
MADISON COUNTY HEALTH NEEDS ASSESSMENT
AND
COMMUNITY HEALTH PLAN 2011-2016



HEALTH PRIORITY AREAS:

Air Quality/Environment
Mental Health
Obesity
Substance Use and Abuse
Teen Pregnancy

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For
Illinois Department of Public Health
Springfield, IL
March 2011

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Printed June 2011

LETTER FROM PUBLIC HEALTH ADMINISTRATOR

The Madison County Health Department adopted its first Community Health Assessment and Plan in 1996. This document conveys the fourth time in 15 years of conducting a needs assessment and developing a community health plan for Madison County, State of Illinois. I am happy to report that the process remains to be an active engagement of community partners, elected officials, and citizens interested in maintaining a living-breathing plan with community involvement to achieve positive health outcomes for our county.

We wish to extend our sincere appreciation to elected officials, appointed members of the Health Advisory Committee, community leaders, agency partners and stakeholders that participated in the focus groups, assessments, data analysis, priority selection, community health summit, and Madison County Partnership for Community Health (MCPCH) priority committees. Their commitment to improving the health of Madison County is indisputable.

Finally, I would like to thank the managers, staff, and interns at the Madison County Health Department for their participation, contributions, and teamwork throughout this IPLAN process. We look forward to working together as a community to continue to address the needs in Madison County.

Sincerely,



Toni M. Corona, Public Health Administrator
Madison County Health Department

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EXECUTIVE SUMMARY

The Institute of Medicine's (IOM) landmark report, *The Future of Public Health*, recommends a renewal of efforts from all corners of society to address the mission of public health. The report reaffirmed local public health agencies as "the final delivery point for all public health efforts" and called for "policy development and leadership that foster local involvement and a sense of ownership, that emphasize local needs, and that advocate equitable distribution of public resources and complementary private activities commensurate with community needs." The Madison County Health Needs Assessment and Community Health Plan is a response to the IOM's recommendation and provides the methodology to achieve a healthier community. According to 77 *Illinois Administrative Code 600*, last revision effective June 3, 2004; every five years local health departments are required to lead the process of assessment and plan development with community partners as part of the recertification process by the Illinois Department of Public Health. The project for this assessment and plan development process in Illinois is known as the Illinois Project for Local Assessment of Needs (IPLAN). In this fourth round of IPLAN for Madison County, a stronger emphasis has been placed on involving various community partners and the public at different points in the process and considering layers of quantitative and qualitative data as the core for guiding discussions leading to the selection of health priorities.

This assessment and plan are the result of cumulative efforts by health professionals, community agencies and organizations, educators, citizens, and health department personnel. The Health Needs Assessment documents the process and elements for identifying and establishing the Health Priorities for the next five years. The Community Plan establishes objectives and strategies that will address the Health Priorities and positively impact the health of the community. The Madison County Community Health System will utilize the assessment results and community health plan to guide program development designed to address the health concerns.

The 2011-2016 Madison County Community Health Plan addresses the five health priority areas that were identified through the 2010 Madison County Health Needs Assessment. The 2011-2016 Madison County Health Priorities include: Air Quality/Environment, Mental Health, Obesity, Substance Use and Abuse, and Teen Pregnancy. Each priority area includes at least one outcome objective, one impact objective, and strategies to foster the achievement of outcomes over the next five years. Objectives and strategies for each priority take into consideration the current state of perception, acceptance, and knowledge of the problem within Madison County, feasibility of attaining goals, and resources available or accessible to implement the plan.

The document provides accurate, concise, and defensible information to identify and describe public health needs in Madison County, Illinois. In compliance with Illinois Department of Public Health Illinois Project for Local Assessment of Needs (IPLAN) protocol, the following categories were a portion of the elements examined in this countywide needs assessment which included: demographic and socioeconomic characteristics; general health and access to care; maternal and child health; chronic disease; infectious disease; environmental, occupational, and injury control; and sentinel events. Also in compliance with IPLAN protocol, progress and achievements of the 2007-2012 Madison County Community Health Plan were received, reviewed, and considered during the data analysis phase of the 2010 Health Needs Assessment. Finally, in accordance with IPLAN protocol, Madison County Health Department fulfilled the requirement of conducting an Organizational Capacity Assessment by engaging in a Strategic Planning Process. This report is intended to provide a general assessment of health in Madison County, IL and a community health plan to address the identified health needs. Any given indicator can and should be analyzed in more detail than is possible here for the purposes of program planning. This assessment is useful in identifying broad health problems and establishing priorities for program interventions.

WHAT IS IPLAN?

Illinois Project for Local Assessment of Needs is a community health assessment and planning process led by local health jurisdictions in Illinois as part of their certification process with a concentration on community involvement. IPLAN is grounded in the core functions of public health which are assessment, policy development, and assurance. IPLAN addresses public health practice standards and is conducted every 5 years to establish at least 3 health priorities and collaborate to impact those health issues for the community.

The general IPLAN Process includes the following elements for all certified local health departments in Illinois:

- Conduct Organizational Capacity and Self-Assessment
- Assemble Community Stakeholders and a Core Team
- Conduct Community Health Needs Assessment
- Analyze Data and Set at least 3 Health Priorities
- Inventory Community Health Resources
- Develop Community Health Plan
- Submit Recertification Application
- Through Community Coalition and Community Organizations:
 - Conduct Program Development
 - Implement Community Health Plan
 - Evaluate Progress on Community Health Plan

Local Boards of Health review the proposed health priorities and community health plan for approval of implementation in their jurisdiction. Upon approval, the IPLAN document is submitted to Illinois Department of Public Health for review and approval as part of the local health department's recertification package. Finding the local health department in substantial compliances, local health departments are then recertified for a five year period and IPLAN implementation begins in that jurisdiction.

For more information about IPLAN, access IPLAN data, or view IPLAN-related webinars, visit <http://app.idph.state.il.us/>.

ASSESSMENT AND PLAN DEVELOPMENT PROCESS

Statement of Purpose:

Health Needs Assessment and Community Health Plan

The purpose of the Health Needs Assessment is to collect and analyze a variety of data to obtain a current, clear picture of the state of health in Madison County, Illinois. Data is collected from various sources including: statistical data in specific categories, information and feedback from community leaders, observational data from trends in health, and citizen perception of health needs and their origins. Data is analyzed to identify common themes and specific health issues that exhibit concern for health impact through the statistical data as well as concern for health impact as seen by community leaders and citizens. Health concerns that were prevalent continued through the process for consideration as possible health priorities. The Health Needs Assessment process and resulting data was the primary source of information for review during the Core Group Meeting to set the 2011-2016 Health Priorities. Highlighted data from the Health Needs Assessment is included in this document for use by the community as general information and for program and strategic planning purposes.

The purpose of the Community Health Plan is to create a five-year roadmap to impact each chosen health priority. Community members came together to:

- consider the data and current state of the health priority for Madison County
- discuss existing programs and opportunities addressing the health priority
- identify gaps in service and programs
- identify current community knowledge and perceptions about the priority and any existing interventions addressing the priority
- explore available and possible resources
- determine feasible objectives to impact the health priority as supported by strategies grounded in best practices and evidence-based approaches.

The collaborative development of the Community Health Plan establishes a partnership among key stakeholders and community organizations to work together while creating the plan and implementing it over the next five years. The Community Health Plan then becomes a living, breathing document to guide strategic planning and programming among all agencies, organizations, hospitals, and schools throughout the county as well as an opportunity for everyone to join in a collaborative effort to address the health priority in a meaningful way for the lives of Madison County residents.

2011-2016 Process Highlights

During 2010, Madison County Health Department led the IPLAN Process for Madison County in cooperation with Madison County Partnership for Community Health (MCPCH) and community stakeholders. Many of these components occurred simultaneously from May 2010 through January 2011. Below are the major components of the process that will be mentioned or expanded upon in this document.

Health Needs Assessment Phase

- Organizational Capacity Assessment via Strategic Planning Process
- Community Needs Assessment
 - Data Collection and Analysis
 - Focus Groups
 - Community Health Survey
 - Quantitative Data
 - Convene Core Group Meeting to Set Health Priorities
(culmination of Assessment Phase)

Community Health Plan Phase

- Community Plan Development
 - Community Health Plan Summit
- Implementation of Plan
 - Madison County Partnership for Community Health (MCPCH)
 - Madison County Community (residents and organizations)

HEALTH NEEDS ASSESSMENT PHASE

Organizational Capacity Assessment

In accordance with IPLAN protocol, Madison County Health Department fulfilled the requirement of conducting an Organizational Capacity Assessment by engaging in a 6-month Strategic Planning Process. The National Association of County and City Health Officials (NACCHO) “Local Health Department Self-Assessment Tool – Operational Definition of a Functional Local Health Department Capacity Assessment for Accreditation Preparation” tool was applied and used to assess department’s strengths and weaknesses based on the essential services framework. The process was facilitated by Ms. Laurie Call, Director of the Center for Community Capacity Development with Illinois Public Health Institute. The Strategic Planning Committee included: Board of Health members, Health Advisory Committee members, Public Health Administrator, and Health Department Division managers. The Madison County Health Department Strategic Plan, 2011-2016 is a separate document which was adopted at the same time as the Needs Assessment and Community Health Plan. To view the Strategic Plan, visit www.madisonchd.org.

Community Health Needs Assessment

The purpose of the Community Health Needs Assessment is to collect and analyze data to obtain a clear, broad picture of the current state of health in Madison County to inform the decision making process for setting health priorities to address over the next five years. Madison County’s Community Health Needs Assessment included three types of data collection, data review and analysis, and the convening of a Core Group to set the health priorities. This section will illustrate the process for each of the three methods of data collection, highlight key data that was discovered, summarize the Core Group Meeting process, and identify the selected health priorities to address.

Data Collection and Analysis

At the core of the Health Needs Assessment is the collection and analysis of data. IPLAN protocol dictates that, at minimum, data groupings designated by the Illinois Department of Public Health in the IPLAN Data System be reviewed and analyzed to determine the health status and health problems most meaningful for the community within each grouping. The IPLAN Data System categories include:

IPLAN DATA SYSTEM CATEGORIES

- Demographic and socioeconomic characteristics
- General health and access to care
- Maternal and child health
- Chronic disease
- Infectious disease
- Environmental/occupational/injury control
- Sentinel event

During April-August, 2010, specific health problems within each IPLAN Data System category as well as additional categories not included in the IPLAN Data System but relevant to the status of health in Madison County were identified, data was collected and analyzed, and gaps in available data were noticed. In total, 27 different health concern areas with multiple data points were entered in Excel Spreadsheets, reviewed and analyzed, and then collapsed to 140 slides of highlighted data. The Top 10 health concern areas were identified using this quantitative data, Focus Group results, and Community Health Survey data. This Data Collection and Analysis Section provides key data findings used during this process. The full set of 140 slides of highlighted data can be found at www.madisonchd.org.

Madison County Health Department's method for data collection and analysis included a three-tiered approach in order to obtain the perspective of community partners working in the field, interacting with residents, and providing services; the perceptions of the general community; and the statistical evidence available related to a variety of health problems. This component was accomplished by conducting Stakeholder Focus Groups, administering a Community Health Survey, and collecting and analyzing multiple statistical data points. Additional data considered during the process included: Madison County Youth Forum problem statements and recommendations, 2007-2012 Madison County Community Health Plan outcomes, program data, community trends, and identified needs through the general course of business. Data from all three types of data sources was analyzed and cross-referenced to generate the Top 10 health concerns list for the Core Team to begin the health priority setting process.

Stakeholder Focus Groups

Madison County Health Department conducted Stakeholder Focus Groups as one of three data collection and analysis components. The purpose of the Focus Groups was to obtain qualitative data from community partners to help generate key health concern areas for the Community Health Assessment. The information gathered from the focus groups assisted in identifying themes of health concerns. These themes were the foundation for the content of the Community Health Survey and carried through into the health priority setting and plan development phases.

67 community partners from 42 different organizations participated in 7 focus groups which were held at Madison County Health Department on the following dates:

Friday,	June 11, 2010,	10:00-11:30 am
Monday,	June 14, 2010,	1:30-3:00 pm
Wednesday,	June 16, 2010,	1:30-3:00 pm
Monday,	June 21, 2010,	1:30-3:00 pm
Wednesday,	June 23, 2010,	10:00-11:30 am
Friday,	June 25, 2010,	10:00-11:30 am

A list of Focus Group Participants located in Appendix B.

Focus group participants were given background information on IPLAN, overview information for the day, handouts including health-related definitions to ensure everyone had the same foundation, and a copy of the 2007-2012 Madison County Health Needs Assessment and Community Health Plan. The focus group discussion centered on the following question categories:

- a. General Question – Round Robin (10 minutes)
 - i. What is important to the health of our County?
- b. Perception and Needs (50 minutes = 10 minutes/question)
 - i. What are the most urgent health concerns that you perceive in Madison County?
 - ii. What are the most urgent health concerns that the community perceives?
 - iii. What are the causes of these problems? (Physical health problems, social problems that affect health like substance abuse and violence, mental health problems, etc.)
 - iv. What are the strengths of the health services available in your community?
 - v. What do you see as the greatest obstacles to good health?
- c. Any Final Comments regarding Health Needs in Madison County

Participants were asked to assist with upcoming steps in the Assessment Phase including: distribution of the Community Health Survey, participation in the Community Health Plan Summit, and for some community partners – an invitation to participate on the Core Group for setting health priority recommendations.

RESULTS

Discussion from the 7 Focus Groups yielded 64 pages of combined notes by health educators documenting the discussion points. This focus group response data was analyzed for trends and themes and subsequently collapsed into categories. Here are the results:

Madison County Urgent Health Concern Themes Derived from IPLAN Stakeholder Focus Groups June 2010

Access to Care

- Accountability
- Affordability
- Location/proximity of services to populations
- Communication issues on several levels
- Knowledge or use of services
- Quality of doctors and services
- Transportation
- Decrease or elimination of programs and services
- Lack of specialists
- Difficult/challenging to get or afford appropriate and/or needed prescriptions
- Difficulty navigating the health system
- Lack of one stop shop
- Services do not always match needs
- Office hours are not conducive to people's availability (time or financially) to schedule and attend health appointments
- Discrimination by healthcare providers
 - Race
 - Elderly
 - Insurance status
 - Mentally ill
 - Medicaid
- Particular problems/challenges for special needs populations (this was mentioned for several other topic areas below as well)

Poverty

Obesity

Substance Use/Abuse

- lack of detox facilities and residential treatment, esp. for adults
- underage drinking
- smoking
- drug use
- drugs prevalent in communities (certain drugs predominant in certain communities)
- prescription drug abuse
- drinking and drug use tied to sexual behaviors

Transportation

Apathy

Lack of Self-Worth

Lack of Initiative

Loss of Sense of Community

Sexually Transmitted Diseases

Teen Pregnancy

Influence of the media

Wired Society

Mental Health (a multitude of issues were mentioned throughout from various aspects)

Lack of Funding/Decrease in Services

Lack of Resources

Lack of Knowledge of Resources

Lack of Utilization of Resources and Services when they do know about them

Lack of Support

Dental Health

- access to care (multitude of barriers mentioned)
- dental health not being part of lifestyle
- lack of dentists that accept coverage

Attitude

Lifestyle

Behaviors

Lack of Personal Responsibility

Loss of Standards

Priorities that are chosen by people

Lack of an Attitude/Lifestyle of Prevention

Environment (a multitude of issues were mentioned throughout from various aspects)

- Physical Environment
 - poor air quality
 - water
 - soil
- Societal Environment
 - safety concerns, esp. personal safety and the safety of children

- food choices in restaurants
- lack of available/affordable healthy foods
- lack of access to physical recreation
- lack of access to social recreation
- loss of sense of community/neighbors
- Government/Political Environment
 - Mayors not taking a position on health or even getting involved in their community
 - Own agendas of politicians
 - Governmental irresponsibility in the fiscal aspect (various degrees and examples mentioned)

Lack of Health Literacy

Lack of Education

Lack of Prevention

Lack of Comprehensive Health Education

Lack of Community and Individual Awareness of various aspects related to health

Unemployment/Lack of Job Opportunities

Lack of money and resources (by individuals) to live healthy lifestyles, access opportunities, or pay for healthcare costs

Lack of Coping Skills

Stress

Violence – especially teen on teen

- substance abuse
- bullying
- general violence

Senior Care issues and concerns (various mentioned)

USE OF DATA

The Focus Group data was used to build the selections on the Community Health Survey. The rationale was such that if the community stakeholders were identifying and facing interactions with these health concerns in their organizations and services, then the next step was to measure the community's perception and level of concern and urgency for these identified health concerns. The data was also used as part of the Core Group discussion in the process of setting health priority recommendations.

Community Health Survey

As one of three data collection and analysis components, Madison County Health Department administered a Community Health Survey to Madison County residents. Community perception is a substantial factor in developing interventions, identifying root causes, and gaining community support and engagement for behavior change to occur. The purpose of the Community Health Survey was to obtain qualitative data from citizens who live or work in Madison County to gather their thoughts about health concerns in Madison County for the Community Health Assessment. The information gathered from the Survey assisted in identifying the core health concerns of the community and the factors influencing those health problems. This data was analyzed and utilized by the Core Group discussion in the process of setting health priority recommendations and during the Community Health Summit and Plan Development Phase.

The Community Health Survey was distributed during July-August 2010. The Survey was distributed to hundreds of people through various modes, including:

- Press Releases sent on July 20, 2010 and August 3, 2010 to all newspapers, radio, television, and media contacts (over 20 media sources) in the Metro St. Louis area servicing Madison County
- Emails with the survey and the web link to the online survey were sent to over 300 contacts including:
 - Community partners
 - Focus Group Participants and Invitees
 - Friends and family
 - Madison County employees
 - Madison County Board/Board of Health
 - Health Advisory Committee
 - Community coalitions
- Paper surveys and promotion sheets directing people to the survey web link were distributed to over 146 different locations:
 - Local businesses
 - Community partner sites
 - Community events
- Websites – the link to the survey was posted on a few websites including:
 - Madison County Health Department
 - Madison County Government
 - Lewis & Clark Community College

The Community Health Survey content was based upon data derived from the Stakeholder Focus Groups in June 2010. The Community Health Survey was provided primarily in a web based survey format through a Survey Monkey Link. Paper versions of the Survey were also available and distributed upon request. The web based survey and paper survey contained the exact same questions and information. All data from the paper surveys was inputted into the web based survey database so the Survey data could be compiled and analyzed together. The survey was conducted using a convenience sample instead of a random sample due to time, cost, size of county population, and feasibility of conducting the survey and reasonably collecting the data during the time allocated. Limitations of the survey were to people who: saw the survey in a community location, were given the survey, had some readability issues with multiple choices, and who lacked motivation or willingness to contribute their answers.



Madison County Community Health Assessment Survey

For all residents and people who work in Madison County

Madison County Health Department is beginning its 5-Year community health assessment process. Citizen input is important to us! Please complete the following survey. Also, encourage your family, friends, neighbors, and co-workers to complete the survey by visiting www.madisonchd.org.

We appreciate your help!

1. What do you feel are the most urgent health-related concerns in Madison County?
(Please list up to 5)

- 1.
- 2.
- 3.
- 4.
- 5.

2. Please rate the following on a scale of Very Important to Not Important at All as they relate to accessing health care in Madison County.

	<u>Very Important</u>	<u>Important</u>	<u>Neutral</u>	<u>Not Important</u>	<u>Not Important at All</u>
Accessibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accountability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Affordability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Location of services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowledge or use of services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality of doctors and services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limited programs and services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of specialists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cost of prescription drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty navigating the health system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Office hours for appointments are not convenient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____					

3. What keeps people in Madison County from being healthy? (Check all that apply)

- ☐ Lack of caring and concern about being healthy
- ☐ Not feeling worthy or good about yourself
- ☐ Lack of motivation or initiative
- ☐ Lack of personal value for a healthy lifestyle
- ☐ Lack of personal responsibility
- ☐ Decreased sense of community
- ☐ Lack of or poor communication skills
- ☐ People not making healthy choices
- ☐ An attitude that health is not important or a priority
- ☐ Lack of personal money for your family to have a healthy lifestyle
- ☐ Decrease in money for organizations and health programs
- ☐ Don't know what services, programs, and resources are available
- ☐ Services and programs are hard to access
- ☐ Limited community awareness of health problems and how to prevent them
- ☐ Limited or no health education for parents and the community
- ☐ Limited or no health education for students throughout their school years
- ☐ Lack of involvement in health by the church/faith-based community
- ☐ Lack of involvement and focus by local politicians on the health of residents and their communities
- ☐ Too many liquor stores and restaurants serving unhealthy food choices
- ☐ Not enough parks, playgrounds, sidewalks, walking distance to libraries and grocery stores
- ☐ Other _____
- ☐ Limited or no affordable healthy fresh foods and recreation
- ☐ Limited or no social activities and places
- ☐ Not enough jobs or employment opportunities
- ☐ High levels of stress and not knowing how to handle stress
- ☐ Unsafe communities
- ☐ Too much "wired society", technology, and electronic communication
- ☐ Air, water, and/or soil that is polluted

4. Please rate the following health-related issues on a scale of Most Urgent to Not a Problem.

	<u>Most Urgent</u>	<u>Urgent</u>	<u>Somewhat Urgent</u>	<u>Least Urgent</u>	<u>Not a Problem</u>
Access to Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poverty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance use/abuse (alcohol, tobacco, other drugs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teen Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Senior Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Air Quality/Environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. What would motivate you to become involved (or more involved) in improving health in Madison County? (Check all that apply)

- ☐ Do my part for myself, my family, and my community
- ☐ Get involved in a local committee to work on a health issue
- ☐ Get involved in a countywide committee to work on a health issue
- ☐ Write letters and make calls to people who make policies and rules
- ☐ An emergency in my family or a family/friend affected by a health issue
- ☐ To help kids and youth learn to make healthy choices
- ☐ To help make changes in my community to the physical surroundings such as building parks and playgrounds, getting sidewalks put in, getting healthy fresh food stands, making a safe community, etc.
- ☐ Getting involved with groups in my community to make a difference
- ☐ Other _____

Please tell us about you (Optional Questions)

AGE: ☐ 14-24 ☐ 25-44 ☐ 45-64 ☐ 65 and over

GENDER: ☐ Male ☐ Female

RACE: ☐ Black ☐ White ☐ Other _____

EDUCATION LEVEL: ☐ Less than High School
☐ High School/GED
☐ Associate's Degree/Trade School
☐ Bachelor's Degree
☐ Master's Degree or Higher

ZIP CODE: _____

INSURANCE STATUS: (Check all that apply)

- ☐ I have good health insurance
- ☐ I have health insurance but high deductibles and costs
- ☐ I have no health insurance
- ☐ I have Medicare
- ☐ I have Medicaid
- ☐ I have All-Kids for my child/children
- ☐ Other _____

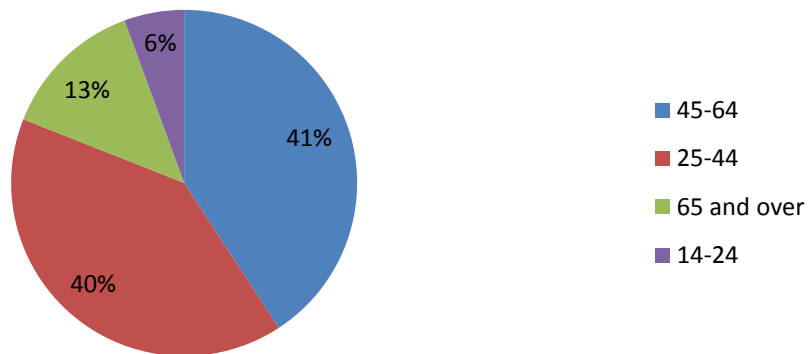
Please return survey by August 8, 2010 to:

IPLAN
Madison County Health Department
101 E. Edwardsville Road
Wood River, IL 62095

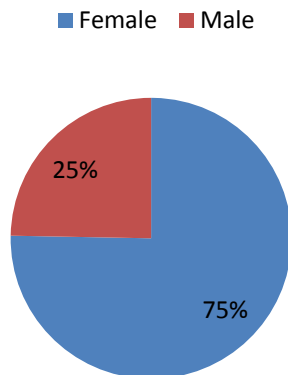
RESULTS

The results of the Community Health Survey were 1,212 responses collected July-August 2010 and analyzed for trends, perceived health needs and concerns, and to help inform the status of health in Madison County as part of the health priority setting process. The following tables are highlights from the survey data results that were used by the Core Group and at the Community Health Summit:

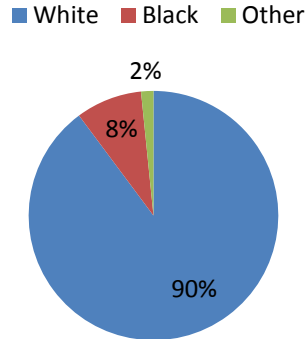
Survey Respondents by Age



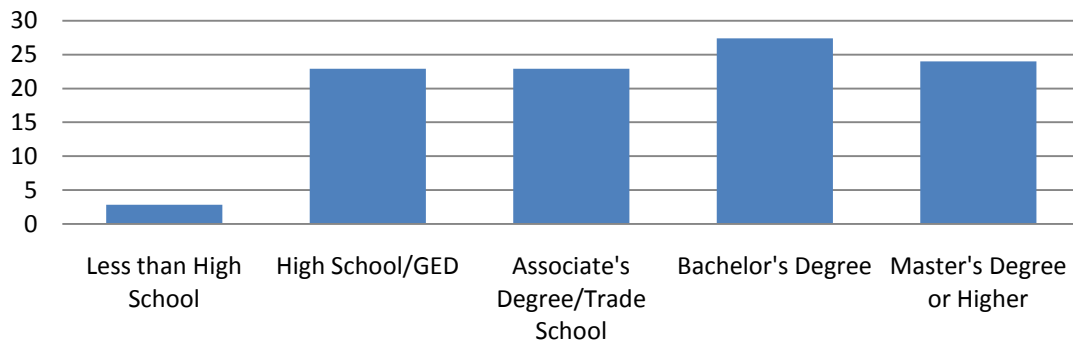
Survey Respondents by Gender



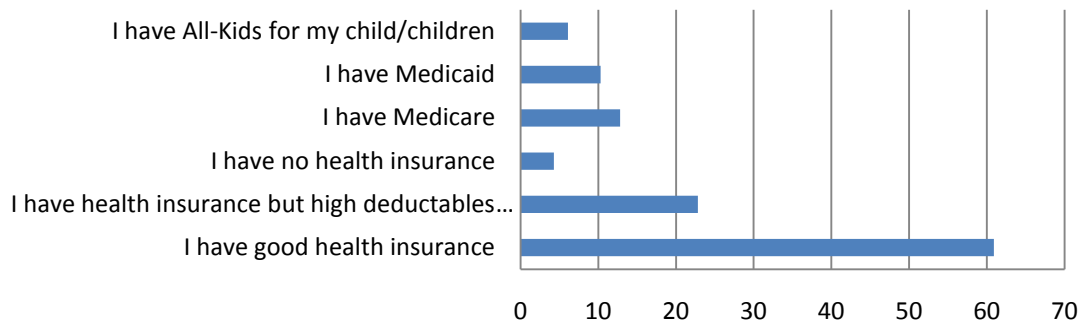
Survey Responses by Race

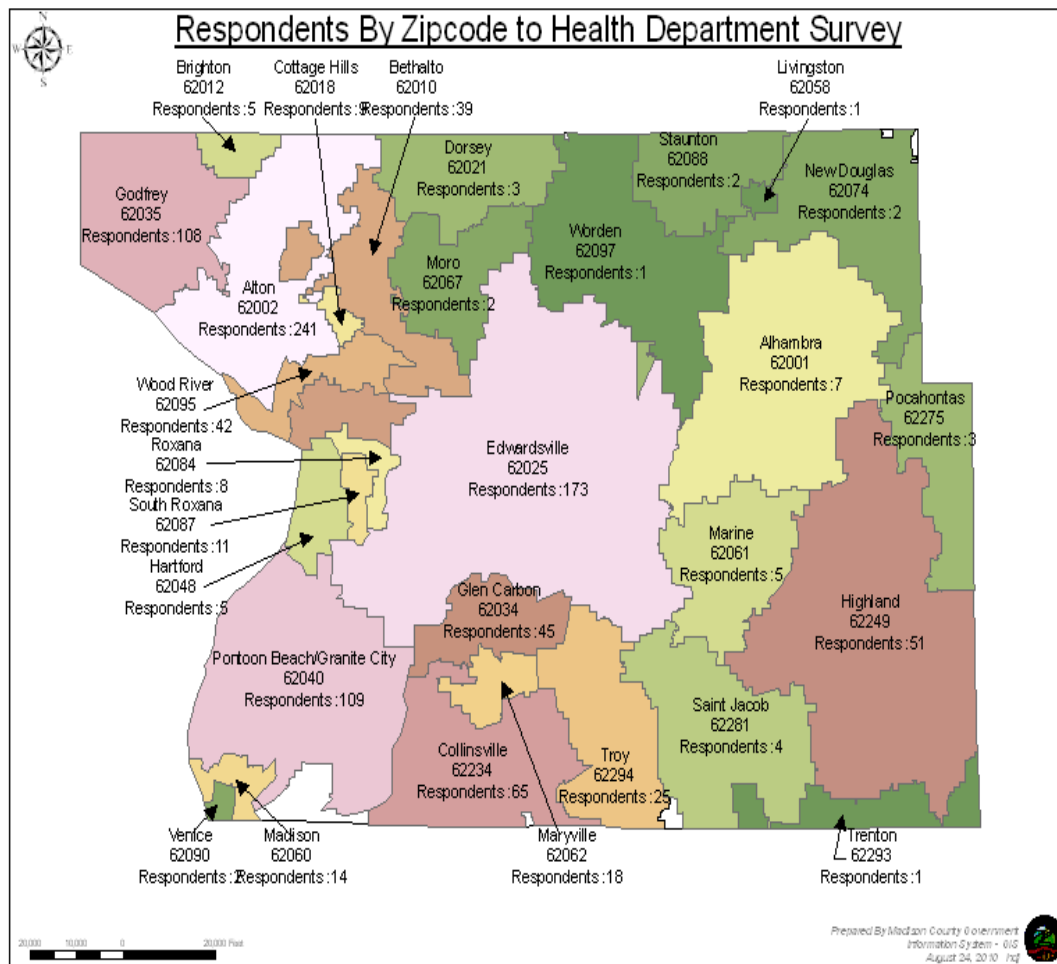


Survey Respondent by Education Level



Insurance Status of Survey Respondents





Madison County Demographic Data Compared to Survey Respondents

According to the 2005-2009 American Community Survey (ACS) 5-Year Estimates by the U.S. Census Bureau, the following data was available to help compare the Madison County population to the demographics of Madison County Community Health Survey (MCCHS) respondents to determine if the Survey, which used a convenience sample approach, was representative of the resident population. The base population for the ACS data was 266,886 unless otherwise indicated. The number of MCCHS respondents was 1,212. ACS indicates 107,219 occupied housing units; therefore, 1,212 MCCHS respondents represent 1.13% of the households in Madison County. This 5-Year Estimate Survey data was found at www.census.gov by indicating Madison County, Illinois.

Age:

This data indicates that the survey respondents were skewed toward the 25-64 year olds completing the survey which is expected considering the survey distribution and their activeness in the general population.

ACS Age Range	ACS % of Population	MCCHS Age Range	MCCHS % of Respondents
15 to 24 years old	13.8 %	14 to 24 years old	5.6%
25 to 44 years old	26.8%	25 to 44 years old	40.2%
45 to 64 years old	26.2%	45 to 64 years old	40.8%
65 and older	13.9%	65 and older	13.4%

Gender:

This data indicates that the survey respondents were skewed as more females for the gender of respondents completing the survey which is not uncommon.

ACS Gender	ACS % of Population	MCCHS Gender	MCCHS % of Respondents
Female	51.5%	Female	75.3%
Male	48.5%	Male	24.7%

Race:

This data indicates that the survey respondents were almost exactly reflective of the racial composition of Madison County indicating a representative cross-section balance of the population completing the survey.

ACS Race	ACS % of Population	MCCHS Race	MCCHS % of Respondents
White	88.77%	White	89.9%
Black	8.05%	Black	8.6%
Other	3.18%	Other	1.6%

Education Level:

This data indicates that the survey respondents were skewed toward those people that have a bachelor's degree or higher; however, it is difficult to compare based on the variance in categories and that ACS broke down the data by two age groups. Given the fact that the MCCHS was conducted primarily through a web-based survey tool (although paper surveys were distributed) and that the distribution method including emailing the survey link to various partners and community groups, the MCCHS education levels are not as surprising.

MCCHS Education Level	MCCHS % of Respondents
Less than High School	2.8%
High School/GED	22.9%
Associate's Degree/Trade School	22.9%
Bachelor's Degree	27.4%
Master's Degree or Higher	24.0%

From ACS based on a population of 25,792 in the age group 18 to 24 years old

ACS Education Level	ACS % of Population
Less than High School Graduate	11.6%
High School Graduate (includes GED)	26.6%
Some college or Associate's Degree	53.0%
Bachelor's Degree or higher	8.8%

From ACS based on a population of 178,923 in the age group 25 years and over

ACS Education Level	ACS % of Population
Less than 9 th grade	3.9%
9 th to 12 th grade, no diploma	7.5%
High School Graduate (includes GED)	33.4%
Some college, no degree	24.3%
Associate's Degree	8.3%
Bachelor's Degree	14.7%
Graduate or professional degree	7.9%
Percent high school graduate or higher	88.6%
Percent bachelor's degree or higher	22.6%

Insurance Status:

This data indicates that the survey respondents were reflective of the healthcare coverage indicated through the Round 4 (2007-2009) Behavioral Risk Factor Surveillance Survey (BFRSS) data for Madison County with most people having some kind of healthcare coverage.

