimates Data Profiles,
Abbreviations: CSA; Community status assessment

Social Vulnerability Index

The Social Vulnerability Index (SVI) refers to the community's capacity to prepare and respond to stressful or hazardous events such as natural disasters or disease outbreaks. This comprehensive measure was developed by the CDC and is derived from 16 factors related to poverty, lack of access to transportation, and housing environment.



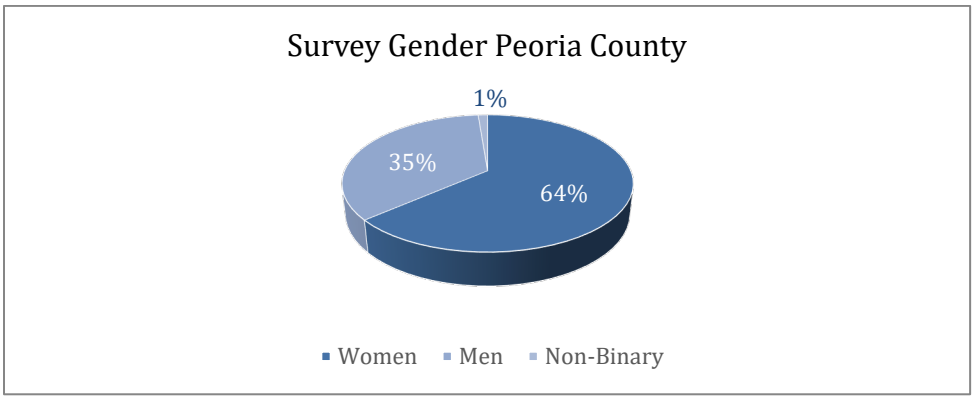
CSA Response Rate

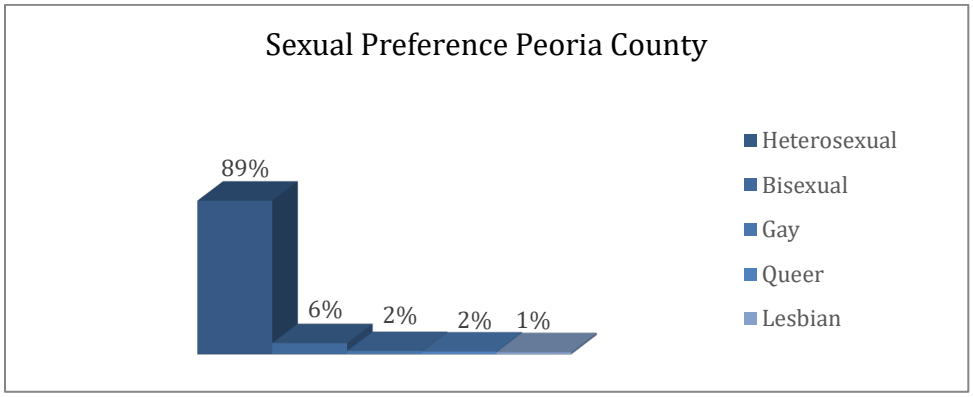


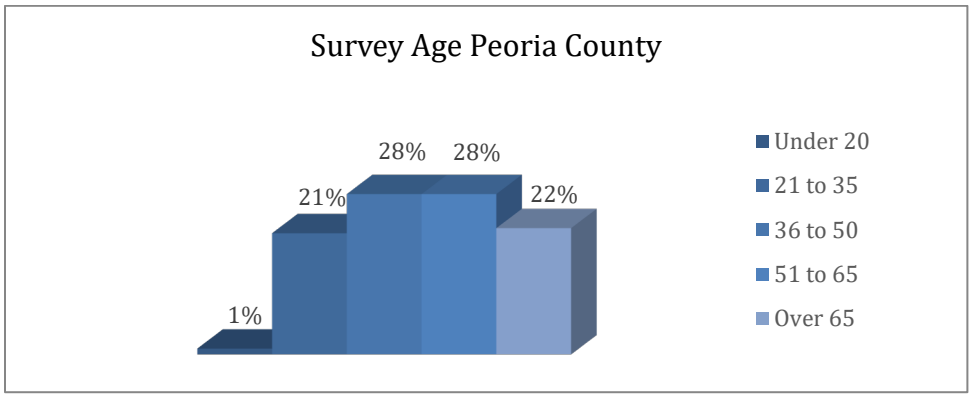
RESPONSE RATE (PER 10,000)

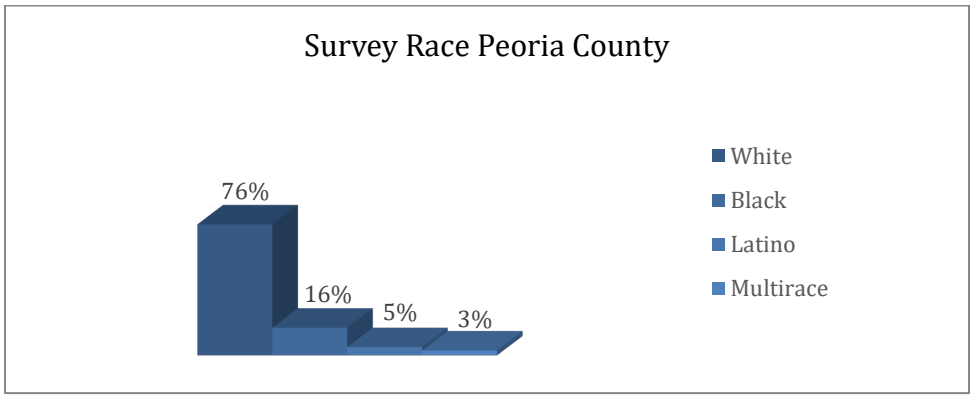
- > 213 - 453
- > 86 - 213
- > 67.7 - 86
- > 49.8 - 67.7
- 22 - 49.8

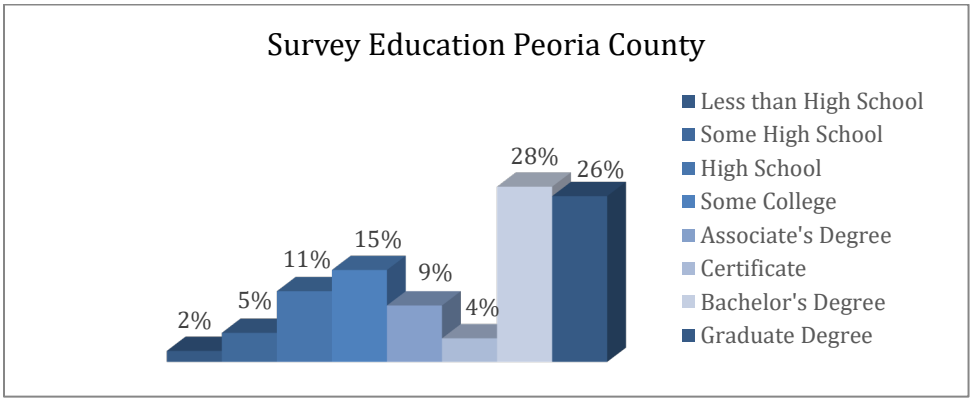
APPENDIX 10: CHNA SURVEY RESULTS FOR PEORIA COUNTY 2025

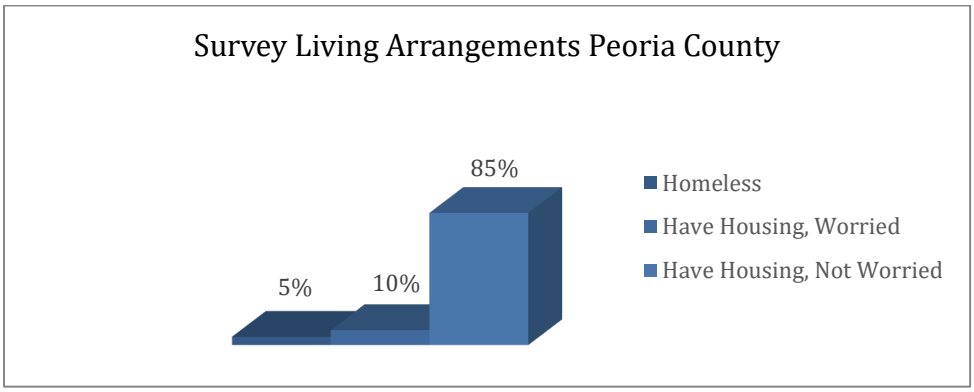


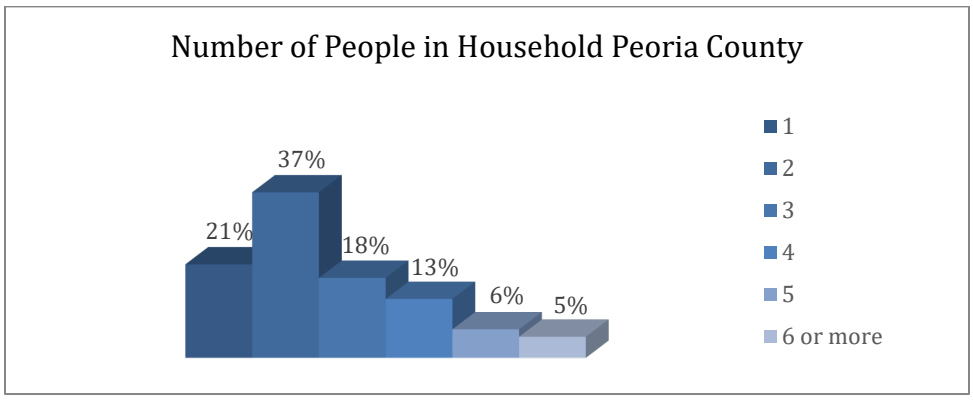


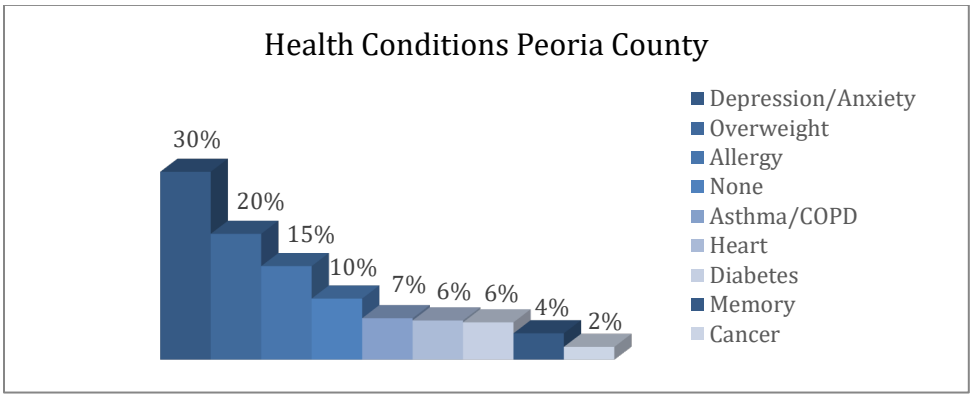


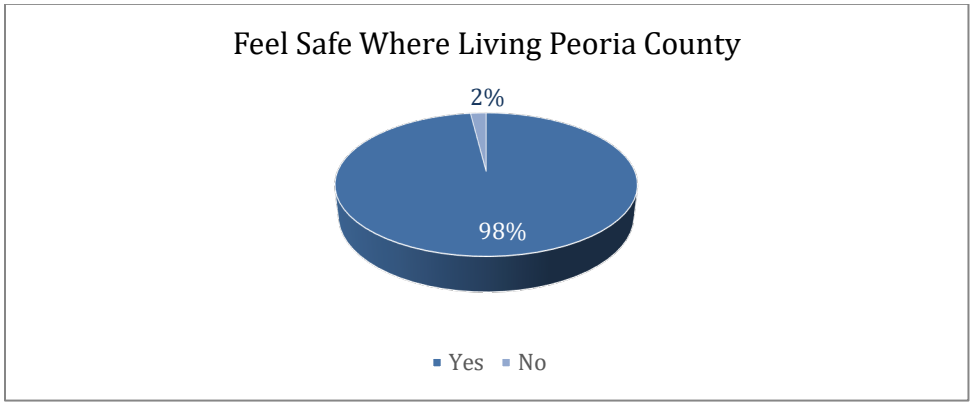

Survey Race Peoria County
76%
16%
5%
3%
White
Black
Latino
Multirace

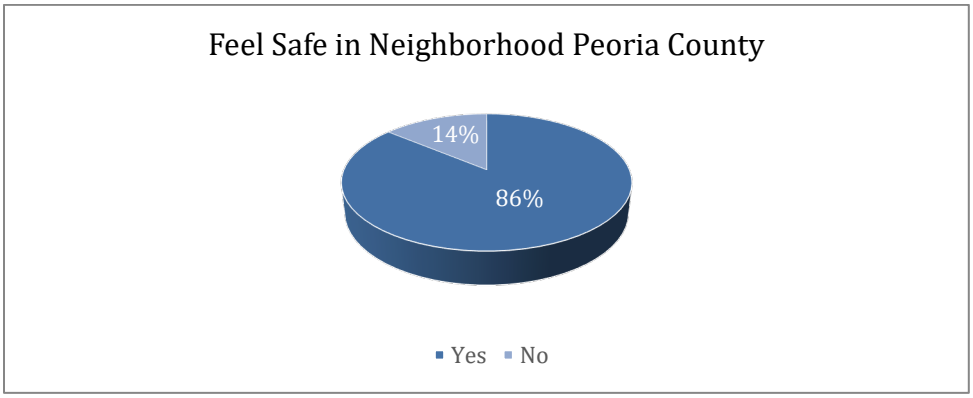

Survey Education Peoria County
2%
5%
11%
15%
9%
4%
28%
26%
Less than High School
Some High School
High School
Some College
Associate's Degree
Certificate
Bachelor's Degree
Graduate Degree

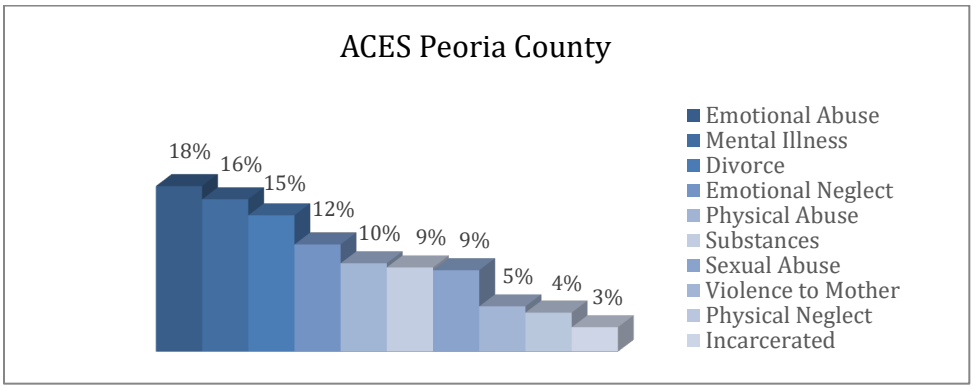

Survey Living Arrangements Peoria County
5%
10%
85%
Homeless
Have Housing, Worried
Have Housing, Not Worried


Number of People in Household Peoria County
21%
37%
18%
13%
6%
5%
1
2
3
4
5
6 or more

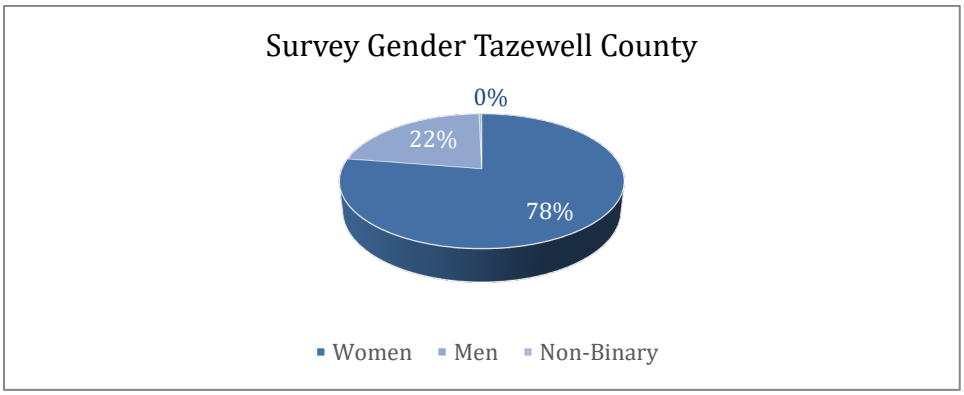

Health Conditions Peoria County
30%
20%
15%
10%
7%
6%
6%
4%
2%
Depression/Anxiety
Overweight
Allergy
None
Asthma/COPD
Heart
Diabetes
Memory
Cancer

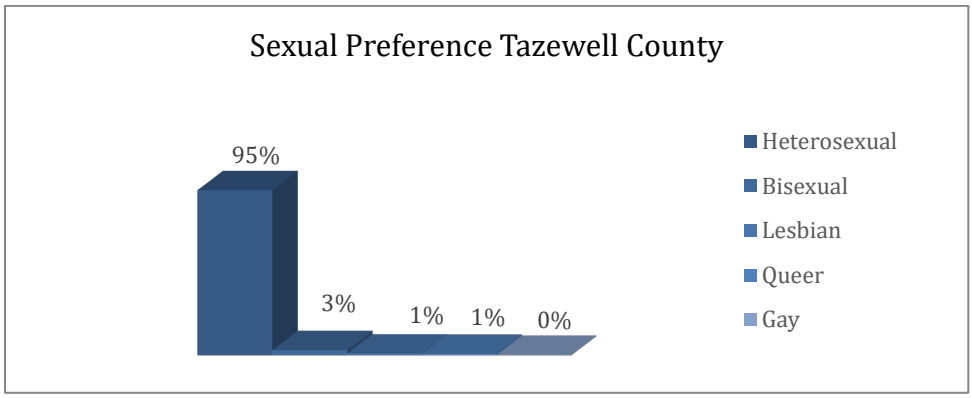

Feel Safe Where Living Peoria County
2%
98%
Yes
No

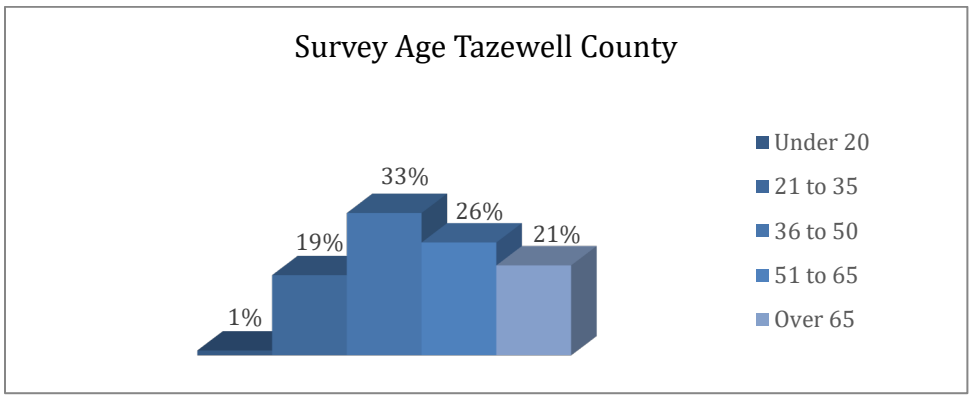

Feel Safe in Neighborhood Peoria County
14%
86%
Yes
No

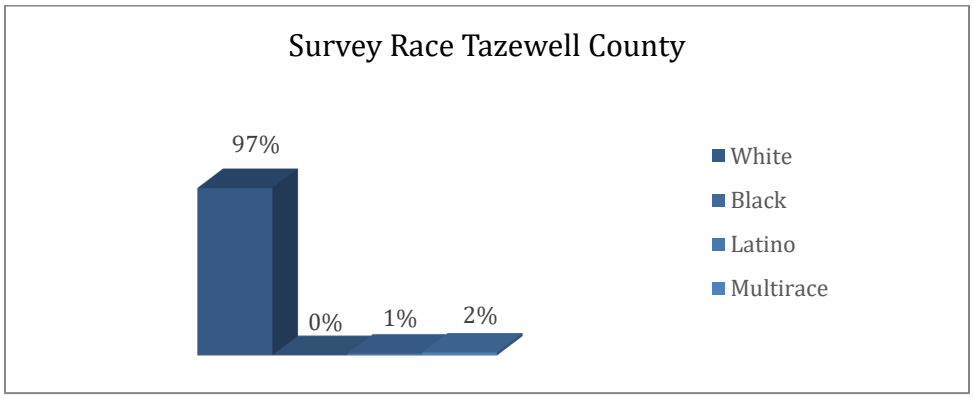

ACES Peoria County
18%
16%
15%
12%
10%
9%
9%
5%
4%
3%
Emotional Abuse
Mental Illness
Divorce
Emotional Neglect
Physical Abuse
Substances
Sexual Abuse
Violence to Mother
Physical Neglect
Incarcerated

