

MADISON COUNTY HEALTH NEEDS ASSESSMENT AND COMMUNITY HEALTH PLAN

2007-2012

HEALTH PRIORITIES:

**Addictive Behaviors
Sexual Risk Behaviors
Cardiovascular Health**

Prepared by

**Toni M. Corona, Public Health Administrator
Amy J. Yeager, Health Promotion Manager
Marcia Custer, Health Advisory Committee
Ann Popkess, MCPCH Coordinator
Madison County Health Department Health Educators and Interns
Madison County Partnership for Community Health**

for

**Illinois Department of Public Health
Springfield, Illinois
March 2006**

MADISON COUNTY BOARD OF HEALTH**Alan J. Dunstan, Chairman**

District	Name	District	Name	District	Name
1	Judy Kuhn	11	Jean Myers	21	Robert Shipley
2	Christopher Wangard	12	Mark Burris	22	Nick Petrillo
3	William S. Meyer	13	Sue Brown	23	Gussie Glasper
4	Robert A. Daiber	14	Theodore Prehn	24	Kent Scheibel
5	Michelle Ruppert	15	Barbara Overton	25	Eric A. Schuler
6	Stephen Adler	16	Helen Hawkins	26	Harry Thureau
7	Mike Walters	17	Hal R. Patton	27	M. Joe Semanisin
8	Michael Holliday, Sr.	18	Jack Minner	28	Joyce Fitzgerald
9	Peggy Voumard	19	Frank Laub	29	Larry Trucano
10	Tom Hoechst	20	Sharon Perjak		

Joseph D. Parente, Director
Madison County Administration

Health Department Committee

Michael Holliday Sr., Chairman
Kent Scheibel
Helen Hawkins
Judy Kuhn
Mark Burris
Christopher Wangard, M.D.
Joyce Fitzgerald

Board of Health Advisory Committee

Harold M. Johnson, M. B.A., Chair
Betty Stone, R.N., MS, NCSN, Chair-Elect
Elouise McMahon, Recording Secretary
Marcia Custer, R.N.C., Ph.D.
Arthur L. Grist, Sr., MPH
Dorothy Droste, R.N., BSN
Jack J. Miller, D.D.S., F.A.G.D, P.C.
Nancy J. Berry, MHA
Gregory Myers, M.D.
David L. Ayres, D.C., M.D.

ACKNOWLEDGMENTS

The Madison County Health Department is grateful for the dedication and commitment of many partners working together to accomplish this assessment and community health plan. Especially noteworthy is Dr. Marcia Custer for her contribution and leadership to the project. We would like to extend our sincere appreciation to the community leaders who served on the Madison County Core Team that guided this process. The Madison County Core Team included: Marcia Custer; Cindy Gavilsky; Michael Holliday, Sr.; Ann Popkess; Rob Shelton; Carol Schlitt; Jean Schram; and Andrew Reinking. A special thank you to the Madison County Community Stakeholders and the Madison County Partnership for Community Health members for their participation in this process and their commitment to improving the health of Madison County. Finally, I would like to thank the managers, staff, and interns at the Madison County Health Department for their leadership, 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.

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

TABLE OF CONTENTS

I. STATEMENT OF PURPOSE	1
II. 2001-2006 HEALTH PRIORITIES REVIEW	
MCPCH Process Evaluation	2
MCPCH Committee 5 Year Plan Analysis and Evaluation 2001-2006	6
Cardiovascular Disease	7
Cancer	10
Falls and Motor Vehicles	13
Respiratory Disease	15
III. ASSESSMENT AND PLAN DEVELOPMENT PROCESS	19
IPLAN Assessment Instruction Sheet	22
Madison County Community Assessment Survey	23
Statistical Data and Sources	24
Demographic and Socioeconomic Characteristics	24
US Census 2000 Demographic Profile Highlights	26
IPLAN Access To Care Primary Data and Resources to Consider	30
Websites for Non-Community Statistical Data Collected	39
IPLAN Data Chart 2000	40
Behavioral Risk Factor Surveillance System for Adults	42
Priority Setting	43
Data Ranks Priority Setting Table	45
Collapsed Subcategories of Community Responses	46
IV. ADDICTIVE BEHAVIORS PLAN	48
V. SEXUAL RISK BEHAVIORS PLAN	53
VI. CARDIOVASCULAR HEALTH PLAN	60
VII. CANCER PLAN	63
VIII. MOTOR VEHICLE PLAN	69
 <u>APPENDICES</u>	
IL Youth Survey Data Tables	A
2005 Madison County Youth Forum Recommendations	B
MCPCH Customer Restaurant Survey Results	C
Madison County Board Resolution for the Priority Areas	D
Madison County Board Resolution for the Community Health Plan	E

I. STATEMENT OF PURPOSE

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 Plan is a response to the IOM's recommendation and provides the methodology to achieve a healthier community. According to *77 Ill. Admin. 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 third round of IPLAN for Madison County, a stronger emphasis has been placed on community responses, expanding the statistical source base, and engaging additional community stakeholders. It evaluates the extent of progress in meeting previously set goals and priorities, and if necessary, re-directs the community's efforts in addressing community health needs.

The Madison County Community Health Plan addresses the three new health priority areas of Addictive Behaviors, Sexual Risk Behaviors, and Cardiovascular Health that were identified by the latest Madison County Health Needs Assessment. The Community Health Plan also addresses the continuation of two existing priority areas, Unintentional Injury/Motor Vehicle and Cancer. Each priority area includes the aspects of prevention and treatment. In addition, each priority includes at least one objective and/or strategy that addresses Access to Care for that health issue. This assessment and plan are the result of cumulative efforts by health professionals, community agencies and organizations, 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 intervention strategies that will address the Health Priorities and impact positively on the health of the community. The Madison County Community Health System will utilize the assessment results and community health plan to develop programs designed to address the health concerns.

This 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 some of the elements examined in this countywide needs assessment. They included: Demographic and Socioeconomic Characteristics, General Health and Access to Care, Maternal and Child Health, Chronic Disease, Infectious Disease, Environmental/Occupational Health and Injury Control. This report is intended to provide a general assessment of health in Madison County and a community 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.

II. 2001-2006 HEALTH PRIORITIES REVIEW

Madison County Partnership for Community Health Process Evaluation

Submitted on May 3, 2002 by Amy J. Yeager, MPH

In June 1996, the community members who comprised the first Community Health Needs Assessment committee reorganized into a community coalition known as the Madison County Partnership for Community Health with a 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.