BFRSS Data	BFRSS % of Population
Do you have Health Care Coverage?	90.5% Yes
Do you have Medicare?	25.8%

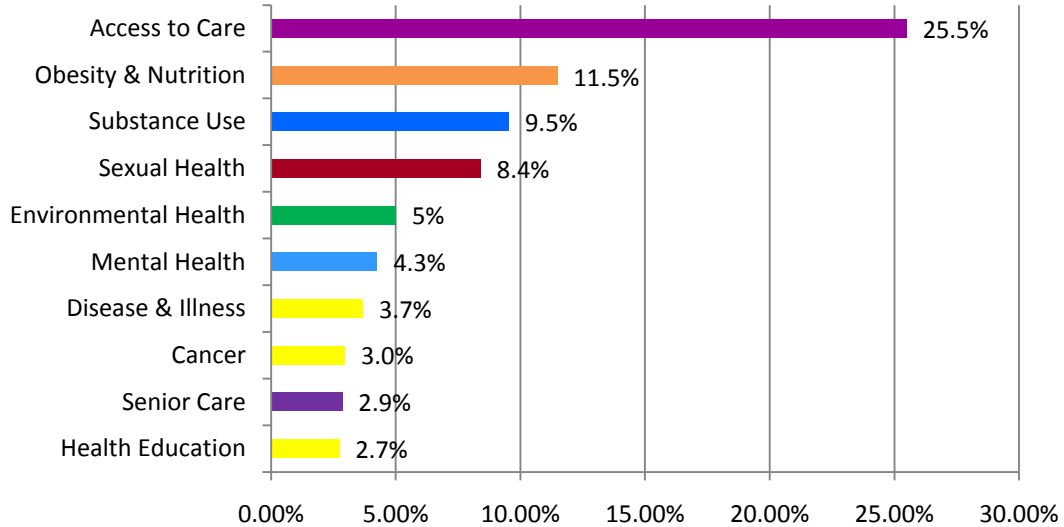
MCCHS Data	MCCHS % of Respondents
I have All-Kids for my child/children	60.9%
I have Medicaid	22.8%
I have Medicare	4.3%
I have no health insurance	12.8%
I have health insurance but high deductibles	10.3%
I have good health insurance	6.1%

Zip Codes:

The largest number of respondents for the MCCHS came from the largest communities/regions of Madison County including: Alton/Godfrey, Edwardsville, Granite City/Pontoon Beach, Collinsville, and Highland. This response pattern is reflective of the population centers in Madison County.

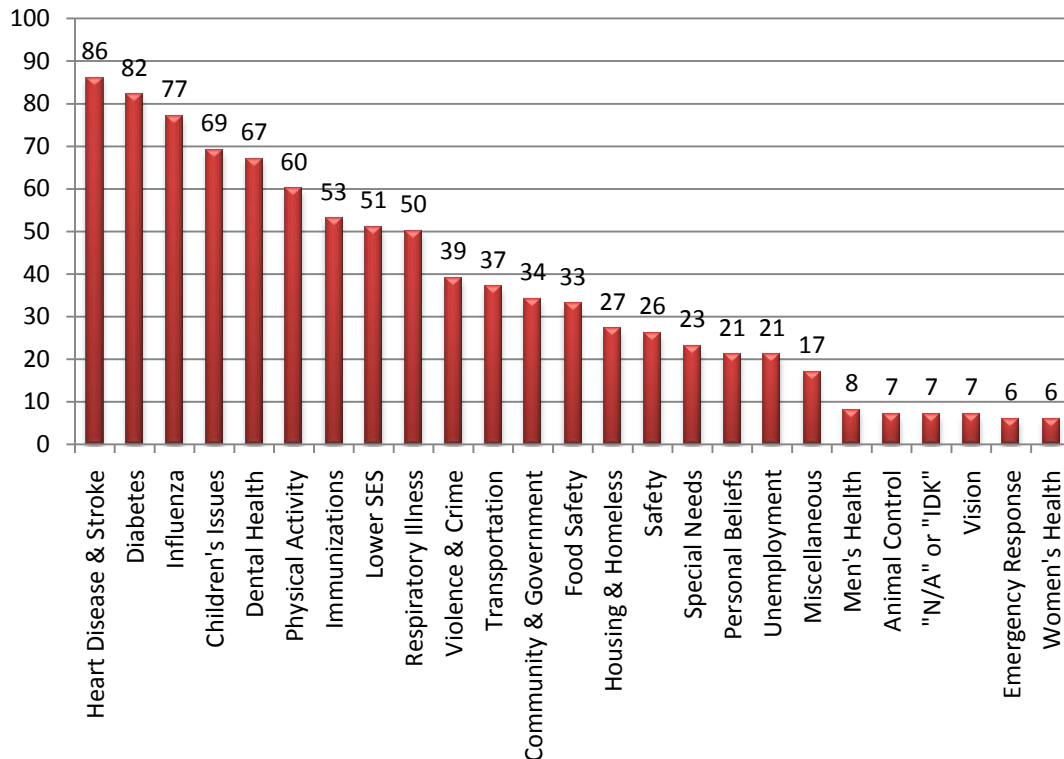
Top Ten Categorical Responses to Question 1

N=3877

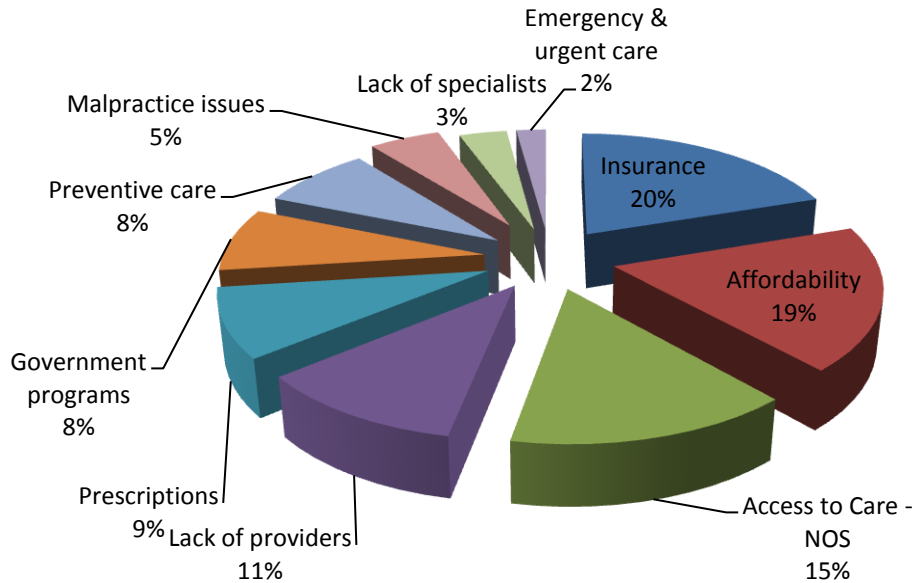


Categorical Responses to Question 1

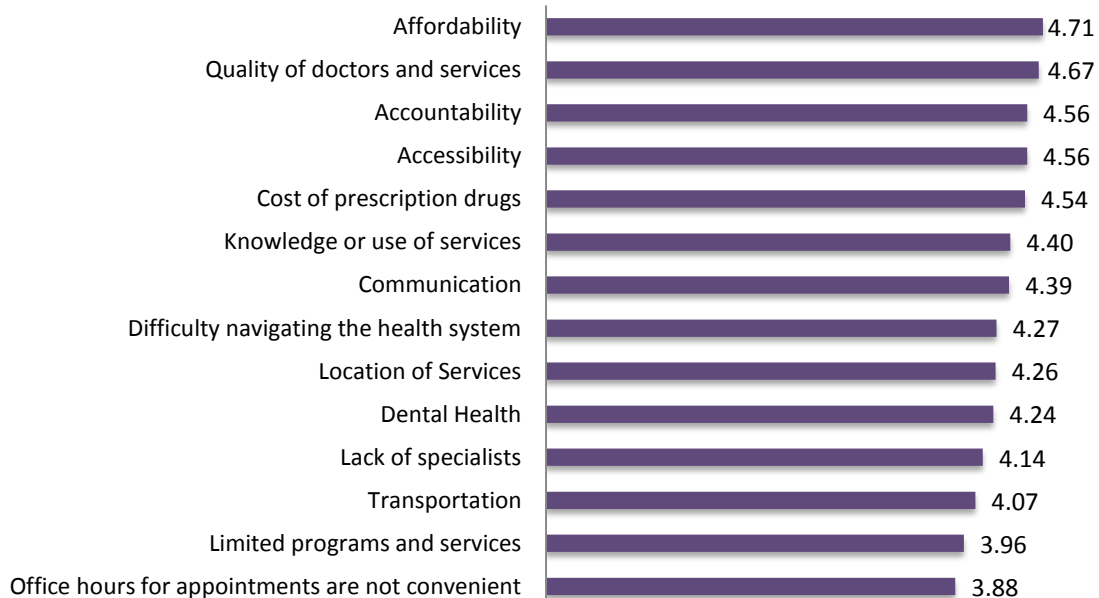
(N=3877, <100 per category)



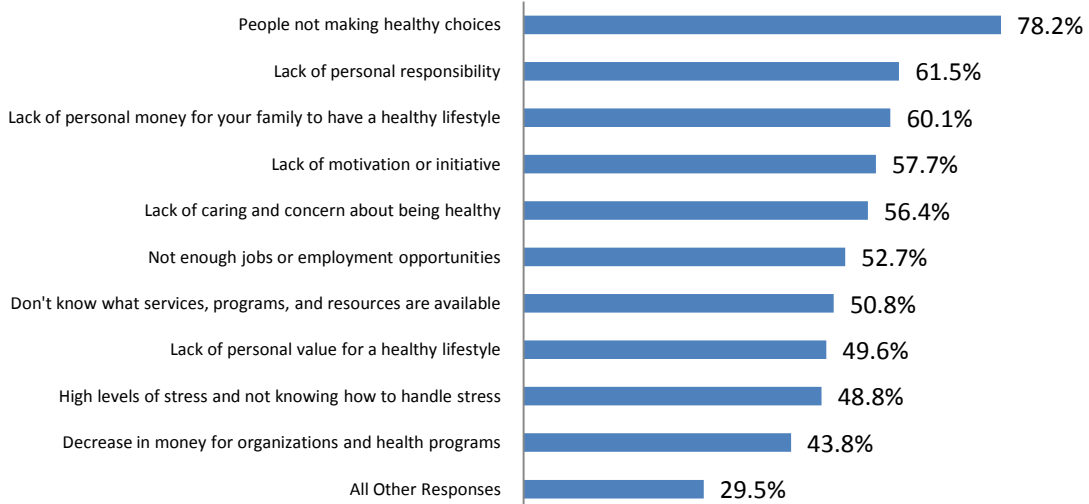
Combining (Access to Care) Answers from Question 1 N=988



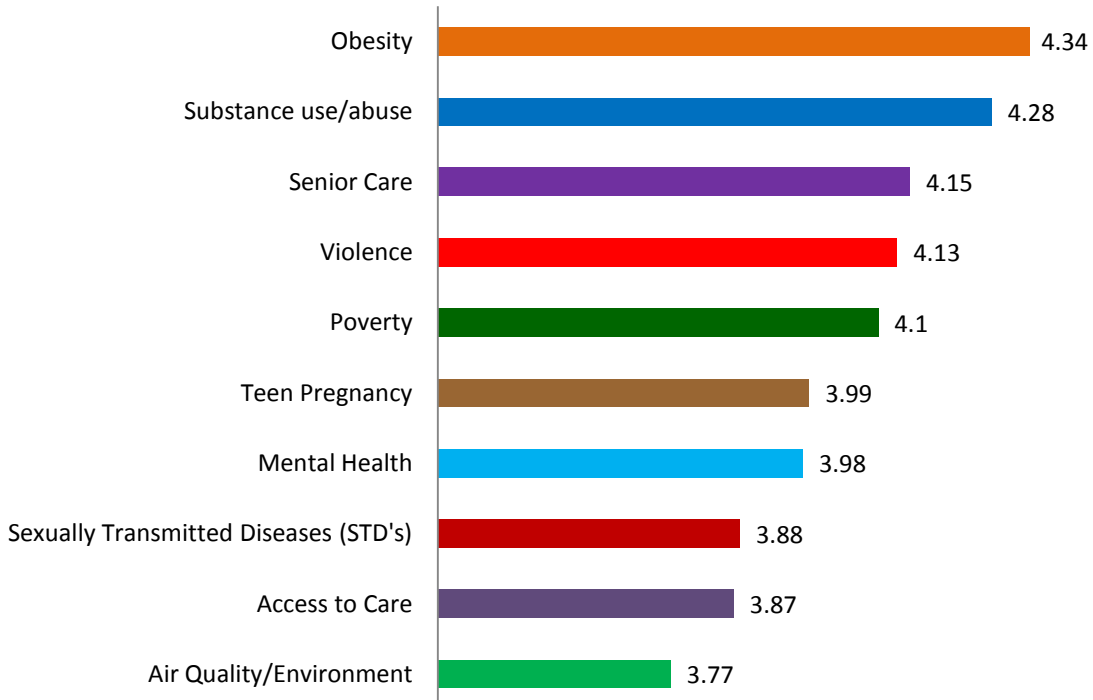
2. Please rate the following issues on a scale of Very Important to Not at All as they relate to health care in Madison County. (N=1199, 13 skipped)



3. What keeps people in Madison County from being healthy? (N=1177, 35 skipped)



4. Please rate the following health related issues on a scale of Most Urgent to Not a Problem. (N=1186, 26 skipped)

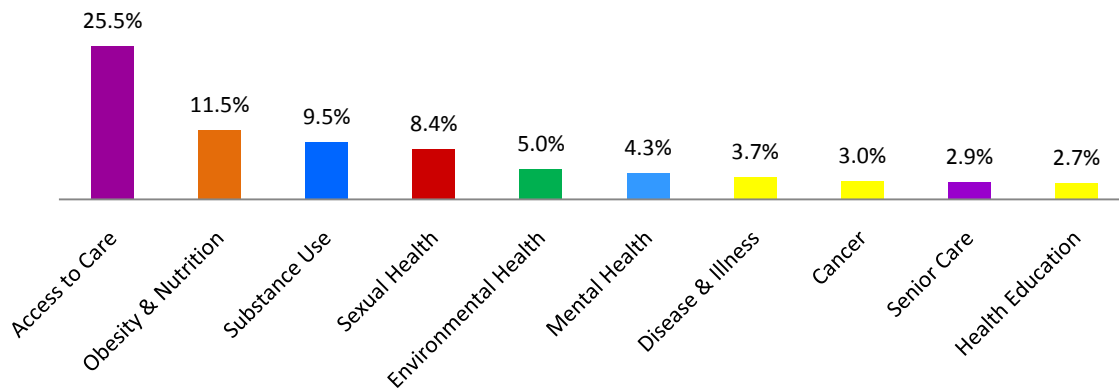


Comparing Questions 1 & 4

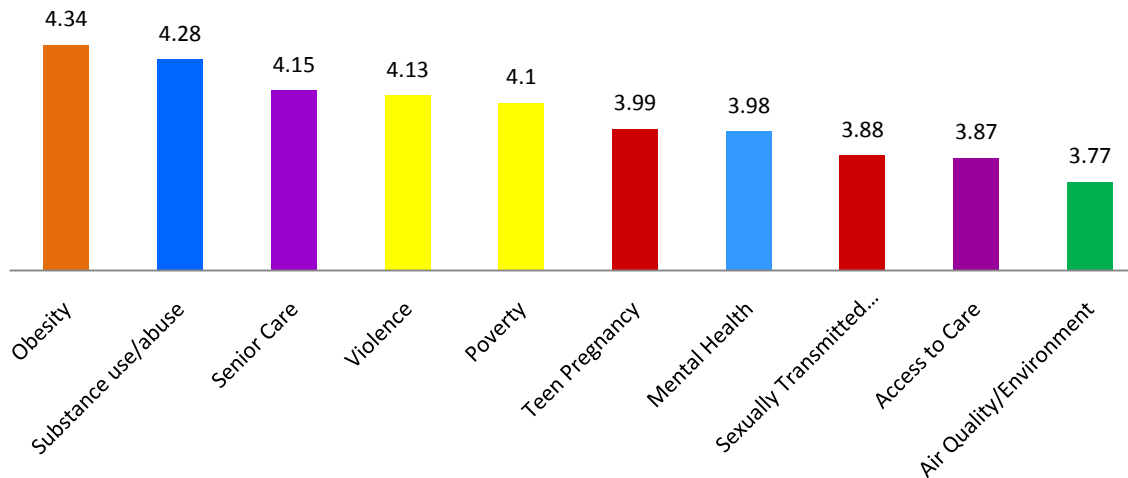
In Question 1, survey respondents were asked an open ended question to list their top health concerns for Madison County. In Question 4, survey respondents were asked to choose from a list of the top health concerns derived from the Stakeholder Focus Groups. Comparing the data from both questions, there were only 5 categories (the yellow columns below) that did not surface in both sets of answers. Therefore, community perception of health concerns and stakeholder perception of health concerns were very similar and generated a foundation for further examination of quantitative (statistical) data for these categories.

Top Ten Categorical Responses to Question 1

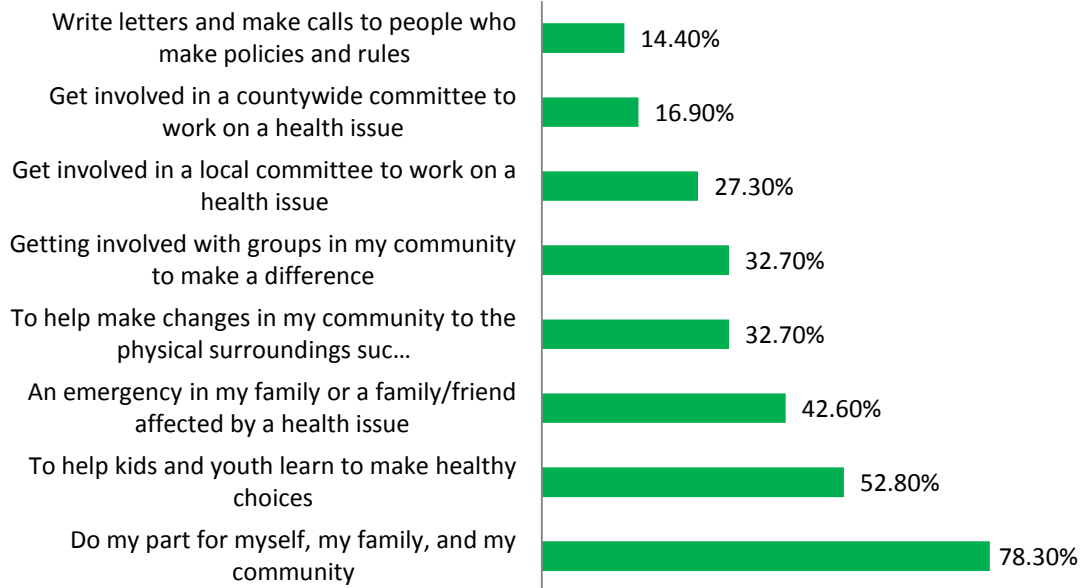
N=3877



4. Please rate the following health related issues on a scale of Most Urgent to Not a Problem.



**5. What would motivate you to become involved (or more involved) in improving health in Madison County?
(Check all that apply) (N=1128. 84 skipped)**



Quantitative Data Review

During April-August 2010, data was collected, reviewed, and analyzed within the 7 required IPLAN Data System as well as other categories identified as relevant and timely in regard to health status in Madison County. In total, 27 different health concern areas with multiple data points were entered in Excel Spreadsheets, reviewed and analyzed, and then collapsed to 140 slides of highlighted data. The following data categories and key data findings culminated the most urgent health concerns identified from the three data collection sources and were utilized by the Core Team during the health priority setting process. Data on sentinel events was collected and reviewed as part of the Quantitative Data Analysis; however, no sentinel events appeared to be in urgent need of addressing nor indicated concerning rates for Madison County.

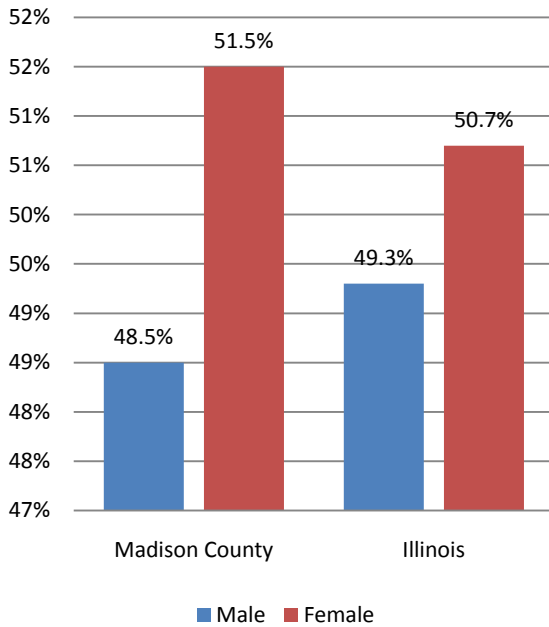
Madison County Demographics

Total Population of Madison County:

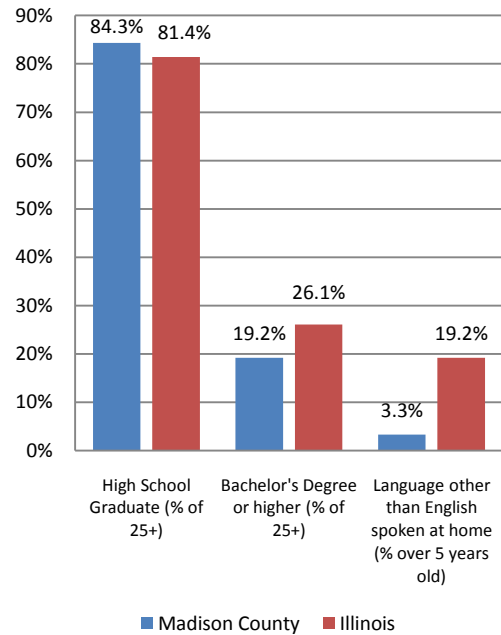
268,457

(US Census 2000, 2009 Population Estimate)

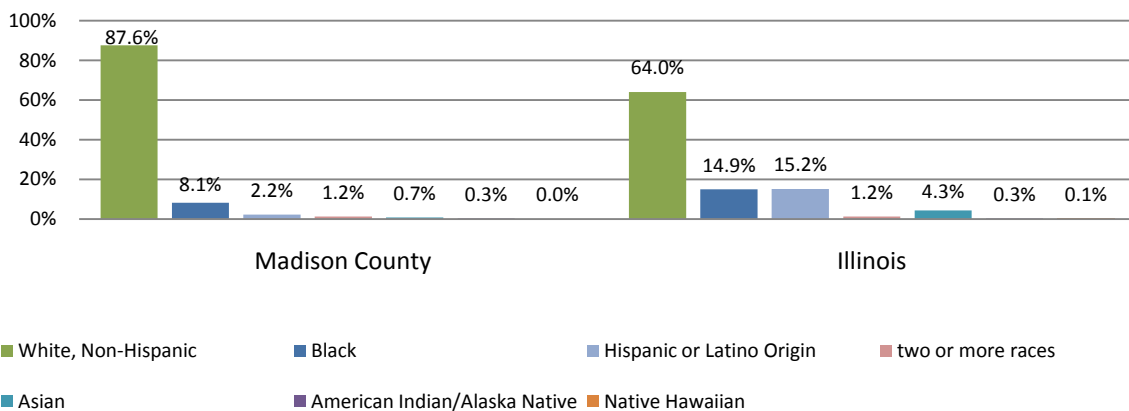
Population Characteristic: Gender

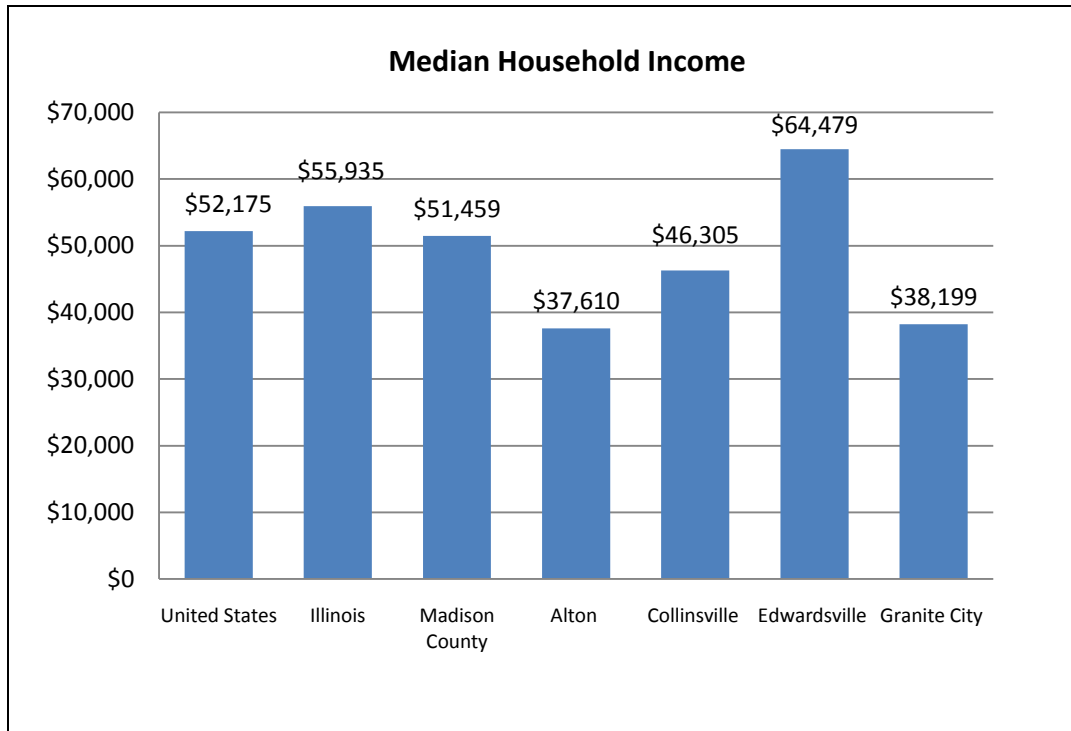


Population Characteristic: Education

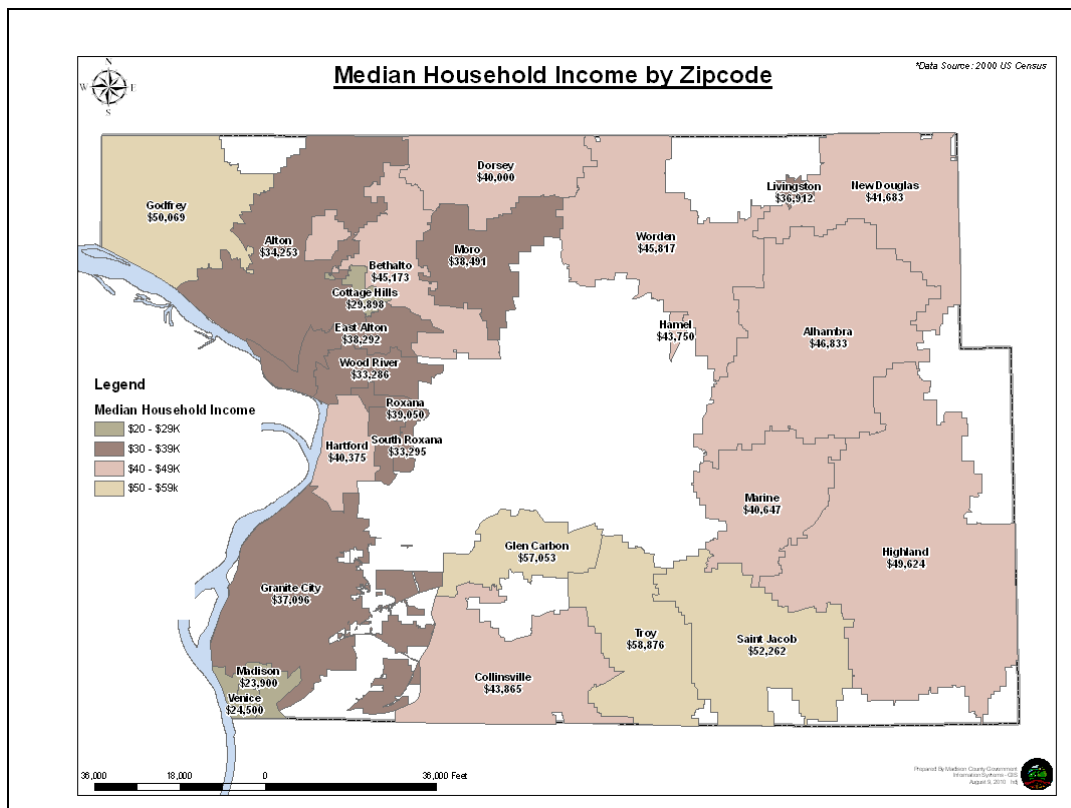


Population Characteristic: Race





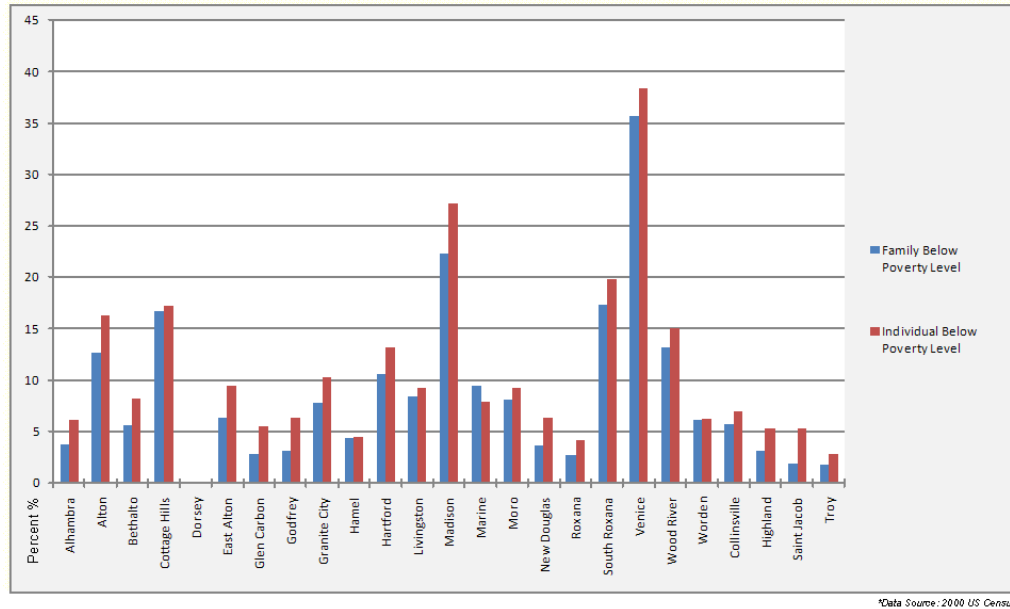
Source: Social IMPACT Research Center's analysis of U.S. Census Bureau, 2006-2008 American Community Survey 3-Year Estimates.



Source: 2000 US Census Data

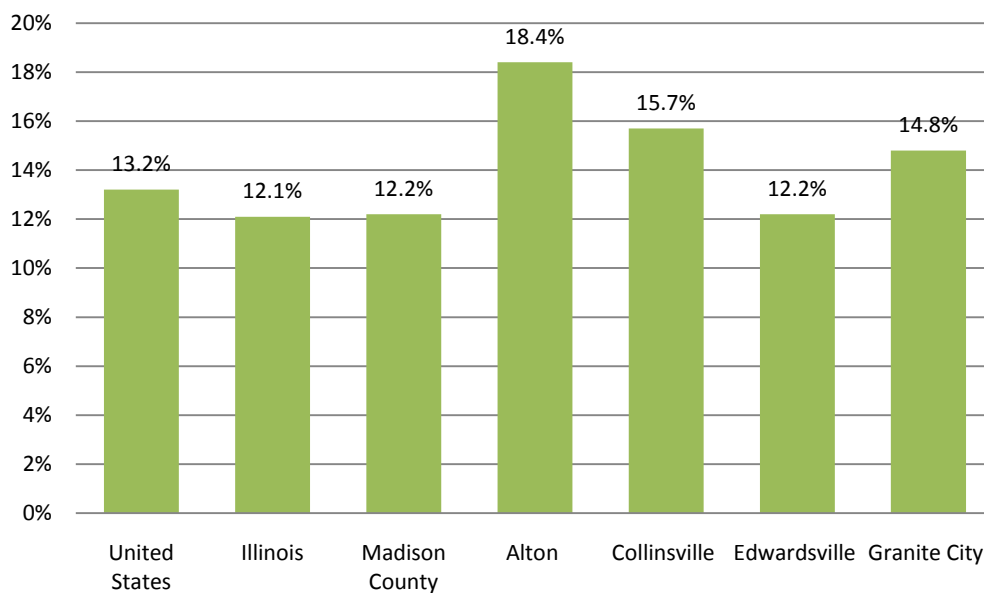
Madison County Needs Assessment and Community Health Plan

Percentage of Family & Individuals Below Poverty Level by Municipality



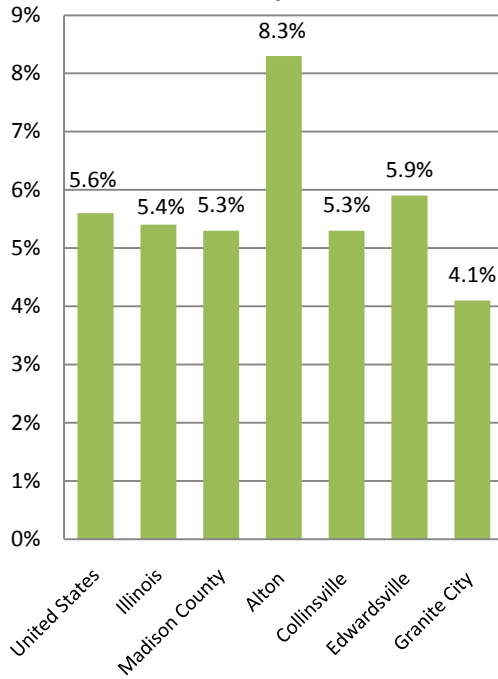
Source: 2000 US Census Data

Poverty: 0-99% of the Federal Poverty Level

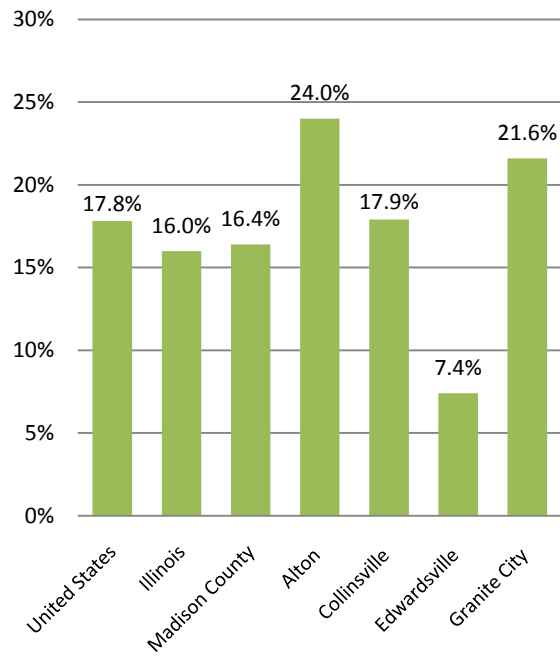


Source: Social IMPACT Research Center's analysis of U.S. Census Bureau, 2006-2008 American Community Survey 3-Year Estimates.