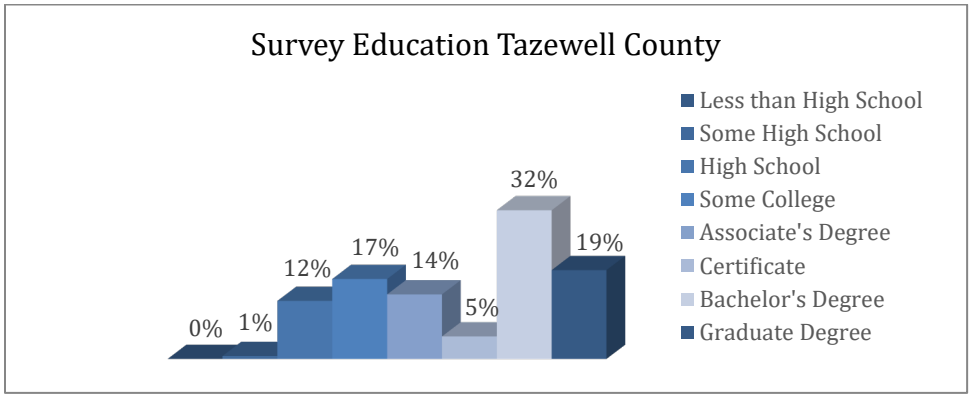
APPENDIX 11: CHNA SURVEY RESULTS FOR TAZEWELL COUNTY 2025

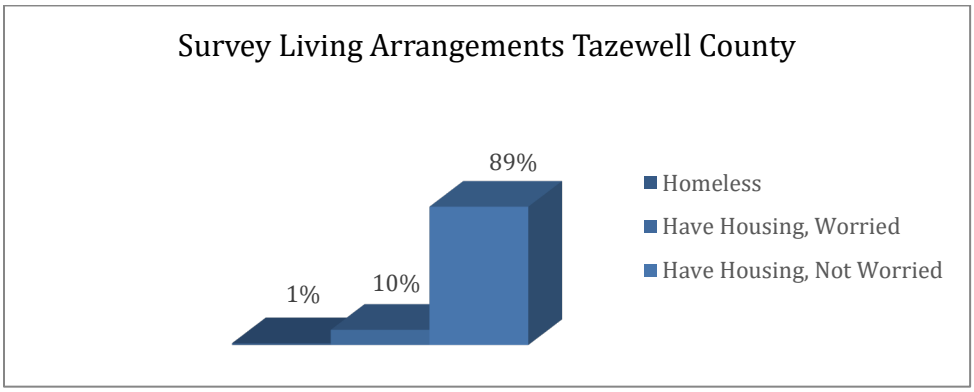


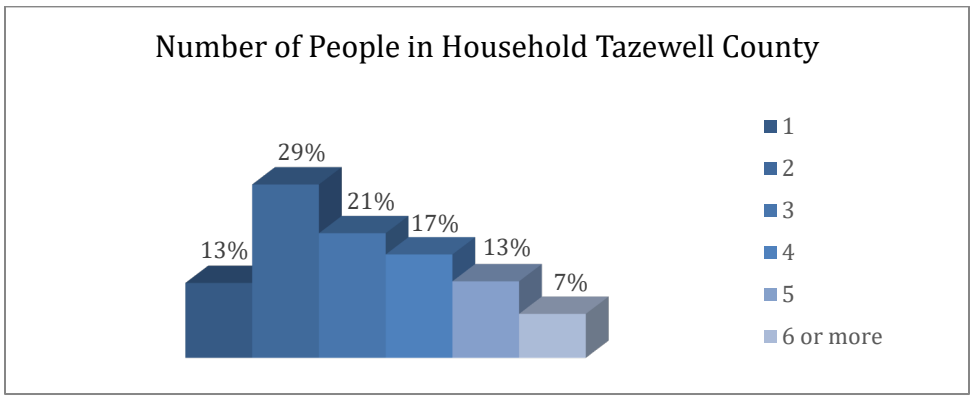


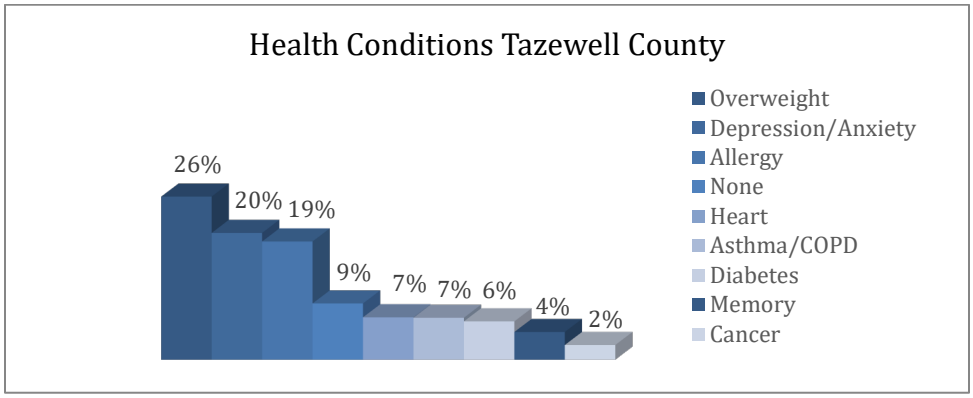


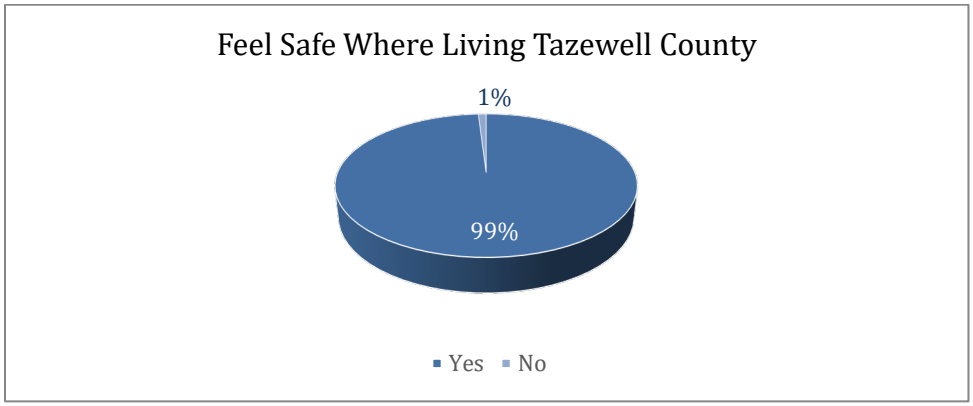

Survey Race Tazewell County
97%
0%
1%
2%
White
Black
Latino
Multirace

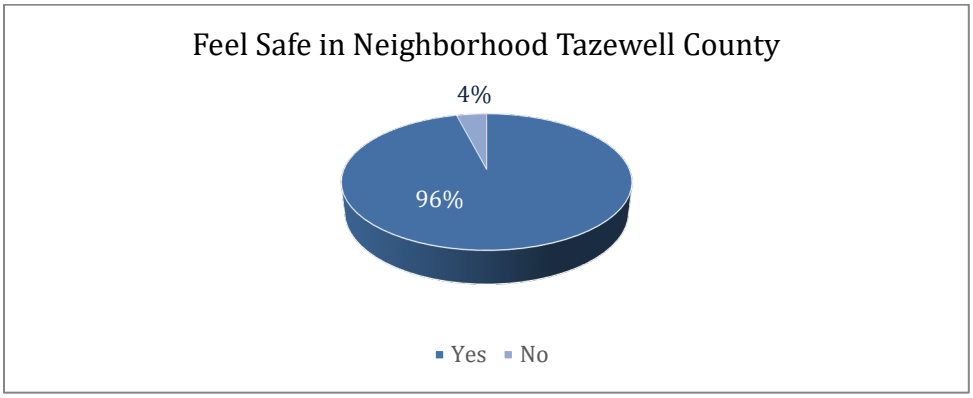

Survey Education Tazewell County
0%
1%
12%
17%
14%
5%
32%
19%
Less than High School
Some High School
High School
Some College
Associate's Degree
Certificate
Bachelor's Degree
Graduate Degree

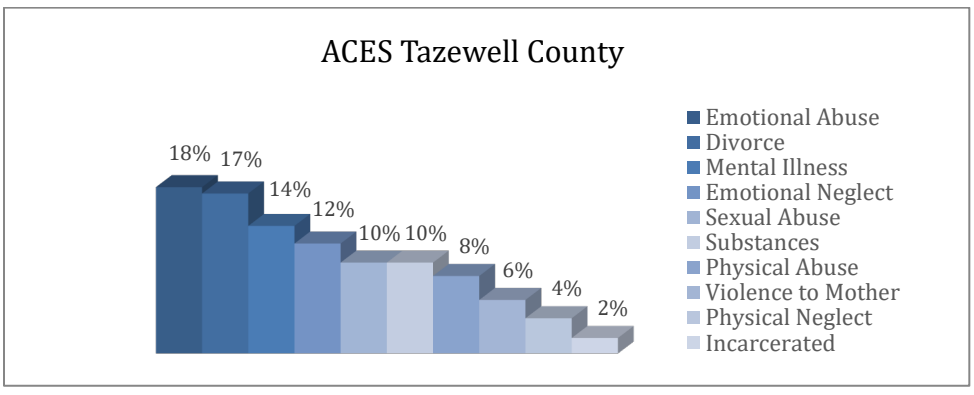

Survey Living Arrangements Tazewell County
1%
10%
89%
Homeless
Have Housing, Worried
Have Housing, Not Worried


Number of People in Household Tazewell County
13%
29%
21%
17%
13%
7%
1
2
3
4
5
6 or more

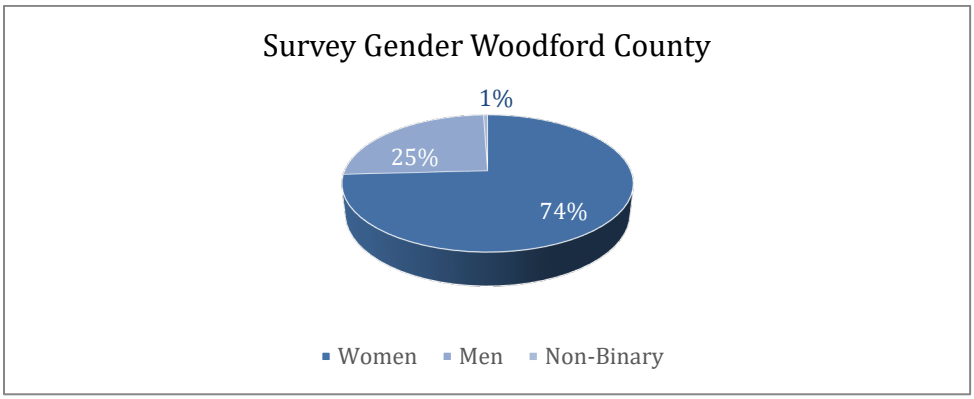

Health Conditions Tazewell County
26%
20%
19%
9%
7%
7%
6%
4%
2%
Overweight
Depression/Anxiety
Allergy
None
Heart
Asthma/COPD
Diabetes
Memory
Cancer

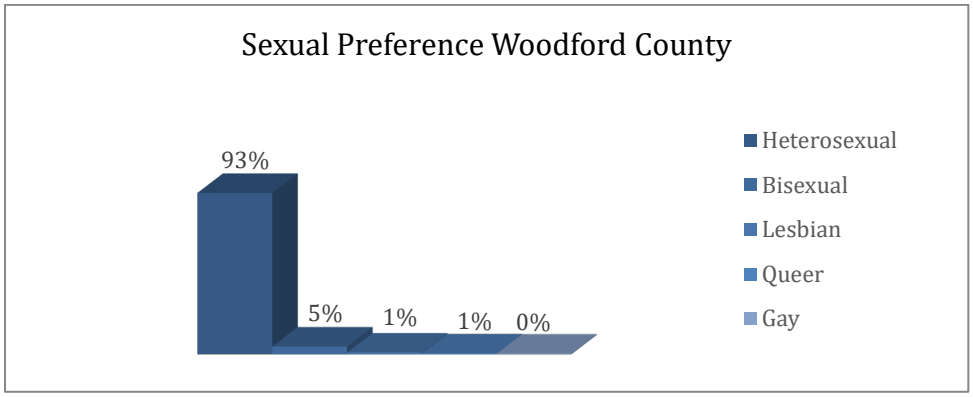

Feel Safe Where Living Tazewell County
1%
99%
Yes
No

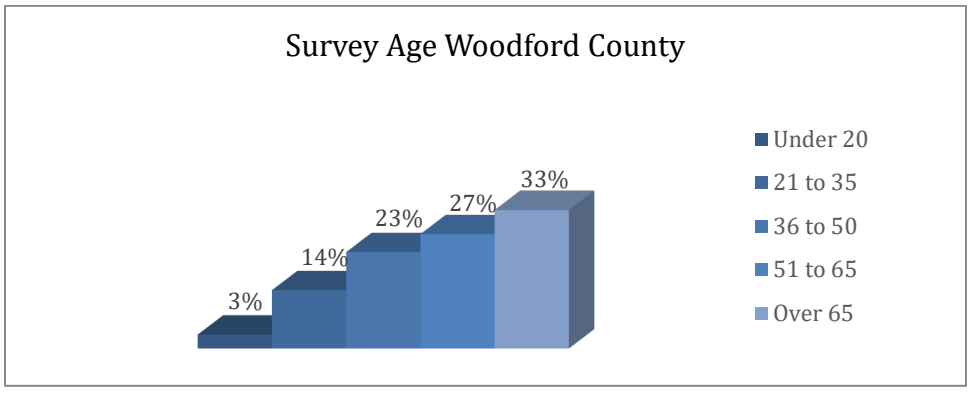

Feel Safe in Neighborhood Tazewell County
4%
96%
Yes
No

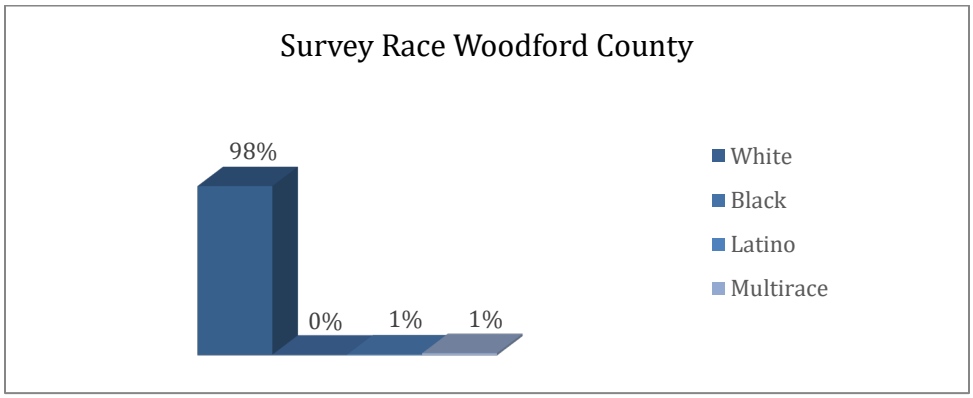

ACES Tazewell County
18%
17%
14%
12%
10%
10%
8%
6%
4%
2%
Emotional Abuse
Divorce
Mental Illness
Emotional Neglect
Sexual Abuse
Substances
Physical Abuse
Violence to Mother
Physical Neglect
Incarcerated

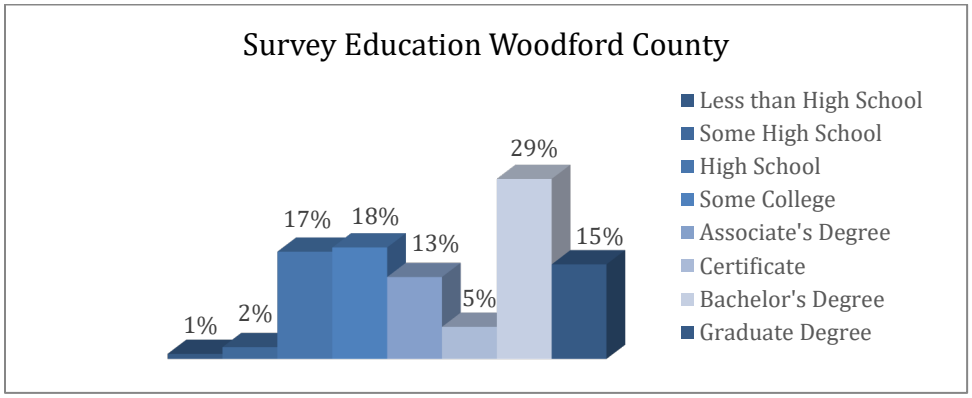
APPENDIX 12: CHNA SURVEY RESULTS FOR WOODFORD COUNTY 2025

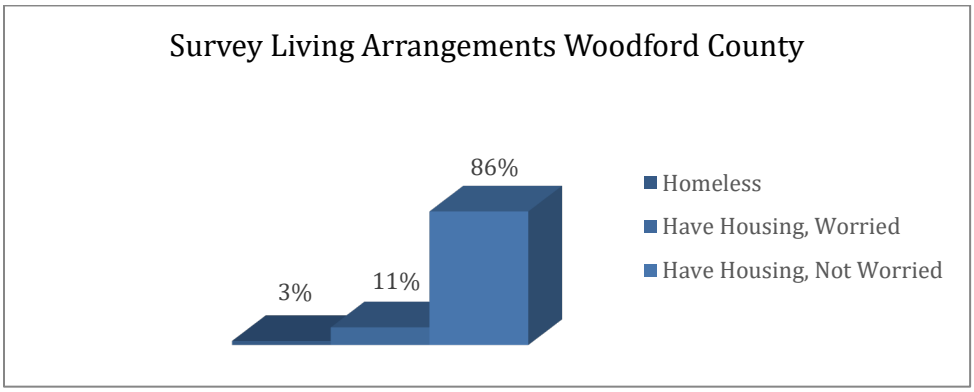


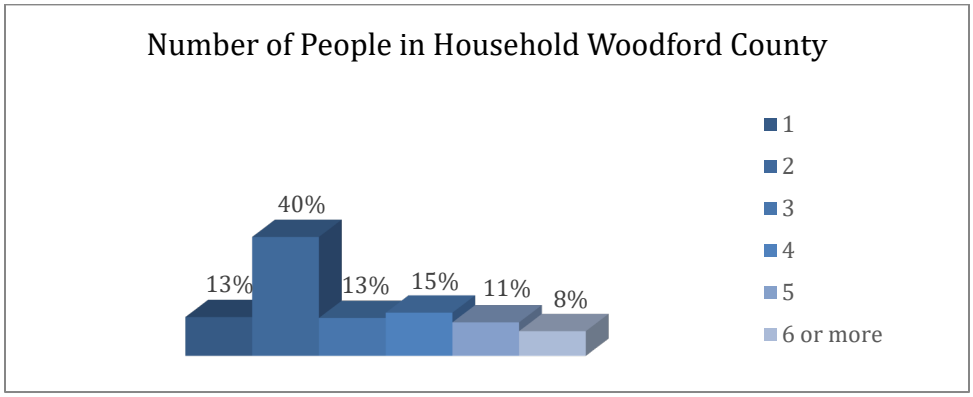


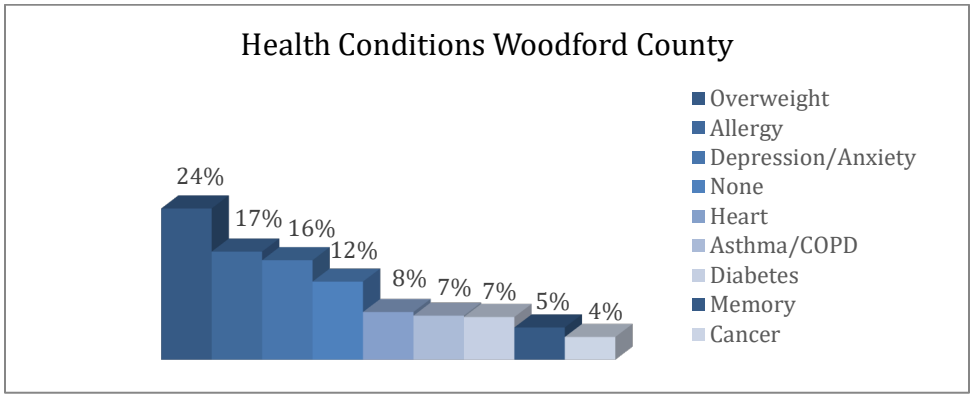


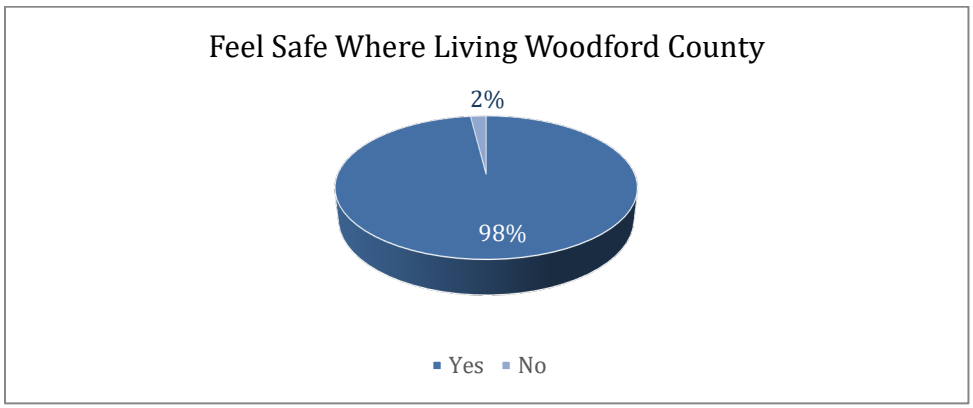

Survey Race Woodford County
98%
0%
1%
1%
White
Black
Latino
Multirace

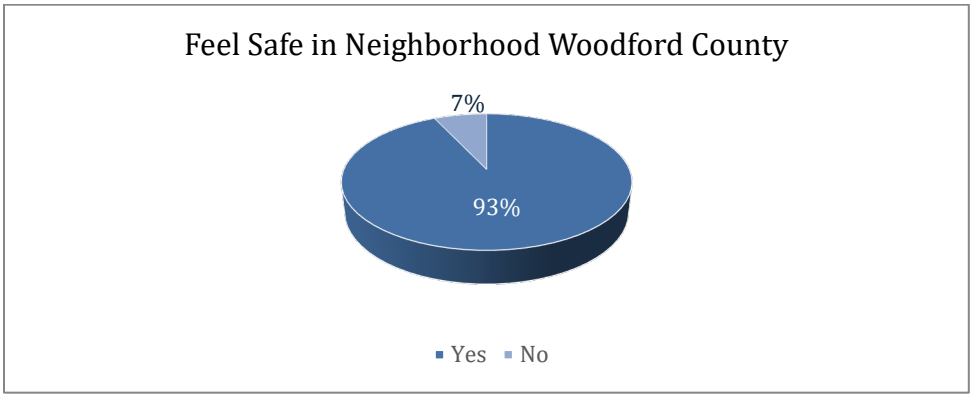

Survey Education Woodford County
1%
2%
17%
18%
13%
5%
29%
15%
Less than High School
Some High School
High School
Some College
Associate's Degree
Certificate
Bachelor's Degree
Graduate Degree