In April 2001, Madison County Partnership for Community Health (MCPCH) completed the development of objectives and interventions to address the four Madison County health priorities of respiratory disease, cancer, cardiovascular disease, and unintentional injury. The 2001-2006 Madison County Needs Assessment and Madison County Community Health Plan were submitted to the Illinois Department of Public Health (IDPH) for approval as the county IPLAN (Illinois Project for Local Assessment of Needs) as required for health department recertification. The documents were approved and deemed one of the best IDPH has received since employing this requirement. The Administrator and Health Education Manager from Madison County Health Department were invited to serve on the IDPH planning committee to refine and improve the IPLAN process.

Madison County Health Department leads the process of plan development; however, MCPCH members play a vital role in the development and implementation of the plan. MCPCH Subcommittees are formed driven by the health priorities. Currently, five subcommittees work toward accomplishing the Community Health Plan objectives that they helped create five years ago. The subcommittees include Respiratory Disease, Cancer, Cardiovascular Disease, Motor Vehicle (unintentional injury), and Falls (unintentional injury). Average attendance varies among the groups from two to eight per meeting. During this evaluation, it has been determined that the Falls and Motor Vehicle subcommittees are severely lacking in leadership, membership, and direction. Falls has not met since August 2001. Motor Vehicle has experienced the loss of grants by members influencing the participation of members.

Purpose of this Process Evaluation:

The purpose of this process evaluation was to assess the progress of the subcommittees toward maintaining their timelines, assess the progress of achieving objectives in the health plan, and capture the perspective of their involvement. Objectives and interventions are outlined by health priority area in the 2001-2006 Madison County Community Health Plan. Please refer to this document for specific timelines and objectives.

Accomplishments toward Interventions:

The Respiratory Committee has maintained their timelines and accomplished their interventions. As well, Respiratory has developed and distributed four surveys to capture tobacco-related information from select populations in the county. Surveys included asthma information from pediatricians, local ordinance and promotion information from city clerks,

school information, and business information on smoking policies. Results are being collected and tabulated.

The Cancer Committee has maintained their timelines and accomplished most of their interventions. They have focused on the development and dissemination of a risk assessment for patients, acquiring information about local and regional tobacco initiatives, implementation of the breast and cervical cancer screening program, and administered the Center for Disease Control and Prevention Youth Risk Behavior Surveillance System at one middle school and one high school. The committee has identified a barrier in fully accomplishing this objective as schools were interested but unwilling to participate during an academic year with elections, referendums, and teacher strikes. The committee will pursue this objective further during the 2002-2003 academic year.

The Cardiovascular Disease Committee has maintained their timelines and accomplished their interventions through April 2002. They have established a baseline of smoke-free restaurants in the county, conducted a survey of restaurant owners to determine healthy eating selections and environments, compiled healthy restaurant data into a chart to be distributed later this year, revised and distributed the Heart Healthy Curriculum to schools, received feedback from schools implementing the curriculum in February, conducted the annual Madison County Walk Day, and increased the number of participating teams in the Beat the Odds Holiday Weight Maintenance program. The committee continues to implement their interventions and refine annual initiatives.

Unintentional injuries are addressed by the Motor Vehicle and Falls Subcommittees. Both subcommittees have struggled with lack of attendance during this year. Motor vehicle has not fully accomplished all of their interventions due to loss of a grant. However, the committee continues to provide coordination of traffic safety for the county and implement some traffic safety initiatives. The committee has primarily focused on media initiatives and presentations. The Falls Committee had realigned their direction last summer to meet quarterly and focus on providing information through health promotion tools for senior citizens in the county, especially in nursing homes and residential care facilities. Establishment of a link between the Falls Committee and the Madison County Senior Services program was achieved. Osteoporosis education has been provided throughout the county at worksite presentations and health fairs.

Process Evaluation Survey Results:

MCPCH Process Evaluation Surveys were mailed to approximately 40 MCPCH members with 16 completed surveys returned, 1 incomplete with a note that the member was too new, and 1 with a note that they are no longer a member of the committee. Subcommittee members received surveys as follows:

Motor Vehicle 1
Cardiovascular Disease 4
Respiratory 4
Cancer 5
Falls 2

The number of surveys returned was fairly reflective of the number of active members on each subcommittee. Amy J. Yeager abstained from the survey as she is the 2002-2003

MCPCH Coordinator over all the committees and administered this process evaluation project.

Survey data was tabulated combining input from all subcommittees. A breakdown by committee was provided to that committee chair for reassessment of the group. A 5 point Likert scale was used asking members to rate items on a scale of 1 (highly disagree)-5 (highly agree) and answer three questions requiring qualitative answers.

My subcommittee has worked together 3.9

My subcommittee has made an effort to complete our written objectives for the first year 4.1

My subcommittee has worked toward our objectives but has discovered other issues that need addressed first 3.2

My subcommittee has identified the need for new or additional direction on our health priority area 3.3

My subcommittee is committed to improving the health of Madison County regarding this health priority 4.3

Please list any strengths or successes of your subcommittee and/or the process of implementing subcommittee objectives.

- **Our individual members are often doing the work at their own agencies-making this a true collaboration.**
- **Good discussion on risk survey (for patients). Committee involvement gives better understanding of local risk data.**
- **We have several committed members.**
- **People who are knowledgeable in their field**
- **Good working relationship**
- **Members**
- **They work as a team**
- **We have committed members who regularly attend**
- **Great leadership, Carol has been invaluable! The cooperation and commitment of the entire group has been great!**
- **Carol Schlitt and other members-open to ideas-work very hard**
- **The CVD committee is a group of dedicated professionals. We are active but could use some new blood.**

Please list any barriers or challenges of your subcommittee and/or the process of implementing subcommittee objectives.

- **We need more members; unfortunately, we lose many due to the loss of grants.**
- **Appear to be slow in accomplishing things because one key member is gone or hasn't reported-perhaps could get report from person if they can't be there.**
- **Getting info to the public at large**
- **Not enough direction.**

- Although we are working on projects, we don't seem to be getting anywhere, and it is a few people doing all the work. Also, attending members seem to vary and when certain people attend, we seem to lose focus.
- Members (myself included) not always available to attend meetings due to workplace priorities.
- No input on Tobacco Settlement programming
- Overlap with other committees
- More variety in members
- Community participation/response is slow
- School system-appears to be better this year-Small funds to draw on
- Getting people to commit to meetings
- No members attending, low morale
- Chair is not committed, we haven't had a meeting since August

Please list any ideas or suggestions for addressing barriers and challenges.