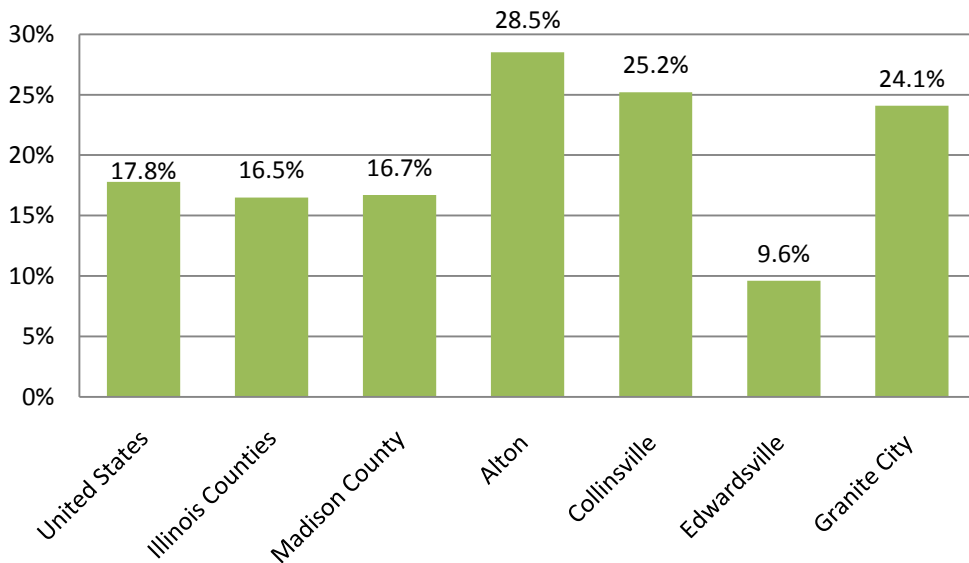
Extreme Poverty: 0-49% of the Federal Poverty Level



Low Income: 100-199% of Federal Poverty Level

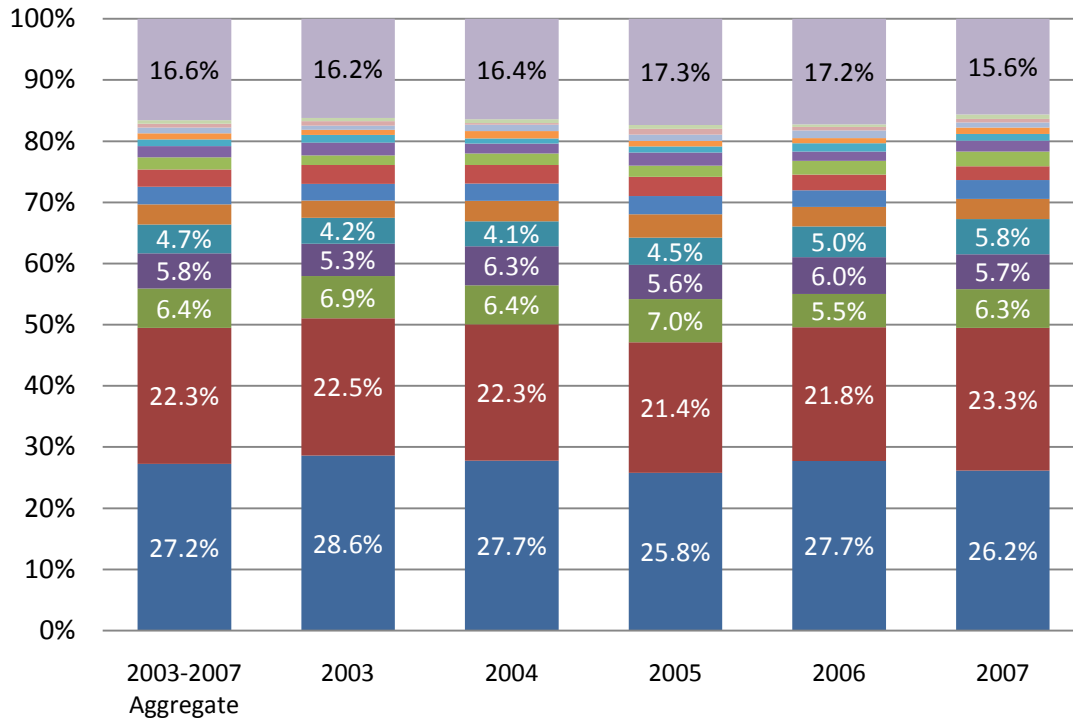


Child Poverty



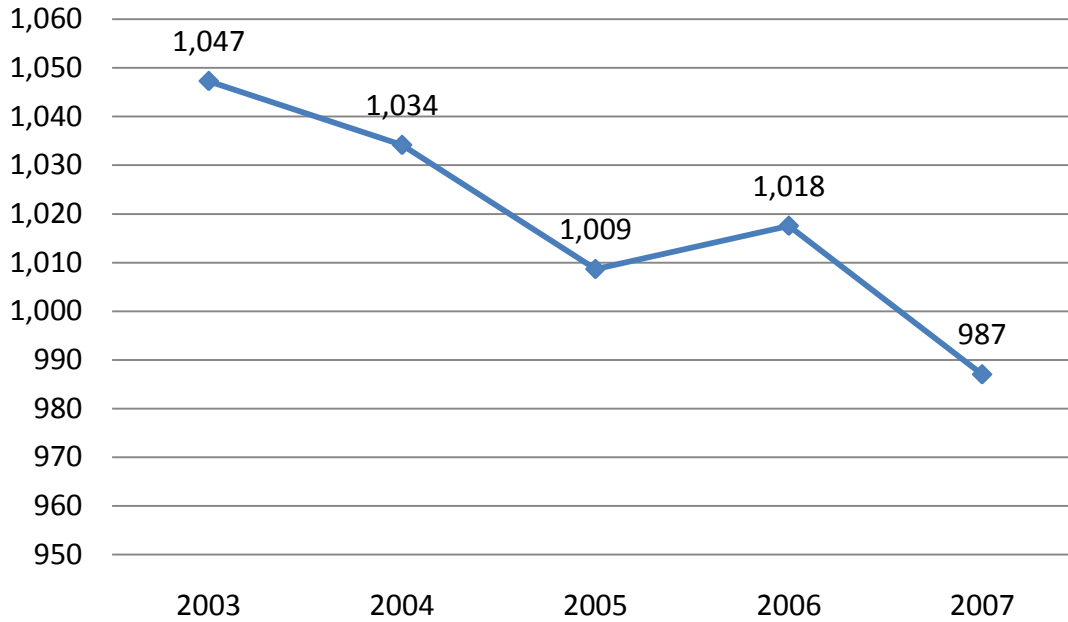
Source: Social IMPACT Research Center's analysis of U.S. Census Bureau, 2006-2008 American Community Survey 3-Year Estimates.

Cause of Death All Ages, Madison County (Percent of Total)



- Diseases of Heart
- Malignant Neoplasms
- Cerebrovascular Diseases
- Chronic Lower Respiratory Diseases
- Accidents
- Alzheimer's Disease
- Diabetes Melitus
- Influenza and Pneumonia
- Nephritis, Nephrotic Syndrome and Nephrosis
- Septicemia
- Intentional Self-harm (Suicide)
- Chronic Liver Disease and Cirrhosis
- Essential Hypertension and Hypertensive Renal Disease
- Parkinson's Disease
- Pneumonitis due to Solids and Liquids
- All other Causes

Mortality Rate in Madison County

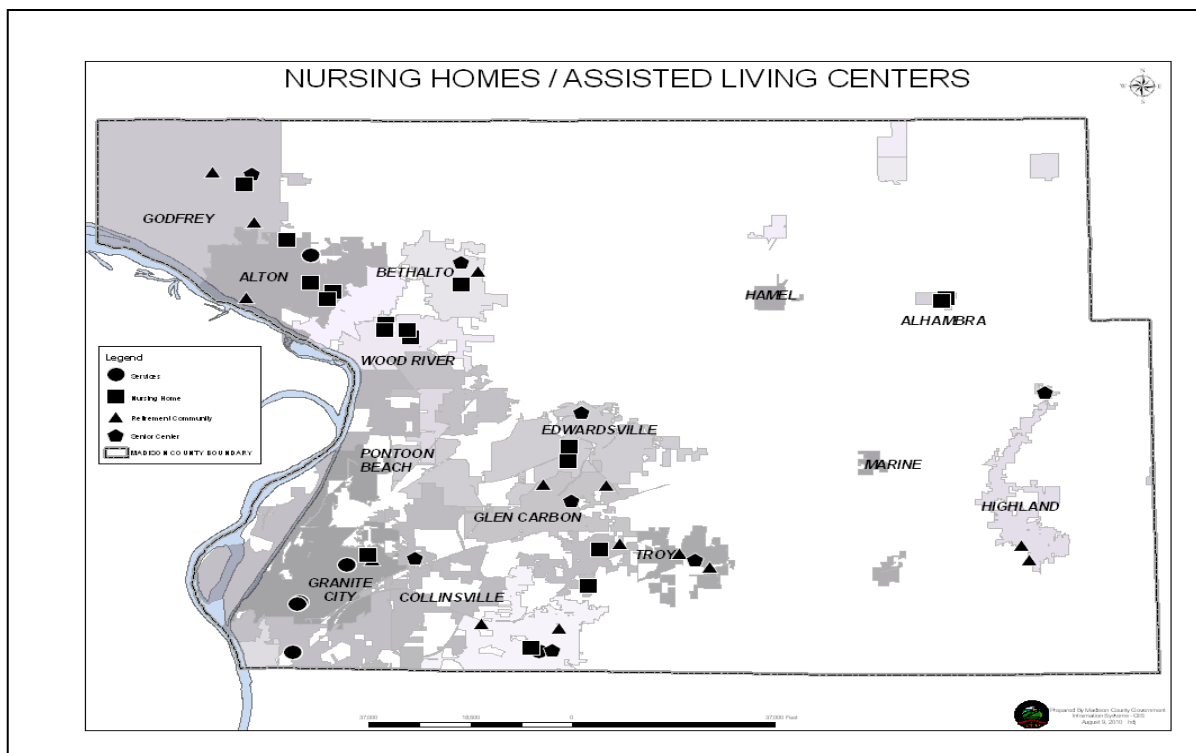
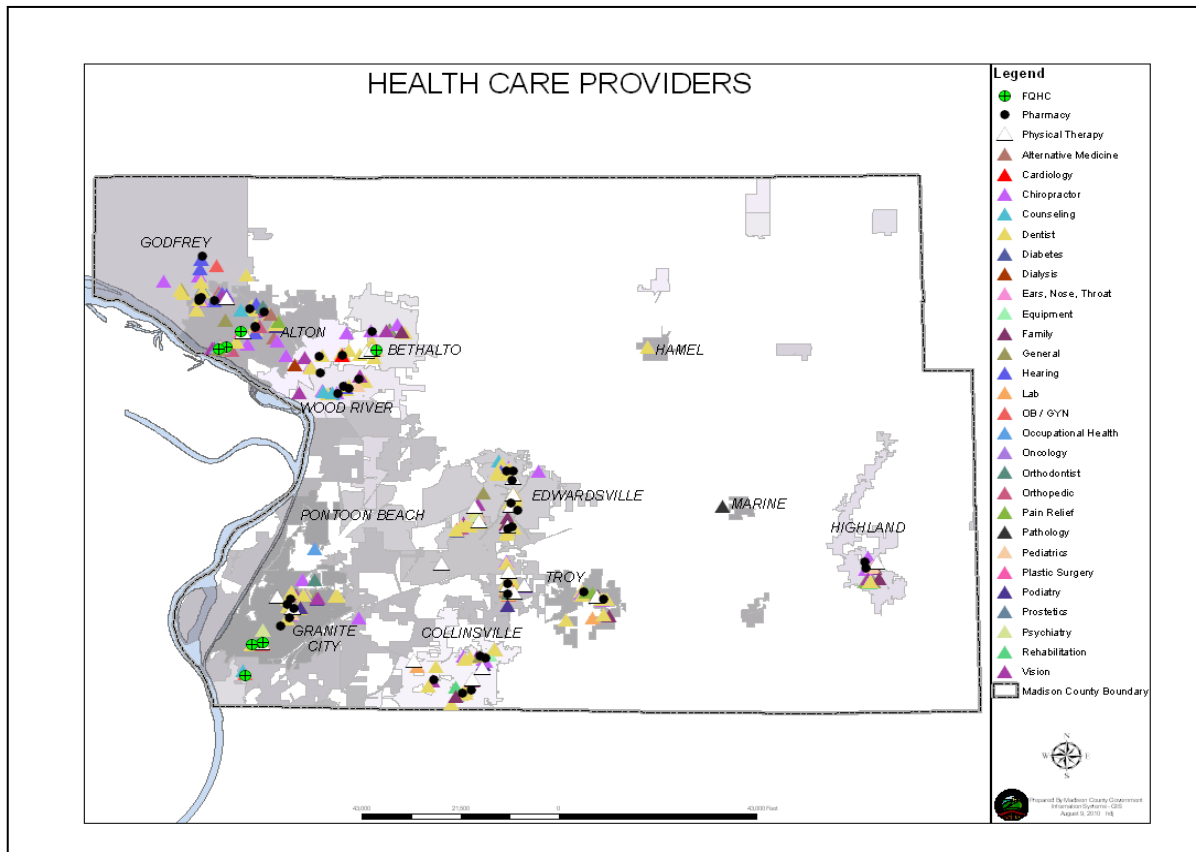


County Health Ranking

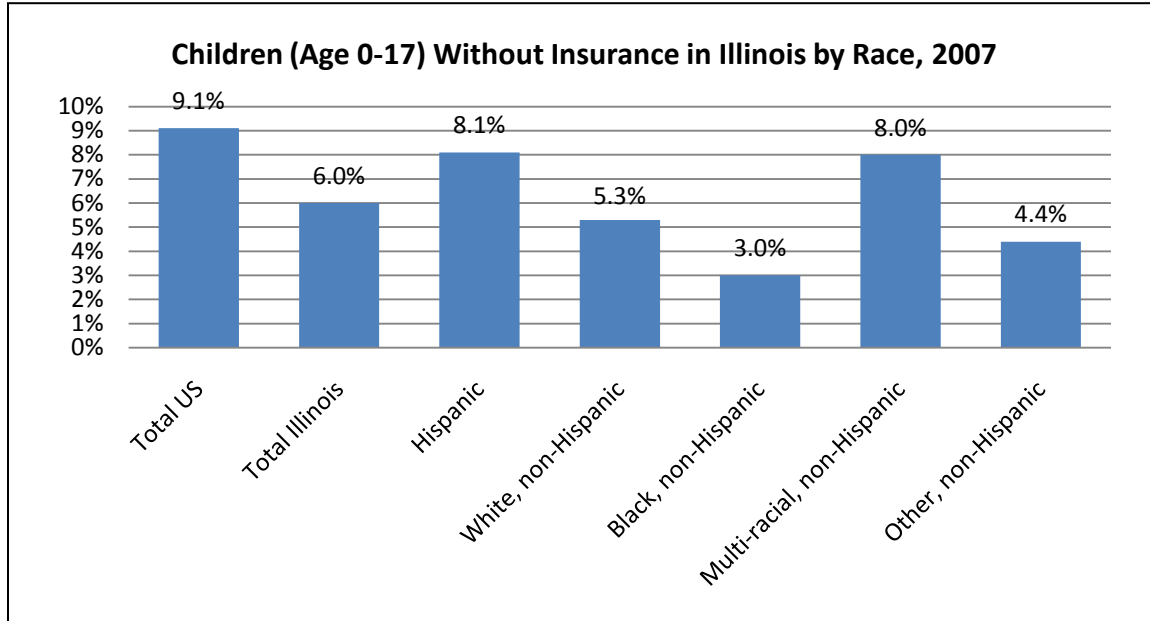
Category	Ranking (out of 101 counties in IL)
Health Outcomes	78
Mortality	64
Morbidity	82
Health Factors	86
Health Behaviors	88
Clinical Care	57
Social & Economic Factors	52
Physical Environment	101

Source: County Health Rankings – Mobilizing Action Toward Community Health, Illinois, 2010
 A program of the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, www.countyhealthrankings.org

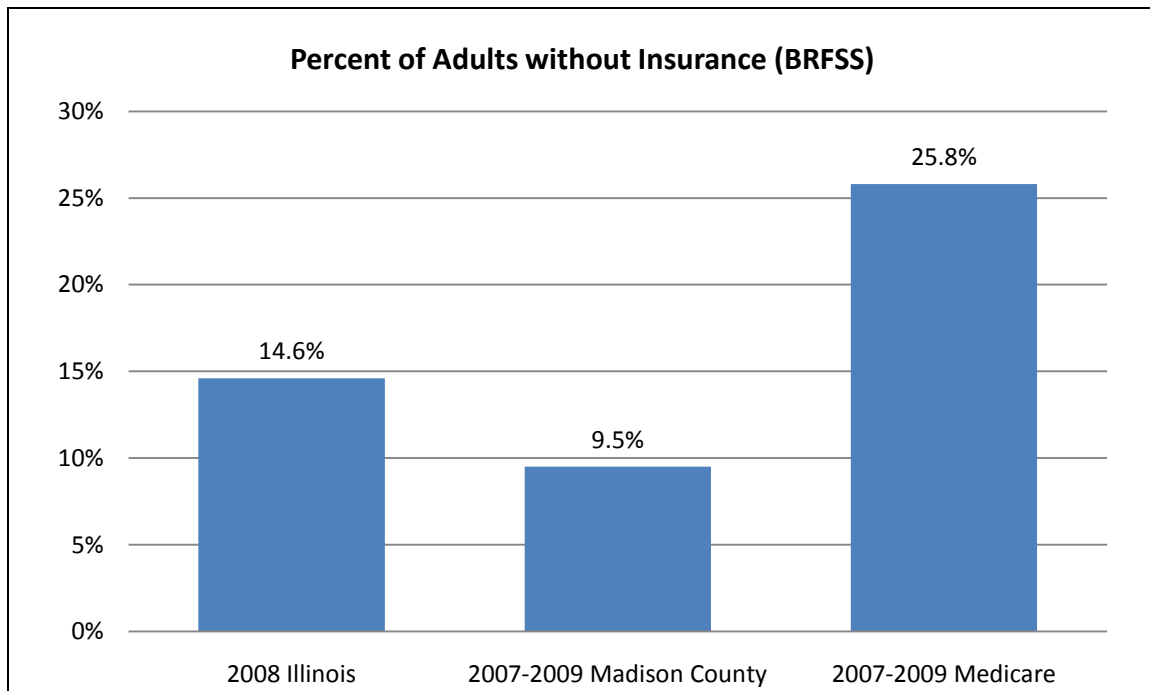
Madison County Needs Assessment and Community Health Plan

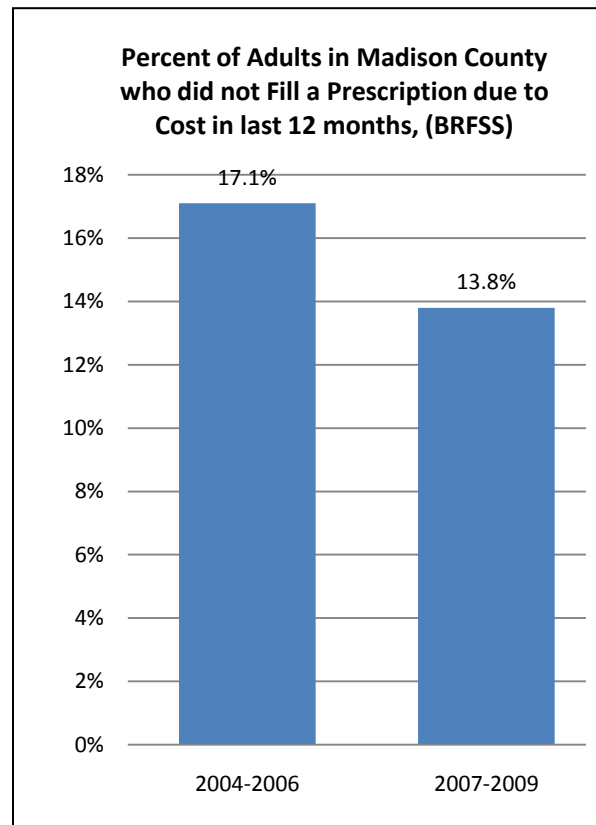
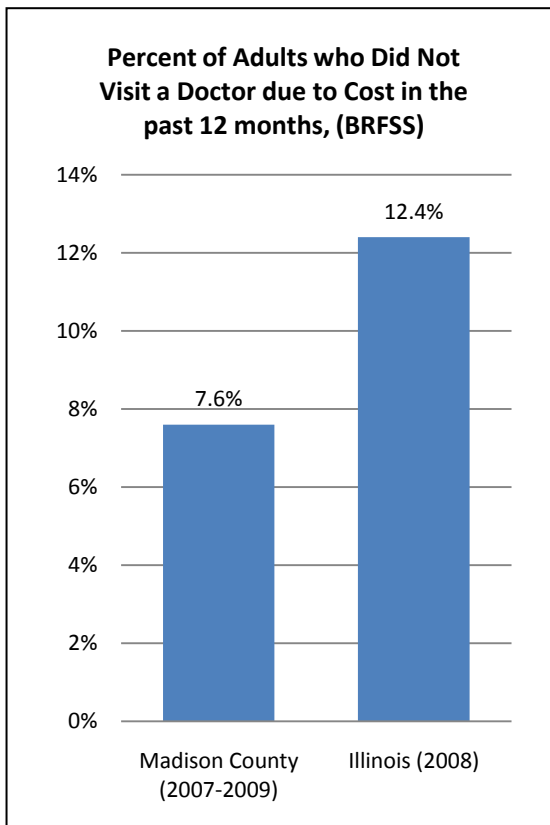
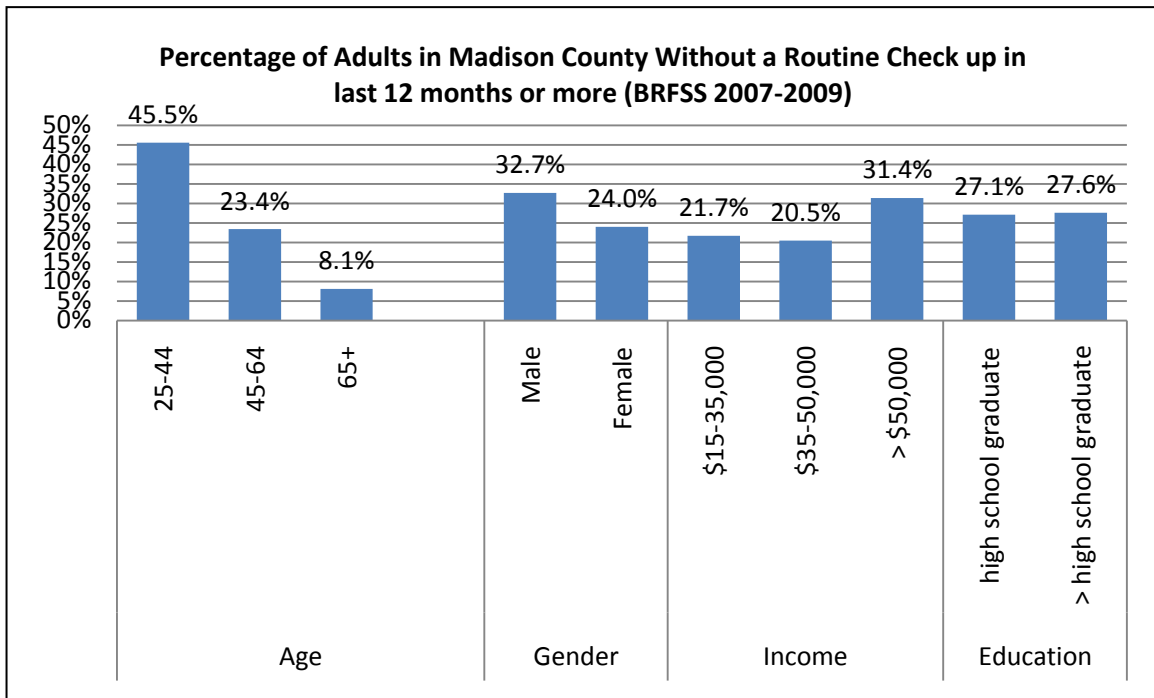


Access to Care



Source: National Survey for Children's Health, 2007



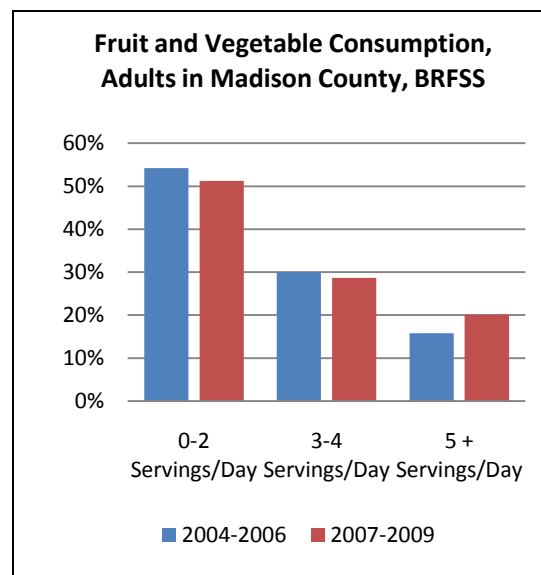
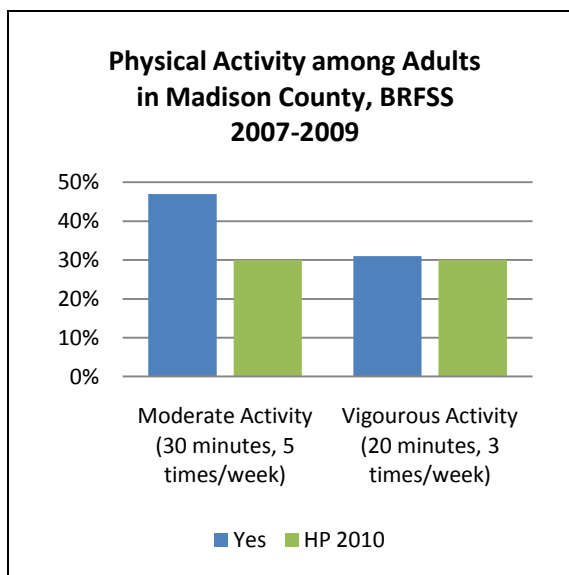
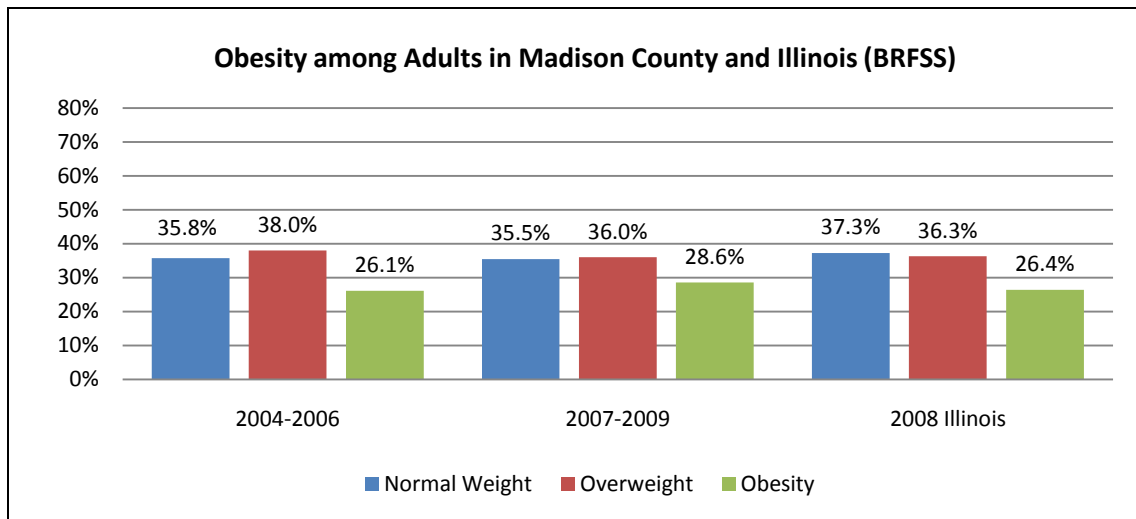


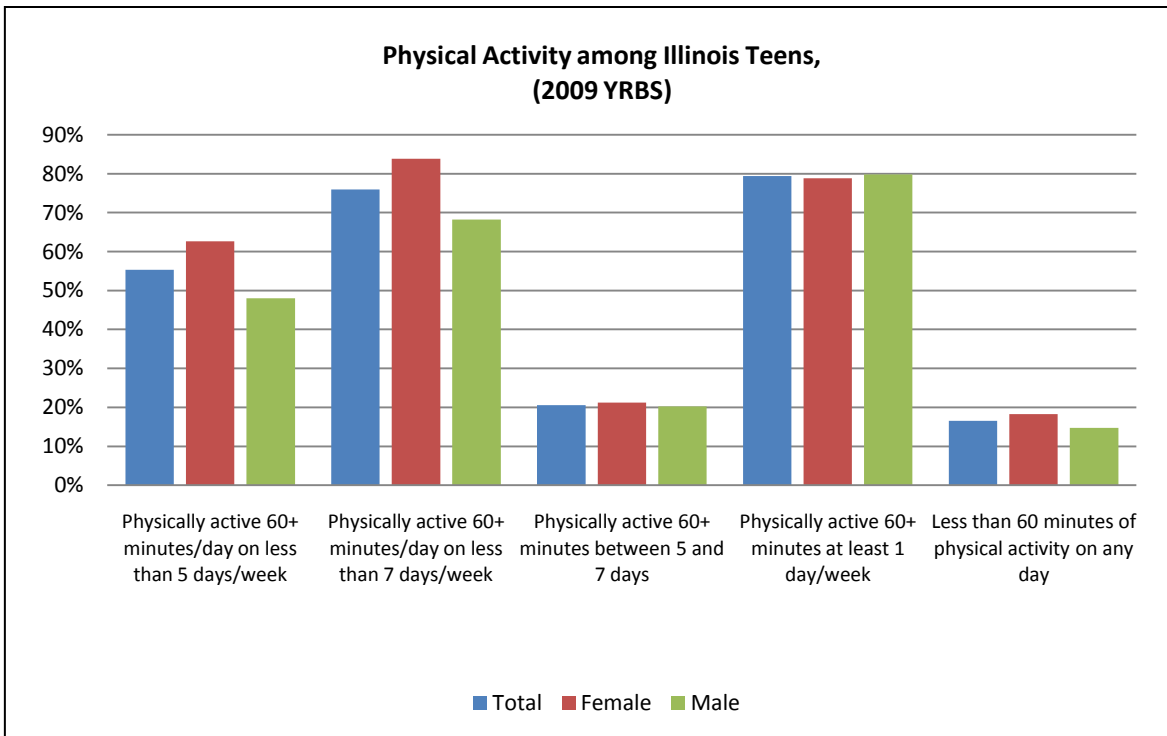
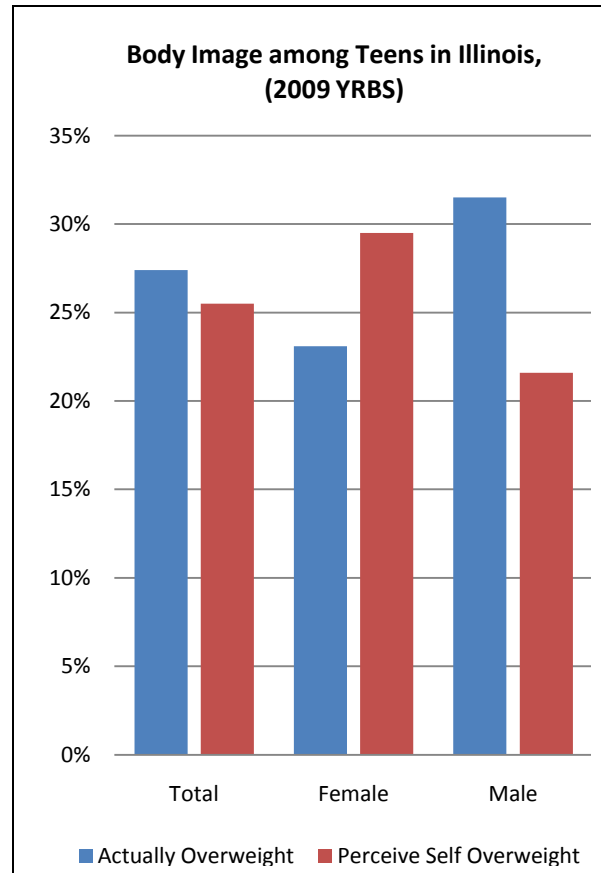
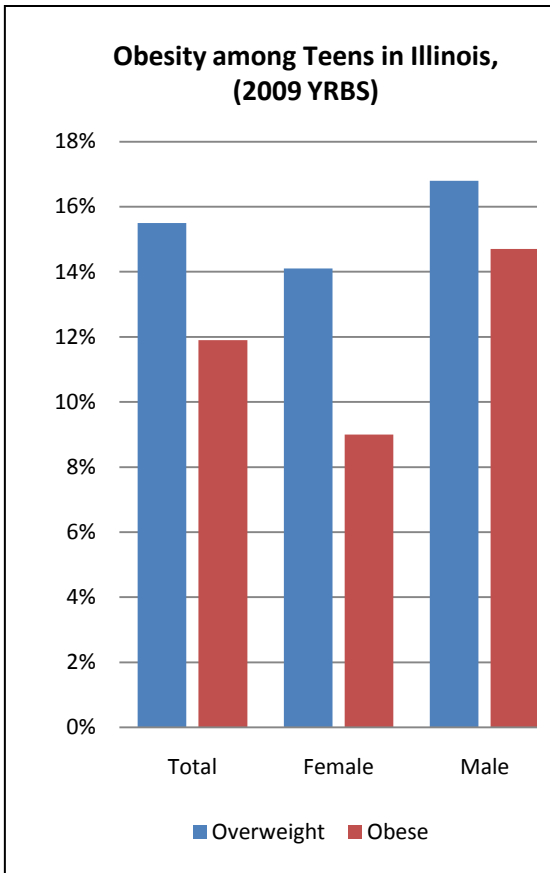
Poverty

In the **Madison County Demographics** section, key Poverty-specific data was demonstrated.