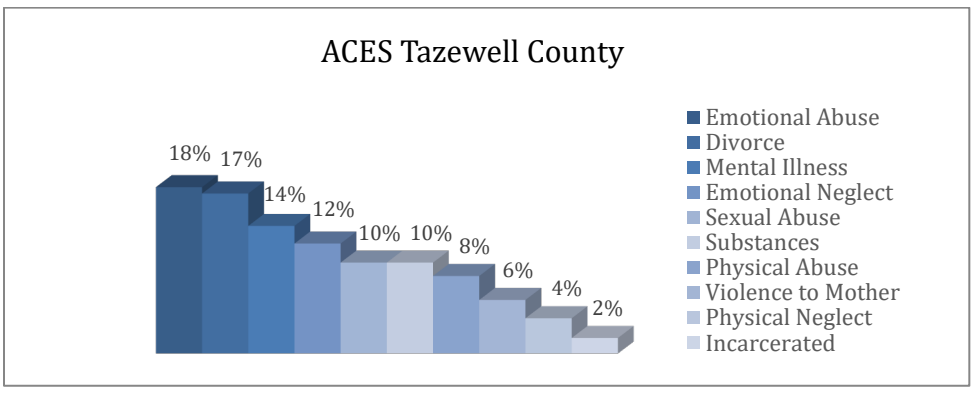

Survey Living Arrangements Woodford County
3%
11%
86%
Homeless
Have Housing, Worried
Have Housing, Not Worried


Number of People in Household Woodford County
13%
40%
13%
15%
11%
8%
1
2
3
4
5
6 or more


Health Conditions Woodford County
24%
17%
16%
12%
8%
7%
7%
5%
4%
Overweight
Allergy
Depression/Anxiety
None
Heart
Asthma/COPD
Diabetes
Memory
Cancer


Feel Safe Where Living Woodford County
2%
98%
Yes
No


Feel Safe in Neighborhood Woodford County
7%
93%
Yes
No


ACES Tazewell County
18%
17%
14%
12%
10%
10%
8%
6%
4%
2%
Emotional Abuse
Divorce
Mental Illness
Emotional Neglect
Sexual Abuse
Substances
Physical Abuse
Violence to Mother
Physical Neglect
Incarcerated

APPENDIX 13: COMMUNITY PARTNER ASSESSMENT

COMMUNITY PARTNER ASSESSMENT

2025

Partnership for a Healthy Community

EXECUTIVE SUMMARY

OVERVIEW

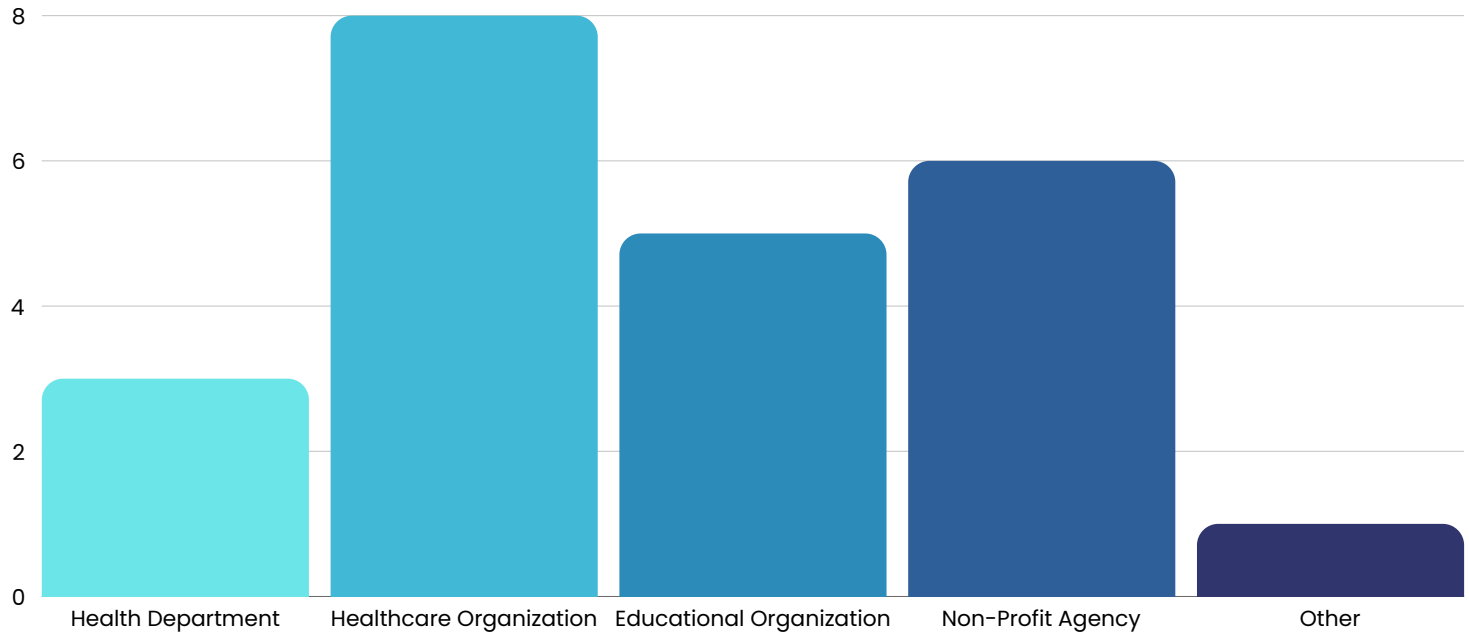
The **Community Partners Assessment (CPA)** evaluates various domains to understand how participating organizations address community health and overall well-being. This report specifically focuses on their commitment to health equity and related concepts.

Representatives from **18 organizations** completed the survey. The survey explored their community work, the populations they serve, the focus of their organizations, and the strategies they employ. The CPA is divided into the following sections:

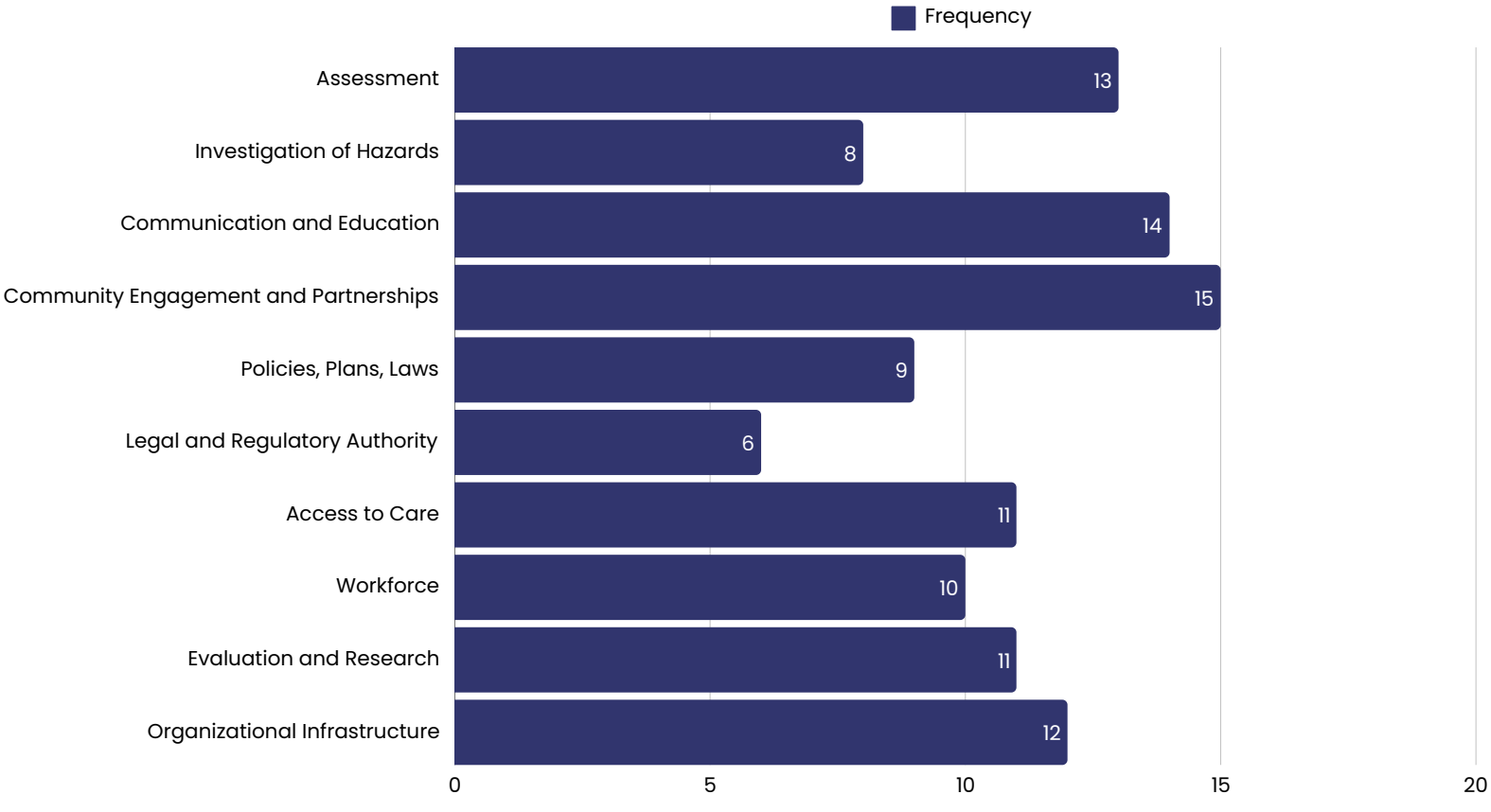
- **DESCRIPTION OF ORGANIZATION**
- **FOCUS OF ORGANIZATIONS**
- **POPULATIONS SERVED**
- **SHARED GOALS**
- **COMMUNITY ENGAGEMENT**
- **DATA COLLECTION**
- **COMMUNICATION**