- More attention needs to be given on increasing attendance and membership
- Accomplish specific goal for each meeting
- We need more focus. Perhaps, choosing 1 goal would be better than working on several pieces.
- Clarifying committee work where overlap occurs
- Need non-health care members
- County needs to allot funds to a "petty cash" fund that could be used by the health dept. at the discretion of administration.
- Must make the meetings relevant to members-must relate to their own job-WIIFM!! (What's in it for me)
- Chair needs to be more involved

Recommendations as a Result of the Process Evaluation:

Responses varied consistently by subcommittee providing a base for each chair to address barriers and build on strengths. A general consensus seemed to prevail that committed members are the key and a wider variety of members was needed. Overall, members seemed to feel committed to improving the health of Madison County through their health priority area. This core belief and the sense of teamwork will be our cornerstones to move forward.

MCPCH Committee 5 year Plan Analysis and Evaluation – 2001-2006

Submitted on February 10, 2006 by Ann Popkess, MSN and MCPCH Committee Chairs

In early 1995, an eighteen member Community Health Committee was appointed from a list of persons identified as representing a variety of health provider organizations and interests within Madison County who were felt to have valuable information about community health status. This committee was charged with conducting a community health needs assessment and developing a Community Health 5-year-Plan in accordance with certification requirement of the Illinois Department of Public Health. Additional participants were added to the committee when specific expertise was needed to develop the goals and objectives relevant to the 3 specific health priority areas selected for focus during the initial 5-year plan. The work of this task force was completed in March 1996 when the Madison County Board of Health approved the 5-year Plan and created the Madison County Health Department. Subsequent to this, the Madison County Partnership for Health (MCPCH) was formed in June 1996 and consisted of persons who had worked on conducting the Needs Assessment and developing the Madison County Community Health 5-year-Plan.

The MCPCH group developed the following mission statement:

“Our mission is 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 health environments and lifestyles through education, understanding and action.”

Subsequently, the 2001-2006 Health Plan was developed from the previous plan’s goals and objectives. A community assessment was completed and the resultant MCPCH committees were formed. Since 2001, five MCPCH committees have met regularly to discuss and implement interventions related to the Community Health Plan. The committees are listed below:

1. Cardiovascular Disease
2. Cancer
3. Respiratory
4. Falls/Unintentional Injuries
5. Motor Vehicle/Unintentional Injuries

Initially, priority groups adopted the specific goals, objectives and strategies from the Madison County Community Health Plan as guides to developing interventions. Committees meet monthly. An All-MCPCH business meeting is held biannually (February and September) to discuss committee progress and provide an educational presentation on a new or relevant topic. Minutes are kept on file in the Madison County Public Health Administrative Office. Each committee has submitted a report of the goals and objectives and the resulting achievements over the past five years. This data will provide guidelines to assess health status changes in general of the Madison County residents.

Cardiovascular Disease

OUTCOME OBJECTIVES

By 2005, reduce the premature death rate from cardiovascular disease to no more than 52/100,000 population under age 65. (Madison County baseline: 55.8/100,000; Source Crude date from Madison County 1997)

Data from the IPLAN Data System indicated that premature (<65 years of age) coronary mortality rate in Madison County was 51.4/100,000 in 1995, 45/100,000 in 2000, and 58.6/100,000 in 2001. These rates are consistently higher than the state rates of 43.5/100,000 in 1995, 37.5/100,000 in 2000 and 37.4/100,000 in 2001.

These rates show an ongoing concern for Madison County and underscore the need for consistent intervention to help lower these rates over the next decade.

IMPACT OBJECTIVES

By December 2003, the number of food service establishments inspected by the Madison County Health Department who receive “smoke-free” certification will increase by 10%. (Baseline will be established in 2001)

In 2001, seventy-four restaurants received the official certification as a “smoke-free” restaurant. By February, 2005, 112 restaurants were listed on the official IDPH Smoke Free Restaurant Website. This represents a 51% increase. Restaurants were recognized through mandatory inspection reports and through reporting in surveys distributed by the Cardiovascular Disease Committee in both 2002 and 2005 which resulted in a “Madison County Healthy Restaurant Dining Guide”. This guide not only indicated restaurants that were smoke-free but also highlighted those restaurants that serve healthier options (low-fat milk, egg substitutes, etc).

By December 2003, there will be a decrease in childhood obesity as measured by a sample of Body Mass Index (BMI) readings from mandated health records for students entering kindergarten, fifth, and ninth grades. (Baseline to be determined in 2001)

In 2001, the Cardiovascular Disease Committee enlisted the help of Madison County School Nurses to voluntarily submit data to the CVD committee each year for the next five school years. Each spring, nurses are asked to report a sampling of their kindergarten, fifth and ninth grade student’s health information including the following: date of birth, height and weight. From this information a BMI was determined for each student. An average BMI for each grade level per school was determined as well as a county-wide average for all kindergarteners in the sample. In 2001, over 1300 students were entered into the data base by school. In subsequent years, the nurses have submitted the same data. The data is still be analyzed and a final report for the five year study will be prepared in the summer of 2006.

The purpose of this study is to collect data on Madison County children to be able to compare our obesity rates to Illinois and national rates and to help determine future programming needs with data specific to our county.

INTERVENTION STRATEGIES

1. By July 2001, determine baseline for smoke-free restaurants in Madison County after completing the first year of the Illinois Smoke-Free Restaurant Recognition program. This will be an ongoing program for the Environmental Health Division.

Strategy discussed above

2. By September 2001, update the Heart Healthy School Curriculum, developed by MCPCH Cardiovascular Disease Priority Group, to include more information on smoking and obesity as related to cardiovascular disease.

The Heart Healthy School Curriculum, developed by the Cardiovascular Disease Priority Group in 1999 was updated to include information on smoking and obesity in the fall of 2001. Hard copies were provided for each Madison County School in January 2002. A Madison County Heart Healthy Week was designated for February 4-8, 2002 and schools were encouraged to use the curriculum during that time period. Only two Granite City Schools reported using the entire curriculum through the printed survey/evaluation forms. Several schools reported that they used portions of the program and only one school district indicated they utilized the suggested menus. Due to the low response rate, it was decided not to continue with this project in 2003.