Obesity

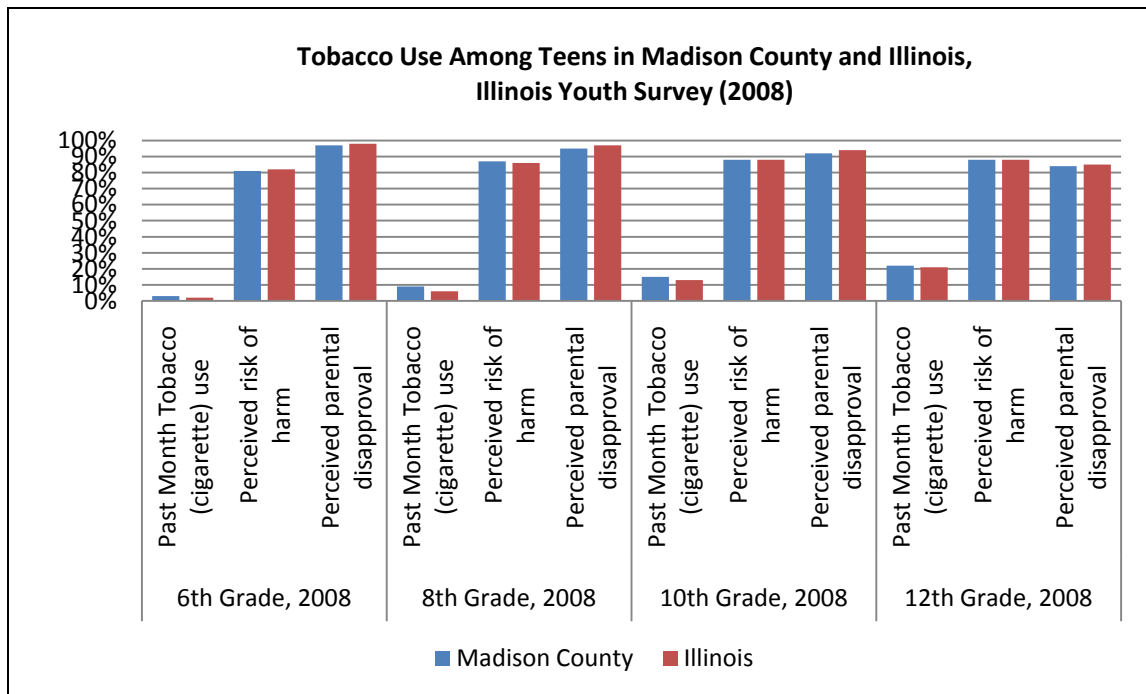
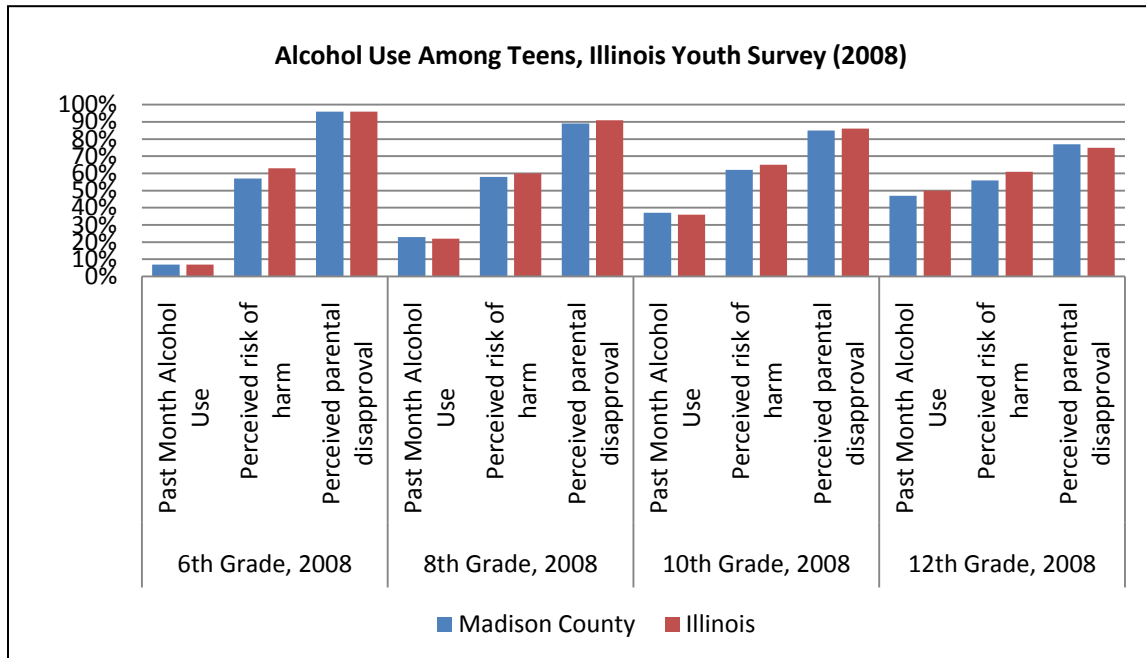
Obesity seems to be the hot issue and is a common risk factor for several chronic diseases. Data included in this section and from the Focus Groups and Community Surveys also included physical activity, nutrition, food consumption and availability as key factors.

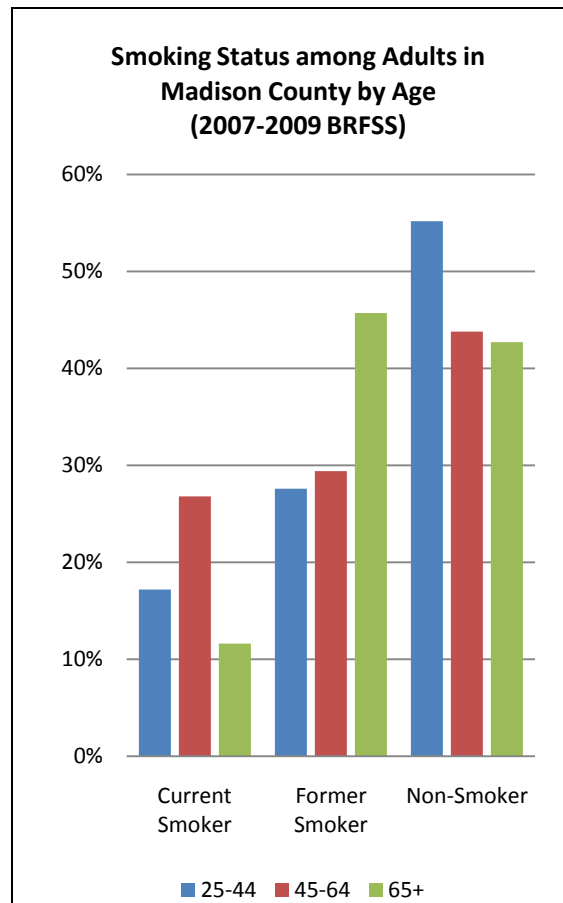
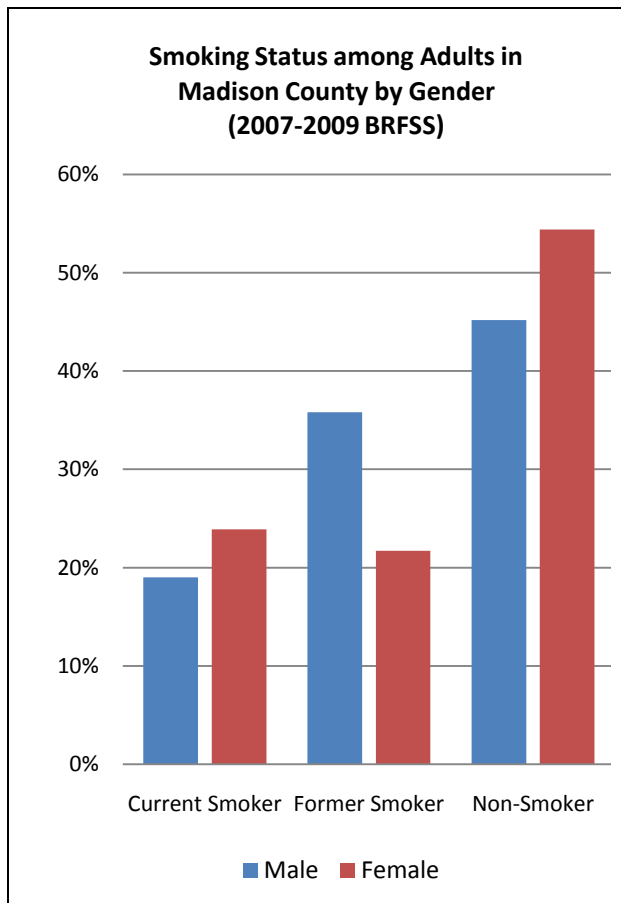
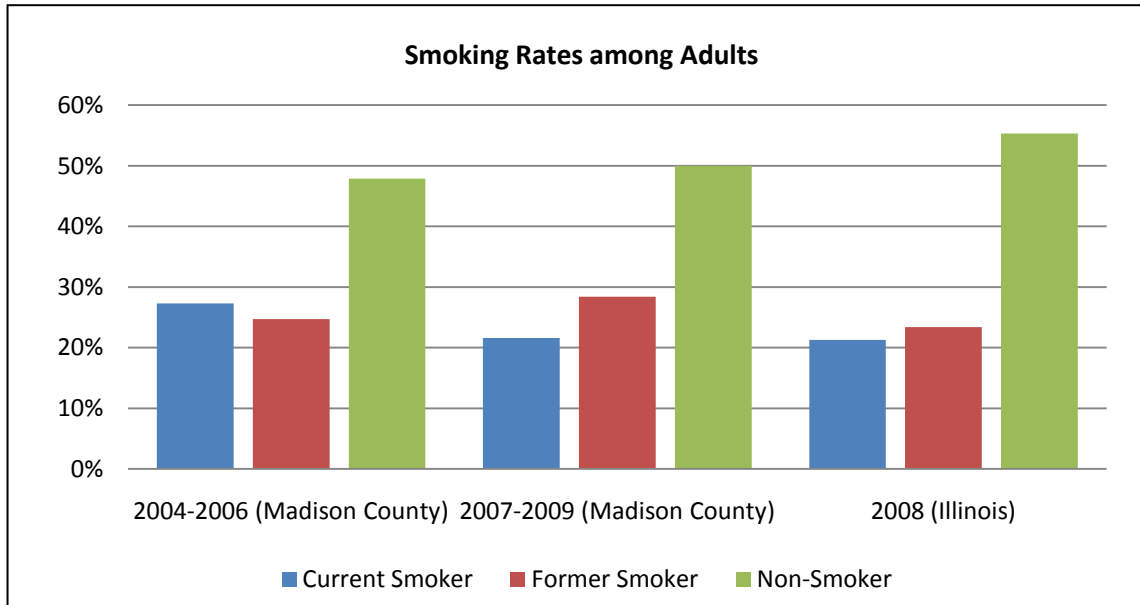




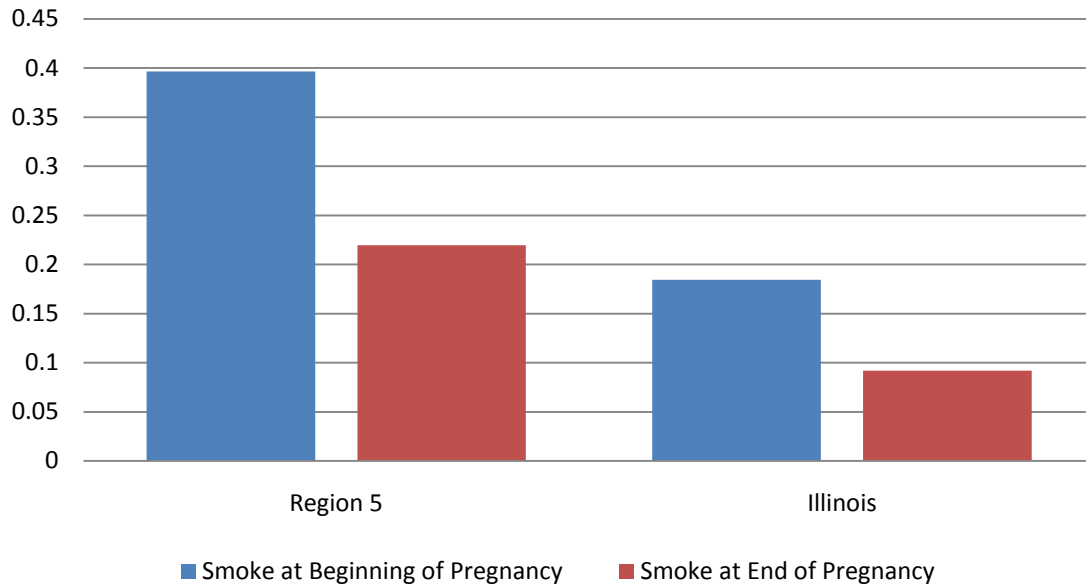
Substance Use/Abuse

Alcohol, Tobacco, and Other Drugs (specifically marijuana, heroin, and methamphetamine)





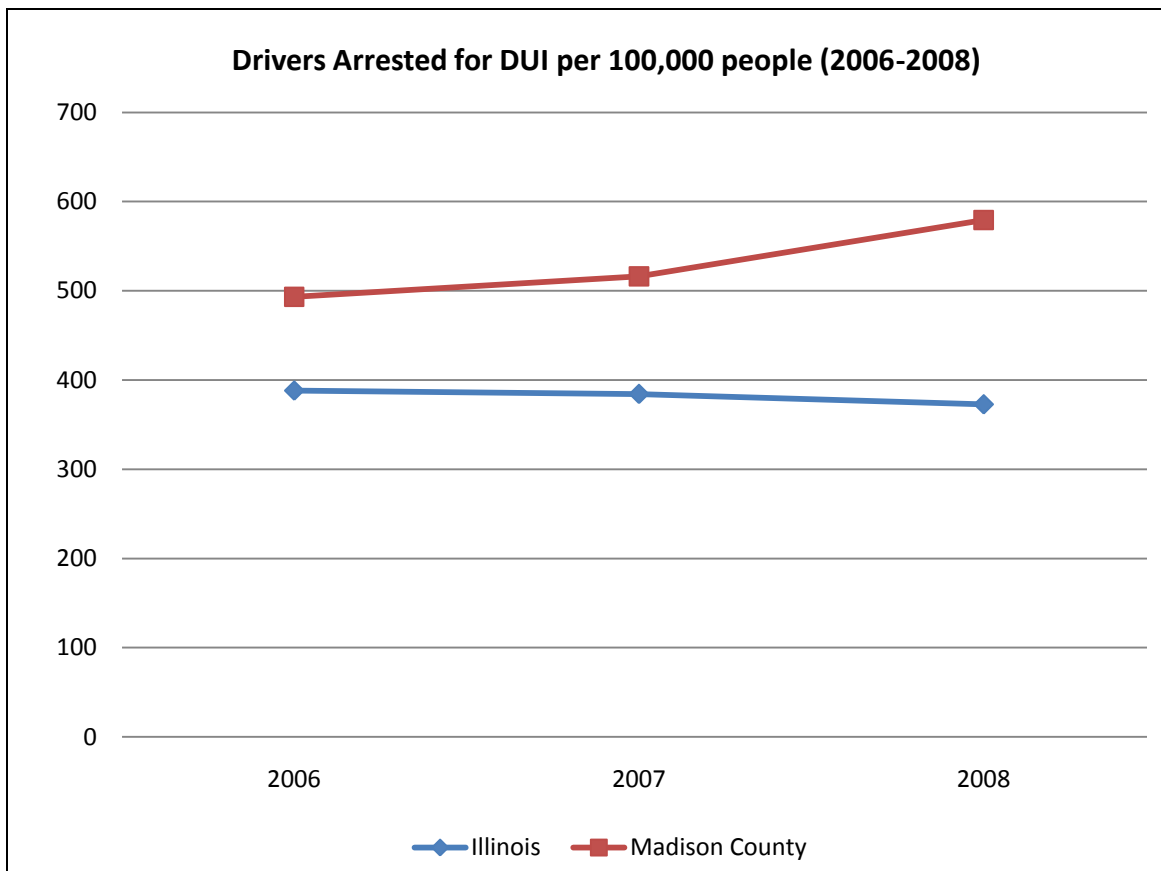
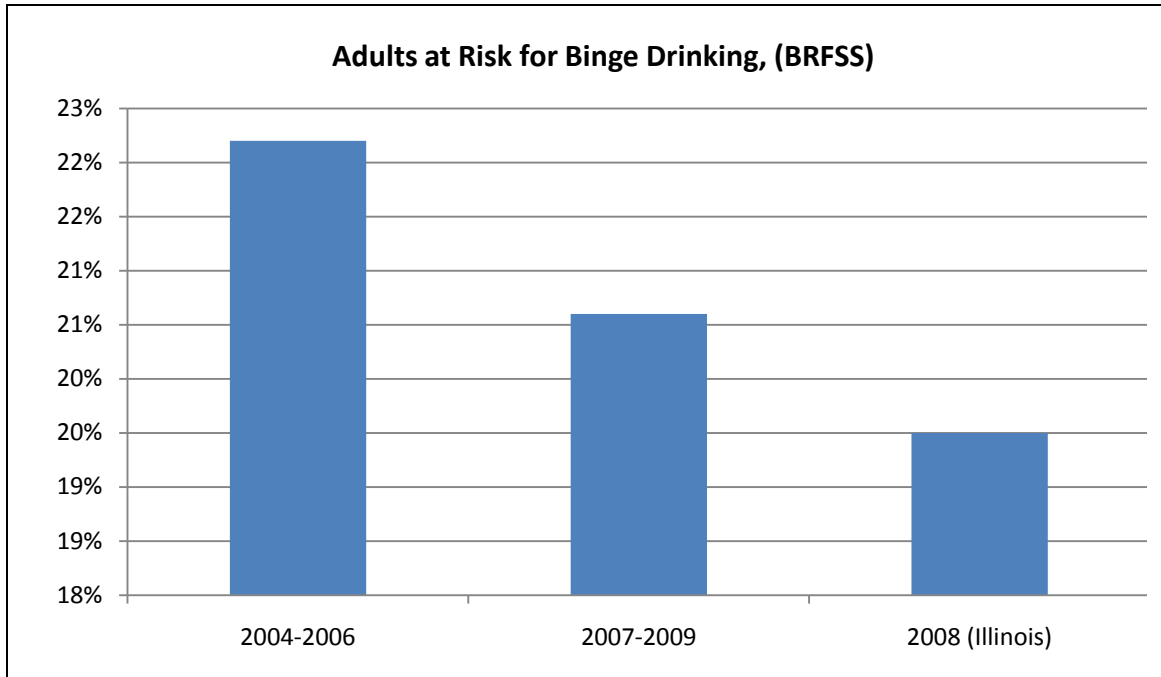
Smoking while Pregnant



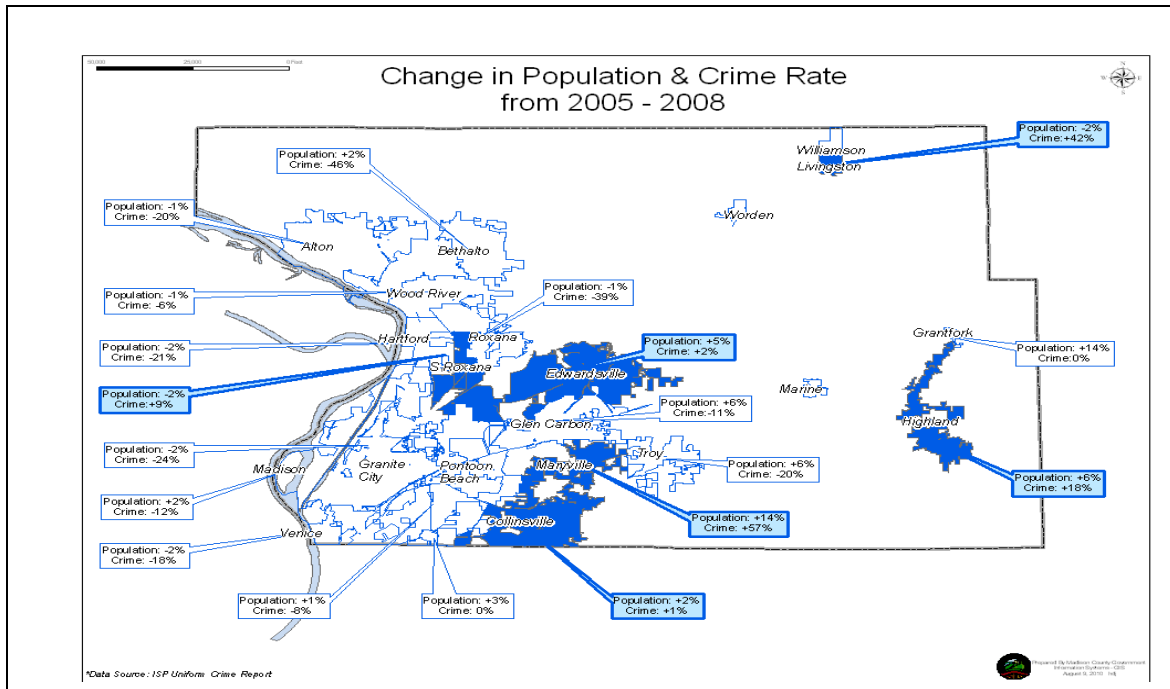
Smoking while Pregnant – raw data

		Total	% Smokers	Total	Percent	Total	Percent
Agency Name		Smokers		Stopped	Stopped	Decreased	Decreased
Region 5 Total:	1779	695	39.0668915	304	0.437	542	0.7
Statewide Total	20255	3736	18.4448284	1872	0.501	2884	0.77
Region 5		0.396689	0.2197				
Illinois		0.184448	0.09202666				

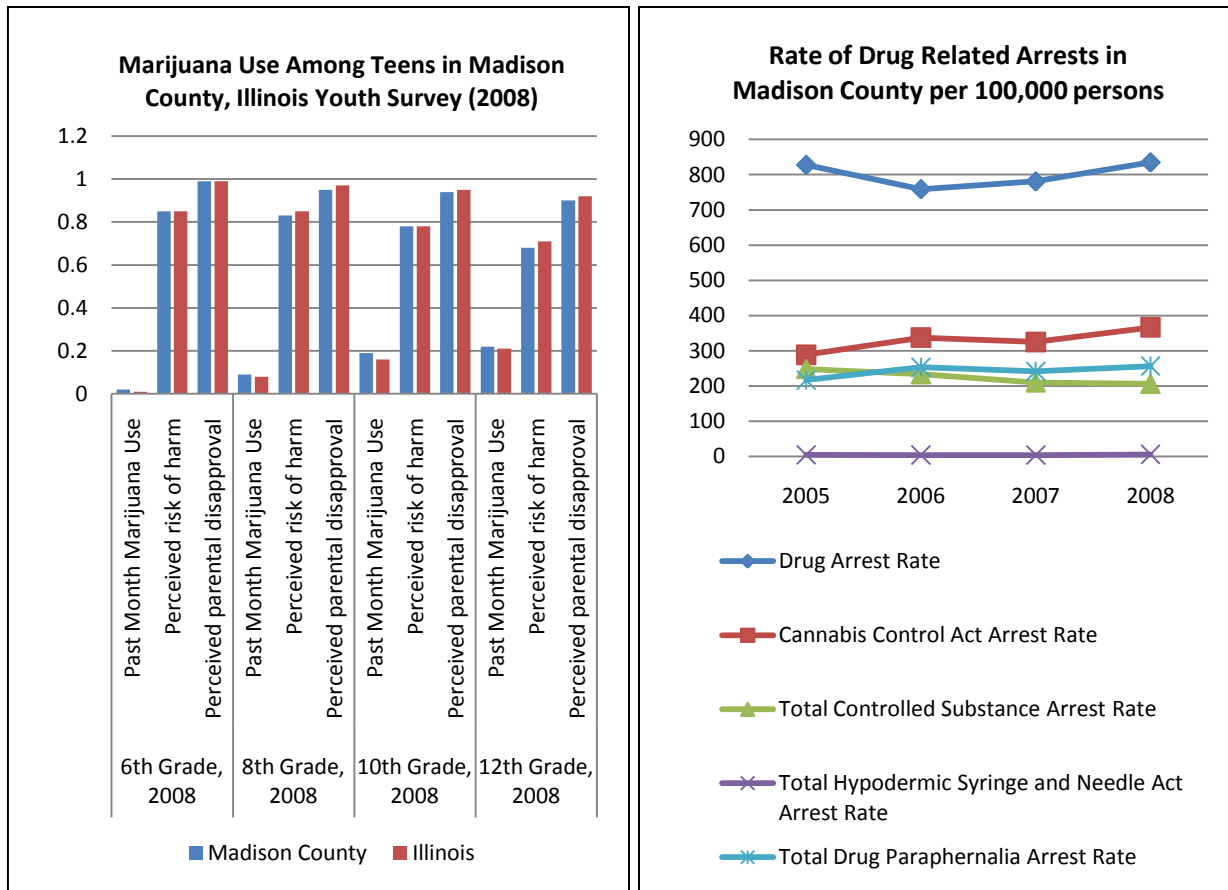
Source: Illinois Department of Human Services (DHS), WIC & FCM Quarterly Performance Reports, DHS Region 5
<http://www.dhs.state.il.us/page.aspx?item=33625>



Madison County Needs Assessment and Community Health Plan

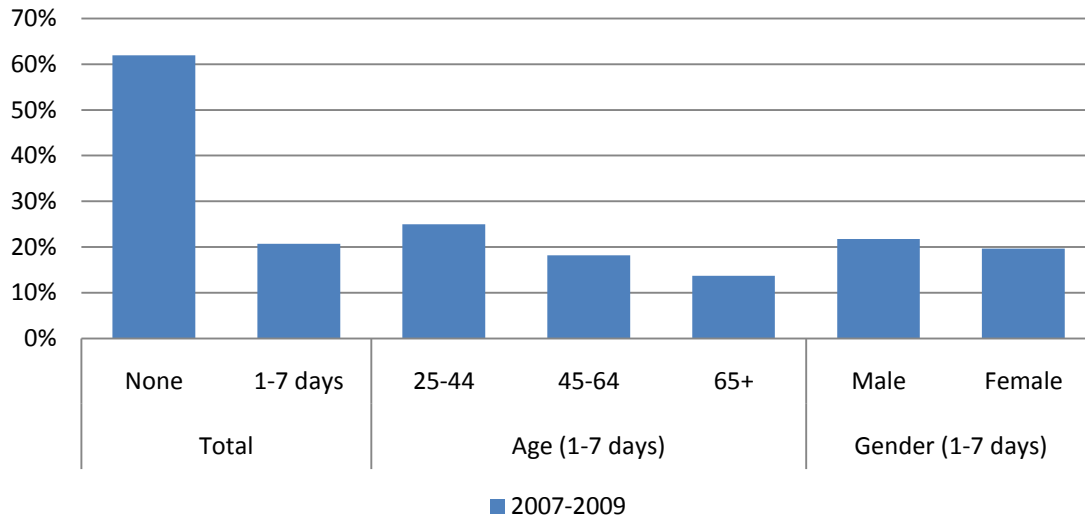


Drug Arrests in Madison County

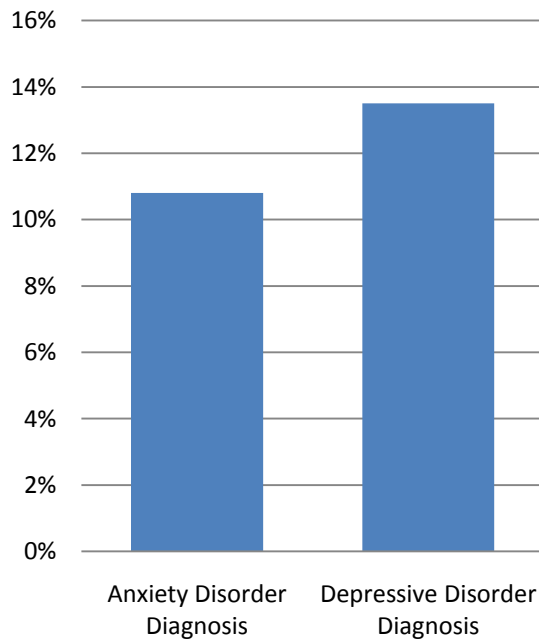


Mental Health

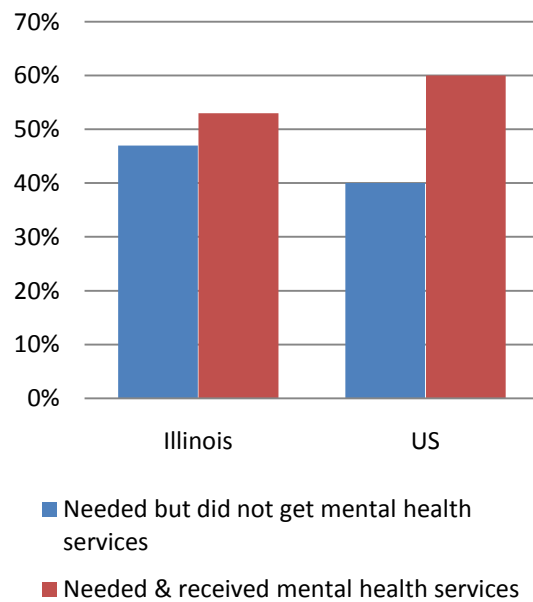
**Adults Reporting Days of Mental Health
Not Being Good (BRFSS, 2007-2009)**