DESCRIPTION OF ORGANIZATIONS

Types of organizations that completed the CPA

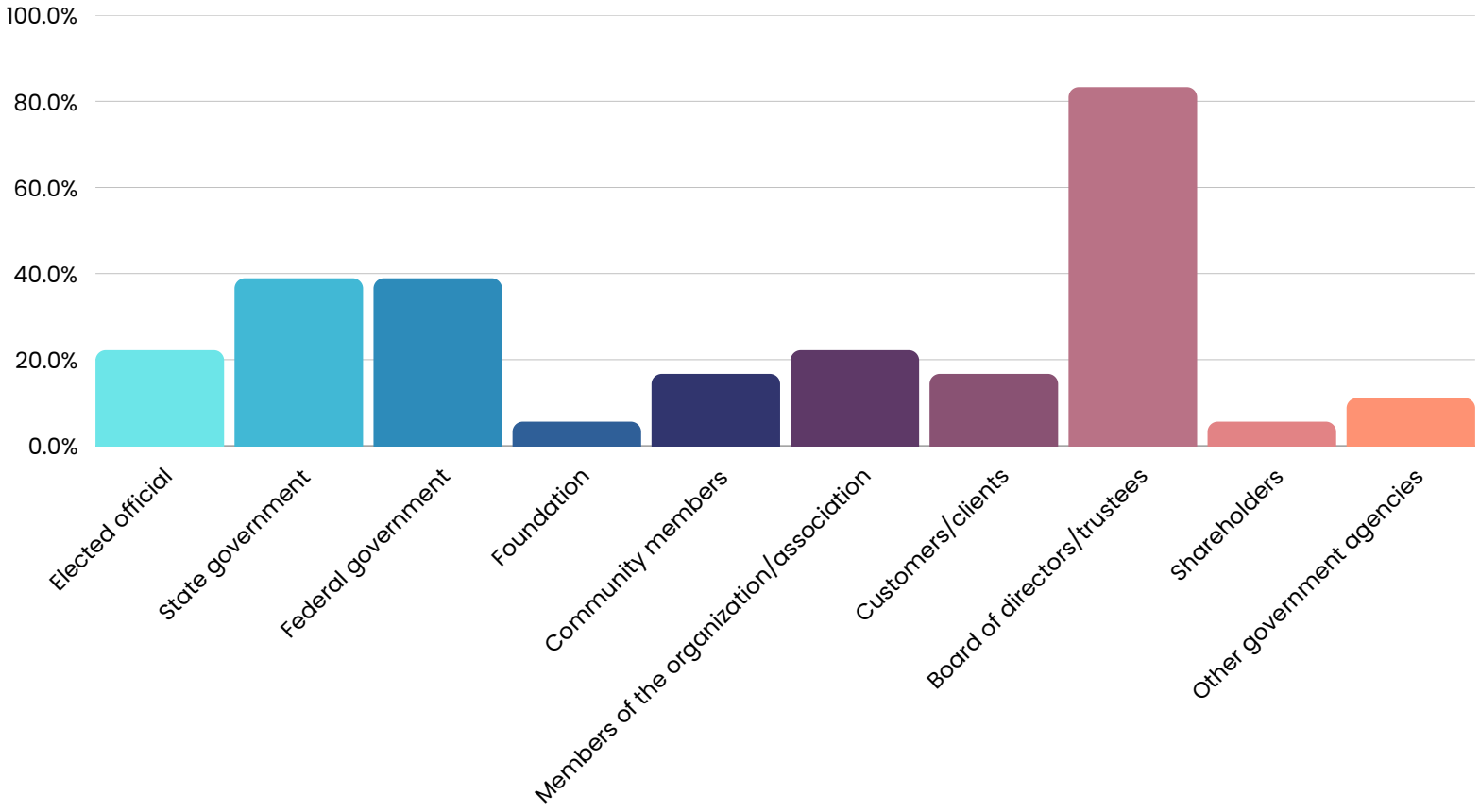


Regular activities reported by organizations

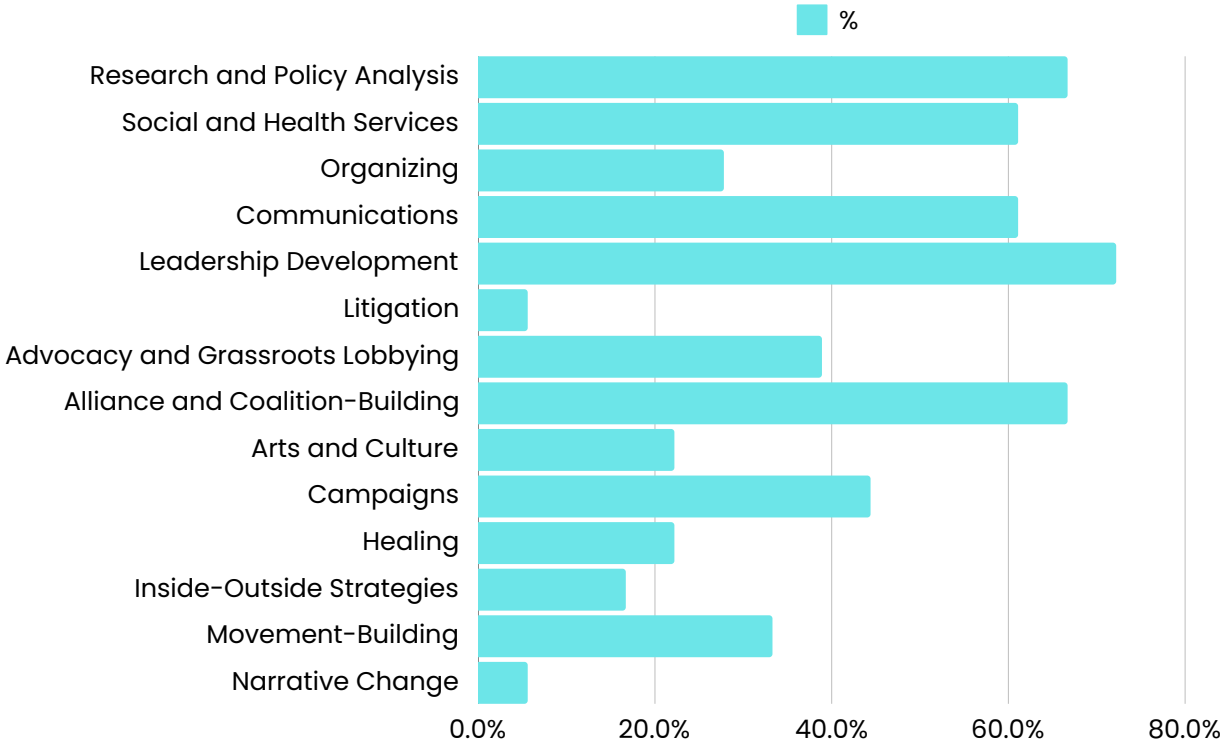


DESCRIPTION OF ORGANIZATIONS

Organization reports to



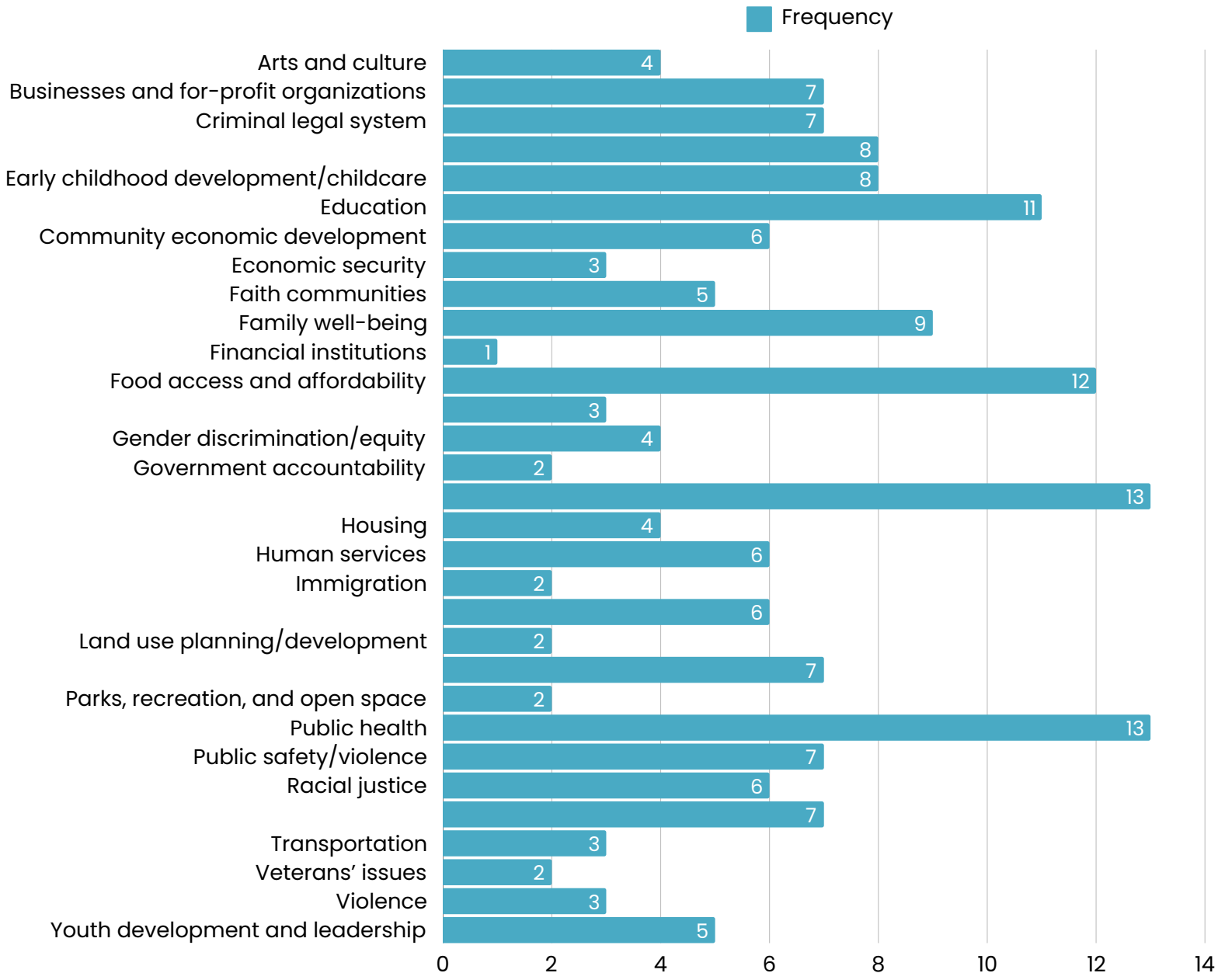
Organization strategies reported



Research and Policy Analysis: Gathering and analyzing data to create credibility and inform policies, projects, programs, or coalitions. **Social and Health Services**: Providing services that reach clients and meet their needs (including clinical and healthcare services). **Organizing:** Involving people in efforts to change their circumstances by changing the underlying structures, decision-making processes, policies, and priorities that produce inequities. **Communications:** Messaging that resonates with communities, connects them to an issue, or inspires them to act. **Leadership Development:** Equipping leaders with the skills, knowledge, and experiences to play a greater role within their organization or movement. **Litigation:** Using legal resources to reach outcomes that further long-term goals. **Advocacy and Grassroots Lobbying**: Targeting public officials either by speaking to them or mobilizing constituents to influence legislative or executive policy decisions. **Alliance and Coalition-Building**: Building collaboration among groups with shared values and interest. **Arts and Culture**: Nurturing the multiple skills of an individual through the arts and encouraging connection through shared experiences. **Campaigns**: Using organized actions that address a specific purpose, policy, or change. **Healing**: Addressing personal and community trauma and how they connect to larger social and economic inequalities. **Inside-Outside Strategies:** Coordinating support from organizations on the "outside" with a team of like-minded policymakers on the "inside" to achieve common goals. **Movement-Building**: Scaling up from single organizations and issues to long-term initiatives, perspectives, and narratives that seek to change systems. **Narrative Change**: Harnessing arts and expression to replace dominant assumptions about a community or issue with dignified narratives and values.

DESCRIPTION OF ORGANIZATIONS

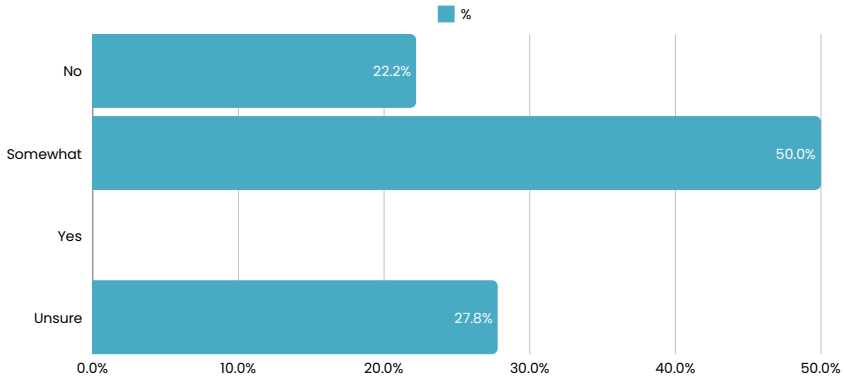
Issues that organizations work on in the community



The most common issues worked on include: healthcare access/utilization, public health, and food access and affordability.

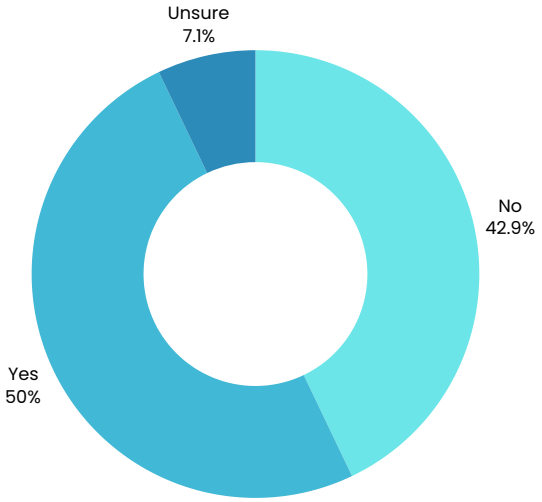
DESCRIPTION OF ORGANIZATIONS

Work with other populations

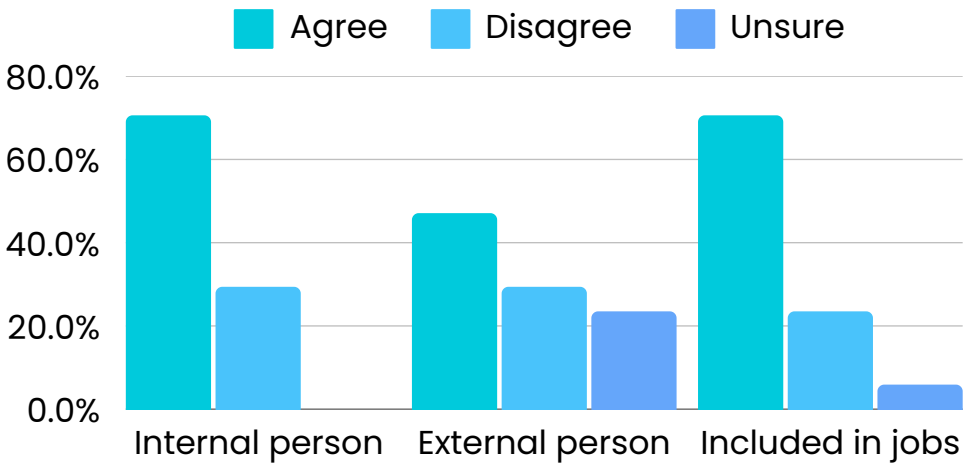


Organizations also reported serving other marginalized populations including: unsheltered persons, persons who use drugs, those who perform sex work, and those facing other daily stressors.

Administrative/frontline staff reflect the demographics of the community served

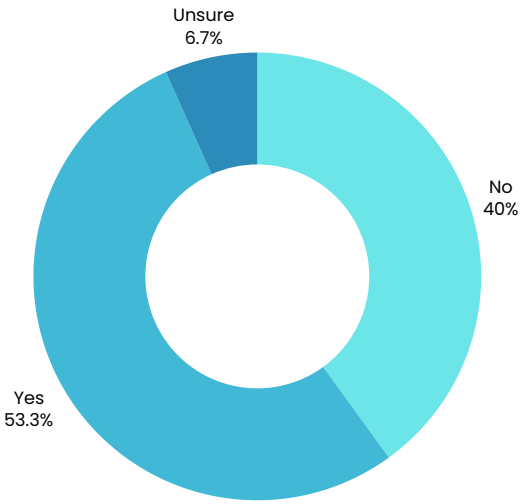


Diversity, equity, and inclusion among organizations



70.6% (n=12) reported they had at least one person internally dedicated to addressing this issue
47.1% (n=8) reported they had at least one person externally dedicated to addressing this issue
70.6% (n=12) state that advancing equity/addressing inequities is included in all or most of the job requirements

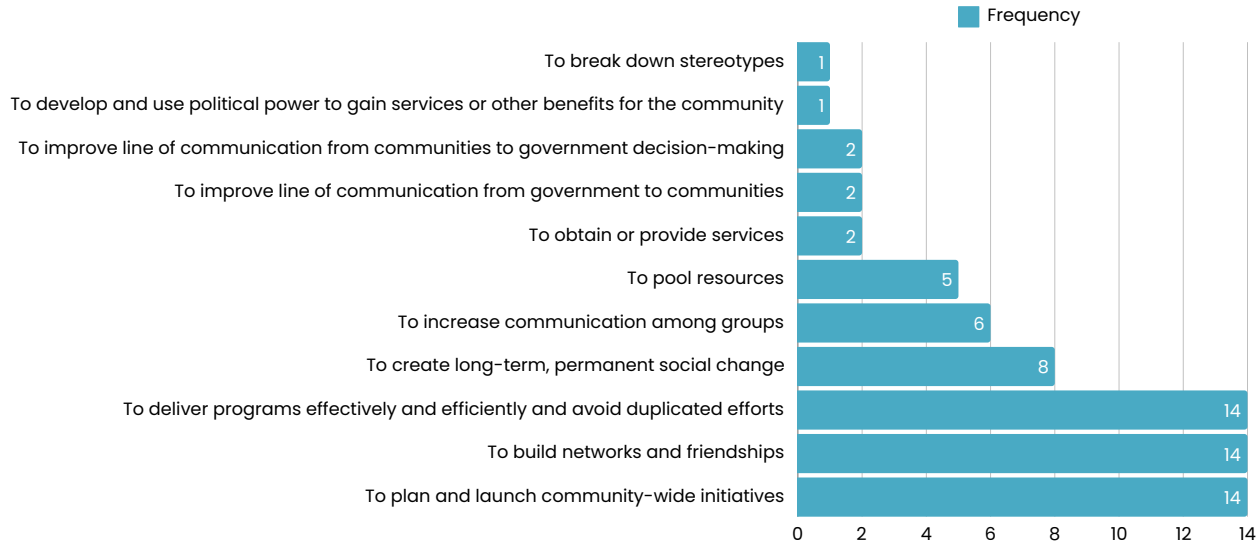
Management of the organization reflects the demographics of the population served



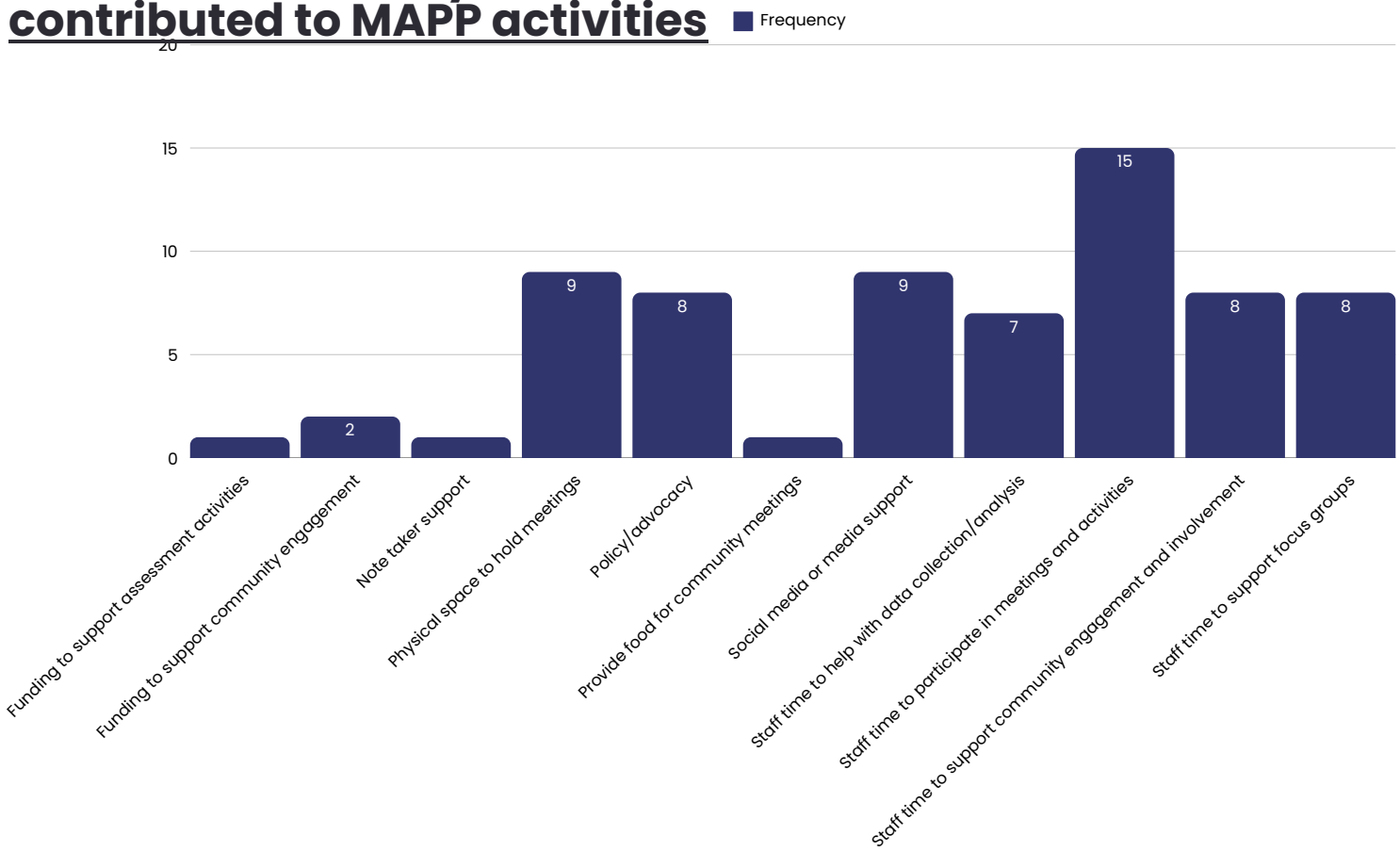
Approximately half of these organizations report management or staff reflecting the demographics of the population served

FOCUS OF ORGANIZATIONS

Top 3 reasons in joining the community health improvement partnership

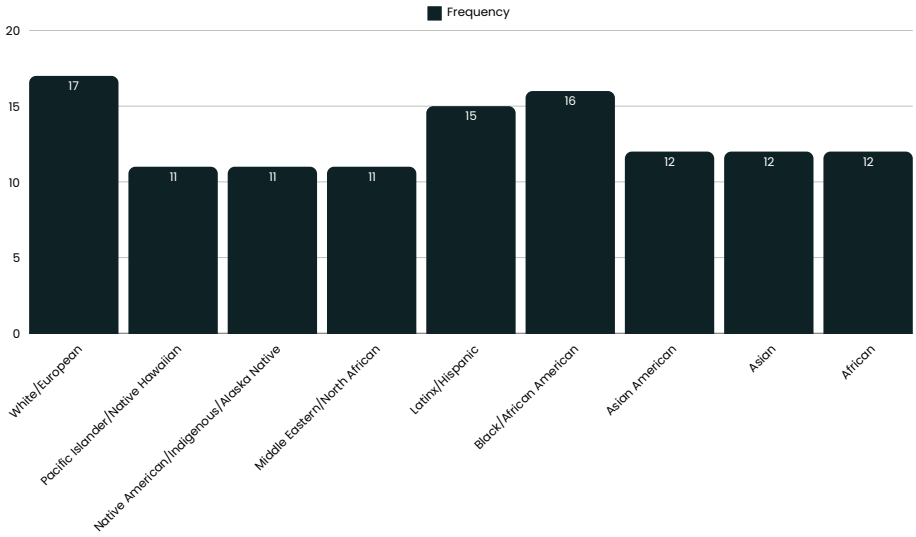


Resources that may be contributed to MAPP activities

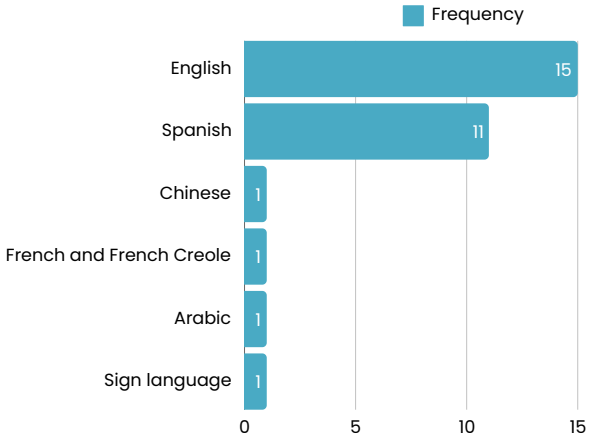


POPULATIONS SERVED

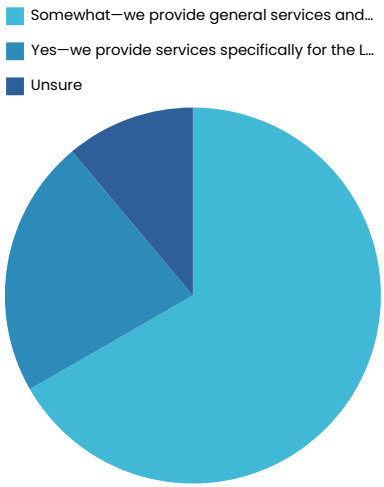
Racial/ethnic populations organizations work with who completed CPA



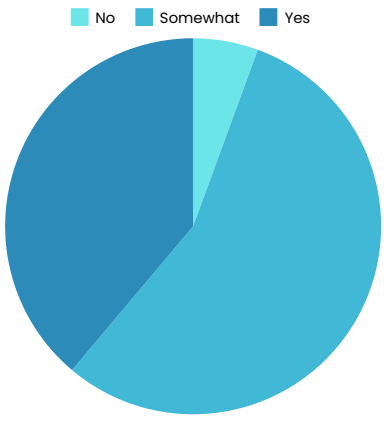
Languages spoken at organizations

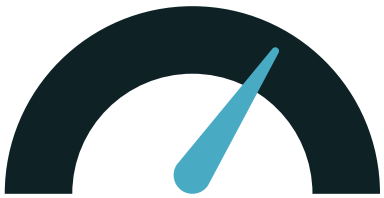


Organizations that provide services for transgender, non-binary, and other members of the LGBTQIA+ community



Organizations that offer services specifically for people with disabilities



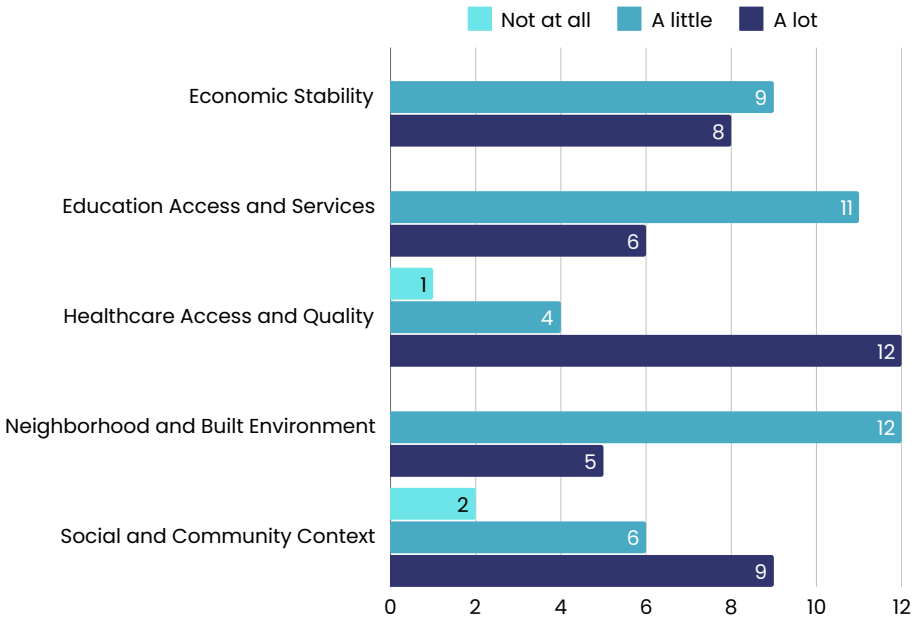


67% of organizations report working with immigrants, refugees, asylum seekers, and other populations who speak English as a second language