3. By December 2001, submit press release supporting the Illinois Smoke-Free Restaurant project in Madison County.

In conjunction with the first printing of the Madison County Healthy Restaurant Guide, the Cardiovascular Disease Committee prepared and distributed a press release announcing both the guide and our support of the Illinois Smoke-Free Restaurant project. The news release was distributed to all Madison County newspapers in September 2002.

4. By December 2001, present Heart Healthy Workshops for Madison County teachers and students.

To help spread the word about the Cardiovascular Disease Committee's "Heart Healthy School Curriculum, Gayle Lloyd, RD and member of the CVD team, presented a workshop for teachers and school nurses at the October 2001 Madison County Teacher's Institute. The purpose of this workshop was to introduce the Heart Healthy Curriculum, to discuss the 5-year BMI study and to acquaint the teachers and nurses with the Madison County Partnership for Community Health's CVD Committee.

5. By October 2002, increase by 10% the participation in the annual WALK DAY sponsored by MCPCH and Madison County Government. (Baseline 72 walkers in 2000)

One of the first and most successful events sponsored by the CVD committee has been the annual Madison County WALK DAY. Since it's beginning in 1998, this annual event has

steadily grown in both numbers and publicity for the Madison County Partnership for Community Health. Confirmed walkers for 2000 was 72; 2001 = 134, 2002 = 425, 2003 = 465,

2004 = 4,461 and 2005 = 7,213. This represents a 1000 % increase from our baseline in 2000! In 2004, every school in Madison County was personally delivered flyers announcing the Madison County Walk Day and students and teachers alike were encouraged to “Walk A Mile for Your Health” on the official Madison County WALK DAY (proclaimed by County Board Chairman). Teachers were encouraged to either email or leave a voice mail with their name, school and number of students who participated that day. Almost every public school district in the county had at least one classroom walking – some schools had their entire student/teacher body walk the designated day. We found that schools loved the opportunity to encourage their students to walk and most teachers reported that they appreciated the simplicity of this event.

6. By December 2002, collaborate with the MCPCH Respiratory and Cancer priority groups to share data, planning and interventions related to common risk factors.

At the MCPCH chairs meeting, the chairs regularly discussed planning and intervention strategies that could benefit each of the committees. It was decided in 2003 that each of the committees should hold a countywide event that would showcase their committee’s efforts. The Cardiovascular Disease Committee decided to be the first committee to take up this challenge and in collaboration with Anderson Hospital held the first of three “Jazz Up Your Heart” seminars. This seminar is designed to bring together health professionals to speak on topics related to heart issues – which overlap with strategies and interventions for both the respiratory and cancer committee (diet, exercise, stop smoking, etc.). Sixty-two people attended the first session, which featured displays on smoking, exercise and diet. The second seminar was co-sponsored by Alton Memorial Hospital and was held in May 2004. The third seminar was also held in Alton and was co-sponsored by St. Anthony’s Wellness Center at Alton Square Mall in September 2004. The success of these seminars, reaching over 150 people, has shown that MCPCH committees can be effective at bringing engaging education that touches on common risk factors for all our committees.

7. By January 2003, increase by 9 the number of Madison County classrooms using the Heart Healthy School Curriculum (Ire-K to 12). (Baseline: 3 classrooms in winter 2000)

As discussed in 2, the Heart Healthy Curriculum was dropped as an intervention strategy in the fall of 2003 due to lack of response from the schools in Madison County. The cost of reproducing the curriculum coupled with the low number of teachers who reported they used the curriculum forced the committee to shift their efforts to other ventures that garnered better returns (Jazz Up Your Heart and Walk Day)

8. By February 2003, increase by 18 the number of teams participating in the “Beat the Odds” holiday weight maintenance program. (Baseline 18 teams in 1999)

The Beat the Odds program, begun in 1998, is a 5-week group holiday weight maintenance program designed for workplace health intervention. The premise of the program is to have teams working together to help each other maintain their weight during the most difficult time of the year – the time between Thanksgiving and New Years. Each year, the CVD

committee produces a team manual complete with weekly ideas for helping the team members to resist the many weight-gaining temptations during the holidays. Also, the team

weighs as a team at the beginning of the program and then again at the end to assess if the team maintained their weight. While the program is not designed to have the teams lose weight, our findings indicate that 3 out of 4 teams do lose weight. After the 2002 holiday season, 40 teams reported that they took the "Beat the Odds" challenge and reported their pre- and post-weights. This represented a 22 team increase over our baseline and more than achieved our goal.

In 2005, the Beat the Odds program was revamped to become a media 5-week campaign. News releases were sent to all the Madison County papers in late November, encouraging them to print the weekly columns in their newspapers. The CVD committee hopes to reach a new audience with these weekly columns and to encourage the public at large to "Beat the Odds" during the holidays.

Cancer

OUTCOME OBJECTIVE

By 2005, there will be no increase in the overall cancer mortality rate in Madison County. (Baseline 234/100,000 population, 1997 IPLAN)

IMPACT OBJECTIVES

By January 2003, the CDC Youth Risk Behavior Survey Surveillance will indicate at least a minimal improvement in desired nutritional practices, increased physical activity levels, and later initiation and overall decreased tobacco use in selected groups of middle and high school students in Madison County. (Baseline to be established in 2002)

The baseline was established in 2002 and 2003 through the participation of 2 county high schools and middle schools. The second round of data collection has been completed in one school district and will be reported.

The sample participating school districts was smaller than anticipated since a number of school administrators and school boards declined to participate in the survey because of the perceived sensitivity of questions about sexual risk even though they were invited to omit those items. Most school districts administer drug and alcohol surveys that are required by grants received. Unfortunately, several were not convinced of the value of the more comprehensive health risk assessment even though it would be cost neutral for them.

By January 2003, increase opportunity for early detection for at-risk women in Madison County through the Illinois Breast and Cervical Cancer screening program (baseline to be established in 2001).

During calendar year 2001, we provided 67 breast and cervical cancer screenings to women in Madison County.

During calendar year, we provided 121 breast and cervical cancer screenings to women in Madison County.

By January 2003, we increased our screenings for breast and cervical cancer by 55% over our baseline established in 2001.

INTERVENTIONS

1. By June 2001, identify Madison County cancer prevention education programs (to include prevention of risk factors and early screening) currently available to public school students and county citizens.

2. By June 2001, collaborations among Madison County Partnership for Community Health (MCPCH) priority groups will define how the Respiratory, Cardiovascular and Cancer Committee will specifically address common cancer risk factors with minimal programmatic overlap.