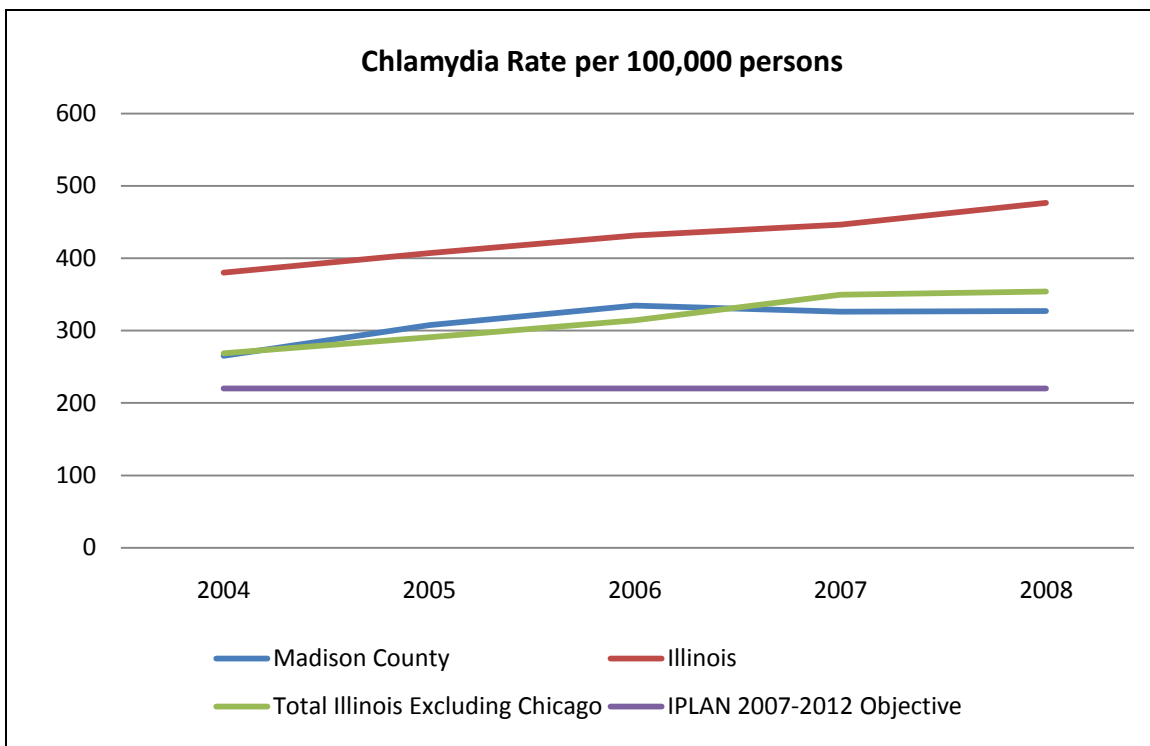
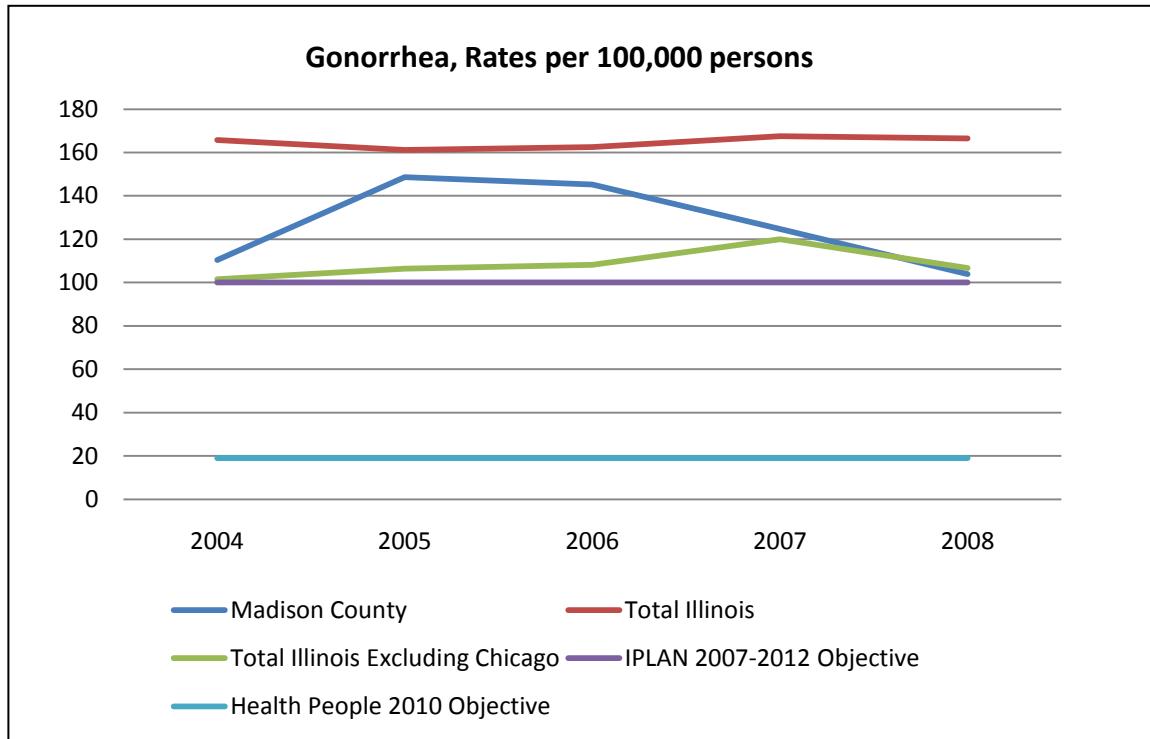
**Anxiety and Depression among Adults
in Illinois (BRFSS 2007-2009)**

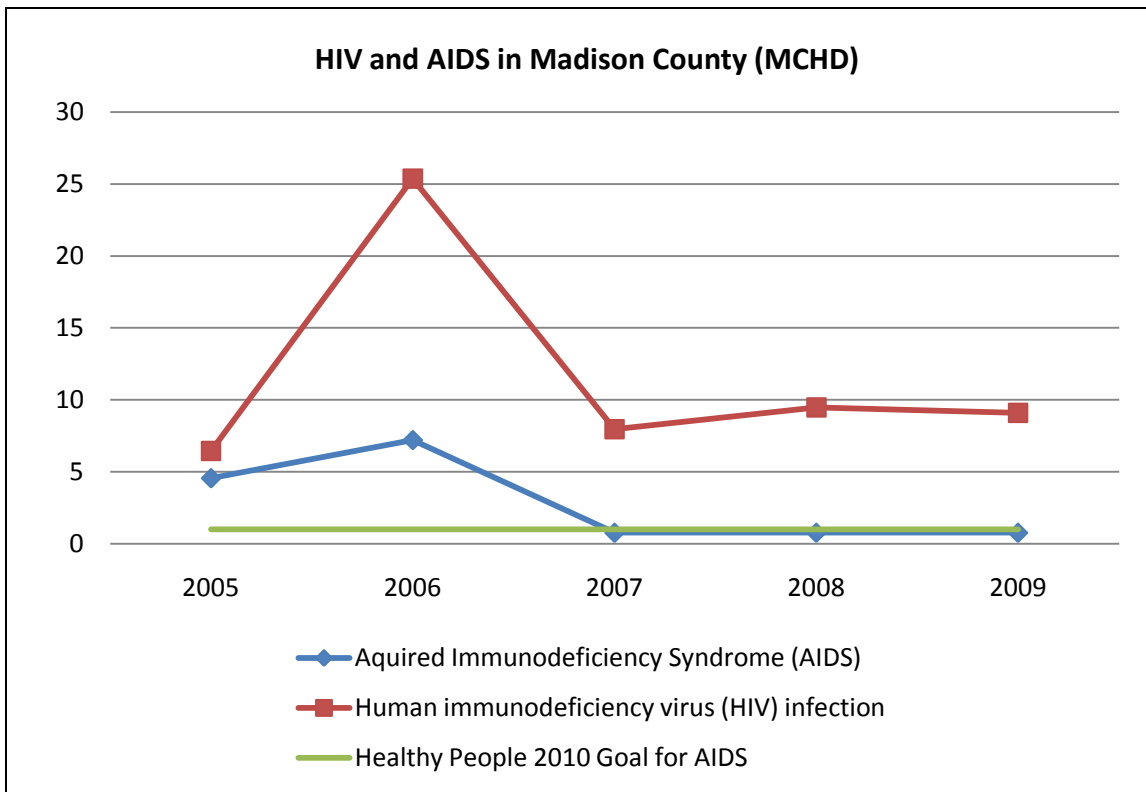
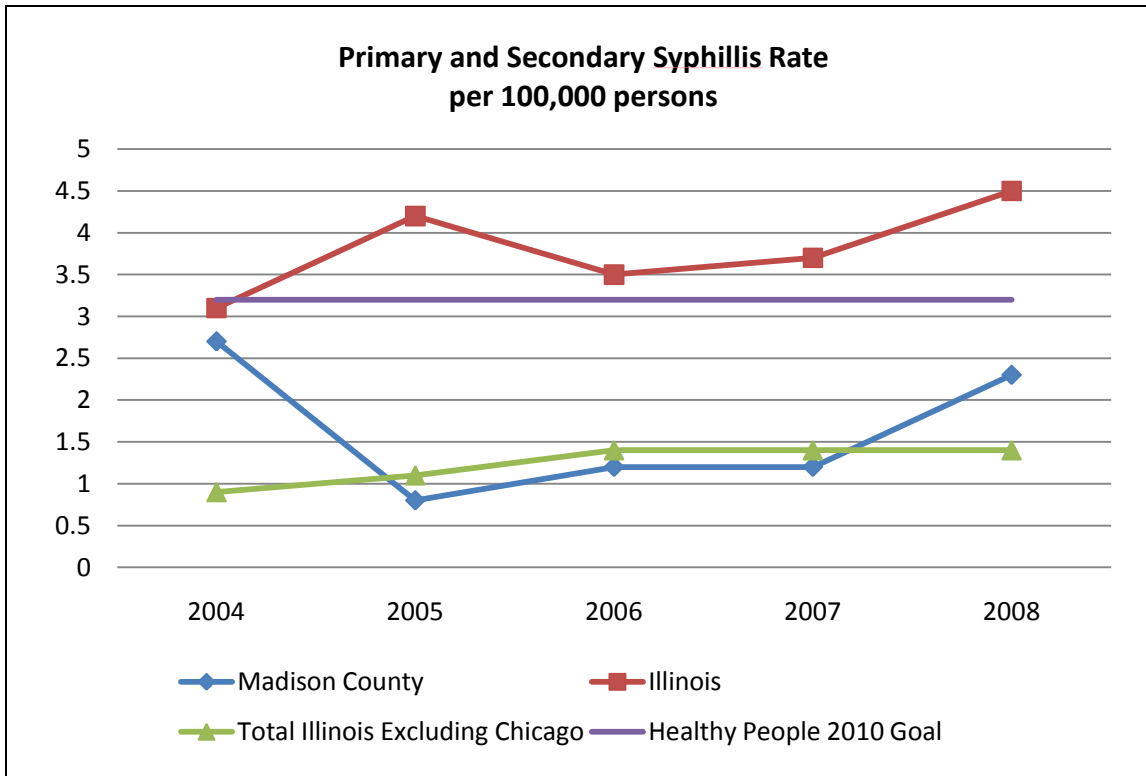


**Mental Health Services for Children
(age 2-17), National Survey of
Children's Health 2007**



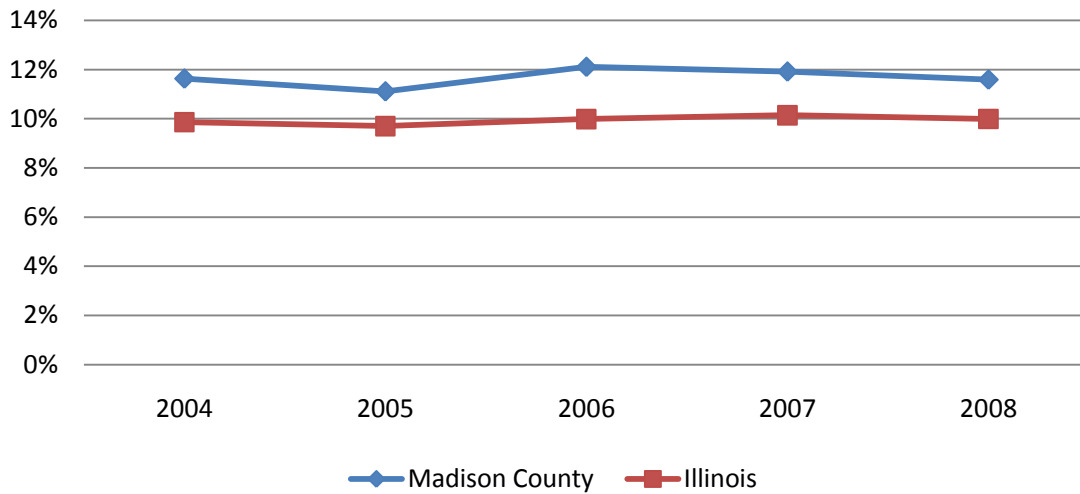
Sexually Transmitted Diseases



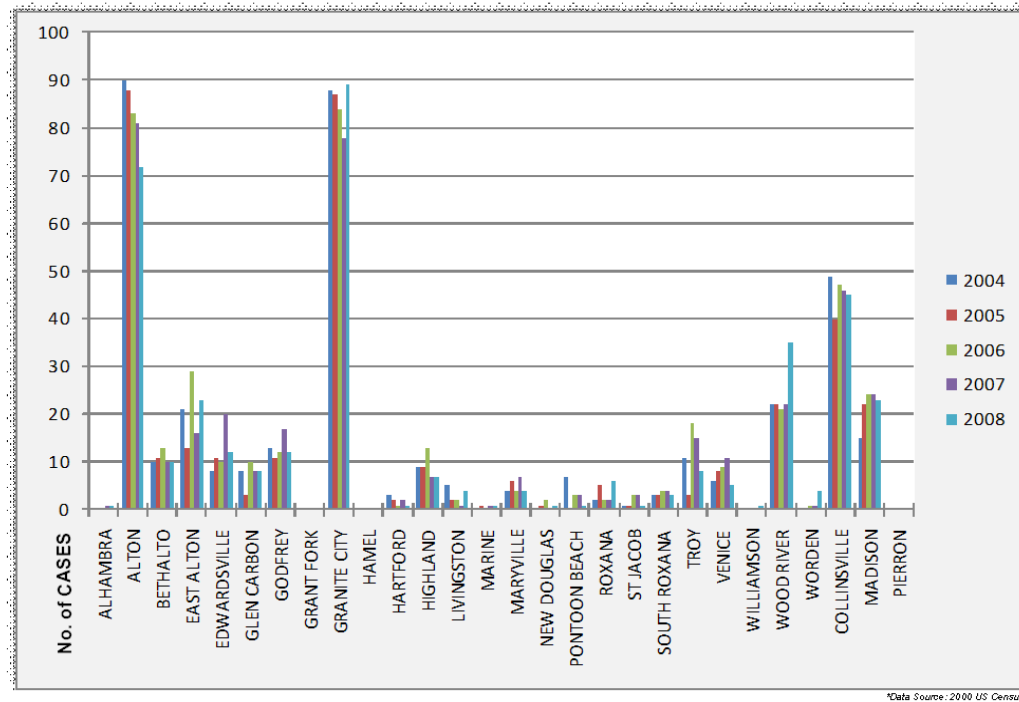


Teen Pregnancy

Percent of Live Births Born to Teenagers,
IDPH Vital Statistics 2004-2008



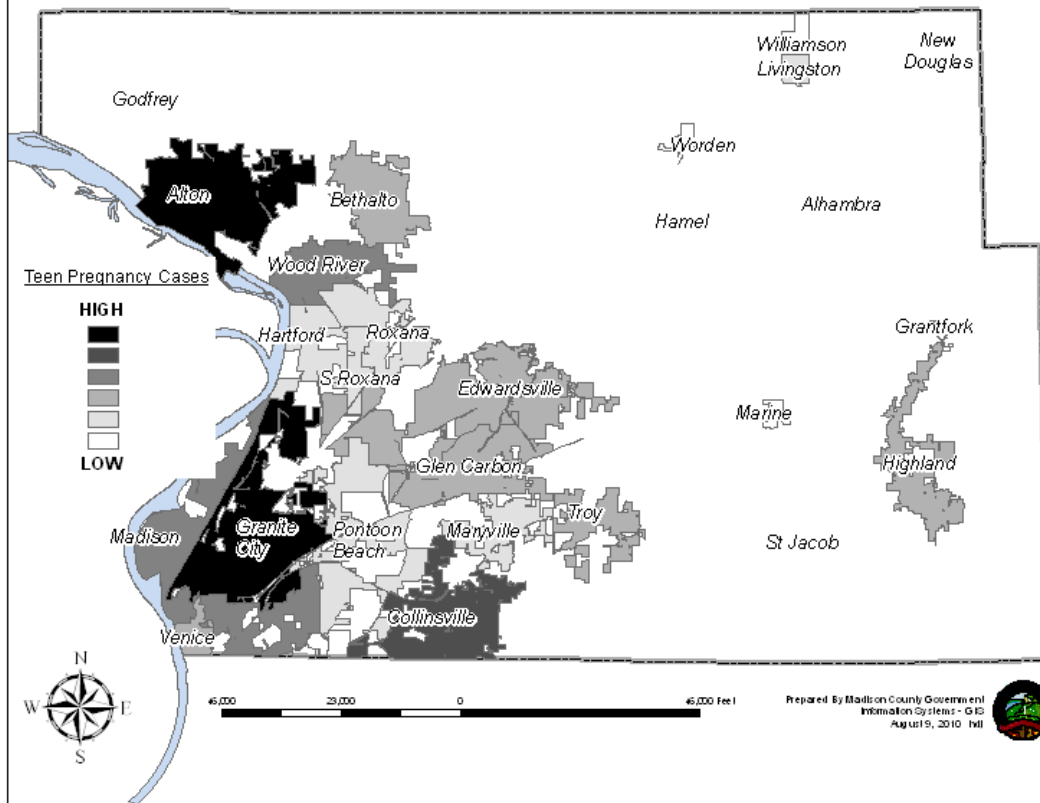
Teen Pregnancy Cases By Municipality From 2004 - 2008



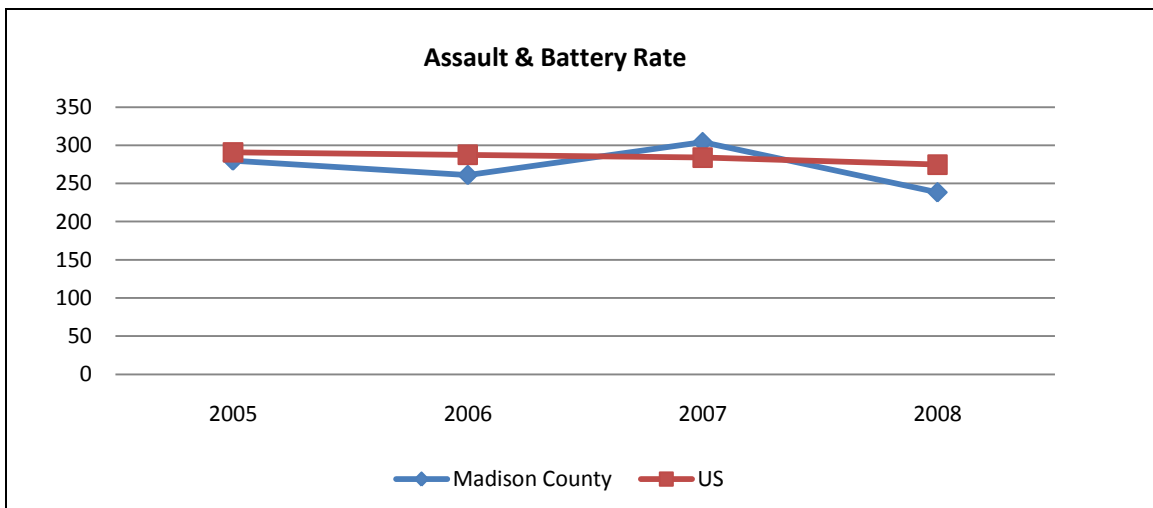
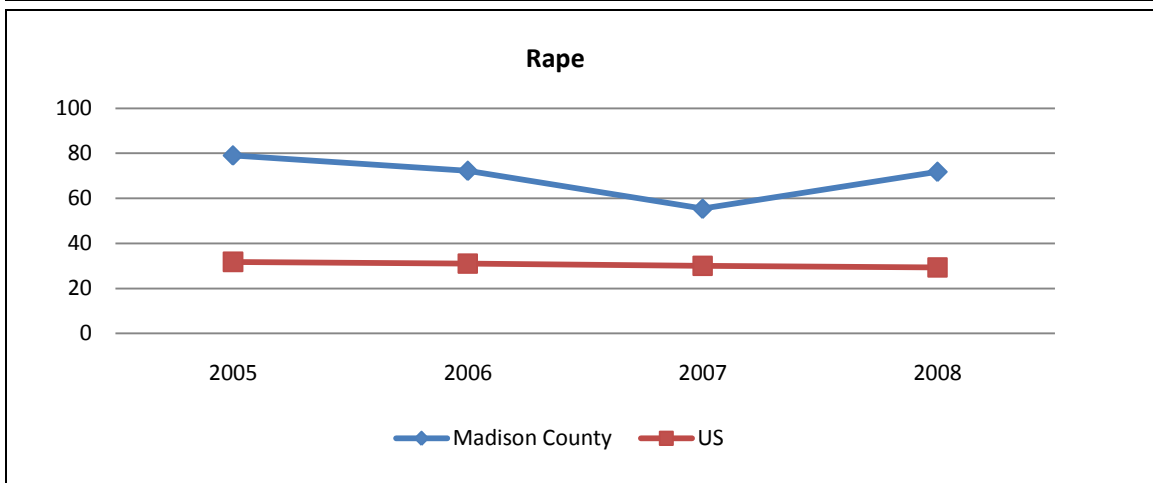
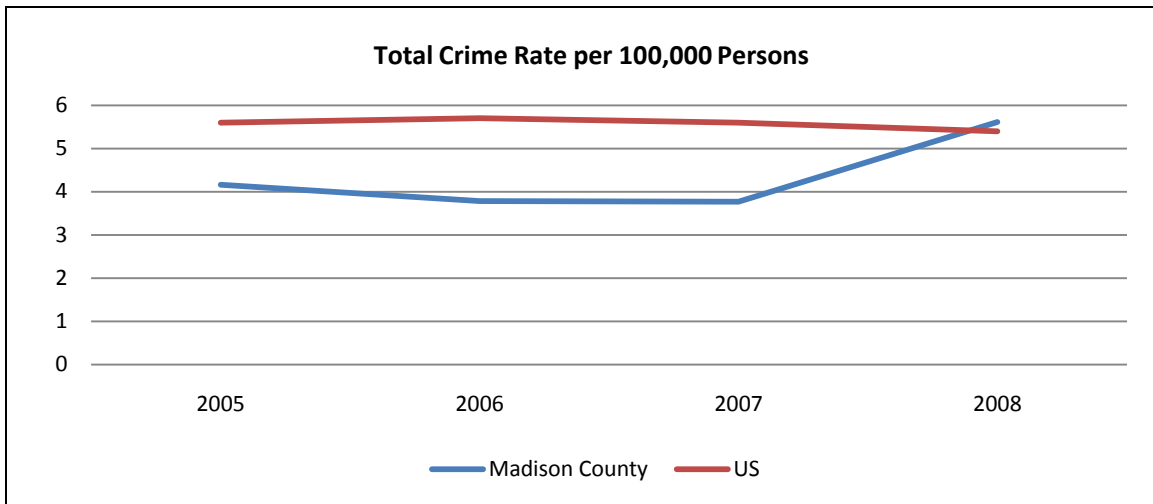
*Data Source: 2000 US Census

Source: 2000 US Census Data

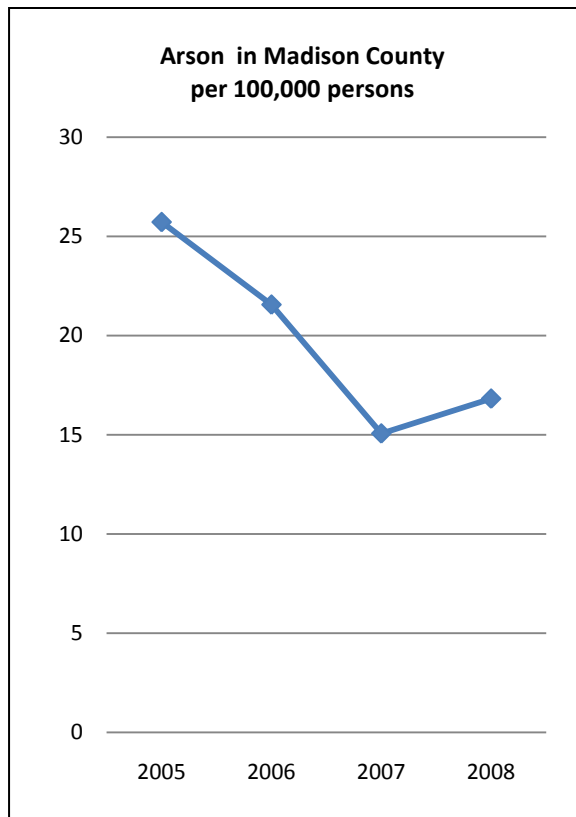
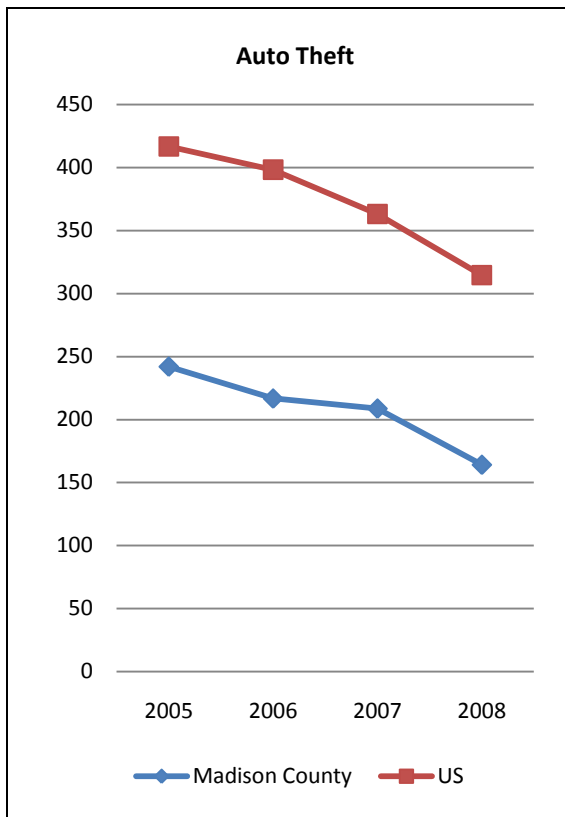
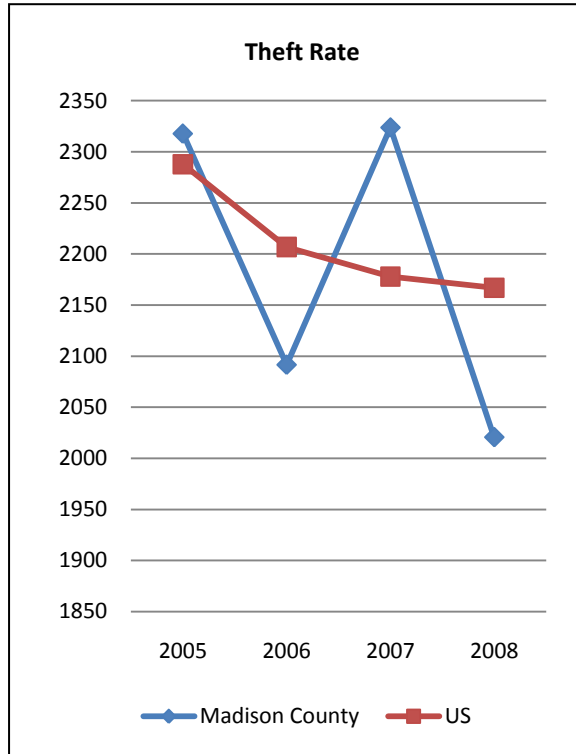
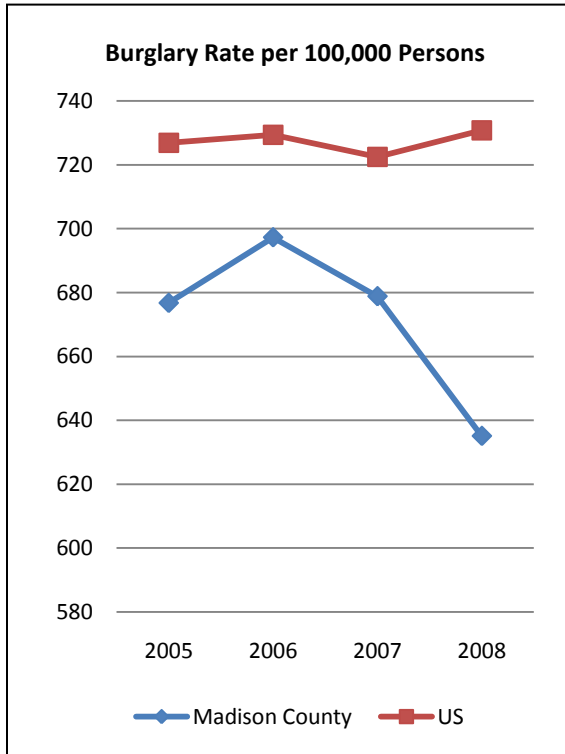
Teen Pregnancy By Municipality 2004 - 2008



Violence

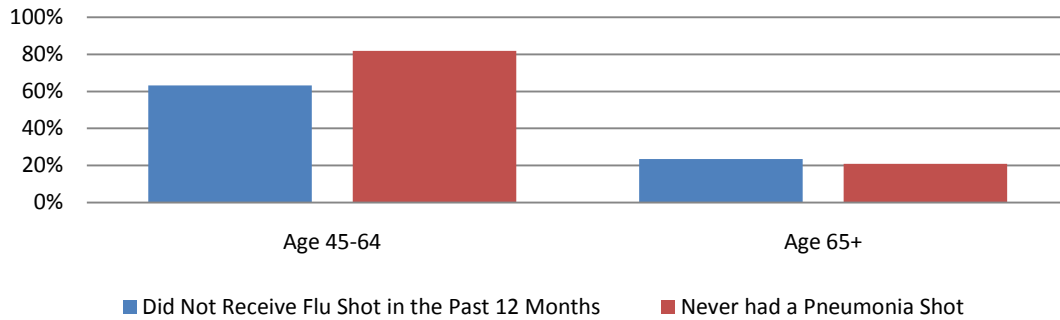


Madison County Needs Assessment and Community Health Plan

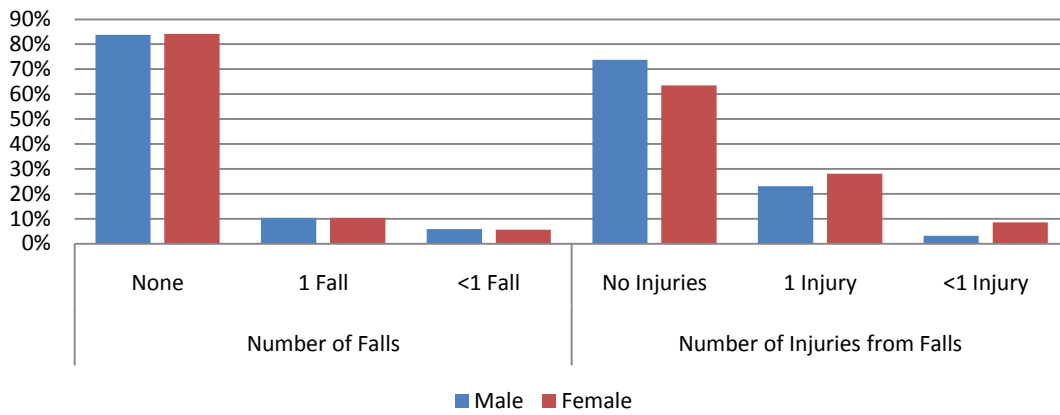


Senior Care

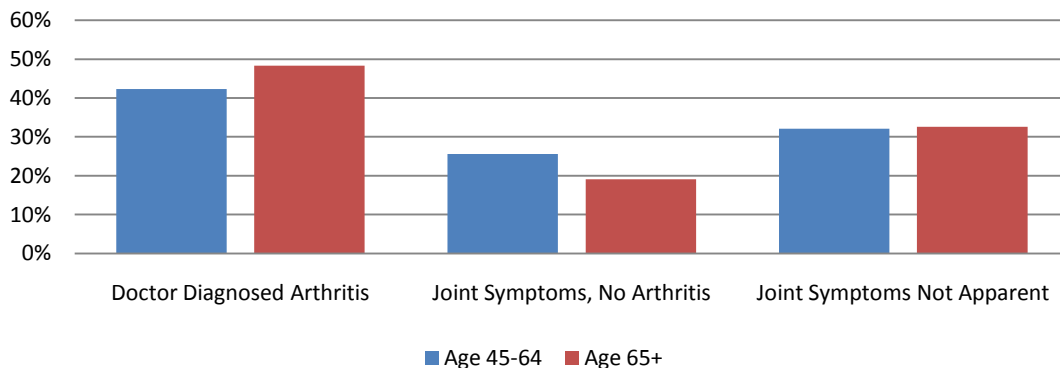
Flu and Pneumonia Shots among Adults in Madison County (BRFSS 2007-2009)



Number of Falls and Injuries Among Illinois Adults Age 45+ by Gender

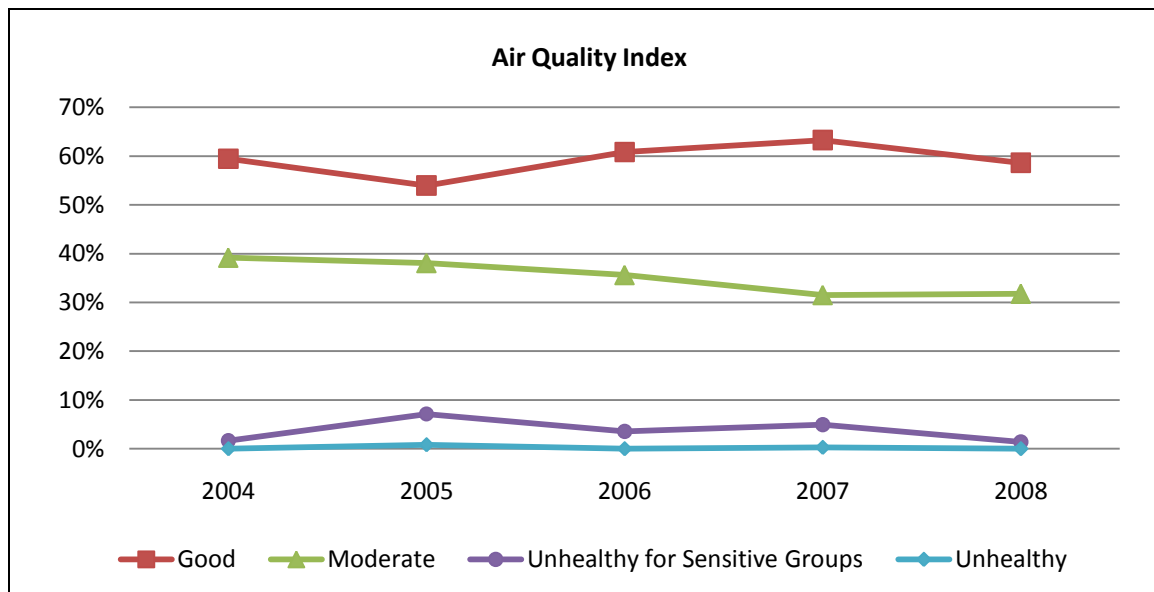
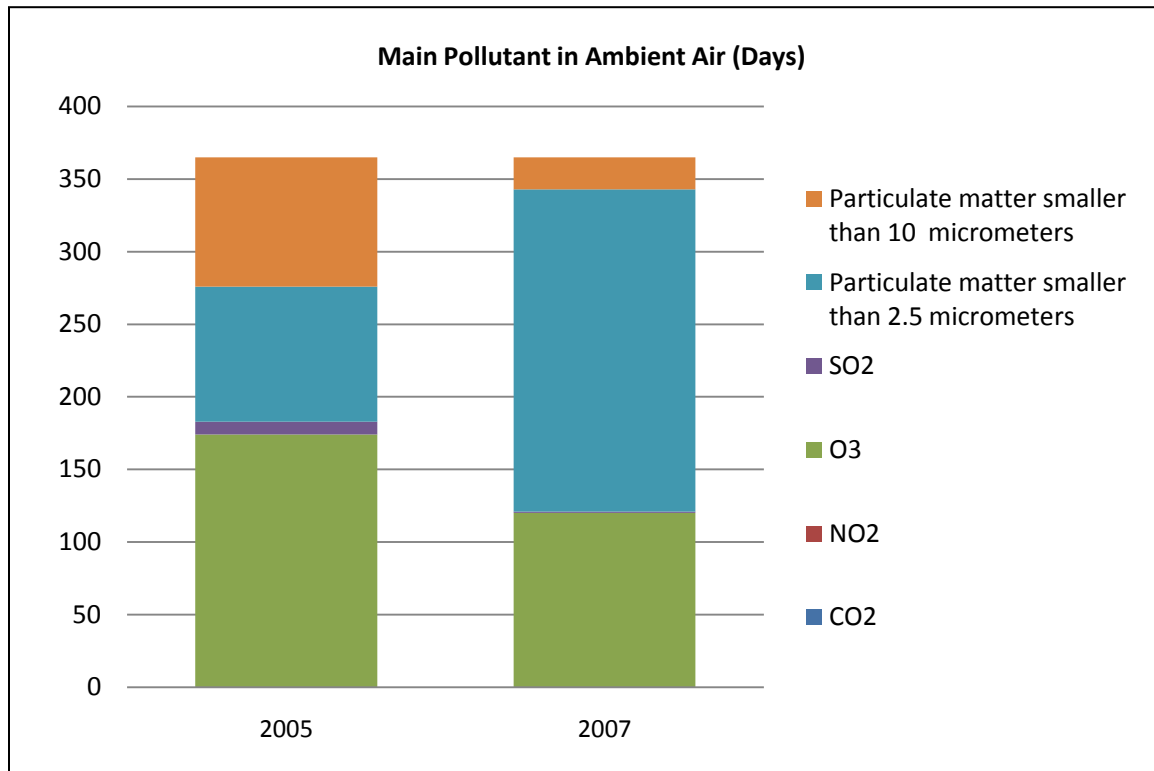


Arthritis Among Madison County Adults Age 45+ (BRFSS 2007-2009)



Air Quality and Environment

Environment surfaced in three main forms: physical, social, and political. For this data and the Environmental Health selections of Survey and Focus Groups, physical environment, specifically air quality, is the key data point.