83% of organizations report access to interpretation and translation services

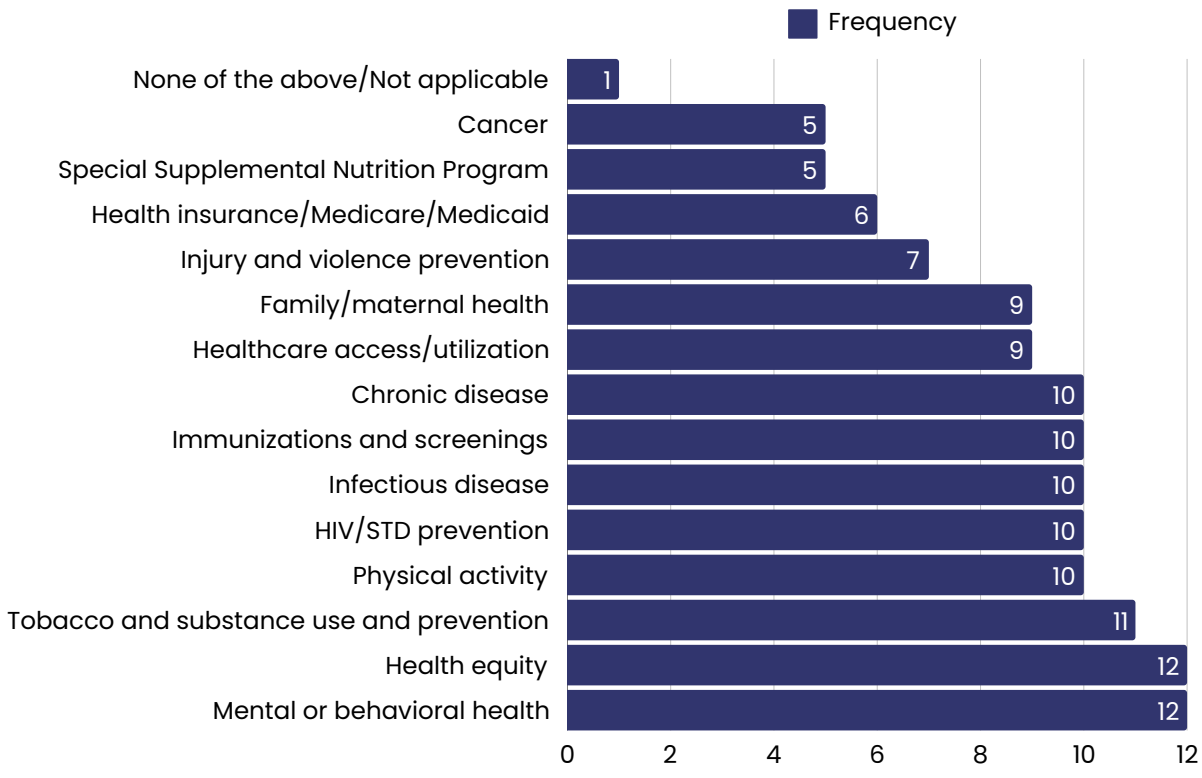
SHARED GOALS

Amount that the organizations focus on the following issues



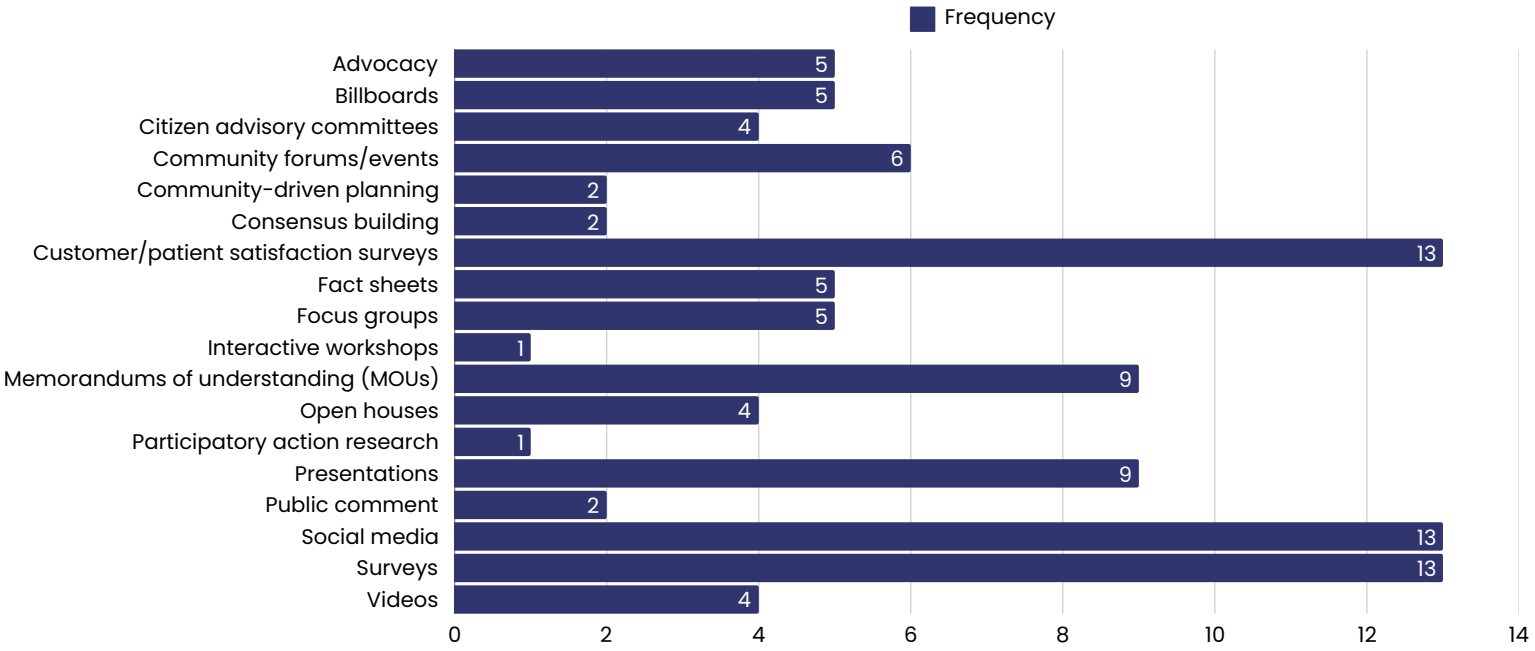
E**conomic Stability**: The connection between people's financial resources—income, cost of living, and socioeconomic status—and their health. This includes issues such as poverty, employment, food security, and housing stability.
Education Access and Services: The connection of education to health and well-being. This includes issues such as graduating from high school, educational attainment in general, language and literacy, and early childhood education and development.
Healthcare Access and Quality: The connection between people's access to and understanding of health services and their own health. This includes issues such as access to healthcare, access to primary care, health insurance coverage, and health literacy.
Neighborhood and Built Environment: The connection between where a person lives—housing, neighborhood, and environment—and their health and well-being. This includes topics like quality of housing, access to transportation, availability of healthy foods, air and water quality, and public safety.
Social and Community Context: The connection between characteristics of the contexts within which people live, learn, work, and play, and their health and well-being. This includes topics like cohesion within a community, civic participation, discrimination, conditions in the workplace, violence, and incarceration

Specific topics that organizations work on in the Tri-County region



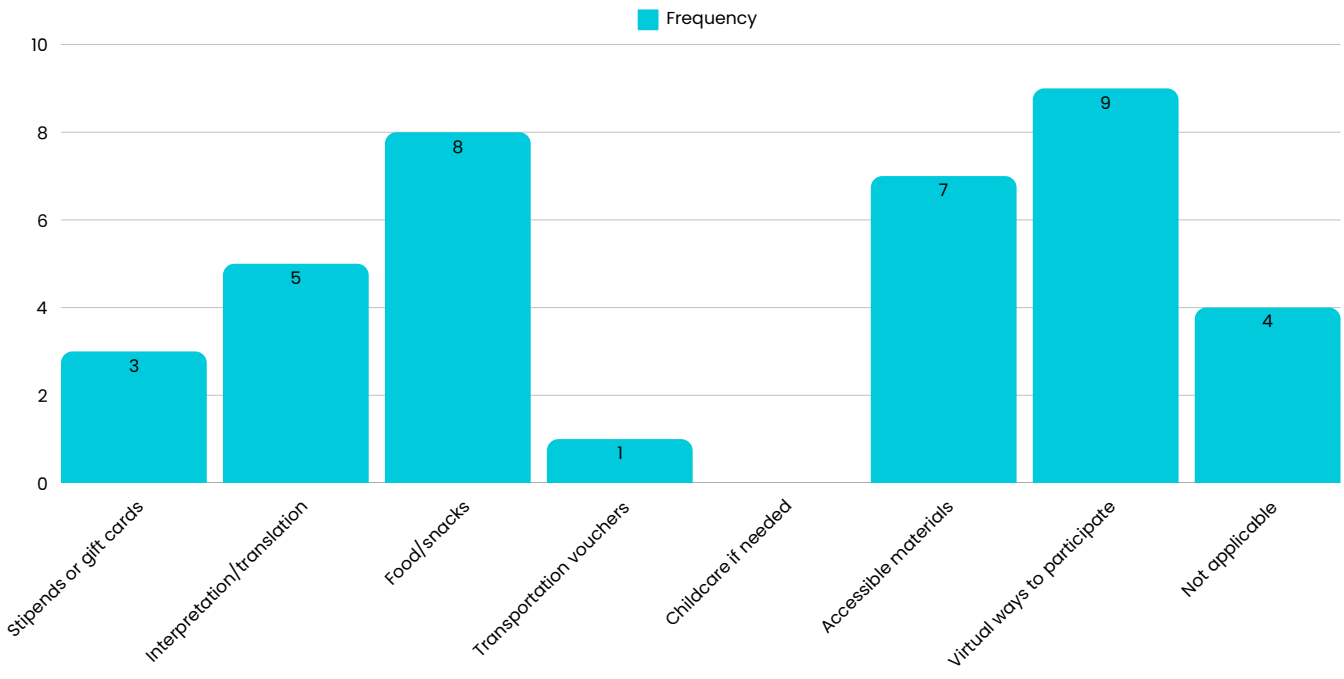
COMMUNITY ENGAGEMENT

Most common methods of community engagement reported by organizations

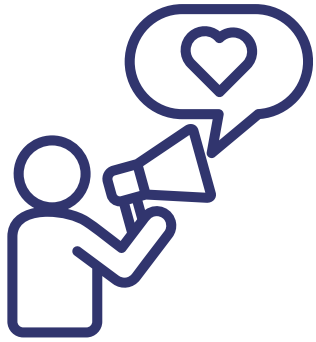


The following methods of community engagement were not reported: community organizing, house meetings, polling, open planning forums with citizen polling, and participatory budgeting.

Things offered by organizations at community meetings



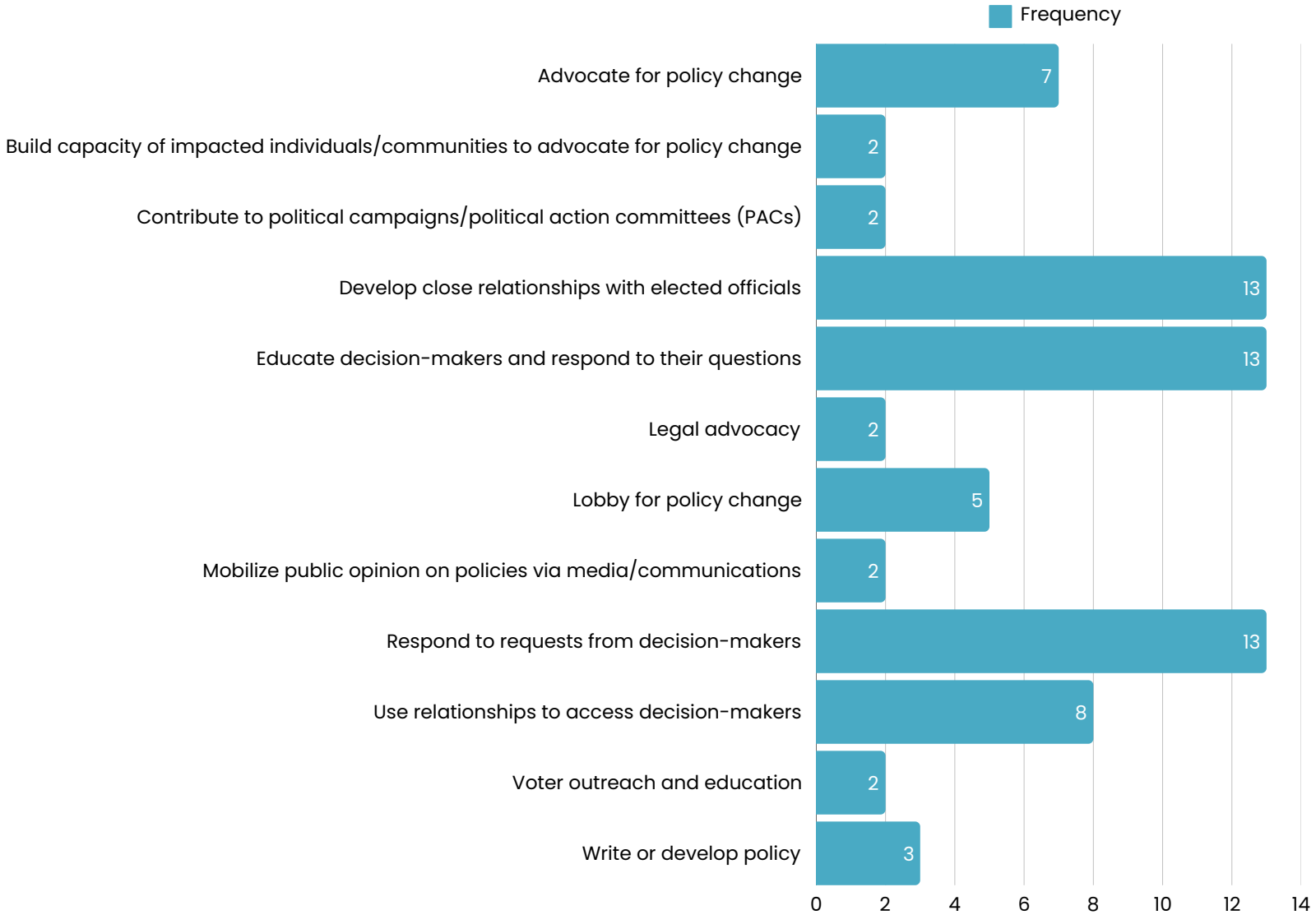
COMMUNITY ENGAGEMENT



The top three types of policy/advocacy work reported were:

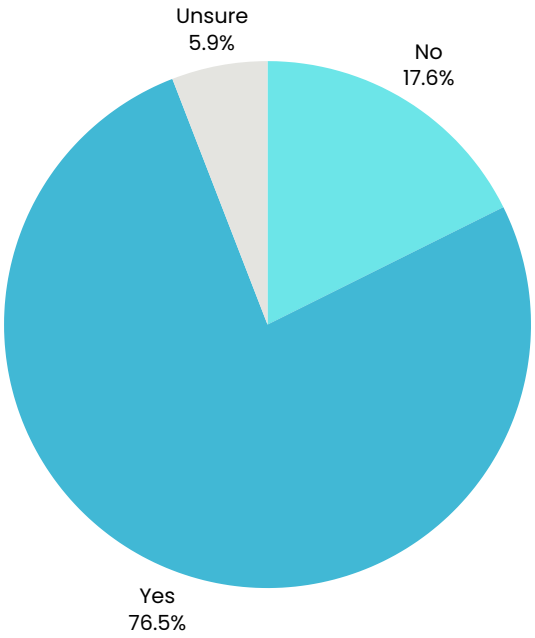
1. Develop close relationships with elected officials
2. Educate decision-makers and respond to their questions
3. Respond to requests from decision-makers

Policy/advocacy work reported by organizations

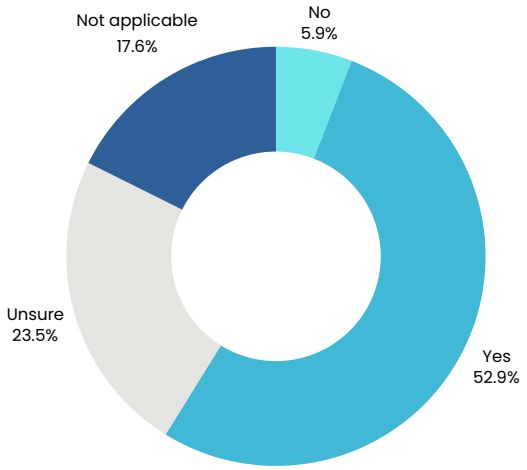


DATA COLLECTION

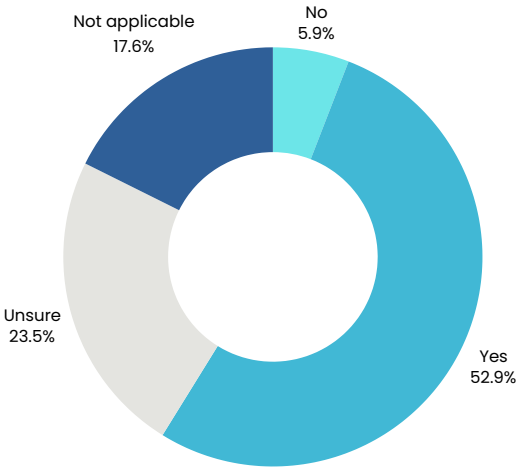
Organization conducts assessments



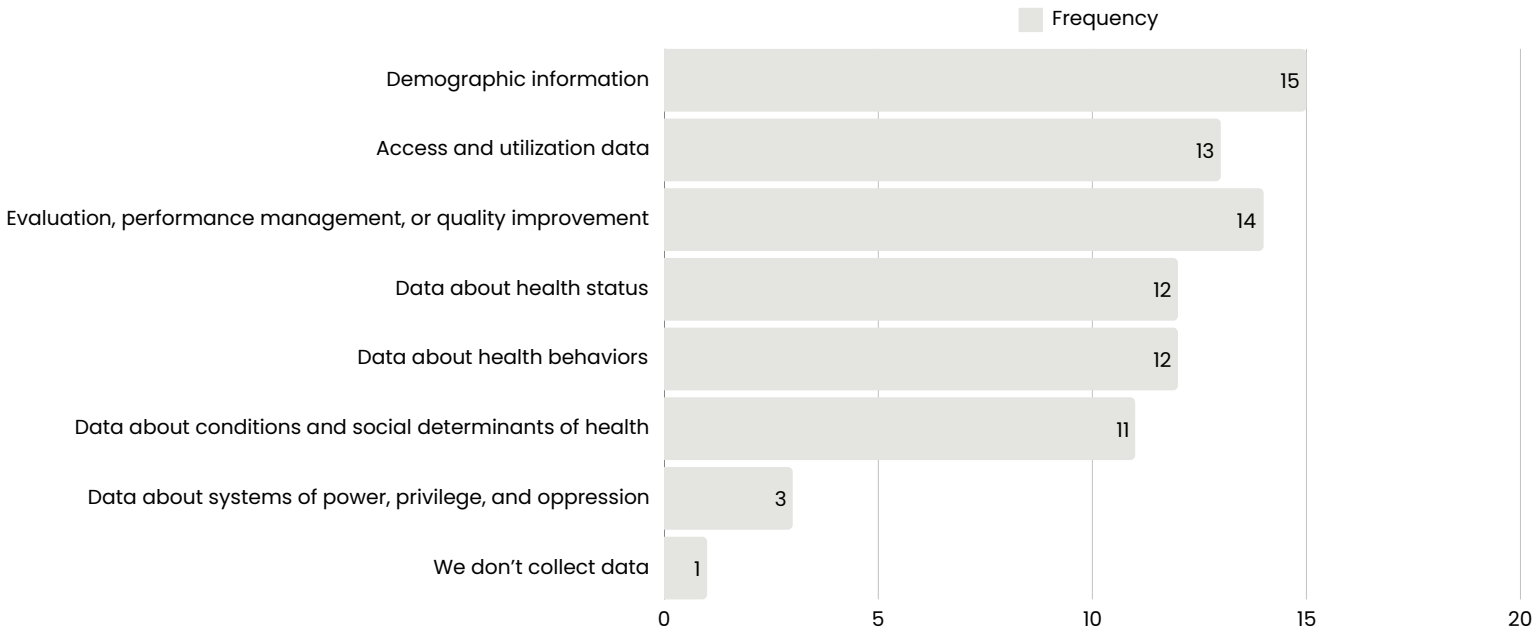
Able to share assessments with MAPP collaborative