2.1 It was decided that since both the Respiratory and Cardiovascular priority groups address risk factors that are common to many forms of cancer, the Cancer committee would confine activities to issues not covered by them, i.e. Breast, cervical, colon and prostate cancers.

3. By June 2001, identify county resources (i.e. Family Resource Alliance, Madison County Senior Services Program) who agree to participate in disseminating information to the community available cancer prevention and treatment programs.

Granite City:

***Salvation Army
Protestant Welfare Organization
US Post Office***

Madison:

City Hall

Maryville:

Maryville Food Pantry

Alton:

***Salvation Army
Crisis Food Center
Catholic Charities
Oasis Women's Center
Riverbend Head Start and Family Services***

Venice:

***Township Office
Venice Library
City Hall
New Shining Light MB Church***

Wood River:

Operation Blessing

Other:

***William BeDell Achievement Resource Center
Local Interagency Council
Madison County Newborn Coalition***

4. By July 2001, MCPCH Cancer subcommittee members will meet with the Southwest Region Advanced Practice Nurse's Association to explore the willingness of area nurse practitioners to develop and pilot a one-page cancer health risk assessment to determine if its presence in client records increases preventive education and/or screening.

4.1 Through a review of the literature, a one-page cancer risk assessment was developed for both men and women. However, the Regional Advanced Nurse Practitioner's Association no longer meets regularly and therefore has not been a feasible source of distribution. This strategy is an area that needs attention in the remainder of this 5-year plan.

5. By October 2001, increase public awareness regarding the Illinois Breast and Cervical Cancer Program (IBCCP) with Madison County Health Department.

5.1 IBCCP materials were distributed to all of the above community resources as well as the following private companies to increase the public awareness about the IBCCP (as of November 2005)

Granite City: Big Lots, Dollar Tree, Dollar General, Shop-N-Save, Aldi's, Schnucks, Great Clips, Cloud Nine Beauty Salon, Hair Express, Laundromats (3)

Madison: Food for Less, Farm Fresh, Beauty Supply/Salon,

Venice: Red Fox Grocery, Family Hair Care, Western Union, Laundry Mat

Collinsville: VFW, American Legion, Fireman's Hall

Edwardsville: American Legion, Knights of Columbus

Highland/Grantfork: Public Library, UCC Churches

SIUE Women's Health Fair

Alton Women's Health Fair

All MCHD Flu shot clinics

6. By October 2001, enroll 50 at risk women into the breast and cervical cancer-screening program through the MCHD.

6.1 By October 2001, 49 screenings of at-risk women had been done through Madison County Health Department.

7. By January 2002, obtain the cooperation of a sample of three Madison County Middle schools and three Madison County High Schools to agree to annually administer the CDC YRBSS to students in grades six, nine and twelve. Information will be used to plot

longitudinal changes in youth risk behavior that might be attributed to prevention initiatives on national, state, and local levels.

7.1 It was more difficult than expected to obtain willingness to participate in the YRBSS among county school districts. Many felt the YRBSS was redundant with the drug and alcohol surveys already being done and feared objections from parents about the sex risk questions. Two school districts are currently participating in the survey process and continued assessment of other school districts is ongoing.

8. By July 2002, assist in the implementation of at least three solution related to tobacco as identified at the 2001 Madison County Tobacco Youth Forum.

8.1 Numerous recommendations from each Youth Forum was implemented.

9. By July 2002, provide at least two trainings for Madison County students developing their leadership skills, tobacco knowledge, and enhancing related life skills and lifestyle choices.

9.1 For each year during the IPLAN cycle, training was conducted to address these points in youth including:

- Two annual trainings for Camp Success teen staff and teen leaders training,***
- Two annual camp success weekends for youth (one middle school, one high school)***
- One annual Teens Against Tobacco Use training for middle school students,***
- One annual Madison County Youth Forum***
- Peer Leadership training through Chestnut Health (ALPHA)***

Falls and Motor Vehicles

Falls and Motor Vehicles Committees were combined in 2003 because of lack of membership and interest in the fall prevention committee and similar safety objectives for both committees.

OUTCOME OBJECTIVES

By 2005, reduce death caused by motor vehicle injuries to no more than 18.5/100,000 population (Baseline: 20.6/100,000 population, 1990 IPLAN)

Baseline 53 people killed in motor vehicle accidents in Madison County (IPLAN, 1997). Target projected at 48 killed in motor vehicle accidents. Actual motor vehicle accident fatalities in Madison County for the following years:

2001 – 39

2002 – 49

2003 – 42

2004 – 35

By 2005, maintain and/or reduce the rate of alcohol-related motor vehicle deaths at 5.5/100,000 population. (Baseline 5.5/100,000).

Baseline: 14 alcohol related motor vehicle fatalities in Madison County, (IPLAN,

1997). Actual alcohol related motor vehicle fatalities in Madison County for the following years:

2001 – 7

2002 – 6

2003 – 15

2004 – 9

IMPACT OBJECTIVES

By 2003, increase the use of driver restraints to 69%. (Baseline: 58%, Chestnut Health Systems).

Seat belt Surveys were conducted by the committee at Chestnut Health Systems and Madison County Health Dept periodically. A combined site usage rate for August 2001 was 59%. Combined usage for December 2003 was 64%. January 2005 check was 63.5%. Checks are ongoing.

INTERVENTIONS

1. By September 2002, safety information will be provided for at least six community events.

Met and exceeded this target. Traffic safety information displays continue in the areas of: child safety seats, bike safety, pedestrian safety, occupant protection.

2. By January 2003, develop and implement public awareness activities in observance of 3-D (Drunk and Drugged Driving) Prevention Month.

2.1 Annual December Drunk and Drugged Driving Prevention Month activities included placing an article in the Madison County Employee newsletter. Press packets were distributed to TV/Radio and print media outlets the packets included informational pieces, editorials, fact sheets and public service announcements. Paycheck inserts were provided to Madison county employees, Chestnut Health Systems employees and selected divisions at Anderson Hospital.

2.2 3,000 Christmas tree tags stating “Drive Smart-Drive Sober” were provided to tree lots and bank drive through for distribution.

3. By January 2003, participate annually in IDHS Alcohol Server Training Program

3.1 In December 2001, Server Training “Operation Straight ID” was conducted in E. Alton and Wood River. In Feb 2002, participated in Youth Investigative Aide Training. In April 2002 performed compliance checks with Madison County

Sheriff's office. Periodic server/seller education will continue to be provided as well as assistance with the conduction of undercover compliance checks.