Core Team Meeting to Set Health Priorities

As the final element culminating the Assessment Phase, a Core Team was convened in a group meeting format for the purpose of: reviewing the data analysis information, discussing the identified health concerns and their current state in Madison County, and participating in a process to select a set of health priority areas to recommend for adoption by the Board of Health. Core Team members were invited to represent various community sectors impacted by health in different ways. 10 community partners served as Core Team Members. A list of Core Team Members is located in Appendix C.

On August 26, 2010, the Core Team convened 1:00-4:00 p.m. at the Madison County Health Department to fulfill their purpose. The agenda included: an overview of the IPLAN process; purpose, structure, and goal for the day; demographic data review, qualitative and quantitative data review (including Focus Group Data, Community Health Survey Data, Quantitative Data, and a Summary Chart of 3 Data Collection Sources); overview of the health priority setting process; Nominal Group Process to determine Top 5 health concerns to further consider; enactment of the Hanlon Method including PEARL; and a final consensus agreement for the 2011-2016 Madison County Health Priorities to recommend to the Board of Health for adoption.

Priority Setting

The goal for the Core Team was an end of day result of consensus on health priorities. The process components to achieve this included:

- Reasonable
- Clearly Understood by Committee Members
- Have Objective Components
- Be based on an Analysis of Available Data and Community Input

APEX PH model for community assessment and plan development suggests that five (5) health problems be identified. IPLAN certification requires that “Prioritization shall result in the establishment of at least three (3) priority health needs” (Certified Local Health Dept. 77 Ill. Adm. Cod 600.400. (a)(d)). The Core Team was asked to set 3-5 health priority areas by the end of this process.

To ensure that participants were discussing health problems from the same foundation, the health problem definition was provided as follows:

APEX PH definition:

Health Problem: A situation or condition of people which is considered undesirable, is likely to exist in the future, and is measured as death, disease, or disability.

IPLAN protocol:

Allows LHD's to broaden this definition to include local public health system issues that go beyond this more traditional definition.

Methods Used:

The methods used to set the Health Priorities are standard Public Health methods for priority setting and included: Nominal Group Process and Hanlon Method with the PEARL Test (APEX-PH, August 1996).

Nominal Group Process: A group of individuals discusses select topics, asks questions, and then votes on a certain number of the topics in order to narrow down the choices. After hearing the information and data, the Core Team had a discussion and then each member was able to choose 5 of the 10 health concerns that they thought were feasible and timely to address based on the Assessment information. The 5 health concern areas receiving the most number of votes then moved onto the next step in the process which was the Hanlon Method including the PEARL test.

*Hanlon Method*¹: The Hanlon Method addresses a rating of the size (actual statistical size) of the problem (Column A in Table A), rating the seriousness of the health problem (Column B in Table A), rating the health problem for the estimated effectiveness of intervention(s) under consideration (Column C in Table A), and then the Basic Priority Rating score which is calculated using the formula $(A + B)C/3$. This score is used as part of the Overall Priority Rating formula as well.

PEARL Test: As part of the Hanlon Method, the PEARL test can be applied to gain additional insight on the health problem while in the process of determining health

¹ *NOTE*: This method, which has been called both the Hanlon Method and the Basic Priority Rating System (BPRS), is described in Public Health: Administration and Practice (Hanlon and Pickett, Times Mirror/Mosby College Publishing) and Basic Health Planning (Spiegel and Hyman, Aspen Publishers).

APEX PH manual citation (Appendix E) is J.J. Hanlon, *"The design of public health programs for underdeveloped countries."* Public Health Reports, Vol. 69. and Hanlon and Pickett, Public Health Administration and Practice, 9th ed. 1990.

priorities. PEARL is a group of factors that, although not directly related to the health problem, have a high degree of influence in determining whether a particular problem can be addressed. The PEARL Test requires a Yes or No response receiving a corresponding score of 1 for Yes and 0 for No to each of the following five areas labeled as follows (D1-D5 in Table A): P – Propriety, E-Economics, A-Acceptability, R-Resources, and L-Legality. Each D subarea is multiplied together to obtain a total D score to be used in the Overall Priority Rating formula such as $(D1) (D2) (D3) (D4) (D5) = D$. The OPR column is the cumulative calculation of the Overall Priority Rating incorporating all of the elements of Hanlon and PEARL using the formula $(A + B)C/3xD$. Column E is the final rankings of health concerns in accordance to the order that the calculations projected. This order does not imply importance, preferential significance, or priority. These methods and this final column were tools to aid the Core Team in their final discussion as to how many and which health concerns to recommend to the Board of Health as 2011-2016 health priority areas.

PEARL FACTORS

P Propriety:

Is an intervention suitable?

Is the problem one that falls within the agencies' overall missions?

E Economic Feasibility:

Does it make economic sense to address the problem?

Are there economic consequences if the problem is not addressed?

A Acceptability:

Will the community and/or target population accept an emphasis on this problem and accept the proposed intervention?

R Resources:

Are resources available to address the problem?

L Legality:

Do the current laws allow the problem to be addressed?

Results:

From the Data Analysis and Collection component of the Assessment Phase, 10 health concerns were identified as the most prevalent to address in congruence with all data sources. The 10 health concerns included and presented to the Core Team:

TOP 10 HEALTH CONCERNS IDENTIFIED THROUGH THE ASSESSMENT PROCESS

Access to Care
Poverty
Obesity
Substance use/abuse (alcohol, tobacco, and other drugs)
Mental Health
Sexually Transmitted Diseases
Teen Pregnancy
Violence
Senior Care
Air Quality/Environment

After reviewing the data analysis information, asking questions, and group discussion, Core Team members participated in a Nominal Group discussion and decision making process to narrow the field of Top 10 health concerns to 5 health concern areas to use in the priority setting tool of the Hanlon Method with the PEARL test. The 5 health concerns included:

TOP 5 HEALTH CONCERNS FOR THE HANLON METHOD

Obesity
Substance use/abuse (alcohol, tobacco, and other drugs)
Mental Health
Teen Pregnancy
Air Quality/Environment

Core Team members then participated in the Hanlon Method for Priority Setting including the PEARL test. After extensive discussion on these columns, categories, and health concerns, here is the final result of this health priority setting method:

Madison County 4th IPLAN Health Problem Priority Worksheet

Health Problem	A - Size	B - Seriousness	C - Effectiveness of Interventions	BPR – Basic Priority Rating = $(A+B)C/3$	D1 - P - Propriety	D2 - E – Economic Feasibility	D3 - A – Acceptability	D4 - R- Resources	D5 - L – Legality	OPR – Overall Priority Rating = $(A+B)C/3xD$	E – Final Rankings of Health Concerns
Obesity	8	18	3	26	1	1	1	1	1	26	5
Substance use/abuse (ATOD)	8	18	5	43.33	1	1	1	1	1	43	4
Mental Health	9	16	8	66.67	1	1	1	1	1	67	1
Teen Pregnancy	4	12	9	48	1	1	1	1	1	48	2
Air Quality-Environment	10	18	5	46.67	1	1	1	1	1	47	3

Rationale for Selections:

After discussion and questions, the Core Team came to a consensus to recommend that all 5 of these final health problems be adopted by the Board of Health as the 2011-2016 Madison County Health Priorities. Here is a summary of the rationale behind the selection of each of the 5 health concern areas as the Top 5:

Obesity: Data demonstrated need and concern, community perception and acceptance of problem, long-term and short-term impacts, feasible strategies exist to begin to address the problem, national trend with the possibility for funding to help further address the problem, problem contributes to multiple long-term health concerns that are leading causes of death and greatly impacts morbidity and mortality, and current efforts are not sufficient or do not have sufficient enough resources to impact the size of the problem.

Substance Use and Abuse: Data demonstrated need and concern, community perception and acceptance of problem, long-term and short-term impacts, feasible strategies exist to address the problem, presence and availability of funding to help and continue and further address the problem, problem contributes to multiple long-term health concerns that are leading causes of death and greatly impacts morbidity and mortality, and current efforts are working but not sufficient enough resources to impact the size of the problem.

Mental Health: Data demonstrated need and concern, lack of data is a concern, community perception of the problem, stigma and lack of knowledge by community impacts ability to address the problem and impacts prevention efforts and seeking treatment, multiple levels of impact on the community and individual by not addressing the problem, feasible strategies exist to begin to educate the community about the problem and decrease stigma, national trend with the possibility for funding to help further address the problem, problem contributes to multiple long-term health and economic concerns, and current efforts need to be streamlined and coordinated to begin to impact the size of the problem.

Teen Pregnancy: Data demonstrated need and concern, community perception and acceptance of problem, long-term and short-term impacts on individuals and the community, economic and lifestyle impact on individuals, economic impact on schools and community, impact on generational trends and recidivism, feasible strategies exist to address the problem, opportunities for future funding to help a continue and further address the problem, problem contributes to multiple long-term health concerns, problem directly connected to other current public health concerns, current efforts are

working but not sufficient enough resources or strategies to impact the size of the problem.

Air Quality/Environment: Data demonstrated need and concern, County Health Rankings data of Madison County on this problem elevated the concern level, community perception of problem, long-term and short-term impacts, feasible strategies exist to educate the community on air quality and steps they can take, need and interest for collaboration on this issue, problem contributes to some long-term health concerns that are leading causes of death and greatly impacts morbidity and mortality, and current efforts are not sufficient or do not have sufficient enough resources to impact the size of the problem.

2011-2016 Madison County Health Priority Areas

On August 26, 2010, the Core Team convened and participated in a process to select a set of health priority areas to recommend for adoption by the Board of Health. On September 2, 2010, the Health Advisory Committee reviewed the recommended health priority areas and approved for their submission to the Health Department Committee. On September 8, 2010, the Health Department Committee reviewed the recommended health priority areas and approved for their submission to the full Board of Health. On September 15, 2010, the Madison County Board of Health adopted the following health priority areas to be addressed 2011-2016 for Madison County:

HEALTH PRIORITY AREAS:

Air Quality/Environment

Mental Health

Obesity

Substance Use and Abuse

Teen Pregnancy

The Madison County Board of Health Resolution to adopt the Health Priority Areas is located in Appendix D.

COMMUNITY HEALTH PLAN PHASE

On March 2, 2011, the Health Advisory Committee recommended that the Community Health Plan be submitted to the Health Department Committee. On March 9, 2011, the Health Department Committee recommended that the Community Health Plan be submitted to and adopted by the full Board of Health. In compliance with IPLAN protocol, the Community Health Plan was adopted by the Madison County Board of Health on March 16, 2011. The Madison County Board of Health Resolution to adopt the Community Health Plan is located in Appendix F.

The purpose of the Community Health Plan is to create a five-year roadmap to impact each chosen health priority. The development of Madison County's Community Health Plan included a Community Health Plan Summit, the development of objectives and strategies by community stakeholders to implement over the next five years to impact the health problem, and the collaborative efforts of the Madison County Partnership for Community Health to assure that the plan is implemented to further enhance the health and quality of life for Madison County residents

Community Health Plan Summit

On November 16, 2010, Madison County Health Department and Madison County Partnership for Community Health (MCPCH) hosted the *Community Health Plan Summit – Innovation and Collaboration for Community Health*. The Summit was held 8:30 a.m.-3:00 p.m. at Belk Park Golf Course in Wood River, IL. The purpose of the day was to convene people interested in the health priority areas to work together to develop the Community Health Plan and serve as a catalyst for continued collaboration to implement the Plan. The focus of the day was for community partners to meet to create an effective and collaborative health plan to address the health priority areas by setting reasonable solutions and discussing interventions to impact the health priorities for 2011-2016. Community agencies, organizations, and businesses committed to addressing health concerns in Madison County were encouraged and invited to attend. 79 community partners from 46 community organizations participated in the Community Health Plan Summit. A list of participating agencies is located in Appendix E.

During the Summit, community partners heard an overview of the current IPLAN process; an introduction to MCPCH; and for each health priority area - a review of data, best practices, current trends, and suggested recommendations to address health

problems. For the remainder of the day, community partners chose one of the health priority areas and participated in a Work Group which included discussion points on the following:

- Risk and Contributing Factors
- Where Can We Enter the Problem
- What Can We Do
- How Are We Going to Do It
- What Might Be a Barrier
- Who Can Help
- Available Resources
- How Will We Know if We Did It

The goal by the end of the day for each health priority group was to determine 1 Outcome Objective, 1 Impact Objective, and 1 Intervention Strategy to include in the Community Health Plan. Definitions were provided to ensure all community partners were congruent with their point of reference. In compliance with IPLAN protocol, each Work Group completed Risk Factor and Community Health Plan Worksheets to aid in discussion and decision making and resulting in the Community Health Plan content for each health priority. Work group discussions were led by a facilitator who received training prior to the Summit.

Community partners were encouraged to continue to work with these newly-formed health priority groups to ensure the implementation of their Plan. From this point forward, these groups become the MCPCH Committees which are the action arm of this process to implement the Community Health Plan over the next five years. Each group will meet on a regular basis, continue to add to and enhance the Plan, identify ways to implement the objectives and strategies both as a group and among their organizations, connect together as a whole body at least once a year, and continue to monitor and feasibly address gaps in programs and services and follow trends among health issues.

2011-2016 Community Health Plan

The Madison County Community Health Plan was developed from the Community Health Summit and subsequent meetings of each Health Priority Area committee. The following section includes the Health Problem, Risk Factors, Contributing Factors, Outcome Objectives, Impact Objectives, Intervention Strategies, Resources, and Barriers for each of the 5 health priority areas. Each health priority area also includes the Healthy People 2020 Objectives and the Illinois State Health Improvement Plan Objectives 2010 (as applicable) that the Madison County objectives and strategies will support and contribute to advancing their target outcomes.

The Community Health Plan will be the core tool for implementation over the next 5 years. These plans may change or be expanded upon as work progresses and measurements occur. The Community Health Plan is intended to be a “living document” that is used by the respective committees and all organizations and citizens for the enhancement of quality of life and health for Madison County.

Air Quality/Environment Priority Plan

<p>Health Problem: Poor air quality Lung & Breathing Problems Pulmonary Disorders</p>	<p>Outcome Objective: By June 2016, improve physical environment ranking by 10% on the County Health Rankings Project.</p> <p>(Baseline: Madison County ranked 101 out of 101 on physical environment, County Health Ranking 2010)</p>
<p>Risk Factor(s) (may be many):</p> <ul style="list-style-type: none"> Exposure to environmental airborne toxins 	<p>Impact Objective(s): By December 31, 2013, improve Madison County's ozone grade to a C on the American Lung Association's State of the Air Report Card.</p> <p>(Baseline: Madison County received a grade F on High Ozone Days, American Lung Association's State of the Air Report Card.)</p>
<p>Contributing Factors (Direct/Indirect; may be many)</p> <ul style="list-style-type: none"> CO2/mobile sources Industry, point source Environmental tobacco smoke Incinerating Open burning Cars and other transportation sources Lawnmowers Wood burning stoves Leaf Burning Refinery and manufacturing Energy usage in large buildings Occupational exposure to tobacco smoke Parental smoking in homes and cars Lack of education 	<p>Proven Intervention Strategies:</p> <p>By December 2011, Madison County Planning & Development, in partnership with the MCPCH Air Quality committee, will have developed a Facebook page devoted to educating the community about environmental issues affecting Madison County</p> <p>By April 2012, MCPCH will conduct 5 <i>Learning in Motion</i> educational programs in Madison County elementary schools.</p> <p>By December 2012, MCPCH will introduce and advocate for a "no idle program" in 5 Madison County school districts.</p> <p>By May 2013, MCPCH will create a marketing strategy to inform Madison County residents about the poor air quality in Madison County.</p>

Resources Available (governmental and nongovernmental):

Youth Centers-Riverbend Center, Asthma and Allergy Coalition, Madison County Community Development, Hospitals, Madison County Planning & Development, Madison County Health Department, University of Illinois Extension, Pharmacies, Alderman, 4H, Boys and Girls Clubs, Scouts, Asthma & Allergy Foundation, American Lung Association, Environmental Protection Agency, Madison County Transit-Ridefinders, Southern Illinois University at Edwardsville.

Barriers:

- Lack of funding
- Politics
- Lack of training in environmental issues
- Lack of staff and time
- Varying beliefs to the extent of environmental problems
- Support of industry and big business
- Individuals not willing to change behaviors

Corrective actions to reduce the level of the indirect contributing factors:

Consumer awareness, education in schools, public education, advocacy to public officials, environmental awards, media campaigns, coalition building.

Proposed community organization(s) to provide and coordinate the activities:

Madison County Planning & Development, Madison County Health Department, University of Illinois Extension, Asthma & Allergy Foundation of America, American Lung Association, Madison County Transit-Ridefinders, St. Louis Regional Clean Air Partnership.

Evaluation plan to measure progress towards reaching objectives:

MCPCH Air Quality Evaluation Plan

Intervention Strategies

- 1) This strategy is currently underway. An intern for Madison County Planning & Development has created the Facebook page and is adding content related to air quality issues. The MCPCH committee will be involved with keeping the webpage updated.
- 2) Learning in Motion-Lisa Modrusic will work with Laura Barton from Madison County Transit to monitor the status of programs being offered and implemented in Madison County schools.
- 3) "No idle program"-Lisa Modrusic will work with the MCPCH committee to advocate for this program in the schools. She will monitor progress.
- 4) The MCPCH Air Quality Committee will coordinate efforts and resources to ensure that this strategy is met by May 2013. We will monitor our progress at our bi-monthly meetings.

HEALTHY PEOPLE 2020 OBJECTIVES SUPPORTED BY THIS PLAN

(taken from www.HEALTHYPEOPLE.GOV/2020)

TOPIC AREA: Environmental Health

OBJECTIVE AREA: Outdoor Air Quality

OBJECTIVES:

EH-1 Reduce the number of days the Air Quality Index (AQI) exceeds 100

Target: 10 days.

Baseline: 11 days exceeded 100 on the Air Quality Index (AQI) in 2008.

Target setting method: Modeling/projection.

Data source: Air Quality System (formerly the Aerometric Information Retrieval System), EPA.

EH-3: Reduce air toxic emissions to decrease the risk of adverse health effects caused by airborne toxics.

EH-3.1 Mobile sources.

Target: 1.0 million tons (2015 modeled data to be reported in 2020).

Baseline: 1.8 million tons of mobile sources of air toxic emissions were reported in 2005.

Target setting method: Modeling/projection.

Data source: National Emissions Inventory (NEI), U.S. Environmental Protection Agency (EPA), Office of Air and Radiation (OAR), Office of Air Quality Planning and Standards (OAQPS).

More information and resources on this health priority from HP2020 visit:

<http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=12>

ILLINOIS STATE HEALTH IMPROVEMENT PLAN 2010 OBJECTIVES SUPPORTED BY THIS PLAN

(taken from http://www.idph.state.il.us/ship/09-10_Plan/SHIP_Final_2010.pdf)

PRIORITY HEALTH CONCERN – NATURAL AND BUILT ENVIRONMENT

The natural and built environment impact health both through exposure to pollutants, diseases, and toxins and by limiting or enhancing healthy lifestyles, such as walking and proper nutrition¹. The public health system should act to:

- Reduce outdoor and indoor environmental exposure to pollutants and infectious diseases.
- Improve the built environment to reduce pollution and promote healthy lifestyles.

Strategic Issue

How can the Illinois public health system monitor priority health concerns and risk factors and implement effective strategies to reduce them?

Long-term Outcome

1. Significantly reduce the negative health impacts caused by pollution (air, land, water, point source, etc.).

Intermediate Outcomes

- Reduce air toxin emissions and decrease the risk of adverse health effects related to air toxins.

Community Engagement/Education

Open communication with education in communities can promote awareness of health threats and change potentially harmful behavior. Affected citizens need to be empowered to improve the environmental health of their homes and communities. Create policy reflecting the need for better outreach and education to exposed persons in high-risk areas.

Non-health community activities provide an opportunity to discuss health issues. Public meetings, such as school boards and village councils, provide opportunities to influence changes in the natural and built environment that can improve people's health.

Leadership/Collaboration/Integration

Collaboration and partnerships that can effectively communicate the risk of health exposure to toxins and strategies for incorporating the use of sustainable environmentally sound practices will require a sharing of responsibility across organizations. This approach will work only if it becomes a core value of multiple public and private organizations.

More information and resources on this health priority from Illinois SHIP visit:

http://www.idph.state.il.us/ship/09-10_Plan/SHIP_Final_2010.pdf

Mental Health Priority Plan

<p>Health Problem:</p> <p>Our communities and citizens do not have access to informed, integrated, and widespread care and support for emotional and behavioral problems.</p>	<p>Outcome Objective:</p> <p>By June 2016, 10 % of community will be trained with mental health first aid.</p> <p>By June 2016, 10% of trained responders will increase events and providers offering an integrated model.</p> <p>Baseline: To be determined and data to be collected.</p>
<p>Risk Factor(s) (may be many):</p> <ol style="list-style-type: none"> 1. Clinical Services: specialized, fragmented, and not well-integrated with community-based support. 2. Stigma and Lack of understanding of mental illness are barriers to identifying, seeking, and providing prevention and support. 	<p>Impact Objective(s):</p> <p>By July 2013, health related events and wellness events, health providers promote integration.</p> <p>By July 2013, promote, provide, and assure mental health first aid countywide.</p> <p>By July 2013, develop and disseminate a caring for caregivers tip sheet.</p>
<p>Contributing Factors (Direct/Indirect; may be many)</p> <ul style="list-style-type: none"> • Silos of care • Emphasis on illness not wellness • Lack of community awareness and involvement • Funding sources • Lack of prevention resources • Overemphasis of emergency/crisis services • Acute care pays better/financial • Minimalization/denial • Lack of human interactions - online 	<p>Proven Intervention Strategies:</p> <ol style="list-style-type: none"> 1. By December 2012, work with community leaders to enhance existing support systems, especially in more closed communities, building on trusted resources/people. 2. By December 2012, promotion of a unified prevention strategy. 3. By December 2012, establish a holistic branding of mental health in Madison County.
<p>Resources Available (governmental and nongovernmental):</p> <p>Churches Ministerial Alliances Service Providers A Wellness Application for your phone</p>	<p>Barriers:</p> <p>Denial Funding restriction Lack of education with funders "It's not my problem" Competing Stigma/lack of education Lack of resources: time, staff Restrictive reimbursement by Medicaid Insurance restrictions</p>

HEALTHY PEOPLE 2020 OBJECTIVES SUPPORTED BY THIS PLAN

(taken from www.HEALTHYPEOPLE.GOV/2020)

TOPIC AREA: Mental Health and Mental Disorders

OBJECTIVE AREAS: Mental Health Status Improvement, Treatment Expansion, Educational and Community-Based Programs

OBJECTIVES:

Mental Health Status Improvement

MHMD–1: Reduce the suicide rate.

Target: 10.2 suicides per 100,000.

Baseline: 11.3 suicides per 100,000 occurred in 2007.

Target setting method: 10 percent improvement.

Data source: National Vital Statistics System (NVSS), CDC, NCHS.

MHMD–2: Reduce suicide attempts by adolescents.

Target: 1.7 suicide attempts per 100.

Baseline: 1.9 suicide attempts per 100 occurred in 2009.

Target setting method: 10 percent improvement.

Data source: Youth Risk Behavior Surveillance System (YRBSS), CDC.

MHMD–3: Reduce the proportion of adolescents who engage in disordered eating behaviors in an attempt to control their weight.

Target: 12.9 percent.

Baseline: 14.3 percent of adolescents engaged in disordered eating behaviors in an attempt to control their weight in 2009.

Target setting method: 10 percent improvement.

Data source: Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.

MHMD–4: Reduce the proportion of persons who experience major depressive episodes (MDE).

MHMD–4.1 Adolescents aged 12 to 17 years.

Target: 7.4 percent.

Baseline: 8.3 percent of adolescents aged 12 to 17 years experienced a major depressive episode in 2008.

Target setting method: 10 percent improvement.

Data source: National Survey on Drug Use and Health, SAMHSA.

MHMD–4.2 Adults aged 18 years and older.

Target: 6.1 percent.

Baseline: 6.8 percent of adults aged 18 years and older experienced a major depressive episode in 2008.

Target setting method: 10 percent improvement.

Data source: National Survey on Drug Use and Health, SAMHSA.

Treatment Expansion

Although this Madison County Community Health Plan does not directly expand on treatment, the reduction of stigma, educating the community, and training on mental health first aid leads to support this set of HP2020 objectives (MHMD-5 through MHMD-12).

Educational and Community-Based Programs

ECBP–10: Increase the number of community-based organizations (including local health departments, tribal health services, nongovernmental organizations, and State agencies) providing population-based primary prevention services in the following areas:

ECBP–10.3 Mental illness.

Target: 69.5 percent.

Baseline: In 2008, 63.2 percent of community-based organizations (including local health departments, tribal health services, nongovernmental organizations, and State agencies) provided population-based primary prevention services in mental illness.

Target setting method: 10 percent improvement.

Data source: National Profile of Local Health Departments, National Association of County and City Health Officials (NACCHO).

More information and resources on this health priority from HP2020 visit:

<http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=28>

ILLINOIS STATE HEALTH IMPROVEMENT PLAN 2010 OBJECTIVES **SUPPORTED BY THIS PLAN**

(taken from http://www.idph.state.il.us/ship/09-10_Plan/SHIP_Final_2010.pdf)

PRIORITY HEALTH CONCERN – MENTAL HEALTH

There is a clear connection between mental and physical health. Mental health is fundamentally important to overall health and well-being. Mental disorders affect nearly one in five Americans in any given year. Mental disorders are illnesses that, when left untreated, can be just as serious and disabling as physical diseases, such as cancer and heart disease. Therefore, the public health system should work to:

- ☐ Prevent mental illness and intervene early with those at risk of mental health issues.
- ☐ Increase treatment of mental health issues in the most appropriate setting.

Strategic Issue

How can the Illinois public health system monitor priority health concerns and risk factors and implement effective strategies to reduce them?

Long-term Outcome

- 1.** Increase prevention and early identification of mental health issues and those at risk for mental health issues.

Intermediate Outcomes

- Increase community-based primary mental health promotion programs.
- Increase the training to conduct and to deliver mental health screenings across the lifespan by primary-care providers.
- Increase mental health education and screenings in primary care settings and schools for adolescents by professionally trained personnel.
- Increase mental health data collection, monitoring, and utilization for policy formation and program development.
- Increase resources and funding within community- and school-based programs to support children, adults, and families to develop positive social and emotional capacities and skills.

Social Determinants of Health

The health care and public health systems need to develop a more comprehensive understanding that mental health is a vital part of overall health status, and the implications that social and economic conditions have on mental health, including environmental and behavioral factors, income, education, race/ethnicity, and societal stigma. Health care and public health systems need to work to integrate health care and mental health services across all systems in Illinois.

Mental health services and systems need to recognize and address cultural differences in the perception of mental health and willingness to seek services. Mental health screening tools must be reviewed to assure they do not contain cultural or social biases.

Community Engagement/Education

Promoting mental health and wellness, and education on prevention, on early identification, and on treatment of mental health issues needs to be integrated in communities at the grassroots level. Communities must be engaged, educated, and empowered to both promote mental health and help build systems of care locally through collaboration among community members, professionals, and local health and public health systems.

Comprehensive health education programs in schools should include a strong focus on improving mental health and supporting and promoting children's self-esteem.

Efforts must be made at the community level to reduce the stigma of mental illness in order to promote care-seeking.

Leadership/Collaboration/Integration

Mental health is a critical issue on college campuses, and it is important to engage higher education in the development of solutions and interventions.

Among public health system stakeholders, employers can be specifically engaged to support improved mental health through workplace efforts.

More information and resources on this health priority from Illinois SHIP visit:

http://www.idph.state.il.us/ship/09-10_Plan/SHIP_Final_2010.pdf

Obesity Priority Plan

At the Community Health Summit, the Obesity Workgroup divided into 3 subgroups to develop the Plan. This Obesity Committee now contains many people with varying interests to address all 3 of these Plan areas. The following contains all 3 areas listed separately by subgroup.

Health Problem: <p style="text-align: center;">Obesity Group 1</p>	Outcome Objective: <p>By June 2016, to reach 25% of all healthcare providers in Madison County with the tools they need to have a thorough discussion about obesity with their patients.</p> <p>Baseline: To be established by securing the healthcare providers list.</p>
Risk Factor(s) (may be many): <p>Culture Education: Lack of nutrition and exercise resources</p>	Impact Objective(s): <ol style="list-style-type: none"> 1. By 2012, develop criteria for healthcare resources that will be distributed to providers or community organizations. 2. By 2013, create an accurate list of providers or community organizations for resource dissemination. 3. By 2014, distribute list to providers or community organizations for resource dissemination. 4. By 2015, create a media campaign kickoff event utilizing TV and newspapers. 5. By 2015, re-evaluate and re-update materials. 6. By 2016, include 3rd party organizations in resource dissemination.
Contributing Factors (Direct/Indirect; may be many) <p>MD/patient relationships Body image Lack of awareness Appropriate resources Behavioral Control</p>	Proven Intervention Strategies: <p>Support groups Family involvement Meals and exercise Education Meal planning Incentives Behavioral contracts</p>
Resources Available (governmental and nongovernmental): <p>U of I Extension Local Hospital Academy of Pediatrics MCHD Cancer.org CDC Exerciseismedicine.org</p>	Barriers: <p>Time Expectation Cost Access- transportation Immediate gratification</p>

Group 1 Summary:

We discussed creating a packet or tool kit of information for physicians that would 1) make it easy for them to bring up the subject of obesity with their patients and 2) gives local resources on where they can get started. The resources will include free, reduced cost as well as full price resources that will help them on their way to reducing their BMI. We feel physicians do not always address obesity as the epidemic that it truly is, and they do not always bring up the topic to their patients for fear of offending them.

The kit might include: Speaking points for the physician to spark that conversation with the patient, local parks and hours of operation, local gyms, nutritionists, farmers markets, running groups, etc. We did not determine the specific criteria for being a part of this resource list, however, we recognize that it could be a slippery slope and that a lot of time should be devoted to thinking through the details of this.