Able to share other data collected with MAPP collaborative

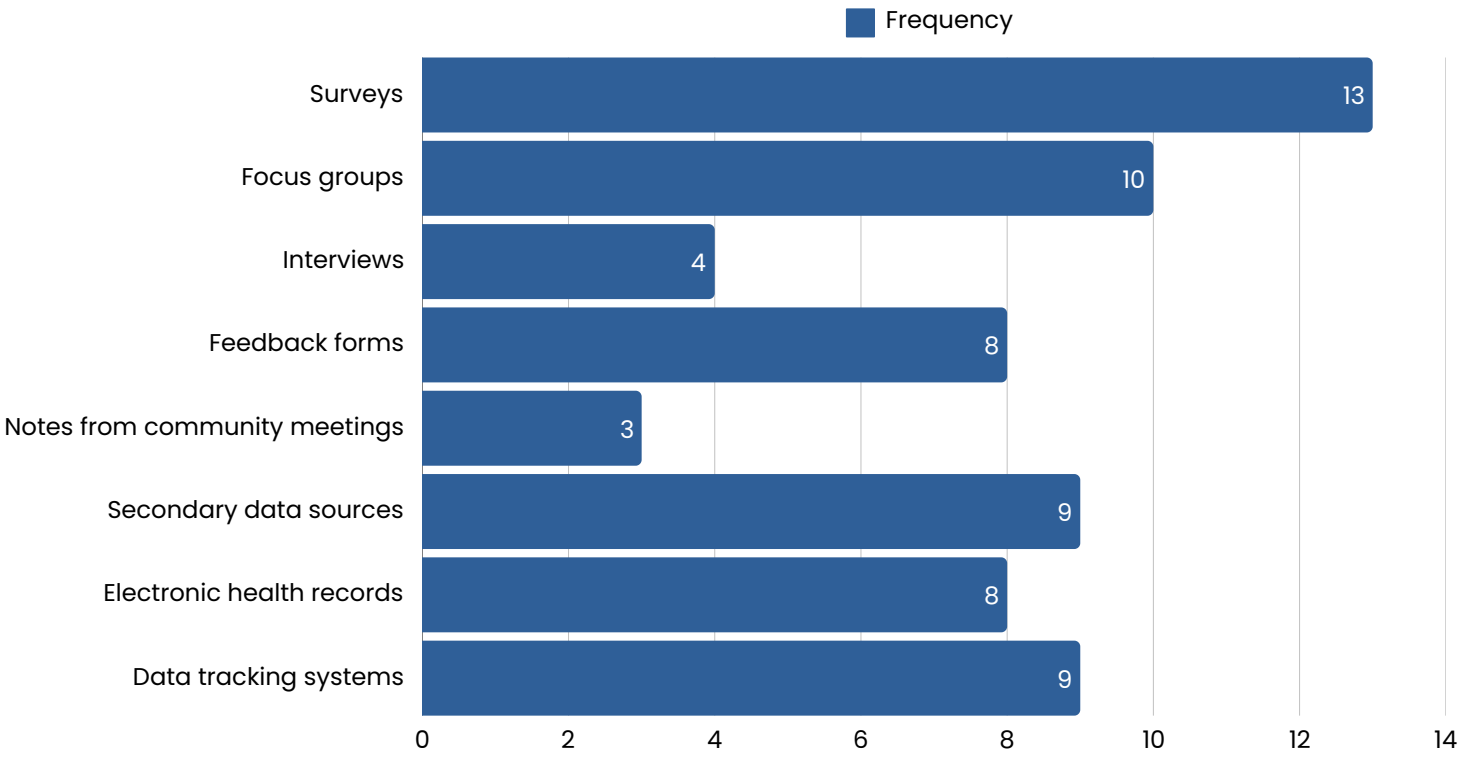


Types of data collected by organizations

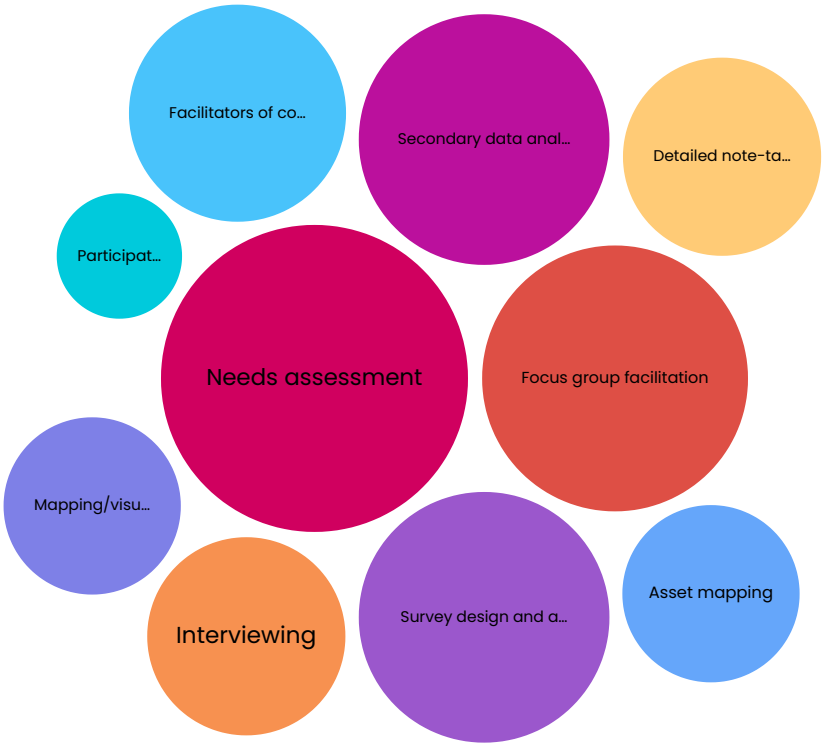


DATA COLLECTION

Method of data collection by organizations

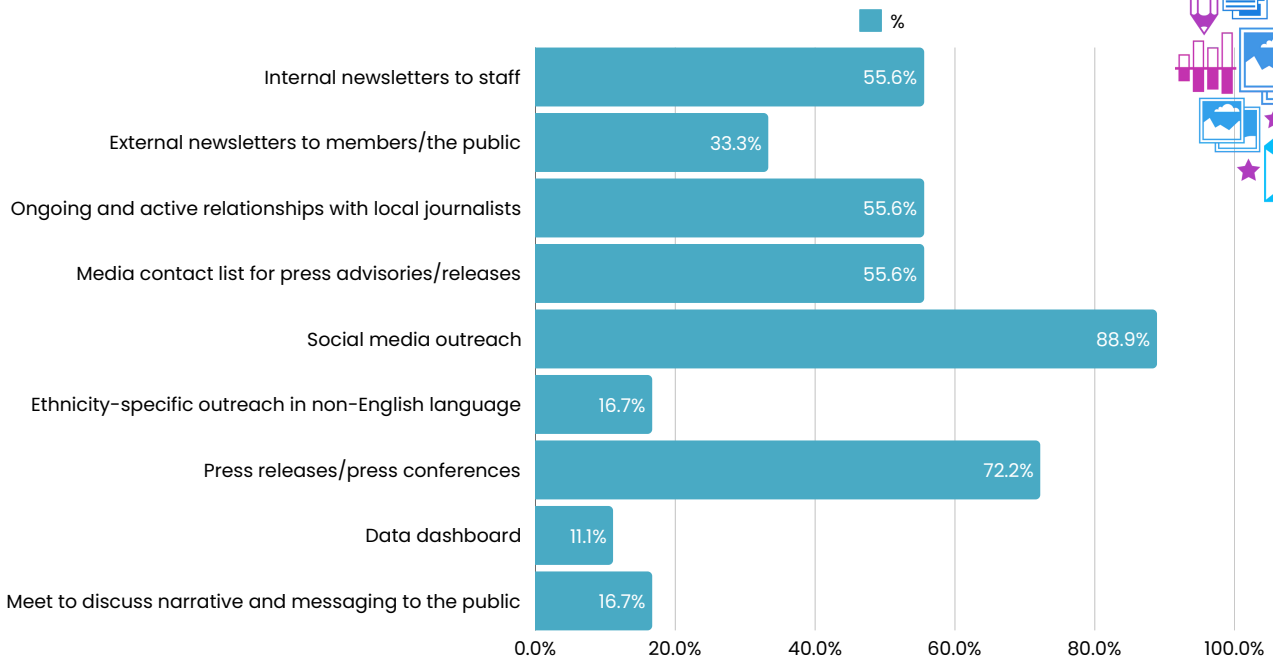


Data skills in organization

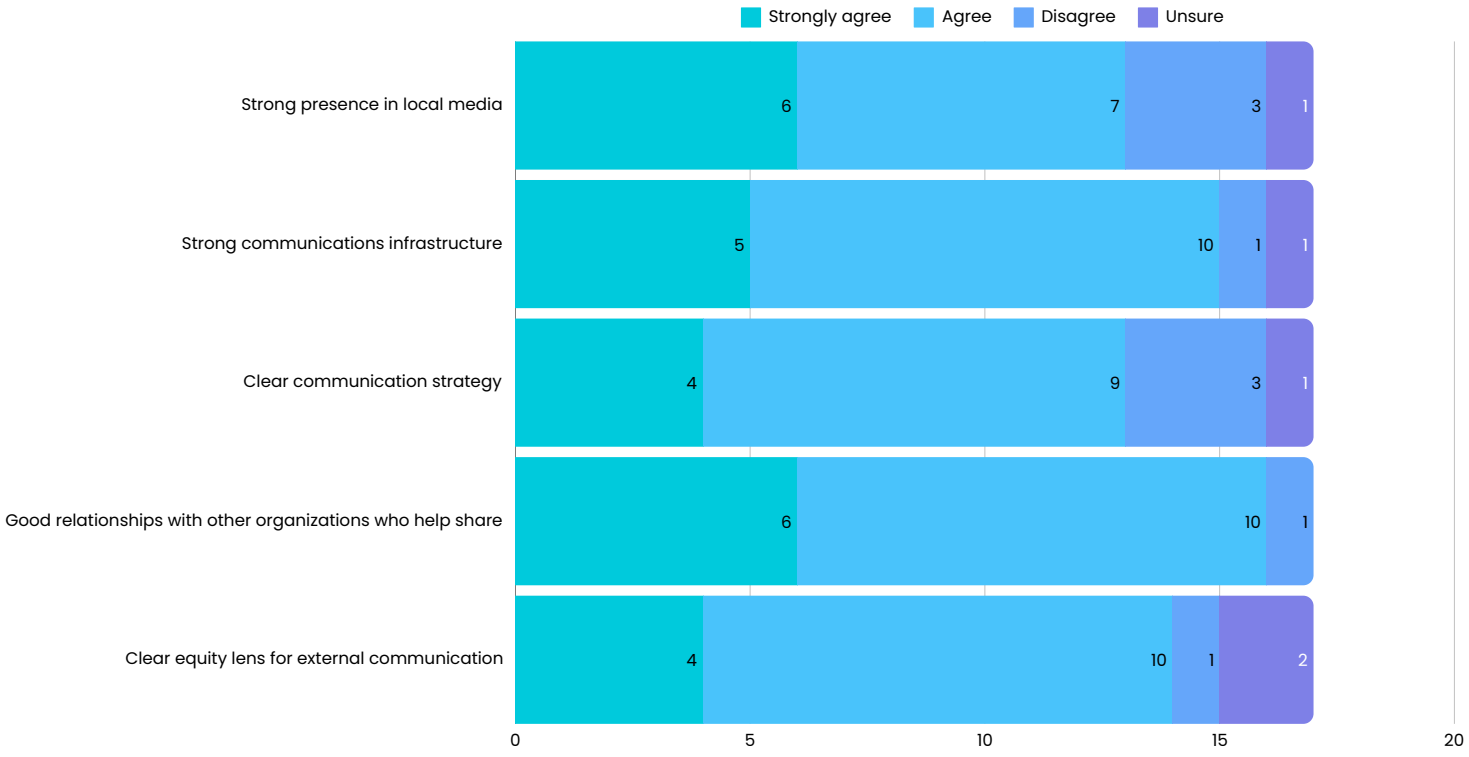


COMMUNICATION

Types of communication methods used by organizations



Describing communication among organizations



Thank You

If you have any questions, please don't hesitate to contact us.

PREPARED BY:

PFHC Data Team

skelly88@uic.edu

APPENDIX 14: COMMUNITY CONVERSATIONS SUMMARY

The Community Context Assessment (CCA) is a qualitative tool to assess and collect data. The CCA centers on people and communities with lived experiences and lived expertise. It focuses on the views, insights, values, cultures, and priorities of those experiencing inequities firsthand.

CCA Process

1. Formation of Health Equity Committee and member recruitment
2. Review of CSA and CHNA data
3. Development of CSA infographics and community conversation questions based on MAPP 5 Themes (Health Behaviors and Outcomes, SDOH, Systems of Change/Power, Community Strengths, Organizational Capacities)
4. Identification of populations for community conversations

The group consisted of a diverse representation from the Tri-County area. Below are the members of this group and their corresponding organizations.

Name	**Organization**
Dawn Jeffries, PhD	Girls Light Our Way
Michelle Sanders	IL Primary Healthcare Association
Andre Allen, PhD	Peoria County DEI
Shamra Robinson, PhD	Citylink
Seth Major	OSF Saint Francis Medical Center
Cassie Lucchesi	Peoria Proud
Marvin Hightower	NAACP
Jeff Ekena	ROE 53 (Tazewell/Woodford)
Leslie McKnight, PhD	PCCHD
Sara Kelly, PhD	UICOMP
Todd Northcutt	Haddaway Transport
Kathie Brown	GPEDC
Donna Crowder	PCCEO
Wayne Cannon	PCCEO
Regina Morgan	Southside Community Center
Erica Mutchler	TCHD
Cole Nicholson	TCHD
Amy Dewald	WCHD

Participating agencies that assisted with these qualitative data assessments included:

- Peoria Proud
- Home for All CoC
- Big Brothers Big Sisters
- Children's Home
- GLOW
- Southside Community Center

- Bradley University
- UICOMP
- Manual High School
- Peoria Central High School
- PCCEO
- PCCHD
- TCHD
- WCHD
- Alpha Kappa Alpha Sorority
- Delta Sigma Theta Sorority
- Lambda Chi Alpha
- Peoria County DEI
- OSF
- Fit and Strong Miller Center
- Citylink

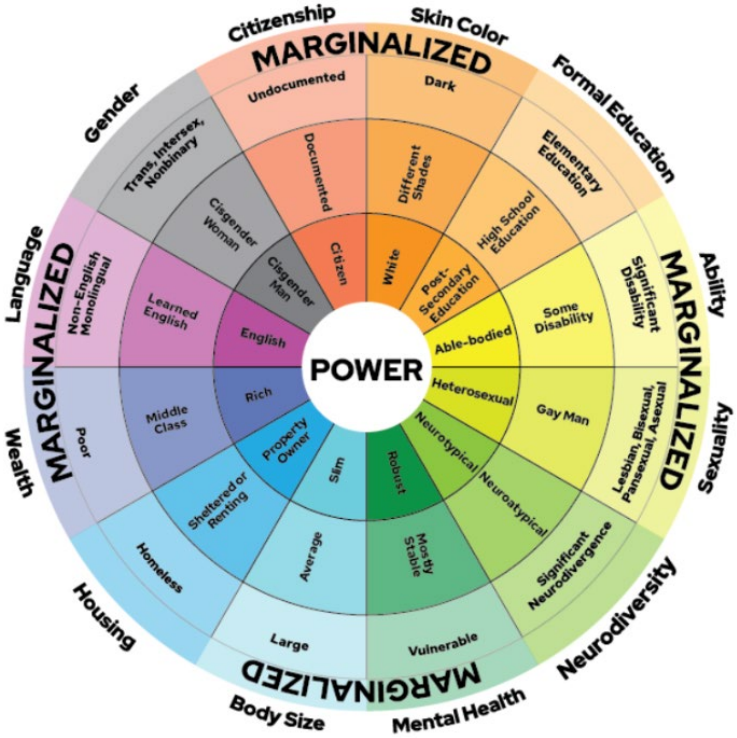
As a result, the CCA group was able to obtain qualitative data through outreach to these specific population which were either underrepresented by the survey (CSA) or are vulnerable to negative health outcomes as depicted by the Wheel of Power and Privilege. In particular there were **18 focus groups**, **30 interviews** resulting in **over 200** participants in this process.

- Black males 12-18
- Black women's health (maternal health)
- White males
- Cancer support groups
- Low-income
- Latinx
- LGBTQA+
- Uninsured-Underinsured
- Homeless population
- Seniors

Questions that guided these conversations included:

1. Is this information the biggest health concerns in your community?
2. What are the barriers to solving these top 3 issues
3. What have you seen that works to address these issues?
4. What specific resources are needed to solve these issues?
5. What are the barriers to obtaining these resources (if any?)

Figure 118 Wheel of Power and Privilege



Adapted from James R Vanderwoerd ("Web of Oppression"), and Sylvia Duckworth ("Wheel of Power/Privilege")

Community Conversations Summary

Communities interviewed included:

- Cancer Patients
- Female (maternal health)
- LGBTQ+
- Low Income
- Male
- Minority
- Seniors
- Youth

When asked about insurance, most individuals said that they had health insurance but that it, and the cost of healthcare, was hard to afford, and many noted that it was hard to find physicians who accept Medicaid.

The results for each community are presented in their own sheet.

Listed below are the themes present in most conversations:

Some health issues nearly in every group included:

- Mental health is a top health issue
- Access to care is a top health issue

Health behaviors:

- Substance use was consistently mentioned as a problem

For social determinants of health, several issues commonly mentioned were:

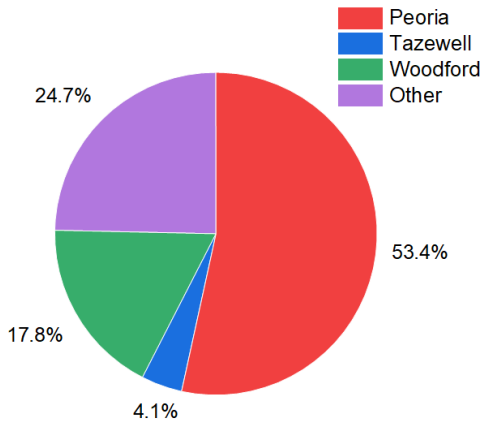
- Housing
- Safety
- Access to nutritious foods

Many people mentioned discrimination when discussing systems of power, privilege, and oppression.

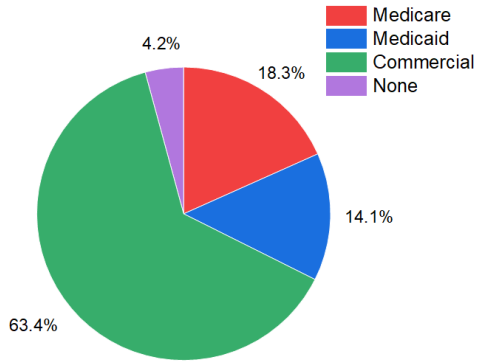
A lot of people mentioned opportunities to improve were health education.