4. By May 2003, twenty educational sessions will be offered annually targeting students enrolled in County Driver Education Programs.

4.1 2001-2002 School year: 142 classes of driver education students received alcohol and/or occupant protection presentations. In 2002-2003, 106 classes received the training. These programs continue.

5. By May 2003, 20 "Learning to CARE" educational programs will be offered for fourth grade students.

5.1 2001-2002 school year: 26 four-session classes were completed. In 2002-2003, 9 four-session classes presented. The decrease is the result of a job change of the presenter. Currently, the class offerings are continuing.

6. By May 2003, annually promote media-based traffic safety education programs that include EMSC Week, SAFE KIDS week, Buckle-Up America Week and Child Passenger Safety Awareness Week.

6.1 MCPCH Motor Vehicle Committee continues to disseminate media information annually on the following traffic safety issues:

Winter Driving

Complete the pass on Super Bowl Sunday

Child Passenger Safety Week

Friends don't let friends drive drunk (St. Patrick's Day)

Buckle Up, America! (Memorial Day weekend)

Fourth of July Safe Travel

Vehicles, Heat, Children....A deadly combination

General school bus safety tips

National Stop on Red Week

Travel Safely this Labor Day

Drive Safely to Work Week

Respiratory Disease

OUTCOME OBJECTIVES

1. By 2005, reduce pneumonia and influenza mortality to 36.3/100,000 population (Baseline: 48.2/100,000 Madison County 1997, 31.8/100,000 state 1997)

2. By 2005, reduce the incidence of premature chronic obstructive pulmonary disease (COPD) mortality to 5.67/100,000 population. (Baseline 6.3/100,000 population under age

65-crude data Madison County 1997. 6.0/100,000 population under age 65-crude data Illinois 1997)

3. By 2005, reduce hospital admissions for uncontrolled asthma to no more than 150/100,000 population. (Baseline 170.8/100,000 Madison County Moving average)

IMPACT OBJECTIVES

1. By January 2003, increase by 10% the annual number of immunization for influenza. (Baseline to be determined)

1.1 The Respiratory Committee attempted to establish a baseline for this objective for almost two years. It was determined that establishing a baseline was impossible due to the complexity of the geographical region and proximity to St. Louis, MO. Hospitals and the health department could submit data for a baseline; however, pharmaceutical companies that manufacture the drug were not willing to provide a listing of providers who give the shots in Madison County. In addition, numerous Madison County residents receive health care in Missouri and vice versa.

2. By January 2003, increase by 10% the annual number of immunization for pneumococcal vaccine. (baseline to be determined.)

2.1 See comments for 1.1 in this section

3. By July 2003, increase knowledge and skills related to tobacco and environmental tobacco smoke through contacts with at least 250 people. (Baseline as determined by interventions 5, 6, 7, 9, 10)

3.1 Madison County Health Department, Chestnut Health Systems, Coordinated Youth And Human Services, American Cancer Society, American Lung Association, and hospitals and schools in Madison County provided continuous and supportive programs during the past five years to achieve this impact objective.

4. By August 2003, reach 250 people through community-based asthma education initiatives. (Baseline as determined by interventions 3 and 17)

INTERVENTIONS

1. By September 2001, establish a baseline of the number of influenza vaccines administered in Madison County.

1.1 See comments under 1.1 of Outcome Objectives for this section

2. By September 2001, establish a baseline of the number of pneumococcal vaccines administered in Madison County.

2.1 See comments under 1.1 of Outcome Objectives for this section

3. By December 2001, reach 25% of teachers and staff in Madison County Schools with the Asthma 101 program

4. By March 2002, Madison County Health Department will offer 57 influenza/pneumonia immunization clinics at 10 sites in Madison County.

4.1 Press Releases and printed Public Service Announcements (PSA's) were sent

informing the public that MCPCH Respiratory Committee encouraging residents to immunize and emphasized availability of flu vaccine at the Health Department. (Sept. 2002)

5. By July 2002, provide 15 educational sessions to civic organizations, community organizations, or businesses about tobacco use and environmental tobacco smoke.

5.1 Rob Semelroth, Illinois Coalition Against Tobacco, gave an informative explanation of Preemption, possible options, and an offer for research resources at the February, 2003 MCPCH meeting.

6. By July 2002, develop and begin implementation of a strategy to inform parents of the harmful effects and consequences of tobacco and environmental tobacco smoke especially on children's health.

6.1 The American Lung Association was supported in its efforts on an Illinois Children's Initiative to raise the tax on cigarettes. The additional funding would be used for education and tobacco prevention programs.

6.2 Eliminate tobacco advertising and promotions that influence adolescents and young adults surveys were sent along with a cover letter to City Clerks in February, 2002.

6.3 The Health Department received the IDPH Asthma – Raising Awareness of World Asthma Day Grant (\$1,000). Children's books were purchased that were provided to Madison County libraries and encouraged to use during reading hours. (Sept. 04)

7. By July 2002, disseminate information to the community through various media and community events regarding health effects of tobacco.

7.1 The committee developed a Smoke Free Restaurant Questionnaire and Customer Questions – Smoke-Free Restaurants and made additions and revisions. And interviewed restaurant owners. (Sept. 03)

7.2 450 Customer Restaurant Surveys have been tallied and hand written notes were forwarded to Representative Jay Hoffman and Senator Bill Haine. (Sept. 2005).

8. By July 2002, identify and assess the availability of smoking cessation offered in Madison County.

8.1 Madison County Health Department promoted the Illinois Tobacco Quitline and collaborated with hospitals, community agencies, and colleges/universities to provide Freedom From Smoking classes.

9. By July 2002, submit six press releases relevant to tobacco prevention and cessation initiatives.

9.1 Madison County Health Department met this objective.

10. By July 2002, provide eight education and/or skill building sessions targeting at-risk populations (e.g. Women, Infant, Children clients, Family Case Management clients, Early Head Start clients).

10.1 An Asthma Adventure Camp was held Labor Day Weekend 2005, for children with Asthma ages of 7-12, to enjoy a weekend of summer camp while learning to better manage their asthma.

11. By December 2002, determine effectiveness of pulmonary education in the home given by respiratory therapists through a local hospital.

12. By December 2002, explore the possibility of initiating mandated asthma management plans in each asthmatic student's school health record.

12.1 The Respiratory Committee explored this possibility. A barrier was identified to mandatory asthma management plans in schools. That barrier was the fact the many children presenting asthmatic symptoms are not diagnosed officially with asthma; therefore, a mandatory asthma management plan in the school health record would not capture these children.