HEALTHY PEOPLE 2020 OBJECTIVES SUPPORTED BY THIS PLAN

(taken from www.HEALTHYPEOPLE.GOV/2020)

TOPIC AREA: Nutrition and Weight Status

OBJECTIVE AREAS: Health Care and Worksite Settings, Weight Status, Food and Nutrient Consumption

OBJECTIVES:

Health Care and Worksite Settings

NWS-5: Increase the proportion of primary care physicians who regularly measure the body mass index of their patients.

NWS-5.1 Increase the proportion of primary care physicians who regularly assess body mass index (BMI) in their adult patients.

Target: 53.6 percent.

Baseline: 48.7 percent of primary care physicians regularly assessed body mass index (BMI) in their adult patients in 2008.

Target setting method: 10 percent improvement.

Data source: National Survey on Energy Balance Related Care among Primary Care Physicians.

NWS-6: Increase the proportion of physician office visits that include counseling or education related to nutrition or weight.

NWS-6.1 Increase the proportion of physician office visits made by patients with a diagnosis of cardiovascular disease, diabetes, or hyperlipidemia that include counseling or education related to diet and nutrition.

Target: 22.9 percent.

Baseline: 20.8 percent of physician office visits of adult patients with a diagnosis of cardiovascular disease, diabetes, or hyperlipidemia included counseling or education related to diet and nutrition in 2007 (age adjusted to the year 2000 standard population).

Target setting method: 10 percent improvement.

Data source: National Ambulatory Medical Care Survey, CDC, NCHS.

NWS-6.2 Increase the proportion of physician office visits made by adult patients who are obese that include counseling or education related to weight reduction, nutrition, or physical activity.

Target: 31.8 percent.

Baseline: 28.9 percent of physician office visits of adult patients who are obese included counseling or education related to weight reduction, nutrition, or physical activity in 2007 (age adjusted to the year 2000 standard population).

Target setting method: 10 percent improvement.

Data source: National Ambulatory Medical Care Survey, CDC, NCHS.

NWS-6.3 Increase the proportion of physician visits made by all child or adult patients that include counseling about nutrition or diet.

Target: 15.2 percent.

Baseline: 12.2 percent of physician office visits of all child or adults patients included counseling about nutrition or diet in 2007 (age adjusted to the year 2000 standard population).

Target setting method: 3 percentage point improvement.

Data source: National Ambulatory Medical Care Survey, CDC, NCHS.

Weight Status

NWS-8: Increase the proportion of adults who are at a healthy weight.

Target: 33.9 percent.

Baseline: 30.8 percent of persons aged 20 years and over were at a healthy weight in 2005-08 (age adjusted to the year 2000 standard population).

Target setting method: 10 percent improvement.

Data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

NWS-9: Reduce the proportion of adults who are obese.

Target: 30.6 percent.

Baseline: 34.0 percent of persons aged 20 years and over were obese in 2005-08 (age adjusted to the year 2000 standard population).

Target setting method: 10 percent improvement.

Data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

NWS-10 Reduce the proportion of children and adolescents who are considered obese.

NWS-10.1 Children aged 2 to 5 years.

Target: 9.6 percent.

Baseline: 10.7 percent of children aged 2 to 5 years were considered obese in 2005-08.

Target setting method: 10 percent improvement.

Data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

NWS-10.2 Children aged 6 to 11 years.

Target: 15.7 percent.

Baseline: 17.4 percent of children aged 6 to 11 years were considered obese in 2005–08.

Target setting method: 10 percent improvement.

Data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

NWS–10.3 Adolescents aged 12 to 19 years.

Target: 16.1 percent.

NWS–6

Baseline: 17.9 percent of adolescents aged 12 to 19 years were considered obese in 2005–08.

Target setting method: 10 percent improvement.

Data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

NWS–10.4 Children and adolescents aged 2 to 19 years.

Target: 14.6 percent.

Baseline: 16.2 percent of children and adolescents aged 2 to 19 years were considered obese in 2005–08.

Target setting method: 10 percent improvement.

Data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

*Ultimately, these objectives will also impact HP2020 Objectives in the **Food and Nutrient Consumption** section.*

More information and resources on this health priority from HP2020 visit:

<http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=29>

ILLINOIS STATE HEALTH IMPROVEMENT PLAN 2010 OBJECTIVES **SUPPORTED BY THIS PLAN**

(taken from http://www.idph.state.il.us/ship/09-10_Plan/SHIP_Final_2010.pdf)

NOTE: The following applies to all 3 of the Madison County Obesity Health Plan sections.

PRIORITY HEALTH CONCERN – OBESITY: NUTRITION AND PHYSICAL ACTIVITY

Obesity, sedentary lifestyle and poor nutrition are risk factors for numerous chronic diseases and they exacerbate others, including heart disease, diabetes, hypertension, asthma, and arthritis. Obesity has reached an alarming rate, with 62 percent of adults overweight; 21 percent of children in Illinois are obese, the fourth worst rate in the nation. The public health system must act quickly to reverse this epidemic through:

- Implementation of individual, family, environmental, and policy initiatives to increase physical activity.
- Implementation of individual, family, environmental, and policy initiatives to improve nutrition.

Strategic Issue

How can the Illinois public health system monitor priority health concerns and risk factors and implement effective strategies to reduce them?

Long-term Outcomes

1. Reduce the proportion of children and adolescents who are overweight or obese.
2. Reduce the proportion of adults who are overweight or obese.

Intermediate Outcomes

- Increase consumption of fruits, vegetables, and whole grains.
- Increase the proportion of children, adolescents, and adults who meet guidelines for physical activity.
- Decrease the proportion of children, adolescents, and adults who lead sedentary lifestyles.
- Increase initiation and early onset of physical activity.
- Enhance the built environment to increase safe opportunities for physical activity and improve infrastructure for physical activity – parks, playgrounds, sidewalks, safe routes to school and school sating, multipurpose use of schools to increase physical activity during non-school hours, enhanced community walkability, and increase access to affordable opportunities for physical activity.
- Increase the access to fresh produce by expanding availability of affordable healthy foods in communities and schools in the long term. Facilitate travel across communities in the short term so residents of low-access communities can more easily access produce in higher-access communities.

Health Care Reform/Policy

Promote availability and use of fresh local foods in schools. Include comprehensive health education in schools, including education on nutrition and physical activity. Reinstate physical education and recess in schools. Establish and enforce a strong competitive foods policy (i.e., a policy regarding foods in vending machines and sold a la carte) in all Illinois schools.

Health Across the Lifespan

Expand systems and opportunities to combat obesity and increase physical activity across the lifespan in schools, child care, the workplace, and settings serving seniors.

Promote development of community gardens to engage children and families in producing and eating fruits and vegetables.

Educate school children on healthy food choices, and eliminate unhealthy foods from school menus to model healthy eating.

Support worksite wellness initiatives that focus on healthy lifestyle promotion.

Social Determinants of Health

The public health system must incorporate strategies to reduce “food deserts” and increase local access to healthy foods. The public health system should work to provide opportunities for and education about physical activity and healthy eating, particularly to the low income and minority most at risk for heart disease and diabetes. Current efforts to promote and develop an Illinois farm and food economy, including the development of urban farms and farm-to-school initiatives, are an important part of the strategy to improve access to food in underserved communities.

The public health system must work with other disciplines to ensure that the built environment supports physical activity by increasing safety, reducing crime, and strengthening infrastructure for active transportation.

Ensure equitable access to safe and affordable parks, gyms, and other facilities for physical activity.

Ensure equitable access to healthy and affordable food by promoting traditional (groceries, corner stores, restaurants) and non-traditional (farmers' markets, produce carts and kiosks) food retail in all communities, particularly to the low-income and minority communities most at risk for heart disease and diabetes.

Community Engagement/Education

Engage the community through culturally competent approaches (e.g., in nutrition education) and provide resources to create culturally appropriate adaptations of traditional cooking and activities.

Work with restaurants, schools, and social centers (e.g., churches) to increase the healthiness of prepared foods and expand the choices available for healthy food selection.

Establish a multi-agency task force at the state level (modeled on Chicago's Inter-departmental Task Force on Childhood Obesity and the newly emerging federal multi-agency taskforce).

Coordinate with the Illinois Food, Farms and Jobs Council on development of strategies to improve access to fresh foods, especially in underserved areas/food deserts.

In an effort to foster obesity prevention and management, build capacity and provide support to local health departments and other components of the public health system to address healthy lifestyle promotion.

<p>Health Problem:</p> <p>Childhood Obesity (Group 2)</p>	<p>Outcome Objective:</p> <p>By June 2016, reduce by 5% the number of Madison County children over the 85th percentile for BMI. below state level BMI statistics for obesity to less than 85th percentile.</p> <p>Baseline: Local data to be determined through Pre-Surveys during year 1. State level BMI statistics for obesity will also be used.</p>
<p>Risk Factor(s) (may be many):</p> <p>Poor Diet</p> <p>Lack of activity</p>	<p>Impact Objective(s):</p> <ol style="list-style-type: none"> 1. By 2012, contact will be made with school nurses and other local pediatric doctors about BMI data collection. 2. By 2012, there will be an active Madison County School Wellness group established for local school districts. 3. By 2013, data will be collected to develop a baseline for childhood BMI for Madison County. 4. By 2014, awareness targeted for school-aged children will be sent out via community health fairs. 5. By 2015, Madison County school wellness policies will be established to increase standard physical activity and healthy consumption of fruits and vegetables. 6. By 2016, evaluation of BMI data and impact of strategies will be analyzed.
<p>Contributing Factors (Direct/Indirect; may be many)</p> <p>Lack of knowledge</p> <p>Lack of resources</p> <p>Lack of Physical Education</p> <p>Lack of motivation</p> <p>Society value</p>	<p>Proven Intervention Strategies:</p> <p>Survey</p> <p>Data collection for community</p> <p>Contact school nurses for data</p> <p>Look at Physical Education curriculum</p> <p>Require daily Physical Education Standards</p> <p>Work with summer programs</p> <p>Create a wellness group for Madison County School Wellness Policy</p> <p>Community member volunteer for walk to school program to increase activity.</p>
<p>Resources Available (governmental and nongovernmental):</p> <p>USDA</p> <p>College Text: Literature on Fitness and Wellness</p> <p>SIUE and Lewis and Clark Community College</p> <p>YMCA</p> <p>Let's Move Campaign</p> <p>Southern Illinois Health Women Task Force</p>	<p>Barriers:</p> <p>Motivation</p> <p>Budget</p> <p>Government mandates</p>

Group 2 Summary:

The group focused on the need for data for children of Madison County. Contact with school nurses and other local pediatric doctors will be made in order to establish an efficient and ethical way to collect the data. If the group has a baseline for Madison County, we can look into ways to decrease the percentage of overweight and obese children. We are in hopes of creating a Madison County District Wellness group where a representative from each school can be involved. We are in hopes that this will lead to other community connections and standard wellness policies for each school in Madison County.

HEALTHY PEOPLE 2020 OBJECTIVES SUPPORTED BY THIS PLAN

(taken from www.HEALTHYPEOPLE.GOV/2020)

TOPIC AREA: Nutrition and Weight Status

OBJECTIVE AREAS: Healthier Food Access, Health Care and Worksite Settings, Weight Status, Food and Nutrient Consumption

OBJECTIVES:

Healthier Food Access

NWS–2 Nutritious foods and beverages offered outside of school meals.

NWS–2.1 Increase the proportion of schools that do not sell or offer calorically sweetened beverages to students.

Target: 21.3 percent.

Baseline: 9.3 percent of schools did not sell or offer calorically sweetened beverages to students in 2006.

Target setting method: Modeled on previous data: 12 percentage point increase.

Data source: School Health Policies and Programs Study, CDC.

NWS–2.2 Increase the proportion of school districts that require schools to make fruits or vegetables available whenever other food is offered or sold.

Target: 18.6 percent.

Baseline: 6.6 percent of school districts required schools to make fruits or vegetables available whenever other foods are offered or served in 2006.

Target setting method: 12.0 percentage point increase.

Data source: School Health Policies and Program Study, CDC.

Health Care and Worksite Settings

NWS–5.2 Increase the proportion of primary care physicians who regularly assess body mass index (BMI) for age and sex in their child or adolescent patients.

Target: 54.7 percent.

Baseline: 49.7 percent of primary care physicians regularly assessed body mass index (BMI) for age and sex in their child or adolescent patients in 2008.

Target setting method: 10 percent improvement.

Data source: National Survey on Energy Balance Related Care Among Primary Care Physicians.

Weight Status

NWS–10 Obesity in children and adolescents

NWS–10 Reduce the proportion of children and adolescents who are considered obese.

NWS–10.1 Children aged 2 to 5 years.

Target: 9.6 percent.

Baseline: 10.7 percent of children aged 2 to 5 years were considered obese in 2005–08.

Target setting method: 10 percent improvement.

Data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

NWS–10.2 Children aged 6 to 11 years.

Target: 15.7 percent.

Baseline: 17.4 percent of children aged 6 to 11 years were considered obese in 2005–08.

Target setting method: 10 percent improvement.

Data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

NWS–10.3 Adolescents aged 12 to 19 years.

Target: 16.1 percent.

NWS–6

Baseline: 17.9 percent of adolescents aged 12 to 19 years were considered obese in 2005–08.

Target setting method: 10 percent improvement.

Data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

NWS–10.4 Children and adolescents aged 2 to 19 years.

Target: 14.6 percent.

Baseline: 16.2 percent of children and adolescents aged 2 to 19 years were considered obese in 2005–08.

Target setting method: 10 percent improvement.

Data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

NWS–11: (Developmental) Prevent inappropriate weight gain in youth and adults.

NWS–11.1 Children aged 2 to 5 years.

Potential data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

NWS–11.2 Children aged 6 to 11 years.

Potential data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

NWS–11.3 Adolescents aged 12 to 19 years.

Potential data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

NWS–11.4 Children and adolescents aged 2 to 19 years.

Potential data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

NWS–11.5 Adults aged 20 years and older.

Potential data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

Food and Nutrient Consumption

NWS–14: Increase the contribution of fruits to the diets of the population aged 2 years and older.

Target: 0.9 cup equivalents per 1,000 calories.

Baseline: 0.5 cup equivalents of fruits per 1,000 calories was the mean daily intake by persons aged 2 years and older in 2001–04.

Target setting method: Evidence-based approach (Considered the baseline in relation to 2005 Dietary Guidelines for Americans [DGA] recommendations, past trends and potentially achievable shift in the usual intake distribution, and applicability of the target to subpopulations).

Data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS and USDA, ARS.

NWS–15: Increase the variety and contribution of vegetables to the diets of the population aged 2 years and older.

NWS–15.1 Increase the contribution of total vegetables to the diets of the population aged 2 years and older.

Target: 1.1 cup equivalents per 1,000 calories.

NWS–8

Baseline: 0.8 cup equivalents of total vegetables per 1,000 calories was the mean daily intake by persons aged 2 years and older in 2001–04 (age adjusted to the year 2000 standard population).

Target setting method: Evidence-based approach (Considered the baseline in relation to 2005 DGA recommendations, past trends and potentially achievable shift in the usual intake distribution, and applicability of the target to subpopulations).

Data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS and USDA, ARS.

More information and resources on this health priority from HP2020 visit:

<http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=29>

Health Problem: <p style="text-align: center;">Obesity (Group 3)</p>	Outcome Objective: <p>By June 2016, reduce by 5% the obesity rate of Madison County.</p> <p>(Baseline: None available. Comparative to State Survey, 2014)</p>
Risk Factor(s) (may be many): <p style="text-align: center;">Poor Diet Inactivity</p>	Impact Objective(s): <ol style="list-style-type: none"> 1. By 2016, there will be a 2% increase of physical activity, and consumption of fruits and vegetable intake of surveyed Madison County residents. 2. By January 2012, baseline survey will be established and reviewed by committee. 3. By 2014, data will be collected to establish activity baseline for Madison County. 4. By 2015, educational materials will be distributed to increase awareness of importance of physical activity and consumption of fruits and vegetables. 5. By 2016, survey Madison County residents to evaluate behavior change.
Contributing Factors (Direct/Indirect; may be many) <p style="text-align: center;">Availability to healthy foods Education Low income Lack of safe parks Access to fitness Low motivation</p>	Proven Intervention Strategies: <p>Supply resources Organize health fairs Organize kids activities Advertise Speakers list to community organizations Presentations Incentives Involve community</p>
Resources Available (governmental and nongovernmental): <p>MCHD Hospitals and other community agencies Food banks Fresh food stands Produce Co-op YWCA-YMCA Fitness facilities Parks Internet</p>	Barriers: <p>Education Economy Motivation Transportation Getting information to the correct demographic</p>

Group 3 Summary:

Our group's objective is to establish a baseline for physical activity/inactivity for Madison county and promote the consumption of more fruits/veggies as part of an overall healthy diet. Before we can determine how we impact the obesity epidemic, it is important to gauge active or inactive of Madison County. Once this baseline is set, we hope to decrease the level of obesity by 1% each year – 5% total over 5 years. To reach our goals, our thought is to implement a plan of action to tackle the two main risk factors (poor diet & inactivity) contributing to obesity. Inactivity will be measured and evaluated through the survey. Poor diet we will attempt to improve through educating those on what healthy eating is, planning healthy meals and gaining physician involvement to help promote increased activity and proper diet to their patients.

HEALTHY PEOPLE 2020 OBJECTIVES SUPPORTED BY THIS PLAN

(taken from www.HEALTHYPEOPLE.GOV/2020)

TOPIC AREA: Nutrition and Weight Status, Physical Activity

OBJECTIVE AREA: Food and Nutrient Consumption

OBJECTIVES:

Food and Nutrient Consumption

NWS-14: Increase the contribution of fruits to the diets of the population aged 2 years and older.

Target: 0.9 cup equivalents per 1,000 calories.

Baseline: 0.5 cup equivalents of fruits per 1,000 calories was the mean daily intake by persons aged 2 years and older in 2001–04.

Target setting method: Evidence-based approach (Considered the baseline in relation to 2005 Dietary Guidelines for Americans [DGA] recommendations, past trends and potentially achievable shift in the usual intake distribution, and applicability of the target to subpopulations).

Data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS and USDA, ARS.

NWS-15: Increase the variety and contribution of vegetables to the diets of the population aged 2 years and older.

NWS-15.1 Increase the contribution of total vegetables to the diets of the population aged 2 years and older.

Target: 1.1 cup equivalents per 1,000 calories.

NWS-8

Baseline: 0.8 cup equivalents of total vegetables per 1,000 calories was the mean daily intake by persons aged 2 years and older in 2001–04 (age adjusted to the year 2000 standard population).

Target setting method: Evidence-based approach (Considered the baseline in relation to 2005 DGA recommendations, past trends and potentially achievable shift in the usual intake distribution, and applicability of the target to subpopulations).

Data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS and USDA, ARS.

NWS–15.2 Increase the contribution of dark green vegetables, orange vegetables, and legumes to the diets of the population aged 2 years and older.

Target: 0.3 cup equivalents per 1,000 calories.

Baseline: 0.1 cup equivalents of dark green or orange vegetables or legumes per 1,000 calories was the mean daily intake by persons aged 2 years and older in 2001–04 (age adjusted to the year 2000 standard population).

Target setting method: Evidence-based approach (Considered the baseline in relation to USDA Food Guide recommendations, past trends and potentially achievable shift in the usual intake distribution, and applicability of the target to subpopulations).

Data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS and USDA, ARS.

TOPIC AREA: Physical Activity

PA–1: Reduce the proportion of adults who engage in no leisure-time physical activity.

Target: 32.6 percent.

Baseline: 36.2 percent of adults engaged in no leisure-time physical activity in 2008.

Target setting method: 10 percent improvement.

Data source: National Health Interview Survey (NHIS), CDC, NCHS.

PA–2: Increase the proportion of adults who meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity.

PA–2.1 Increase the proportion of adults who engage in aerobic physical activity of at least moderate intensity for at least 150 minutes/week, or 75 minutes/week of vigorous intensity, or an equivalent combination.

Target: 47.9 percent.

Baseline: 43.5 percent of adults engaged in aerobic physical activity of at least moderate intensity for at least 150 minutes/week, or 75 minutes/week of vigorous intensity, or an equivalent combination in 2008.

Target setting method: 10 percent improvement.

Data source: National Health Interview Survey, CDC, NCHS.

PA–2.2 Increase the proportion of adults who engage in aerobic physical activity of at least moderate intensity for more than 300 minutes/week, or more than 150 minutes/week of vigorous intensity, or an equivalent combination.

Target: 31.3 percent.

Baseline: 28.4 percent of adults engaged in aerobic physical activity of at least moderate intensity for more than 300 minutes/week, or more than 150 minutes/week of vigorous intensity, or an equivalent combination in 2008.

Target setting method: 10 percent improvement.

Data source: National Health Interview Survey, CDC, NCHS.

PA–2.3 Increase the proportion of adults who perform muscle-strengthening activities on 2 or more days of the week.

Target: 24.1 percent.

Baseline: 21.9 percent of adults performed muscle-strengthening activities on 2 or more days of the week in 2008.

PA–2

Target setting method: 10 percent improvement.

Data source: National Health Interview Survey, CDC, NCHS.

PA–2.4 Increase the proportion of adults who meet the objectives for aerobic physical activity and for muscle-strengthening activity.

Target: 20.1 percent.

Baseline: 18.2 percent of adults met the objectives for aerobic physical activity and for muscle-strengthening activity in 2008.

Target setting method: 10 percent improvement.

Data source: National Health Interview Survey (NHIS), CDC, NCHS.

PA–10: Increase the proportion of the Nation’s public and private schools that provide access to their physical activity spaces and facilities for all persons outside of normal school hours (that is, before and after the school day, on weekends, and during summer and other vacations).

Target: 31.7 percent.

Baseline: 28.8 percent of the Nation’s public and private schools provided access to their physical activity spaces and facilities for all persons outside of normal school hours (that is, before and after the school day, on weekends, and during summer and other vacations) in 2006.

Target setting method: 10 percent improvement.

Data source: School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.

PA–15: (Developmental) Increase legislative policies for the built environment that enhance access to and availability of physical activity opportunities.

PA–15.1 Community-scale policies.

Potential data source: CDC Division of Nutrition, Physical Activity, and Obesity Legislative Database.

PA–15.2 Street-scale policies.

Potential data source: CDC Division of Nutrition, Physical Activity, and Obesity Legislative Database.

PA–9 PA–10

PA–15.3 Transportation and travel policies.

Potential data source: CDC Division of Nutrition, Physical Activity, and Obesity Legislative Database.

More information and resources on this health priority from HP2020 visit:

<http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=29>

<http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=33>

Substance Use and Abuse Priority Plan

Health Problem: Substance Use and Abuse	Outcome Objective: By June 2016, increase of 10% in number of students reporting parents have talked to them about ATOD. Baseline: Illinois Youth Survey data every two years.
Risk Factor(s) (may be many): <ul style="list-style-type: none"> • Parental Attitude/Response (Objectives based on this Risk Factor) • Availability and accessibility • Community Norms • School Factor • Social Norms (kids) • Early Age of Onset 	Impact Objective(s): By December 2013, increase of 15 of number of informational outlets for parental knowledge for ATOD prevention. Baseline: Unknown
Contributing Factors (Direct/Indirect; may be many) Objectives based on these Factors: <ul style="list-style-type: none"> • Lack of knowledge “laissez-faire” • Denial “head in the sand” • Lack of parenting skills • Single parent families • Parental use • No good system for information busy parents • Lack of knowledge of technology • Lack of resources • Negative stigma to attending parenting classes Other Contributing Factors: <ul style="list-style-type: none"> • Number of opportunities to purchase – high density • Access at home • Older friends and siblings • Illegal sales • Advertising • Increasing percentage of latchkey kids • Parents in denial/lack of knowledge of law • Parents use/provision • Lack of consequences • Community Norms • Provision of alcohol at community events • Inconsistent enforcement • Lack of reporting 	Proven Intervention Strategies: Social Marketing Campaigns Communication Campaigns Parent Workshops Seller Server Training Tobacco Prevention and Cessation

<ul style="list-style-type: none"> • Pro-alcohol messaging • Money over kids • Tradition • Double standards • Varies from community police departments • “No snitching” • Don’t want to get involved • High percentage of signage and sponsorship • Increased perception of use by peers • Infallibility/invincibility • Low risk of harm • Lack of information • Lack of credibility in data 													
<p>Resources Available (governmental and nongovernmental):</p> <p>SIUE (evaluation) Parent Campaign Community Colleges: Lewis & Clark and SWIC School – Life Skills Parent Handout Facebook Groups – distribute information/bulletins Speakers Judge distributes information to parents Treatment programs distribute information to parents</p>	<p>Barriers:</p> <p>Parents are busy Campaigns are expensive Traditions and culture Cultural mistrust of organizations Lack of knowledge of technology by some parents Parents not knowing where to get information</p>												
<p>Corrective actions to reduce the level of the indirect contributing factors:</p> <ul style="list-style-type: none"> • Use of technology – Facebook, blogs • Easy access to information • Parenting sessions to live chat • Use forms of media (radio, TV) to provide information to parents • Attaching to school websites, community websites • Working with area doctors to provide information to parents during routine physicals 													
<p>Proposed community organization(s) to provide and coordinate the activities:</p> <table border="0"> <tr> <td>Chestnut Health Systems</td> <td>Community websites</td> </tr> <tr> <td>Faith based community</td> <td>Doctors</td> </tr> <tr> <td>Criminal Justice system</td> <td>Schools</td> </tr> <tr> <td>TASC</td> <td>Community coalitions</td> </tr> <tr> <td>Public TV/radio/Facebook</td> <td>Court system</td> </tr> <tr> <td>Teen Reach</td> <td></td> </tr> </table>		Chestnut Health Systems	Community websites	Faith based community	Doctors	Criminal Justice system	Schools	TASC	Community coalitions	Public TV/radio/Facebook	Court system	Teen Reach	
Chestnut Health Systems	Community websites												
Faith based community	Doctors												
Criminal Justice system	Schools												
TASC	Community coalitions												
Public TV/radio/Facebook	Court system												
Teen Reach													
<p>Evaluation plan to measure progress towards reaching objectives:</p> <p>Based on 2010, 2012, and 2014 Illinois Youth Survey Data, the following will be monitored for changes attributed to the implementation of Plan objectives and strategies:</p> <ul style="list-style-type: none"> • Increased parental disapproval (Baseline: IYS data) • What are the chances I will get caught (Baseline: IYS data) • Parent surveys 													

HEALTHY PEOPLE 2020 OBJECTIVES SUPPORTED BY THIS PLAN

(taken from www.HEALTHYPEOPLE.GOV/2020)

TOPIC AREA: Substance Abuse

OBJECTIVE AREA: Policy and Prevention

OBJECTIVES:

Policy and Prevention

SA-2: Increase the proportion of adolescents never using substances. SA-2.1 Increase the proportion of at risk adolescents aged 12 to 17 years who, in the past year, refrained from using alcohol for the first time. Target: 94.4 percent. Baseline: 85.8 percent of adolescents aged 12 to 17 years who had never used alcohol in their lives refrained from using alcohol for the first time in 2008. Target setting method: 10 percent improvement. Data source: National Survey on Drug Use and Health (NSDUH), SAMHSA.SA-2.2 Increase the proportion of at risk adolescents aged 12 to 17 years who, in the past year, refrained from using marijuana for the first time. Target: 96.4 percent. Baseline: 94.4 percent of adolescents aged 12 to 17 years who had never used marijuana in their lives refrained from using marijuana for the first time in 2008. Target setting method: 2 percentage point improvement. Data source: National Survey on Drug Use and Health (NSDUH), SAMHSA.SA-2.3 Increase the proportion of high school seniors never using substances—Alcoholic beverages. Target: 30.5 percent. Baseline: 27.7 percent of high school seniors reported never using alcoholic beverages in 2009. Target setting method: 10 percent improvement.

SA-3

Data source: Monitoring the Future Survey (MTF), NIH. SA-2.4 Increase the proportion of high school seniors never using substances—Illicit drugs. Target: 58.6 percent. Baseline: 53.3 percent of high school seniors reported never using illicit drugs in 2009. Target setting method: 10 percent improvement. Data source: Monitoring the Future Survey (MTF), NIH. **SA-3:** Increase the proportion of adolescents who disapprove of substance abuse. SA-3.1 Increase the proportion of adolescents who disapprove of having one or two alcoholic drinks nearly every day—8th graders. Target: 86.4 percent. Baseline: 78.5 percent of 8th graders reported that they disapproved of people having one or two alcoholic drinks nearly every day in 2009. Target setting method: 10 percent improvement. Data source: Monitoring the Future Survey (MTF), NIH.SA-3.2 Increase the proportion of adolescents who disapprove of having one or two alcoholic drinks nearly every day—10th graders. Target: 85.4 percent. Baseline: 77.6 percent of 10th graders reported that they disapproved of people having one or two alcoholic drinks nearly every day in 2009. Target setting method: 10 percent improvement. Data source: Monitoring the Future Survey (MTF), NIH.SA-3.3 Increase the proportion of adolescents who disapprove of having one or two alcoholic drinks nearly every day—12th graders. Target: 77.6 percent. Baseline: 70.5 percent of 12th graders reported that they disapproved of people having one or two alcoholic drinks nearly every day in 2009. Target setting method: 10 percent improvement. Data source: Monitoring the Future Survey (MTF), NIH.

SA-3.4 Increase the proportion of adolescents who disapprove of trying marijuana or hashish once or twice—8th graders. Target: 82.8 percent. Baseline: 75.3 percent of 8th graders reported that they disapproved of people trying marijuana or hashish once or twice in 2009. Target setting method: 10 percent improvement. Data source: Monitoring the Future Survey (MTF), NIH.SA-3.5 Increase the proportion of adolescents who disapprove of trying marijuana or hashish once or twice—10th graders. Target: 66.1 percent. Baseline: 60.1 percent of 10th graders reported that they disapproved of people trying marijuana or hashish once or twice in 2009. Target setting method: 10 percent improvement. Data

source: Monitoring the Future Survey (MTF), NIH.SA-3.6 Increase the proportion of adolescents who disapprove of trying marijuana or hashish once or twice—12th graders. Target: 60.3 percent. Baseline: 54.8 percent of 12th graders reported that they disapproved of people trying marijuana or hashish once or twice in 2009. Target setting method: 10 percent improvement. Data source: Monitoring the Future Survey (MTF), NIH.

SA-4

Increase the proportion of adolescents who perceive great risk associated with substance abuse. SA-4.1 Increase the proportion of adolescents aged 12 to 17 years perceiving great risk associated with substance abuse—Consuming five or more alcoholic drinks at a single occasion once or twice a week. Target: 44.6 percent. Baseline: 40.5 percent of adolescents aged 12 to 17 years reported that they perceived great risk associated with consuming five or more alcoholic drinks at a single occasion once or twice a week in 2008. Target setting method: 10 percent improvement.

SA-5

Data source: National Survey on Drug Use and Health (NSDUH), SAMHSA.SA-4.2 Increase the proportion of adolescents aged 12 to 17 years perceiving great risk associated with substance abuse—Smoking marijuana once per month. Target: 37.3 percent. Baseline: 33.9 percent of adolescents aged 12 to 17 years reported that they perceived great risk associated with smoking marijuana once per month in 2008. Target setting method: 10 percent improvement. Data source: National Survey on Drug Use and Health (NSDUH), SAMHSA.SA-4.3 Increase the proportion of adolescents aged 12 to 17 years perceiving great risk associated with substance abuse—Using cocaine once per month. Target: 54.7 percent. Baseline: 49.7 percent of adolescents aged 12 to 17 years reported that they perceived great risk associated with using cocaine once per month in 2008. Target setting method: 10 percent improvement. Data source: National Survey on Drug Use and Health (NSDUH), SAMHSA.

More information and resources on this health priority from HP2020 visit:

<http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=40>

ILLINOIS STATE HEALTH IMPROVEMENT PLAN 2010 OBJECTIVES
SUPPORTED BY THIS PLAN

(taken from http://www.idph.state.il.us/ship/09-10_Plan/SHIP_Final_2010.pdf)

PRIORITY HEALTH CONCERN – ALCOHOL/TOBACCO

Tobacco use causes chronic diseases, including lung, oral, laryngeal, and esophageal cancers, and chronic obstructive pulmonary disease (COPD), as well as diseases in non-smokers through exposure to secondhand smoke. Similarly, excessive alcohol use, either in the form of heavy drinking or binge drinking can lead to increased risk of health problems such as liver disease or unintentional injuries. Alcohol or tobacco initiation and use by youth are of particular concern, given their addictive properties and long-term health effects.

Therefore, the public health system should work to:

- Decrease tobacco and excessive alcohol use by adults and prevent alcohol use and tobacco initiation among youth.

Strategic Issue

How can the Illinois public health system monitor priority health concerns and risk factors and implement effective strategies to reduce them?

Long-term Outcome

Decrease abuse of alcohol among adults and use of alcohol among adolescents.

Intermediate Outcomes

Increase the proportion of adolescents who remain alcohol free and increase the age at which adolescents try alcohol.

Long-term Outcome

Decrease use of tobacco.

Intermediate Outcomes

Reduce tobacco use by adults and adolescents.

Reduce initiation of tobacco use among children, adolescents, and young adults.

Reduce adolescents' access to alcohol and tobacco.

Increase smoking abstinence during pregnancy.

Health Care Reform/Policy

Evidence indicates that implementing policies that promote a change in social norms appear to be the most effective approach for sustained behavior change.

Consistent enforcement of local policies and laws that reduce youth access to alcohol and tobacco has proven to be an effective strategy to deter youth use of tobacco and alcohol.

Health Across the Lifespan

Support and/or facilitate tobacco prevention and control and alcohol prevention coalition development, as well as links to other related coalitions (e.g., cancer control).