Community Conversations: Demographics

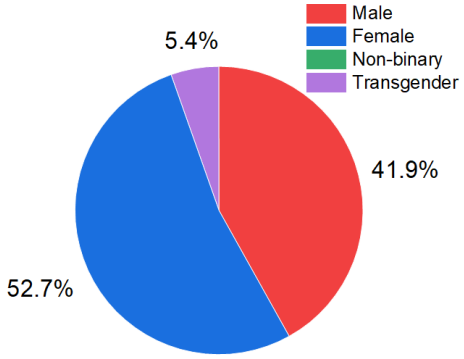
County



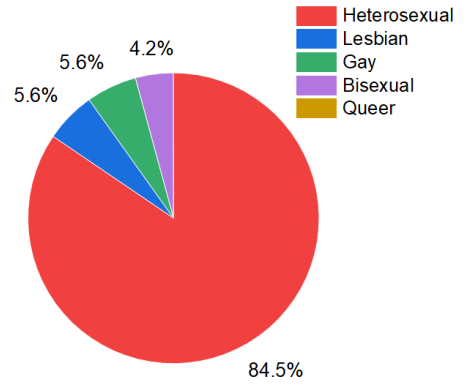
Insurance



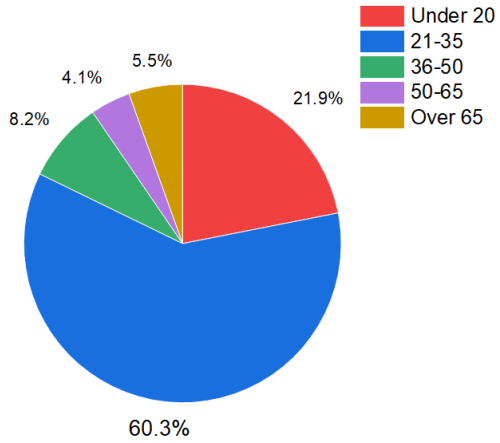
Gender



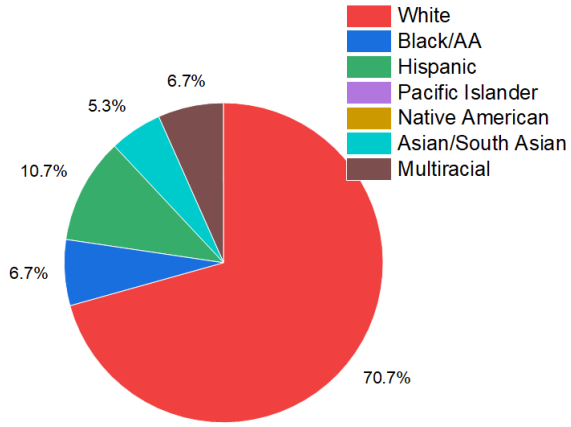
Sexual Orientation



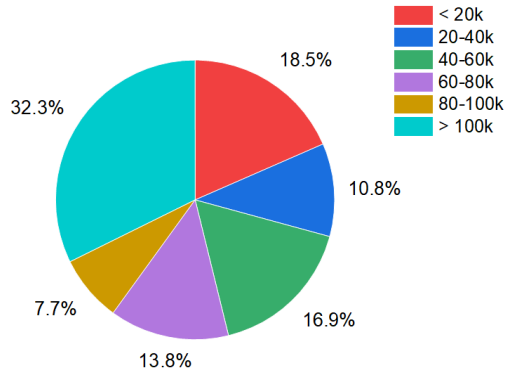
Age



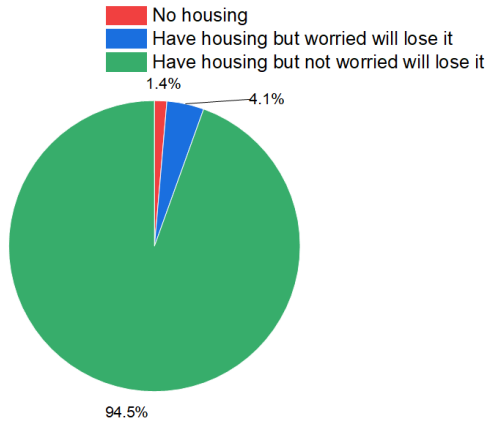
Race/Ethnicity



Income



Stable Housing



Cancer Patient Conversations

Four Patients Interviewed in Peoria and Woodford

Health Challenges Discussed	Quotes/Summaries
Emotional management of condition	Hard to deal with diagnosis Hard to deal with hair loss Lack of support system (would appreciate more support groups)
Insurance	All had insurance or received financial assistance
Diagnosis	For one, it was a surprise (went to ER for one thing, found out they had cancer)

LGBTQ+ Conversations

One Group Interviewed in Peoria (~12 participants)

Health Issues Discussed	Context of Health Issues	Quotes/Summaries
Access to care	Coverage of insurance is bad, making it hard to afford healthcare. So much control around transitioning that access to do this is extremely limited and can take years. Many physicians aren't knowledgeable about this community and how to treat them. May have to travel far to get care, which creates transportation barrier	"From the Trans perspective, having healthcare is huge... There's so much control around it, no access." "We need more primary care physicians who are more knowledgeable." "My doctor looked at me in the eyes and was like, I can't help you with this." "Not going to find it through OSF due to religious affiliations" "No more driving across the state to get healthcare" "Trans broken arm syndrome: When something happens, they get told to stop their treatment needed" Access to medication is also important
Mental Health	When transitioning, there is a lot of social and physical change to deal with. Hard to find a provider who knows how to work with these populations	"Would have to wait almost three years just to be seen for mental health issues [when on Medicaid] vs. having BCBS who would see you in a week."

Health Behaviors Discussed	Context of Health Behaviors	Quotes/Summaries
Substance Use	Places where you feel welcome may only be bars, and spending time there may lead to substance abuse issues. Further, self medicating with substances happens, especially when you don't have access to mental healthcare.	"Smoking weed would be a way to cope with these problems" "Lots of these social events are at bars, which may cause substance abuse"
Healthy eating	Have to spend money on other things (e.g., rent), so you don't have money left for good food.	Poor eating is a problem driven by poverty

Social Determinants of Health Discussed	SDOH Context	Quotes/Summaries
Money (poverty)	Discussed in context or rent and of being able to afford healthcare	High rent, can't afford to buy healthy food
Transportation	Going to the grocery store can take forever. Riding bus isn't convenient and crossing river without reliable transportation is hard.	"Peoria is very car-dependent." "Sidewalks and bike lanes are bad as well"

Systems of Power, Privilege, and Oppression

- Voice matters depending on environment
  - "When I talk to others I feel minimized"
  - "I don't think I can put up a pride flag without experiencing hate"
- Many have felt hopeless but try to focus on the small things that matter.
- Discrimination felt around same-sex marriage and where it is/isn't recognized, which can leave the person making decisions not being a spouse in crisis.

Community Strengths and Organizational Capacities (discussed in context of vision, not what currently exists)

- Walkability, decent roads, good transportation
- Mental health providers
- “[A healthy community is] a space where I can look to my left and right and see people who realize who I am, and someone I’m comfortable with looking at me.”
- Appreciate the ability to have art displayed around Peoria and the housing market is relatively friendly compared to most of the country

Low Income Conversations

One Group Interviewed in Peoria (~12 participants)

Health Issues Discussed	Context of Issue	Quotes/Summaries
Access to care	Feeling like won't be seen due to hygiene issues from being unhoused Lack transportation to access care Few providers take Medicaid, making appointment wait times long, especially for oral surgery, and making travel for long distances necessary	"A few barriers we face, almost daily, is true access to healthcare" "Many providers do not accept Medicaid."
Mental Health	Self-medication with drugs and alcohol leads to further issues Mental health problems tend to get called to police [and not necessarily to other resources that may be able to help]	"Mental Health issues are one of the number one issues that we see."
Chronic (e.g., diabetes, kidney disease) or physically disabling conditions	People may not feel comfortable seeking care for these when they are unhoused due to how they may be perceived, so this is a barrier for accessing care	This makes it hard to get services because of how someone is perceived.
Addiction	Drugs (not specific) and alcohol were mentioned, with appreciation for the help that comes together when someone ODs.	Discussed largely in context of mental health

Health Behaviors Discussed	Context of Health Behaviors	Quotes/Summaries
Substance Use	Self-medication	Addiction is second to mental health issues “Mental health became difficult with self-medication of drugs and alcohol. That is in terms of main cause of me not being able to keep a job”
Hygiene	Unstable housing leads to hygiene issues, which lead to a barrier to care due to concerns of how people are perceived	May not be the cleanest/negative perception

Social Determinants of Health Discussed	Context of SDOH	Quotes/Summaries
Lack of technology	Without phones/tablets/internet you can’t access care to see a doctor; impossible to schedule appointments	Can’t schedule appointments
Transportation	If you have to travel 1.5 hours from Peoria to see a specialist, this is a huge barrier to accessing care.	Barrier to accessing care and to medication compliance
Stable housing	Barrier to care because of how they are perceived, and because of not having stable resources	Homelessness was a main issue in conversations

Systems of Power, Privilege, and Oppression

- Quick to call law enforcement rather than deal with mental health issues with a counselor (reprimand rather than correct)

Community Strengths and Organizational Capacities (discussed mostly in context of vision, not what currently exists)

- Like:
  - Dream Center is helpful and doesn't send anyone away unless they are a single man
  - Working together to prevent/treat ODs
- Would like:
  - Unity in the community is desired.
  - Good places to get a hot meal
  - Mobile clinics

Male Conversations

Eleven individual interviews

Health Issues Discussed	Health Issues Context	Quotes/Summaries
Access to care	Lack of Health Coverage Healthcare Workforce & Quality Issues Geographic Barriers Mental Health Access Systemic Inequities & Social Determinants	“There may be a low amount of doctors” “Preventative care isn’t done much” “Everyone should have access to health services, obviously there is an issue” “Too many hurdles to obtain medical care” “Lack of health care and access to health care” “Access to health services - I feel like people don’t know how the health department works. They think everything that comes to us is a detrimental disease, but we help with almost everything.” “Struggle with access to health services since they take so long, so I go to prompt care more often.“
Mental Health/suicide	Communication Barriers: Cultural and generational stigmas around mental health prevent people from seeking help. Suicide & Societal Pressures: Financial stress, relationship breakdowns, and social isolation contribute to rising suicide rates. White men may struggle due to societal expectations to suppress emotions, while younger Black males face challenges in fatherhood and community support. Social Media & Mental Health: Increased exposure to public scrutiny, comparison, and cyberbullying through social media impacts youth	“Never discussed mental health growing up” “I would have suicidal ideation” “Adults may experience undiagnosed mental issues” “Divorce in middle aged men could also affect suicide rates” “Suicide- Potential loneliness is an issue, with family or friends not being there as you age. Masculinity is a factor as well. Stereotype that men are supposed to be “strong”. Within black community, it’s seen as a weakness if you talk about these things. Starts a buildup of stress and mental health issues. This can lead to risky behaviors and substance use. We need to

	mental health and may contribute to suicide rates.	invest in educating the community, advertising the services we have. Communicate with schools better. Need them to know we're transparent." "With suicide rates, again issues later in life would connect, and quality of life is deteriorating. Mobility would affect that, not being able to see friends and family as well. Stress related to mid-life may affect suicide rates. Stress related to supporting families. Lots of responsibilities, with the increase of cost. White males may not be the best at communicating these problems. Younger black males, maybe social media is a factor."
Obesity	Obesity & Diabetes: Strong connections between poor eating habits, lack of exercise, and rising diabetes rates. Limited access to healthy food, lack of nutritional knowledge, and financial constraints contribute to unhealthy lifestyles. Heart Health & Obesity: Poor diet and lack of physical activity increase risks of heart disease.	"Looking at obesity [as one of the top health issues], that doesn't surprise me." "Overweight is the #1 issue; most common I see." "Diabetes can also go hand in hind with obesity and heart health" "Poor eating habits lead to obesity. We do recognize people have certain conditions, but living an active healthstyle helps."
STIs	STIs & Risky Behaviors: Drug and alcohol abuse may lead to risky sexual behaviors, increasing STI rates. There is a gap in STI education, particularly for youth.	"I hear a lot about STIs from mutuals and their mutuals - they are getting around, being young and dating around." But: "STIs? Not [an issue] at all. Kids are sexually active, they know what to do when going about it." "STIs- Peoria has a high rate of STIs. When I'm talking to the community, they don't really understand the risks of unprotected sex. They don't have role models to talk to or the resources that the

		community has. We ask clients if they do drugs or alcohol, and yes I believe it causes risky behaviors." "Drug and alcohol abuse may indirectly lead to STI's and risky behaviors."
Aging issues	Dementia & Alzheimer's Increasing: Aging individuals face memory loss and mobility challenges, yet there are inadequate resources and facilities to support their independence. Concerns for Future Elder Care: Many foresee challenges in accessing quality elder care for themselves and their parents.	"I have a lot of aging adults in my life that are experiencing hearing and memory loss." Quality of life deteriorating

Health Behaviors Discussed	Health Behaviors Context	Quotes/Summaries
Substance Use	Alcohol abuse is linked to systemic issues: Alcohol availability is higher in low-income areas, reinforcing substance abuse as a coping mechanism. Drug use is widespread: Many people, regardless of background, are using some form of substance, which is seen as a systemic issue related to healthcare, stress, and economic conditions. Prescription medication concerns: There is skepticism about how doctors prescribe medications, with concerns that healthcare providers prioritize pharmaceutical solutions over real healing.	"Drug and alcohol abuse may indirectly lead to STIs and risky behaviors" "Everyone is on some kind of drug"
Diet	Unhealthy eating is widespread: Many people consume processed, unhealthy foods, often due to convenience, cost, and lack of nutritional knowledge. Food accessibility issues: Even healthy-labeled foods may still be unhealthy. Limited access to fresh, natural foods is a concern, especially for low-income individuals. Cultural and generational food habits: Some families, particularly immigrants, may struggle with understanding the American food system and its impact on health. Obesity and diabetes link: Poor diet and lack of exercise	"Poor eating habits is definitely the biggest unhealthy behavior since everyone I know has a problem with that." "Parents don't have the knowledge of how to eat healthy" "Poor eating habits is definitely the biggest unhealthy behavior since everyone I know has a problem with that."

	contribute to high obesity rates, which in turn increase diabetes prevalence.	
Exercise	Lack of movement is a common problem: Many individuals acknowledge they do not exercise enough, which contributes to weight gain and chronic disease. Active lifestyles could reduce health risks: More movement could help counteract the negative effects of poor diet and substance use. Exercise is accessible but underutilized: Bike trails and gyms exist, but there is little motivation or incentive for individuals to use them regularly.	"I think lack of exercise should be there as well."
Violence	Violence is more common in low-income areas: Systemic issues such as poverty, lack of employment, and substance abuse contribute to higher crime rates. Gun violence and interpersonal conflicts: Violence is often tied to disputes over money, relationships, or social status, exacerbated by economic struggles and limited conflict resolution skills.	"We have a violence issue" "In a violent environment, you are constantly on edge" "Random shooting could occur at any time here in Peoria" "Violence - Men not allowed to show weakness, so they have resort to firearms for example. Media contributes to angry behavior/violence. People idolize violence essentially. Lifestyle you should look up to, especially with black men."

Social Determinants of Health Discussed	SDOH Context	Quotes/Summaries
Poverty	Rising expenses, stagnant wages, and job instability contribute to chronic stress, affecting mental and physical health.	“My stress is more financial if anything”
Access to foods/food deserts	Many communities lack access to fresh, affordable, and nutritious food, contributing to obesity, diabetes, and heart disease.	“Having accessible healthy food within walking distance (10 minutes max)” “Lack of grocery stores in the south end of Peoria” “Find all alcohol stores in repressed neighborhoods”
Housing	High rent and difficulty obtaining homeownership create instability, which affects overall well-being.	Have a lot of homelessness “Blocks of housing look like they shouldn’t be up” “The affordable healthy housing does make sense for being a problem. With aging issues, I’m going through that with my parents. Facilities for aging adults, theres a problem finding a place for them to go and have some independence. Need more for the near future. Dementia and Alzheimers is only increasing.” “We need more residential and affordable housing here in peoria. Rental companies charge more for rent and are making it hard for people to get homes. It’s tough for first time home owners. Younger people aren’t looking to get homes as early anymore. It’s important to build credit at an early age, financial literacy” “Homelessness is also huge, as we have people sleep in the health department all the time.”

Safety	Unsafe environments and limited community resources contribute to higher violence, stress, and substance abuse.	High crime rates "Violence is an important contribution to poor male health."

Systems of Power, Privilege, and Oppression

- Believe voice matters
- Generational trauma - root cause of [issues] for minorities
- Discrimination experienced by minority communities

Community Strengths and Organizational Capacities (discussed mostly in context of vision, not what currently exists)

- One person thought with Carle/OSF Peoria has good access to care for its size
- Would like:
  - Minimum amount of infections and preventable (chronic) diseases.
  - Mental health support
  - Support groups
  - Places to be active
  - Access to healthy foods (e.g., late night groceries)
  - Late night STI testing, STI education in schools, churches can talk to kids about sex
  - Not seeing people on the streets begging for money
  - Being able to access doctor and health services
  - Financial literacy for young adults
  - More facilities for aging
  - Education opportunities for each student to learn a skill
  - Health education on substance use

Maternal Health Conversations

Six individual interviews and two focus groups (~55 participants total)

Health Issues Discussed	Context of Health Issues	Quotes/Summaries
Access to care	Many families aren't aware of or accessing preventative care. Many moms need more support postpartum. Not feeling comfortable talking with doctors (especially of another race) about health issues because doctors give perception they aren't interested. White women with Medicaid treated better at physician's than Black women with Medicaid.	"Many families use the emergency room as a doctor" Especially important for maternal health; feel like they push you out of the hospital right after giving birth, and many don't access preventative checkups for children or adults "Access to quality healthcare is important for low-income families" "Some of us have no access to healthcare"
Mental Health	Seen more issues in youth, unsure of cause. Violence and neighborhoods deteriorating (litter, buildings boarded up) cause emotional toll. Feeling like you have been held back due to gender for work promotions (glass ceiling) leading to stress Lack of sleep brings anxiety and stress	Increase in mental health issues and less resources for it "It's more acceptable for people to identify as a lesbian or gay, but it has a stigma attached which could lead to mental health issues" "Isolation with our aging population"
Obesity	Poor diets with large portions of poor quality food. No grocery stores in some parts of the city, so can't get to places that have nutritious foods. Lack of income to buy the right foods	"Obesity is a big problem in our country" "...overweight continues to be the number one issue in our community... This is particularly prevalent in the African American community" "There are too many young people with high blood pressure and diabetes"
STIs	People in the African American community aren't talking about	"I've seen that young girls get STIs and they get pregnant and they don't even get

	reproductive health or going to clinics to get testing or birth control	treated" "There's not enough sexual education programs"
Infant mortality	General lack of education for youth around pregnancy, abortions, STIs, etc.	"There is high infant mortality and premature deaths because [of a] lack of education in teenagers and adults"

Health Behaviors Discussed	Health Behaviors Context	Quotes/Summaries
Substance Use	Although drugs aren't manufactured here hard ones (fentanyl, heroin) are here. Cannabis and vaping shops are all around for easy access. Increase in mental health issues leads to increase in self-medication with substances	Peoria has "a lot of drug problems." "it's [heroin] being dropped of into African American neighborhoods on purpose" "Alcohol is a problem in a college campus"
Healthy eating	Eating healthy and physical activity are a stigma in the African American community People not reading food labels and industry producing lots of foods that are bad for you, starting with baby formula Parents don't have time to cook or learn how to cook nutritious foods, some don't know what to do with fruits or vegetables	"Nutrition is a big problem in Peoria" "Walmart closest to us doesn't have fruits and vegetables"
Preventative screenings	People don't talk about or get screenings for colon or prostate cancer	Should be done more, particularly in the African American community.
Violence	Youth don't know how to handle anger, and it ends up in violence	"Fear of crime and shootings in the neighborhood"

Social Determinants of Health Discussed	SDOH Context	Quotes/Summaries
Housing	Lack of insulation leading to stoves needing to be run in winter too often.	A lot of homelessness in the Peoria area Homes falling apart “House has mold and mildew”
Food deserts	Can’t walk or easily get to grocery stores with fresh fruit and vegetables	Can’t access nutritious food
Transportation	Ideally transportation to easily access different resources (e.g., nutritious food)	Needs better transportation services Better access (e.g., vouchers)
Safety	Concerns about youth having access to firearms	“There was an elderly housing program that had security issues on NE Madison… The housing started to have more people hanging around, which brought more issues… more issues can lead the residents to experience trauma with PTSD and physical and mental health problems” Curtail youth violence
Air quality	Said in the context of smoking/vaping, but seemed also to be about pollution in general Also some neighborhoods being near factories is a problem	“We’re also breathing in toxic air”
Poverty	People doing what they are used to and not able to obtain education to change and break out of poverty	Generational poverty
Neighborhood environment	People living in poor conditions and streets are not safe due to litter (including litter from substance abuse). Creates mental health issues	“I started seeing more litter…. There were condoms and needles, chicken bones, and alcoholic beverage bottles.” Need better sidewalks and safer neighborhoods

	from stress. People also don't take pride in neighborhoods Not enough green spaces in low	
Education	Discussed in the context of needing health education and general education to break out of poverty	Barriers to health insurance include lack of money and education

Systems of Power, Privilege, and Oppression

- Locally voice matters
- Work discrimination happens to women
- Loan issues/discrimination
- Many believed in self-advocacy

Community Strengths and Organizational Capacities (discussed mostly in context of vision, not what currently exists)