13. By December 2002, promote collaborative involvement by the school nurse, family, child and physician in asthma related issues.

14. By January 2003, offer two radio public service announcements and eight press releases to eight newspapers regarding the availability of vaccines.

15. By January 2003, post 250 flyers regarding the availability of vaccines at senior feeding centers, crisis food centers, and other community sites.

16. By March 2003, research and disseminate results from the hospital initiated home based pulmonary education program for further consideration form program replication with other interested sites.

17. By March 2003, provide 10 asthma-related education al session or community events.

17.1 The American Lung Association's annual "Whistle on Asthma" Walk was held on Saturday, April 16th, 2005

III. ASSESSMENT AND PLAN DEVELOPMENT PROCESS

SUMMARY

Many of the components of this process occurred simultaneously from May 2004-Summer 2006, especially during the Health Needs Assessment phase. A Core Team was formed through invitations to key members of the Madison County Public Health System. Additional community Stakeholders were also engaged as grassroots consultants and potential plan resources. Community Response Surveys were distributed. Other surveys were administered. Statistical data was gathered and analyzed. Community Response data was collapsed into broader categories and analyzed. The Hanlon Method and PEARL Test were utilized for priority setting. Health Priorities were established by the Core Team and then approved by the Madison County Board of Health. A second Community Stakeholders Meeting was held to unveil the 2007-2012 Madison County Health Priorities and begin the development of the Community Health Plan. New committees of the Madison County Partnership for Community Health (MCPCH) were formed to address the new Health Priorities while other existing MCPCH committees continued with their mission to address prior Health Priorities.

INITIAL PLANNING

In May 2004, the Health Department Administrator, the Health Promotion Manager who is also the IPLAN Coordinator, and Dr. Marcia Custer began to construct the framework in which the 2007-2012 Madison County Health Needs Assessment and Community Plan would be developed. Two main framework points were agreed upon which were to form a Core Team of Community Leaders to guide the process and to convene at least two Community Stakeholders Meetings during the process. Additional meetings occurred to develop options to present to the Core Team regarding assessment strategies, data gathering and analysis, broad community engagement, Community Stakeholders Meeting agenda items, and plan development.

CORE TEAM

The Core Team was chosen as primary stakeholders for their area of expertise as related to this project. The members had an array of backgrounds including environmental health, administration, nursing, human services, government, public relations and outreach, family and consumer sciences, substance abuse prevention and treatment, education, and health education and promotion.

The Core Team members included:

**Toni M. Corona, BS, LEHP
Public Health Administrator
Madison County Health Department**

Marcia Custer, RN, PhD
Associate Professor Emerita
Southern Illinois University, Edwardsville
Madison County Board of Health Advisory Committee

Cindy Gavilsky, MSED
Executive Director
Coordinated Youth and Human Services

Michael Holliday, Sr.
Chairman, Madison County Health Department Committee
County Board and Board of Health Member

Ann Popkess, RN, MSN
Instructor, School of Nursing
Southern Illinois University Edwardsville

Rob Shelton, BS
Manager of Public Relations and Development
Alton Memorial Hospital

Carol Schlitt, MS, CFCS
Extension Educator, Nutrition and Wellness
University of Illinois Extension

Jean Schram, MA, CADC, CSADP
Director of Prevention
Chestnut Health Systems

Andrew Reinking, MSED
Administrative Assistant
Madison County Regional Office of Education

Amy J. Yeager, MPH
Health Promotion Manager
Madison County Health Department

In August 2004, the Core Team convened for the first time. They were provided with an overview of the project, a description of their role, a timeline, history of this process from the previous two rounds of IPLAN, and initial options to consider for community engagement, data collection, and analysis. The Core Team met several times during this process to determine the direction of the project, discuss results, analyze data, utilize priority setting tools, prepare for the Community Stakeholders Meetings, determine the 2007-2012 Madison County Health Priorities, and engage in the development of the Community Health Plan.

COMMUNITY RESPONSE SURVEYS

The Core Team decided to utilize a community survey asking one question and allowing up to five responses to that question. The survey also requested optional demographic data. The survey was administered in both paper and web-based formats. The paper surveys were distributed throughout Madison County by Community Stakeholders, community members, County Board of Health members, Health Advisory Board members, coalition members, schools, and the media. The web-based format was posted on the Madison County Health Department website.

The total number of Community Response Surveys received was 1473 with 919 as paper surveys and 554 as web-based surveys. This sample represents 1.44% of the approximately 102,081 households in Madison County. The formula used to determine this rate was based on 2000 U.S. Census Data for Madison County, IL. The formula was $253,162 \text{ households} \div 2.48 \text{ average household size} = 102,081 \text{ households}$. $1473 \text{ Community Responses} \div 102,081 \text{ households} = 1.44\%$ of the households responded for the Health Needs Assessment.

The Core Team tallied all of the community responses and completed an initial collapsing of categories based upon inability to separate some responses because of how they were submitted. Vivian Moynihan, MD, a graduate intern at the Madison County Health Department from the Saint Louis University School of Public Health, prepared an initial broader collapsing of community response categories based upon grouping similar subcategory areas for the Core Team to review. From that point, the Core Team continued to collapse the community response categories into broader, more collective categories that captured the community's perceptions.

Examples of the Assessment Instructions and Community Survey Tool

Illinois Project for Local Assessment of Needs (IPLAN) Assessment Instructions Sheet For Community Assessment Surveys

Paper Surveys --- Workplace or Community

1. Explain what IPLAN is and the important role that they can play to help collect information to set the next 5-year Health Priorities for Madison County.
2. Distribute copies of the Community Assessment Survey.
3. Return Community Assessment Surveys to:

ATTN: IPLAN Surveys
Madison County Health Department
101 E. Edwardsville Road
Wood River, IL 62095
Phone: (618) 692-8954

4. All surveys must be returned by Friday, April 15, 2005.

Electronic Surveys --- Workplace or Community

1. Explain what IPLAN is and the important role that they can play to help collect information to set the next 5-year Health Priorities for Madison County.
2. Refer employees/members to www.madisoncountyhealthdepartment.org to complete the survey. The link is Community Assessment Survey.
3. All surveys must be returned by Friday, April 15, 2005.

Nominal Groups--- Workplace or Community

Nominal groups are an opportunity for a group to walk through 3 simple steps and develop a group consensus for their top 5 concerns as a group. Each group member can also complete the individual survey as well. Groups are best at a 5-15 person capacity. Time commitment is about 30 minutes to 2 hours (larger the group-longer the time).