Implement evidence-based policy interventions to decrease tobacco and alcohol use initiation, to increase tobacco cessation, and to protect people from exposure to secondhand smoke.

Sponsor local, regional, and statewide training, conferences, and technical assistance on best practices for effective tobacco use prevention and cessation programs, binge and youth drinking prevention programs, and drunk-driving prevention programs.

Conduct mass media education campaigns combined with other community interventions.

Community Engagement/Education

Effective community programs involve and influence people in their homes, work sites, schools, places of worship, places of entertainment, health care settings, civic organizations, and other public places. Changing policies that can influence societal organizations, systems, and networks necessitates the involvement of community partners.

Promote public discussion among partners, decision makers, and other stakeholders about tobacco- and alcohol-related health issues and pro-tobacco and alcohol influences.

Use grassroots promotions, local media advocacy, event sponsorships, and other community tie-ins to support and reinforce the statewide campaign and to counter pro-tobacco and pro-alcohol influences.

Leadership/Collaboration/Integration

Alcohol and tobacco use are critical issues on college campuses, and it is important to engage higher education in the development of solutions and interventions.

PRIORITY HEALTH CONCERN - USE OF ILLICIT DRUGS/MISUSE OF LEGAL DRUGS

Use of illicit drugs cause harm to both the individuals through increased risk of injury, disease, and death, and to communities through increased injuries and decreased community safety. Non-medical use of over-the-counter and prescription drugs is high, particularly among youth. Misuse of legal drugs can lead to injury, addiction, and death. Accidental misuse of legal/prescription drugs also poses a health threat, particularly among the elderly who may be using many prescriptions that interact and cause unintentional injury. Therefore, the public health system should work to:

- Decrease the use of illegal drugs among adults and adolescents.
- Decrease the intentional misuse of legal drugs.

Teen Pregnancy Priority Plan

Health Problem: Teen Pregnancy	Outcome Objective: By June 2016, improve pregnancy prevention efforts to reduce by 5% the number of births to teens under 18 years of age in Madison County. (Baseline: 120 births to adolescents under 18 years of age, Illinois Teen Births by County - IDPH Vital Statistics, 2008)
Risk Factor(s) (may be many): <ul style="list-style-type: none"> • Early onset of sexual activity • Lack of contraception usage (Due to lack of access, knowledge and skill) • Lack of parent education (parents, youth, community) • Lack of school sexual health or sexuality 	Impact Objective(s): By December 31, 2012 increase by 5% the number of sexually active teens under 20 years of age who receive testing and/or treatment for STDs and HIV/AIDS. (Baseline: 79 adolescents under 20 years of age participated in services provided by the Madison County Health Department – Madison County Health Department – Sexual Health Clinic Data, 2010) By December 31, 2013, increase by 4 the number of schools, organizations or churches that provide an evidence-based sexual health program. (Baseline: To be determined)
Contributing Factors (Direct/Indirect; may be many) <ul style="list-style-type: none"> • Lack of education • Lack of positive environments • Lack of positive activities • Lack of Supervision • Lack of Knowledge • Unrealistic perceptions (i.e. It won't happen to me. Not my child.) • No or inconsistent use of contraceptives • Lack of sex education for youth and parents • Low self-esteem among teens • Lack of future goals • Lack of counseling model for physicians • Many sexually active youth • Sexual activity among teens is socially accepted in some families and communities • Media influence/portrayal of sex and relationships • Sex represents love/Having sex proves love • Early initiation of sex (young age of first sex) • Number of partners (many partners) 	Proven Intervention Strategies: By March 2011, MCPCH will establish a 5-year committee plan to address teen pregnancy and STDs and HIV/AIDS. By August 2011, MCPCH will implement a social media campaign to raise awareness of teen pregnancy in Madison County and the benefits of improved education. By December 2011, MCPCH will conduct a youth input meeting. By August 2012, MCPCH will create a marketing strategy to inform community members in a Madison County community about local STD testing and family planning services. By October 2012, MCPCH will establish an annual testing week or awareness day to bring attention to the prevention of sexually transmitted diseases and infections as well as unintended pregnancy. By December 2013, MCHD will provide an evidenced-based program to two additional schools in Madison County.

	<p>By August 2013, MCPCH will promote the Illinois Caucus for Adolescent Health-Lending Library to all Madison County School administrators and health educators.</p> <p>By August 2013, MCPCH will provide a list of evidence-based/promising sexual health programs to all Madison County school administrators, curriculum instructors, physical education teachers, health educators, youth-serving organizations, and churches..</p>
<p>Resources Available (governmental and nongovernmental): College/University Health Services -Southern Illinois University Edwardsville and Lewis and Clark Community College, Family Planning Services - Southern Illinois Healthcare Foundation, Madison County Health Department, Madison County Partnership for Community Health (MCPCH), Mosaic Pregnancy and Health Center, Boys & Girls Club – East Alton Middle School, Department of Health and Human Services, Woman Infant and Child (WIC), Chestnut Health Systems, Teen Parent Services (Madison County ROE, Lewis and Clark Community College), Rel8, Coordinated Youth and Human Services, Madison County AIDS Program (MadCAP), Madison County Schools and Madison County Urban League.</p>	<p>Barriers:</p> <ul style="list-style-type: none"> • Lack of funding • Varying beliefs on how to address teen pregnancy • Lack of time • Lack of staff • Community or organizational opposition • The termination of programs and services due to budget crises • Social pressure • Social acceptance of risky behaviors • Media • Lack of family involvement • Lack of sexual health education • Lack of parent educators • Lack of training for health educators • Inconsistent sexual health education
<p>Description of the health problem, risk factors and contributing factors (including high risk populations, and current and projected statistical trends):</p> <p>Teen Pregnancy continues to be a major concern for community members, organizations and adolescents in Madison County. Teen pregnancy can lead to negative consequences for mother, father and child. Teen mothers are less likely to complete high school or college and more likely to live in poverty and require public assistance. According the Centers for Disease Control and Prevention, pregnancy and birth are significant contributors to high school dropout rates among girls. Nearly 50% of teen mothers receive a high school diploma by age 22, versus nearly 90% of women who had not given birth during adolescence. Teen fathers also experience the consequences of parenting at a young age. Teen fathers are more likely to finish fewer years of schooling and earn less income. Children of teen parents are more likely to have low birth weight and increased risk for child abuse and neglect.</p> <p>Becoming a parent requires support that some teen parents are unable to secure for their young family. Many teen parents look toward community agencies, services and programs to stabilize their family. The Centers for Disease Control and Prevention states that teen pregnancy and childbearing bring substantial social and economic costs through immediate and long-term impacts on teen parents and their children.</p> <p>The direct risk factors that lead to teen pregnancy are early onset of sexual activity, lack of contraception usage (unprotected sex) and lack of education. The contributing factors are low education attainment, violent environments, poor youth supervision, low parental involvement, low self-esteem, inaccessible services or programs and peer influence.</p>	

Corrective actions to reduce the level of the indirect contributing factors:

Social norms and misconceptions about sexual health education

- Address social norms, by implementing a social media campaign to raise awareness of teen pregnancy and the benefits of improved education opportunities.
- Promote the Illinois Caucus for Adolescent Health – Lending Library to all Madison County School administrators and health educators.
- Provide educational materials and a list of evidence-based programs to all Madison County school administrators, curriculum instructors, physical education teachers and health educators.

No knowledge of inexpensive services or programs

- Create and implement a marketing strategy to educate community members about local STD testing and family planning services.
- Establish an annual testing week or awareness day to bring attention to prevention and personal responsibility.

All Risk factors

Lack of education, Lack of positive environments, Lack of positive activities, Lack of Supervision, Lack of Knowledge, Unrealistic perceptions (i.e. It won't happen to me. Not my child.), No or inconsistent use of contraceptives, Lack of sex education for youth and parents, Low self-esteem among teens, Lack of future goals, Lack of counseling model for physicians, Many sexually active youth, Sexual activity among teens is socially accepted in some families and communities, Media influence/portrayal of sex and relationships, Sex represents love/Having sex proves love, Early initiation of sex (young age of first sex) and Number of partners (many partners).

Proposed community organization(s) to provide and coordinate the activities:

College/University Health Services -Southern Illinois University Edwardsville and Lewis and Clark Community College, Family Planning Services - Southern Illinois Healthcare Foundation, Madison County Health Department, Madison County Partnership for Community Health (MCPCH), Mosaic Pregnancy and Health Center, Boys & Girls Club – East Alton Middle School, Department of Health and Human Services, Woman Infant and Child (WIC), Chestnut Health Systems, Teen Parent Services (Madison County ROE, Lewis and Clark Community College), Rel8, Coordinated Youth and Human Services, Madison County AIDS Program (MadCAP), Madison County Schools and Madison County Urban League.

Evaluation plan to measure progress towards reaching objectives:

Monitor yearly IDPH Teen Birth Reports and yearly Madison County Health Department Sexual Health Clinic client data. Interview youth to determine the effectiveness of educational programs and outreach efforts.

HEALTHY PEOPLE 2020 OBJECTIVES SUPPORTED BY THIS PLAN

(taken from www.HEALTHYPEOPLE.GOV/2020)

TOPIC AREA: Educational and Community-Based Programs, Sexually Transmitted Diseases, Family Planning

OBJECTIVE AREA: None indicated under any of the 3 Topic Areas

OBJECTIVES:

Educational and Community-Based Programs,

ECBP–2: Increase the proportion of elementary, middle, and senior high schools that provide comprehensive school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol or other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; and inadequate physical activity.

ECBP–2.7 Unintended pregnancy, HIV/AIDS, and STD infection.

Target: 43.2 percent.

Baseline: In 2006, 39.3 percent of elementary, middle, and senior high schools provided comprehensive school health education to prevent unintended pregnancy, HIV/AIDS and STD infection.

Target setting method: 10 percent improvement.

Data source: School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.

ECBP–7: Increase the proportion of college and university students who receive information from their institution on each of the priority health risk behavior areas (all priority areas; unintentional injury; violence; suicide; tobacco use and addiction; alcohol and other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; and inadequate physical activity).

ECBP–7.7 Unintended pregnancy.

Target: 43.9 percent.

Baseline: In 2009, 39.9 percent of college and university students received health-risk behavior information on unintended pregnancy from their institution.

Target setting method: 10 percent improvement.

Data source: National College Health Assessment, American College Health Association.

ECBP–7.8 HIV, AIDS and STD infection.

Target: 57.8 percent.

Baseline: In 2009, 52.5 percent of college and university students received health-risk behavior information on HIV/AIDS and STD infection from their institution.

Target setting method: 10 percent improvement.

Data source: National College Health Assessment, American College Health Association.

ECBP–10: Increase the number of community-based organizations (including local health departments, tribal health services, nongovernmental organizations, and State agencies) providing population-based primary prevention services in the following areas:

ECBP–10.6 Unintended pregnancy.

Target: 89.4 percent.

Baseline: In 2008, 81.3 percent of community-based organizations (including local health departments, tribal health services, nongovernmental organizations, and State agencies) provided population-based primary prevention services in unintended pregnancy.

Target setting method: 10 percent improvement.

Data source: National Profile of Local Health Departments, National Association of County and City Health Officials (NACCHO).

Sexually Transmitted Diseases

Increased screenings for sexually transmitted diseases and prevention initiatives will impact all of these objectives under this Topic Area through screening, diagnosis, treatment, and prevention education. This area will be impacted indirectly over time.

Family Planning

FP–8: Reduce pregnancy rates among adolescent females.

FP–8.1 Reduce the pregnancy rate among adolescent females aged 15 to 17 years.

Target: 36.2 pregnancies per 1,000.

Baseline: 40.2 pregnancies per 1,000 females aged 15 to 17 years occurred in 2005.

Target setting method: 10 percent improvement.

Data sources: Abortion Provider Survey, Guttmacher Institute; Abortion Surveillance Data, CDC, NCCDPHP; National Vital Statistics System–Natality (NVSS–N), CDC, NCHS; National Survey of Family Growth (NSFG), CDC, NCHS.

FP–8.2 Reduce the pregnancy rate among adolescent females aged 18 to 19 years.

Target: 105.9 pregnancies per 1,000.

Baseline: 117.7 pregnancies per 1,000 females aged 18 to 19 years occurred in 2005.

Target setting method: 10 percent improvement.

Data sources: Abortion Provider Survey, Guttmacher Institute; National Vital Statistics System (NVSS), CDC, NCHS; National Survey of Family Growth (NSFG), CDC, NCHS; Abortion Surveillance Data, CDC, NCCDPHP.

FP–9: Increase the proportion of adolescents aged 17 years and under who have never had sexual intercourse.

FP–9.1 Female adolescents aged 15 to 17 years.

Target: 79.3 percent.

Baseline: In 2006–08, 72.1 percent of female adolescents aged 15 to 17 years reported they had never had sexual intercourse.

Target setting method: 10 percent improvement.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

FP–4

FP–9.2 Male adolescents aged 15 to 17 years.

Target: 78.3 percent.

Baseline: In 2006–08, 71.2 percent of male adolescents aged 15 to 17 years reported they had never had sexual intercourse.

Target setting method: 10 percent improvement.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

FP–9.3 Female adolescents aged 15 years and under.

Target: 91.2 percent.

Baseline: As reported in 2006–08, 82.9 percent of female adolescents aged 15 years had never had sexual intercourse.

Target setting method: 10 percent improvement.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

FP–9.4 Male adolescents aged 15 years and under.

Target: 90.2 percent.

Baseline: As reported in 2006–08, 82.0 percent of male adolescents aged 15 years had never had sexual intercourse.

Target setting method: 10 percent improvement.

Data source: National Survey of Family Growth (NSFG), CDC.

FP–10: Increase the proportion of sexually active persons aged 15 to 19 years who use condoms to both effectively prevent pregnancy and provide barrier protection against disease.

FP–10.1 Increase the proportion of sexually active females aged 15 to 19 years who use a condom at first intercourse.

Target: 73.6 percent.

Baseline: As reported in 2006–08, 66.9 percent of sexually active females aged 15 to 19 years used a condom at first intercourse.

Target setting method: 10 percent improvement.

Data source: National Survey of Family Growth (NSFG), CDC.

FP–5

FP–10.2 Increase the proportion of sexually active males aged 15 to 19 years who use a condom at first intercourse.

Target: 88.6 percent.

Baseline: As reported in 2006–08, 80.6 percent of sexually active males aged 15 to 19 years used a condom at first intercourse.

Target setting method: 10 percent improvement.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

FP–10.3 Increase the proportion of sexually active females aged 15 to 19 years who use a condom at last intercourse.

Target: 58.1 percent.

Baseline: As reported in 2006–08, 52.8 percent of sexually active females aged 15 to 19 years used a condom at last intercourse.

Target setting method: 10 percent improvement.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

FP–10.4 Increase the proportion of sexually active males aged 15 to 19 years who use a condom at last intercourse.

Target: 85.7 percent.

Baseline: As reported in 2006–08, 77.9 percent of sexually active males aged 15 to 19 years used a condom at last intercourse.

Target setting method: 10 percent improvement.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

FP–11: Increase the proportion of sexually active persons aged 15 to 19 years who use condoms and hormonal or intrauterine contraception to both effectively prevent pregnancy and provide barrier protection against disease.

FP–11.1 Increase the proportion of sexually active females aged 15 to 19 years who use a condom and hormonal or intrauterine contraception at first intercourse.

Target: 14.8 percent.

Baseline: As reported in 2006–08, 13.4 percent of sexually active females aged 15 to 19 years used a condom and hormonal or intrauterine contraception at first intercourse.

Target setting method: 10 percent improvement.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

FP-6

FP-11.2 Increase the proportion of sexually active males aged 15 to 19 years who use a condom and hormonal or intrauterine contraception at first intercourse.

Target: 19.9 percent.

Baseline: As reported in 2006-08, 18.1 percent of sexually active males aged 15 to 19 years used a condom and hormonal or intrauterine contraception at first intercourse.

Target setting method: 10 percent improvement.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

FP-11.3 Increase the proportion of sexually active females aged 15 to 19 years who use a condom and hormonal or intrauterine contraception at last intercourse.

Target: 20.2 percent.

Baseline: As reported in 2006-08, 18.4 percent of sexually active females aged 15 to 19 years used a condom and hormonal or intrauterine contraception at last intercourse.

Target setting method: 10 percent improvement.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

FP-11.4 Increase the proportion of sexually active males aged 15 to 19 years who use a condom and hormonal or intrauterine contraception at last intercourse.

Target: 36.3 percent.

Baseline: As reported in 2006-08, 33.0 percent of sexually active males aged 15 to 19 years used a condom and hormonal or intrauterine contraception at last intercourse.

Target setting method: 10 percent improvement.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

FP-12: Increase the proportion of adolescents who received formal instruction on reproductive health topics before they were 18 years old.

FP-12.1 Abstinence—Females.

Target: 95.9 percent.

Baseline: As reported in 2006-08, 87.2 percent of female adolescents received formal instruction on how to say no to sex before they were 18 years old.

Target setting method: 10 percent improvement.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

FP-7

FP-12.2 Abstinence—Males.

Target: 89.2 percent.

Baseline: As reported in 2006-08, 81.1 percent of male adolescents received formal instruction on how to say no to sex before they were 18 years old in 2002.

Target setting method: 10 percent improvement.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

FP-12.3 Birth control methods—Females.

Target: 76.4 percent.

Baseline: As reported in 2006-08, 69.5 percent of females received formal instruction on birth control methods before they were 18 years old.

Target setting method: 10 percent improvement.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

FP-12.4 Birth control methods—Males.

Target: 68.1 percent.

Baseline: As reported in 2006–08, 61.9 percent of males received formal instruction on birth control methods before they were 18 years old.

Target setting method: 10 percent improvement.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

FP-8

FP-12.5 HIV/AIDS prevention—Females.

Target: 97.2 percent.

Baseline: As reported in 2006–08, 88.3 percent of females received formal instruction on HIV/AIDS prevention before they were 18 years old.

Target setting method: 10 percent improvement.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

FP-12.6 HIV/AIDS prevention—Males.

Target: 97.9 percent.

Baseline: As reported in 2006–08, 89.0 percent of males received formal instruction on HIV/AIDS prevention before they were 18 years old.

Target setting method: 10 percent improvement.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

FP-12.7 Sexually transmitted diseases—Females.

Target: 95.2 percent.

Baseline: As reported in 2006–08, 93.2 percent of females received formal instruction on sexually transmitted disease prevention methods before they were 18 years old.

Target setting method: 2 percentage point improvement.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

FP-9

FP-12.8 Sexually transmitted diseases—Males.

Target: 94.2 percent.

Baseline: As reported in 2006–08, 92.2 percent of males received formal instruction on sexually transmitted disease prevention methods before they were 18 years old.

Target setting method: 2 percentage point improvement.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

FP-13: Increase the proportion of adolescents who talked to a parent or guardian about reproductive health topics before they were 18 years old.

FP-13.1 Abstinence—Females.

Target: 69.4 percent.

Baseline: As reported in 2006–08, 63.1 percent of female adolescents talked with a parent or guardian about how to say no to sex before they were 18 years old.

Target setting method: 10 percent improvement.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

FP-13.2 Abstinence—Males.

Target: 45.9 percent.

Baseline: As reported in 2006–08, 41.8 percent of male adolescents talked to a parent or guardian about how to say no to sex before they were 18 years old.

Target setting method: 10 percent improvement.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

FP–13.3. Birth control methods—Females.

Target: 55.6 percent.

Baseline: As reported in 2006–08, 50.5 percent of female adolescents talked to a parent or guardian about birth control methods before they were 18 years old.

Target setting method: 10 percent improvement.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

FP–10

FP–13.4 Birth control methods—Males.

Target: 33.6 percent.

Baseline: As reported in 2006–08, 30.6 percent of male adolescents talked to a parent or guardian about birth control methods before they were 18 years old.

Target setting method: 10 percent improvement.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

FP–13.5 HIV/AIDS prevention—Females.

Target: 60.7 percent.

Baseline: As reported in 2006–08, 55.2 percent of female adolescents talked to a parent or guardian about HIV/AIDS prevention before they were 18 years old.

Target setting method: 10 percent improvement.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

FP–13.6 HIV/AIDS prevention—Males.

Target: 54.3 percent.

Baseline: As reported in 2006–08, 49.3 percent of male adolescents talked to a parent or guardian about HIV/AIDS prevention before they were 18 years old.

Target setting method: 10 percent improvement.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

FP–13.7 Sexually transmitted diseases—Females.

Target: 60.7 percent.

Baseline: As reported in 2006–08, 55.2 percent of female adolescents talked to a parent or guardian about sexually transmitted diseases before they were 18 years old.

Target setting method: 10 percent improvement.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

FP–11 FP–12

FP–13.8 Sexually transmitted diseases—Males.

Target: 42.3 percent.

Baseline: As reported in 2006–08, 38.5 percent of male adolescents talked to a parent or guardian about sexually transmitted diseases before they were 18 years old.

Target setting method: 10 percent improvement.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

More information and resources on this health priority from HP2020 visit:

<http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=11>

<http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=37>

<http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=13>

ILLINOIS STATE HEALTH IMPROVEMENT PLAN 2010 OBJECTIVES **SUPPORTED BY THIS PLAN**

(taken from http://www.idph.state.il.us/ship/09-10_Plan/SHIP_Final_2010.pdf)

NOTE: Teen Pregnancy nor Sexual Health-related issues are addressed as Priority Health Concerns in the State Plan; however, addressing teen pregnancy issues impacts social determinants of health and health disparities.

ADDRESS SOCIAL DETERMINANTS OF HEALTH AND HEALTH DISPARITIES

Health outcome disparities related to race, ethnicity, gender, geography, age, socio-economic status (education, income, and community assets), sexual orientation, and disability status are pervasive in Illinois, and social conditions significantly contribute to these disparities. The public health system should:

- Improve the social determinants that underlie health disparities.
- Work to reduce health disparities.
- Increase individual and institutional capacity to reduce health disparities.

Strategic Issue

How can the Illinois public health system acknowledge and address the social determinants of health that perpetuate health disparities?

Long-term Outcome

A public health system that integrates health improvement efforts with efforts that address the social determinants that affect health outcomes.

Intermediate Outcomes

- Public health system partners incorporate strategies to reduce poverty, adverse childhood events and unequal environmental exposure, and increase educational equity, support independent living; improve housing; eliminate racism, ethnocentrism, and class distinctions; mitigate geographical distance and other health system factors; improve accessibility for less-abled persons; and address other social determinants of health.
- Promote and utilize data that integrates health and social indicators to help identify and promote action on social determinants of health.

Madison County Partnership for Community Health (MCPCH)

During 2011-2016, the Community Health Plan comes to life as the health department, hospitals, schools, agencies, organizations, and citizens use the assessment data and community health plan to inform and guide decisions for programs, services, standards, expectations, and behaviors. The action arm for implementation of the Community Health Plan is the Madison County Partnership for Community Health (MCPCH). MCPCH Committees are formed for each health priority area and those committees meet on a regular basis during the five years to implement the Community Health Plan.

MCPCH Mission:

To work together as interested individuals, professionals, and organizations to improve the health status of residents of Madison County by helping to create, promote, and maintain healthy environments and lifestyles through education, understanding, and action.

MCPCH Membership:

- MCPCH membership is open to any person or agency dedicated to its mission.
- MCPCH has no budget or member dues.
- MCPCH Committees are the action arm of the Community Health Plan and are basically coalitions of parties with similar interests, goals, and objectives dedicated to cooperative efforts to reach mutually desired goals.
- MCPCH Committees focus primarily on developing and implementing the 5 year Community Health Plan

MCPCH Structure & Function:

- MCPCH Coordinator and Committee Chairs are elected.
- MCPCH Committees meet regularly.
- MCPCH has periodic business & educational meetings.
- Health Department is a partner rather than a director of MCPCH activities.



WHAT'S NEXT? HOW DO I GET INVOLVED?

This is the Beginningfrom this point forward, it takes everyone in Madison County working together and doing their part to achieve the goals and make an impact on the health of Madison County over the next 5 years.

VISIT the Madison County Health Department's website at www.madisonchd.org for an electronic version of this document, other related documents and assessment data, and information for each of the 5 health priority groups through the Madison County Partnership for Community Health (MCPCH).

USE this document as a guide and consider making personal changes within your own lives and the lives of your family to improve health which ultimately helps create a healthier county.

GET INVOLVED in one of the MCPCH health priority groups and help with programs and projects in your local community.

For questions, please contact Madison County Health Department at (618) 692-8954 x 5 or email to communityhealthplan@co.madison.il.us.

SOURCE LINKS

A multitude of sources were examined, utilized, and referenced during this Assessment and Plan phases of this process. Below are the key sources that may be of interest or assistance to the community.

Madison County Health Department <http://www.madisonchd.org>

Illinois Department of Public Health <http://www.idph.state.il.us/health/statshome.htm>

Joint Committee on Administrative Rules – Administrative Code
<http://www.ilga.gov/commission/jcar/admincode/077/07700600sections.html>

Illinois Project for Local Assessment of Needs (IPLAN) Data System <http://app.idph.state.il.us/>

Healthy People 2020 <http://www.healthypeople.gov/2020/default.aspx>

Illinois State Health Improvement Plan <http://www.idph.state.il.us/ship/index.htm>

U.S. Census Bureau <http://www.census.gov/>

Illinois Behavioral Risk Factor Surveillance System (BFRSS) <http://app.idph.state.il.us/brfss/>

Emergency Medical Services (EMS) Data Reporting System <http://app.idph.state.il.us/emsrpt/>

Centers for Disease Control and Prevention – Wonder Data 2010 <http://wonder.cdc.gov/data2010/>

Centers for Disease Control and Prevention – National Center for Health Statistics
<http://www.cdc.gov/nchs/>

Centers for Disease Control and Prevention – National Survey of Children’s Health
<http://www.cdc.gov/nchs/slais/nsch.htm>

County Health Rankings <http://www.countyhealthrankings.org/>

Illinois Youth Survey <http://iys.cprd.illinois.edu/>

Illinois Youth Risk Behavior Survey (YRBS) <http://www.cdc.gov/HealthyYouth/states/il.htm>

Illinois Cancer Registry <http://www.idph.state.il.us/cancer/index.htm>

American Lung Association State of the Air Report Card <http://www.stateoftheair.org/>

Environmental Protection Agency <http://www.epa.gov/>

Illinois Department of Human Services (DHS) <http://www.dhs.state.il.us/page.aspx?item=33625>

Key New Source Now Available

Illinois Department of Public Health IQuery Data System <http://iquery.illinois.gov/>

APPENDICES

Appendix A – Madison County Health Priorities

Madison County Health Priorities

- Round 1: 1996-2000
 - Cardiovascular Disease
 - Respiratory Disease
 - Unintentional Injury (motor vehicle & falls)
- Round 2: 2001-2006
 - Respiratory Disease
 - Cardiovascular Disease
 - Cancer
 - Unintentional Injury (motor vehicle & falls)
- Round 3: 2007-2012
 - Addictive Behaviors
 - Sexual Health Behaviors
 - Cardiovascular Health
- Round 4: 2011-2016
 - Obesity
 - Air Quality/Environment
 - Teen Pregnancy
 - Mental Health
 - Substance Use and Abuse

Appendix B – Focus Group Participants – June 2010

Stakeholder Focus Groups held during June 2010 included 67 participants from the following 42 organizations:

Achievement Resource Center (ARC) Wm. Bedell
Alton Community Unit School District #11
Alton Memorial Hospital
Alton Police Department
American Cancer Society
Anderson Hospital
Behavioral Health Alternatives
Boys and Girls Club of Bethalto
Chestnut Health Systems
City of Alton
Community Counseling Center
Community Hope Center
Coordinated Youth and Human Services
Drug Free Alton Coalition Member
Eden United Church of Christ
Edwardsville Community Unit School District #7
Edwardsville YMCA
Health Advisory Committee Members
IDECO, Inc
Illinois Center for Autism
Illinois Department of Human Services
Illinois State Police
Latino Roundtable
Lewis & Clark Community College
MadCAP
Madison Community Unit School District #12
Madison County Board/Board of Health
Madison County Catholic Charities
Madison County Health Department
Madison County Planning and Development

Madison County Probation
Madison County Regional Office of Education
Mosaic Pregnancy & Health Center
NAMI Southwestern Illinois
REL8
Riverbend Head Start and Family Services
Southern Illinois University Edwardsville
St. John's Adult Day Care
St. Joseph's Hospital – Highland
TASC
Triad Community Prevention Coalition Member
University of Missouri – St. Louis

Appendix C – Core Team Members – August 2010

- Alton Memorial Hospital
- Chestnut Health Systems
- Health Advisory Committee Members (2)
- Ideco, Inc.
- Madison County Health Department Administrator
- Madison County Health Department IPLAN Coordinator
- Madison County Mental Health Board
- Madison County Regional Office of Education
- Southern Illinois University Edwardsville School of Nursing
- University of Illinois Extension

Appendix D – Board of Health Resolution to Adopt 2011-2016 Health Priorities – September 2010

A RESOLUTION ESTABLISHING ASSESSMENT PRIORITIES FOR THE 2011-2016 MADISON COUNTY COMMUNITY HEALTH PLAN

WHEREAS, Madison County Health Department is established as a Certified Local Health Department in accordance with the Illinois Local Health Department Code for the period June 3, 2006 to June 2, 2011 and must submit to IDPH for recertification: a community health assessment, a community health plan, an organizational capacity assessment all adopted by the Madison County Board of Health; and

WHEREAS, the health department is required to assess the health needs of Madison County by establishing a systematic needs assessment process that periodically provides information on the health status and health needs of a community; and

WHEREAS, the assessment process involving stakeholders from various agencies, offices, faith-based organizations, community associations, schools, universities, hospitals, and other partners within the public health system of Madison County has been ongoing since March, 2010; and

WHEREAS, the next Madison County Community Health Plan (2011-2016) will be developed to establish objectives and strategies for intervention of at least three priority health issues identified in the assessment process; and

WHEREAS, the Board of Health Advisory Committee and Health Department Committee recommend the acceptance of the assessment findings which identify five priority health issues;

NOW, THEREFORE, BE IT RESOLVED that the Madison County Board of Health establishes the health priorities of *Obesity, Substance Use/Abuse (ATOD), Mental Health, Teen Pregnancy, and Air Quality-Environment* for the 2011–2016 Madison County Community Health Plan, and that the Public Health Director is hereby authorized to submit to IDPH the recertification application by April 3, 2011.

Respectfully Submitted,

s/ Michael Holliday, Sr.
Michael Holliday, Sr.

s/ Kent Scheibel
Kent Scheibel

s/ Helen Hawkins
Helen Hawkins

s/ Judy Kuhn
Judy Kuhn

s/ Mark Burris
Mark Burris

s/ Joyce Fitzgerald
Joyce Fitzgerald

s/ Chris Wangard
Christopher Wangard, M.D.
Health Department Committee

Appendix E – Community Health Plan Summit Participants – November 2010

The Community Health Plan Summit held on November 16, 2010 included 79 participants from the following 46 organizations:

Achievement Resource Center (ARC) Wm. M. Bedell
Alton Memorial Hospital
American Cancer Society
Anderson Hospital
Asthma and Allergy Foundation
Behavioral Health Alternatives
Boys and Girls Club of Bethalto
Boys and Girls Club of East Alton
Chestnut Health Systems
Community Counseling Center
Coordinated Youth and Human Services
Curves – East Alton location
Drug Free Alton Coalition
Edwardsville Community Unit School District #7
Eden United Church of Christ
Edwardsville YMCA
Faccin Chiropractic –Wood River
Gateway Regional Medical Center
Global Drug Testing Services
Health Advisory Committee Members
Highland Community Unit School District #5
Ideco, Inc
Illinois Department of Human Services
Illinois Public Health Institute
Lewis & Clark Community College
Macoupin County Health Department
Madison County Board/Board of Health
Madison County Coroner's Office
Madison County Health Department
Madison County Mental Health Board
Madison County Planning and Development
Marquette Catholic High School
Mosaic Pregnancy & Health Center
Region III Special Education

RideFinders

rjn group

Southern Illinois Healthcare Foundation

Southern Illinois University Edwardsville

St. Anthony's Health Center – Alton

St. Joseph's Hospital – Highland

TASC

University of Illinois Extension

University of Missouri-St. Louis

Women, Infants, and Children (WIC)

Wood River Fire Department

Appendix F – Board of Health Resolution to Adopt Community Health Plan – March 2011

A RESOLUTION ADOPTING THE MADISON COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT AND COMMUNITY HEALTH PLAN 2011-2016

WHEREAS, the health department is required to periodically assess the health needs of the community by establishing a systematic needs assessment process that provides information on the health status and health needs of a community in part by utilizing the process known as the Illinois Project for Local Assessment of Needs (IPLAN) ; and

WHEREAS, the Madison County Board of Health adopted the health priorities of *Air Quality/ Environment, Mental Health, Obesity, Substance Use and Abuse, and Teen Pregnancy* for the 2011–2016 Madison County Community Health Plan, on September 15, 2010; and

WHEREAS, the Madison County Community Health Plan has been developed by health professionals, community agencies and organizations, educators, citizens, and health department personnel and establishes outcome objectives, impact objectives and intervention strategies for the adopted health priorities; and

WHEREAS, the Board of Health Advisory Committee and Health Department Committee recommend the adoption of the Plan;

NOW, THEREFORE, BE IT RESOLVED that the Madison County Board of Health adopts the Madison County Health Needs Assessment and Community Health Plan 2011-2016.

Respectfully Submitted,

s/ Michael Holliday, Sr.
Michael Holliday, Sr.

s/ Kent Scheibel
Kent Scheibel

s/ Helen Hawkins
Helen Hawkins

s/ Judy Kuhn
Judy Kuhn

s/ Mark Burris
Mark Burris

s/ Chris Wangard
Christopher Wangard

s/ Lisa Ciampoli
Lisa Ciampoli
Health Department Committee