- Like:
  - Lots of Community Centers
  - Community gardens
  - Church food pantries
- Would like:
  - Screening and vaccination drives/health fairs
  - Food pantries/drives
  - More mental health resources
  - Education in areas of need (e.g., mental health, STIs, obesity)
  - A community where you aren't held back because of ethnicity
  - Pooling of resources
  - More education classes
  - Prenatal care and healthcare for all from birth to death
  - Schools and churches need to be involved in health campaigns
  - Available birth control, especially on the south side (Peoria)
  - Better employment opportunities

Minority Conversations

People Interviewed in Peoria: Six Minority Males; Six Minority Females

Health Issues Discussed	Health Issues Context	Quotes/Summaries
Access to care	Lack of knowledge about health department services prevents people from seeking help. Many perceive the health department as only dealing with severe diseases, not realizing it provides broader community health support. More education and outreach needed, including better communication with schools to raise awareness of available services.	"I feel like people don't know how the health department works" "I think it all starts with access to healthcare. That's the root cause of getting people to have better help" "Full access for everyone at every level" "Everybody should have access to health services, obviously there is an issue." "Access to health services - I feel like people don't know how the health department works. They think everything that comes to us is a detrimental disease, but we help with almost everything." "I think it all starts with access to health care. That's the root cause of getting people to have better help." "I think access to good health care is probably, in my opinion, a very important issue. Because in my past line of work, many of my families that I work with, they use the emergency room as a doctor. They would go to the emergency room rather than having a primary care physician and I think that's very important that you have a primary care physician to visit for your healthcare needs."
STIs	High STI rates in Peoria, partly due to lack of awareness about the risks of unprotected sex. Absence of role models and resources leaves individuals uninformed about	"Peoria has a high rate of STIs" "When I'm talking to the community, they don't really understand the risks of unprotected sex." "There isn't not enough sexual education programs to teach young people about protecting themselves from teen pregnancy and STD's in the Black community." "They should put in STI education in every school where their parents don't tell them."

	prevention and treatment. Substance use (drugs/alcohol) contributes to risky sexual behaviors, increasing infection rates.	"Also, teen pregnancy and sexually transmitted diseases are concerns with teenagers and their hormones. Some live in single parent families which force a single mother or father to work more than one or two jobs to pay the bills. Their child is left alone at home at times which creates issues as such." "There isn't not enough sexual education programs to teach young people about protecting themselves from teen pregnancy and STD's in the Black community. There needs to be more educational awareness. These issues interrupt the opportunity for a good education, poverty for the teen and baby, lowers self-esteem, and may cause the baby to be premature." " Yes, transmitted infections. They should put in sti education in every school where their parents don't tell them. People are mimicking what they see. Multiple sex on tv and social media need to be educated." "Sexual behaviors earlier now being exposed early because of technology." "I've seen that young girls get STI's, and they get pregnant and they don't even get treated. So, long term STI's are affecting reproductive health." "I hear a lot about STIs from mutuals and their mutuals - they are getting around, being young and dating around. Hears that they go to Central IL Friends every 3 months." "STIs- Peoria has a high rate of STIs. When I'm talking to the community, they don't really understand the risks of unprotected sex. They don't have role models to talk to or the resources that the community has. We ask clients if they do drugs or alcohol, and yes I believe it causes risky behaviors." "STIs, doing drugs and alcohol will inhibit risky behavior, leading to these outcomes."
Mental health/Suicide	Loneliness and isolation increase suicide risk, especially as individuals age and lose family or friend support.	"I don't want to expose myself to anger and violence" "Potential loneliness is an issue, with family or friends not being there as you age." "LGBTQ + some think it's okay. It's more acceptable for people to identify as a lesbian or gay, but it has a stigma attached which could lead to mental health issues. I have seen that with some being LGBTQ+ that they some people may not accept what you are, and they define who you are before you are able

	Masculinity norms discourage men, especially Black men, from seeking mental health support, as discussing emotions is seen as weakness. Unaddressed stress and mental health issues lead to risky behaviors and substance use, perpetuating a cycle of poor health.	to communicate it yourself. This can create mental and emotional stress issues." "The reason blacks are spiking, they have a hard time at work, and come home and still have a battle." "Anger issues: My siblings have anger issues- they were raised in black and asian households and were treated differently. Father taught you to bottle it up, and mother would buy things for the person that was angry (favorite food, new game console, etc.)" "Suicide- Potential loneliness is an issue, with family or friends not being there as you age. Masculinity is a factor as well. Stereotype that men are supposed to be "strong". Within black community, it's seen as a weakness if you talk about these things. Starts a buildup of stress and mental health issues. This can lead to risky behaviors and substance use. We need to invest in educating the community, advertising the services we have. Communicate with schools better. Need them to know we're transparent." "Mental health - I keep my friend group small. I don't want to expose myself to anger and violence. I don't have time for all of that. Growing up, I was raised different compared to my peers. So it's hard to find peers that are ambitious and want to better the community." "Men don't reach out for help with mental health. These males may not have an outlet to have the support they need, especially with all the stress factors there are in today's society. Seeking help is not the first course of action, there's a masculine culture. A sense of pride you want to protect."
Obesity	Fast food is more affordable and accessible than healthier options, making poor dietary choices more common. Economic constraints force unhealthy eating habits, contributing to obesity-related health conditions.	"With obesity, it's a lot easier to spend $5 on McDonalds than $25 on groceries" "Yes, obesity is a pressing problem. There are too many young people with high blood pressure and diabetes." "A lot of young kids like eating unhealthy foods such as hot Cheetos and Taki tortilla chips with red dye." "Well, we still have food desert. We just would do. We must look at the stores that are coming in the area, such as the Dollar Generals or Family Dollars. You're not going to find fresh vegetables or fresh fruit." "families understanding the importance of self-advocacy is lacking."

		"Obesity and diabetes are major issues." "They eat most unhealthy food, even healthy food is unhealthy. We need to go back to smaller farms, get certain items that we know are more natural." "Yes, obesity is a pressing problem. There are too many young people with high blood pressure and diabetes. A lot of young kids like eating unhealthy foods such as hot Cheetos and Taki tortilla chips with red dye." "There are too many foods with fats and sugars that are creating cancer because it's processed." "There needs to be a program to teach families how to shop and understand nutritional values." "Obesity, majority of the people don't get out and move around like they should. They eat most unhealthy food, even healthy food is unhealthy." "For like obesity, overweight continues to be the number one issue in our community." "This is particularly prevalent in the African American community. It's a stigma in the African American community to want to eat healthy, go bike riding, or be on a boat somewhere, where you're rowing. Anything physical is like a stigma." "Its what we eat and not how much we eat. Lack of education in the school systems. Babies formula in the 70's was not overweight. Now formula's are causing infant obesity." "Overweight is #1 issue, most common issue I see." "Diabetes - This connects with obesity and overweight and is due to a lack of resources. My mother coming into this country didn't know how the food works in America and father didn't have the resources. The parents don't have the knowledge of how to eat healthy. I have black family members that have diabetes."

Health Behaviors Discussed	Health Behaviors Context	Quotes/Summaries
Substance Use	Alcohol and drug use contribute to risky behaviors. This includes unsafe sex, aggression, and self-destructive habits. Substance abuse is more prevalent in lower-income areas. Easy access to alcohol and drugs in underserved neighborhoods makes these behaviors more common. Stress and financial struggles increase substance use. People use alcohol and drugs as a coping mechanism.	"If they do drugs or alcohol... I believe it causes risky behaviors" "Form of people status, find all alcohol stores in repressed neighborhoods." "Drug abuse, everyone on some kind of drug, form of racism as well." "Yes, there are a lot of issues in the Peoria area that are contributed to drugs and alcohol. If there is a low income then there's a higher chance of addictions," "When you under the influence, you wind up doing things you wouldn't normally due sober." "Drugs are being distributed in our community." "Alcohol and drugs are tied together they want to numb themselves and go back for more. These drugs and alcohol have triggers cause them to come back for more." "With Minorities, if all you know are bad behaviors growing, its going to translate to your children. There are corner stores that are easily accessible for substance use. If someone is currently poor, they most likely have been poor for a while. This causes stress and angry behavior/violence."
Unhealthy eating	Fast food is more affordable than healthy food. Economic constraints make it easier to eat unhealthy, leading to obesity. Lack of physical activity is a concern. Many people don't	Poor-quality foods easier to access/afford "People don't know the consequences of eating fast food" "With Obesity, it's a lot easier to spend 5$ on mcdonalds than 25$ on groceries." "I think it's diet because in this country I've noticed at a even if it's fast food, the portions are way bigger. But you know, it's almost too much food that we get

	prioritize exercise, either due to a lack of motivation or accessible spaces for physical activity. Generational eating habits play a role. Families pass down unhealthy dietary habits due to cultural norms and limited knowledge of nutrition.	anymore, and I think that's it's diet and it's the shortcuts we're taking." "We have a lot of hormones that are in the food that we're eating because they grow food from the edge of the table in a matter of weeks because the food is injected with hormones and preservatives and things. And I don't think that's good for our physical being."
Violence	Men are often taught to suppress emotions instead of seeking help. This can manifest in violent behavior. Glorification of violence in media influences behavior. Some young men see aggression as a sign of strength. Financial stress and systemic inequities contribute to community violence. Poverty, lack of opportunity, and social frustrations fuel anger and conflict.	"Men not allowed to show weakness, so they have to resort to firearms" "There needs to be good schools throughout to curtail youth violence. We need programs to teach youth how to handle violence without killing one another." "Violence - Men not allowed to show weakness, so they have resort to firearms for example. Media contributes to angry behavior/violence. People idolize violence essentially. Lifestyle you should look up to, especially with black men." "With social media, parents communicating with their kids what they're being exposed to. Watching certain media that idolizes violence is prevalent. Then they normalize it." "Fights are posted when I see things on social media. Mixing arguments with substance use. Its a cycle. You're angry, which leads to substance use, meaning you act out. High schools, you start to see students attacking others there, becoming more prevalent."
Structural & Environmental Challenges	Aging population with unique healthcare access needs. Lack of community outreach to seniors	"I'm not sure if this creates Alzheimer's, memory loss, hearing loss but at an older age you may normally lose some cognitive abilities." "Climate changes occur where it's too hot and there's not enough green space for people with low incomes."

	regarding food options and grocery delivery. Limited options for individuals struggling with housing or financial instability.	'Aging issues can't be controlled. I have a lot of aging adults in my life that are experiencing hearing and memory loss, these are general issues that make sense to me." "Socio-economic issues. Area that we're in, there aren't the resources they need. Role models are needed. Teachers aren't representative of the audience they're teaching. Helps students to relate. Communicating to students that violence isn't always the answer. Teachers may look the other way when something goes on." "Money is 1 barrier that never seems to be enough. Funds. I know that our church has a pantry and every Tuesday it's open for people to come and get food items including fresh vegetables. Funding is a barrier. Location is another barrier."

Social Determinants of Health Discussed	Social Determinants of Health Context	Quotes/Summaries
Stressful living environment	Financial hardship, unsafe neighborhoods, and lack of resources which directly impact health outcomes.	Contributes to how you eat and whether you use substances- "Stress from your lived environment will contribute to how you eat, how you think clearly when deciding to do substances." " In a violent environment you are constantly on edge. If you can walk without being harassed, it is healthier because you don't have much stress. " "If you don't have a decent place to live and I'm not talking about a mansion. If your home is falling apart. There's a hole in the wall for you. Have a leak someplace, and in the wintertime you don't have because of your house is not properly insulated and you stay cold all the time then that leads to keeping your gas stove running when you should not have it running."
Economic Stability	Poverty and financial stress contribute to poor health. Housing affordability is a growing issue. Economic hardship leads to generational health disparities.	"Economically. Growing up in a single-parent household, it becomes a burden on everyone. Stress builds up. Parents have a strong influence on their children and how they deal with issues." "A big barrier is based on your zip code, socio-economic issues. I go to doctor with Medicaid card and they determine what type of care and how much care."
Education	Lack of health education leads to poor health behaviors. Generational knowledge gaps impact family health. Some immigrant families struggle with nutrition knowledge, leading to higher rates of diabetes and obesity.	Low education levels in Hispanic community- "Within Hispanic community, college education is low." "A lot of parents send their kids straight to work and prioritize saving money, rather than college education." "Funding for communities that truly need it. Something that creates equitable outcomes for the community. Mental health services as well to get simple things like flu shots. A majority of this comes down to education, people don't know the

	Parents who grew up without health education may not teach their children healthy habits.	consequences of eating fast food versus cooking at home." "Again, I think some of it is the education piece of it not really knowing what's good for you or what you should be having or those types of things"

Systems of Power, Privilege, and Oppression

- Voice matters somewhat
- Have felt hopeless about future and situations beyond one's control

Community Strengths and Organizational Capacities (discussed mostly in context of vision, not what currently exists)

- What they like:
  - Schools have black history month and promote activities for minorities; that shows that they care
- Would like:
  - Nice housing, clean areas, affordable housing
  - Kids don't experience violence
  - Education on substance abuse in schools
  - Role models
  - Educating community about services
  - Diverse professionals
  - More education in general/better education
  - Health Department to offer more community resources
  - Better drinking water
  - Better community-core relationships
  - In-depth sexual education
  - Minority Support Groups
  - Brown bag testing for STIs

Senior Conversations

One Group Interviewed in Tazewell (10 participants)

Health Issues Discussed	Context of Health Issues	Quotes/Summaries
Overdose Deaths	Agree that overdose deaths are a leading cause of death in Tazewell County	Agree that those are a leading cause of death
Mental Health	Mental health issues have increased due to covid, marijuana use, politics, economic issues, social media	Believes there is still a stigma for those suffering with mental health issues
STIs	Don't agree that STIs are a big issue in this age group/community	Don't think they are a problem in that community/age group
Diabetes and kidney disease	Diabetes & Kidney disease should be in the top 5 causes of death in Tazewell County	Should be in top 5 in Tazewell
Obesity	Poor eating is a big problem, and income is a factor	Most agreed this was an issue

Health Behaviors Discussed	Health Behaviors Context	Quotes/Summaries
Substance Use	Both legal and illegal drug use poses significant challenges which affect individuals and families	Legal and illegal drug use are big problems in my community
Healthy eating	Limited availability of grocery stores and farmers' markets can make it challenging for residents to obtain fresh fruits, vegetables, and lean proteins, leading to a reliance on processed or fast foods that are more readily available.	Poor eating is a big problem, and income is a factor

Social Determinants of Health Discussed	SDOH Context	Quotes/Summaries
Money (poverty)	Living in a rental housing that is not taken care of is unsafe due to mold and cluttered walkways	Cost of insurance too high, and it is expensive to care for your health
Living environment	Substandard rental housing conditions pose significant health and safety risks in this community. Neglected maintenance issues, such as mold growth, structural damage, and cluttered walkways, increase the likelihood of respiratory illnesses, injuries, and overall poor living conditions. Limited tenant rights and financial constraints often leave residents with few options for improving their housing situation.	Unsafe due to mold and clutter

Systems of Power, Privilege, and Oppression

- Most do not think voice matters; policies/politics out of their control; cities aren't listening to citizens
- Many have felt hopeless and also believe that people in their community suffering from mental health and substance use issues feel helpless

Community Strengths and Organizational Capacities (discussed mostly in context of vision, not what currently exists)

- What is working: Churches helping communities with food pantries
- What could be better:
    - Being able to spend time outside without fear of danger/safe neighborhood
    - Community parties/picnics/sharing of food with family members
    - People taking care of homes, keeping yards and streets free of clutter
    - No more school shootings
    - Resources for unhoused
    - Resources and education around healthy living, substance use, and suicide prevention
    - Dental clinics
    - Treatment for mental health issues
    - Transportation vouchers
    - More physical fitness classes.

Youth Conversations

Five Groups Interviewed in Peoria (3), Tazewell (1), Woodford (1), ~58 participants total)

Health Issues Discussed	Health Issues Context	Quotes/Summaries
Homicides/Violence	Homicides, suicides, and drug use are common concerns. Violence and poverty are prevalent and are stressful	“Homicides, suicides, and drugs would be the most around us.”
Suicides	Car accidents and suicide are believed to be leading causes of death for youth, potentially due to risky behaviors influenced by drugs and alcohol.	Expected this and car accidents to be the leading cause of death for people under 18
STIs	High prevalence of STIs in Peoria is a serious concern, compounded by lack of awareness and education about sexual health. Youth in the community are becoming sexually active at earlier ages, further increasing the risk of STIs.	“They don’t currently teach much on sex education now” “More people are being sexually active nowadays”
Mental Health	Adversity and hardship increase mental health struggles. Economic struggles, bad influences, and exposure to violence contribute to stress, depression, and suicidal thoughts. Pressure of school, work, and socializing can be hard on mental health	“If you don’t make enough money then you’re going to have pressure, stress, mental issues” Stress associated with worry about the future, and sometimes become isolated when stressed or overwhelmed.
Aging Issues	Aging-related health concerns are increasing in Peoria. Dementia and mobility issues are common, with older adults struggling to stay independent.	Falling is an issue

	Falling is a major concern, as seen with elderly residents requiring hospitalization.	
Obesity (last)	Obesity is a concern, but its visibility varies. Some individuals don't see obesity as common, while others recognize poor eating habits as an issue. Healthy food access is a concern, with some believing it should be prioritized over housing improvements. Sometimes skip meals or choose unhealthy options due to lack of time and money	"I don't really see obese people around me" "Poor eating habits leads to obesity."
Access to care	No urgent care in Eureka, lack of mental health providers, Feelings of racism, homophobia, or being dimissed because of age, gender, or other factors Rural area without transportation makes it hard to access medical care	Many providers have bias

Health Behaviors Discussed	Health Behaviors Context	Quotes/Summaries
Violence	Violence is seen as an idolized lifestyle, especially among Black men. Media influences violent behavior, portraying it as a symbol of strength or power. Many young men grow up in environments where violence is normalized.	"Even when people don't have guns, they go find parts to make one, making gun violence more dangerous"
Substance Use	Drug and alcohol use is high and socially normalized. Substance use is linked to violence, accidents, and risky behaviors.	Drug and alcohol use are high "With drug and alcohol abuse, we need to limit it, on a federal level." Vaping, smoking happen among high school and college students
Alcohol Use	Alcohol abuse is viewed as a top concern, suggesting it is widespread in the community.	"Alcohol abuse should be the top issue" "Binge drinking, vaping, and ignoring mental health struggles are common"
Healthy eating	Unhealthy eating habits contribute to long-term health issues like diabetes and obesity.	"If healthier foods were not as expensive and more attainable, we could solve the obesity problem"

Social Determinants of Health Discussed	Social Determinants of Health Context	Quotes/Summaries
Money (poverty)	Many people work unstable jobs, get their hours cut, or struggle to afford basic needs. Financial stress contributes to anger, frustration, and even violence in households. Long-term financial struggles lead to chronic stress, which can cause heart disease, high blood pressure, and other health issues.	Issues paying insurance and bills “Income, bills, rent. If you don’t make enough money then you’re going to have pressure, stress and mental issues. How you spend and budget is an issue.“ Not knowing if you can afford insurance, healthcare, or having to work to support yourself in school were issues discussed, also health literacy around insurance is a problem
Safety	Violence directly harms physical health. Homicides, assaults, and injuries from violence are a direct health threat, leading to death, permanent disability, or long-term physical damage.	Discussed in the context of desire to be safe alone outside. “Not hearing gunshots would help us sleep better as well.”
Air quality	Poor air quality leads to chronic respiratory diseases. Air pollution exacerbates existing conditions.	“We’re being polluted more” “Smoke in the air, we’re being polluted more. Carbon dioxide, using it in a more efficient way.”
Food insecurity	Food insecurity leads to unhealthy eating habits, increasing obesity and chronic diseases like diabetes.	“Healthier version of food pantries [is desired]. They give us nearly expired food most of the time.”
Transportation	In a rural location, it is very	“The town itself lacks easy access to things like

	hard to get food and medical care without a car	urgent care, affordable groceries, or public transportation”

Systems of Power, Privilege, and Oppression

- Most think their voice matters
- Have felt discrimination, especially women of color, based on sexual orientation or identify/have witnessed discrimination of family members by doctors
- Many have felt hopeless because of challenges/situations beyond their control
- Generational poverty is a problem
- Think there should be stricter policies for guns, drugs, and alcohol
- Many feel like they aren’t taken seriously because of their age or will be judged

Community Strengths and Organizational Capacities (discussed in context of vision, not what currently exists)

- Having psychologists and dieticians available for kids/college students
- Nursing homes/hospitals close to rural communities
- Health education, especially around sex ed and mental health
- Community safety
- Community events
- No discrimination
- Strict rules on guns and drugs, violence prevention programs
- Health clinics closer to schools/ones that come to schools