1. If interested or you know of a group that may be interested, contact Amy Yeager at 692-7040 ext. 6087.
2. Give her the contact name and number and she will make the rest of the arrangements.

Madison County Community Assessment Survey

For all residents and people who work in Madison County.

The Madison County Health Department is beginning its 5-Year community assessment process. Citizen input is important to us. Please complete the following survey. We appreciate your help.

What do you feel are the most urgent health-related concerns in Madison County?

(Please list up to 5)

1.

2.

3.

4.

5.

Please tell us about you:

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 or Higher**

Zip Code: _____

Please return to:

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

STAKEHOLDERS

Invitation letters were mailed to over 300 Community Stakeholders embodying such community partners as: human service agencies, churches, shelters, health organizations, schools and universities/colleges, fire departments, housing and community development, police and probation, county board, community leaders, community organization, and recreation centers to attend the first Community Stakeholders Meeting held on September 27, 2004 at the University of Illinois Extension Office on Hillsboro Avenue in Edwardsville, IL. Approximately 52 Community Stakeholders attended this meeting. The agenda included an overview of the project, an explanation of the survey, and recruitment of Community Stakeholders to distribute the survey. As a result, the Community Stakeholders distributed the surveys to staff, clients, neighbors, churches, community organizations and clubs, schools, colleagues, friends and family members. The effort of the Community Stakeholders in the process of collecting community data was invaluable to obtain the richness of data and breadth of community participation that was stimulated.

At the first Community Stakeholders Meeting, there was a call for volunteers to be trained to facilitate Nominal Groups as another form of collecting data. These volunteers were invited to training; however, only two community stakeholders along with two health department employees were trained by Dr. Custer. This training served as a Nominal Group as well. Two other Nominal Groups were conducted. One group was led by the Health Department Administrator for the Health Department Committee and Health Advisory Committee members. Another group was led by the IPLAN Coordinator for the Core Team. Collectively, the results were consistent with the responses from the Community Surveys.

On January 13, 2006, approximately 43 Community Stakeholders attended a second Community Stakeholders Meeting at the University of Illinois Extension Office on Hillsboro Avenue in Edwardsville, IL. At this meeting, Stakeholders received an overview of the assessment and priority selection process, an overview of Madison County Partnership for Community Health (MCPCH), information on the next step in the process which was development of the Community Health Plan, and self-selection into MCPCH committees to begin working on the Plan. Community Stakeholders met as committees to develop the Community Plan.

STATISTICAL DATA AND SOURCES

During the data analysis process, many sources were reviewed by Core Team members and agency staff. This section highlights some of the data that was reviewed in parallel to community responses. Elizabeth J. Darling, M.S., health educator at the Madison County Health Department, compiled a complete binder of pertinent data that was reviewed and was available for all participants or interested parties.

Demographic and Socioeconomic Characteristics

According to the 2000 U.S. Census, Madison County had 258,941 residents and a 2005 population estimate of 264,309. Madison County is located in the St. Louis Metropolitan area and is a culturally rich area with a strong diversity among community populations to include inner city, suburban, industrial, and rural communities spanning a vast geographic

region. Transportation, communication, and variability in the education and employment base of residents varies drastically and contributes to rising health concerns and access to address them. In addition, the loss of major business from industry has impacted the employment and insurance of families in Madison County.

In 2004, according to the Illinois Department of Public Health, Division of Vital Statistics, the number of all live births in Madison County was 3,394 and the number of all deaths was 2,678. The overall leading causes of death in 2004 in Illinois in order included: Diseases of heart; Malignant neoplasms; Cerebrovascular diseases; Chronic lower respiratory diseases; Accidents (motor vehicle and all other); Diabetes mellitus; Influenza and pneumonia; Alzheimer's disease; Nephritis, nephrotic syndrome and nephrosis; Septicemia; Chronic liver disease and cirrhosis; Intentional self-harm (suicide); Essential (primary) hypertension and hypertensive renal disease; Assault (homicide); Parkinson's disease; Pneumonitis due to solids and liquids; Certain conditions originating in the perinatal period; In situ neoplasms, benign neoplasms and neoplasms of uncertain or unknown behavior; Aortic aneurysm and dissection; and Atherosclerosis.

In 2000, the median household income was \$41,541 versus the state \$46,590. Although the Madison County poverty rate has declined since 2000, the poverty rate increased from 8.9% in 2003 to 14.6% in 2004. The actual number of people living in poverty also increased from 22,623 individuals in 2003 to 37,624 in 2004.

The Illinois Poverty Summit (2004) reports that children continue to be over-represented among those in poverty, making up 24.3% of the total Madison County population, but 42.2% of those in poverty in 2004. While 15.0% of 9,080 Madison County children lived in poverty in 2003, 25.2% or 15,859 children lived in poverty in 2004. As poverty increases, more and more Madison County households rely on food assistance to meet their basic nutritional needs. 9.5% of Madison County households received Food Stamp benefits in 2004, up from 6.9% in 2003. Within Madison County the household income has decreased sharply since 2003, from \$61,195 to \$46,345 in 2004.

The U.S. Census Bureau (2005) also reported that since 2000, median rent prices in Madison County have risen \$97.00 from \$523.00 in 2000 to \$620.00 in 2004.

The Illinois Department of Employment Security, Economic Information and Analysis Division reported in May of 2005 that Madison County's unemployment rate was 5.2%.

US Census 2000 Demographic Profile Highlights: for Madison County, IL

General Characteristics	Number	Percent	U.S.
Total population	258,941		
Male	124,758	48.2	49.1%
Female	134,183	51.8	50.9%
<u>Median age</u> (years)	36.9	(X)	35.3
Under 5 years	16,277	6.3	6.8%
18 years and over	194,504	75.1	74.3%
65 years and over	36,923	14.3	12.4%
One <u>race</u>	256,145	98.9	97.6%
White	233,645	90.2	75.1%
Black or African American	18,935	7.3	12.3%
American Indian and Alaska Native	700	0.3	0.9%
Asian	1,542	0.6	3.6%
Native Hawaiian and Other Pacific Islander	54	0.0	0.1%
Some other race	1,269	0.5	5.5%
Two or more races	2,796	1.1	2.4%
Hispanic or Latino (of any race)	3,925	1.5	12.5%
Household population	253,162	97.8	97.2%
Group quarters population	5,779	2.2	2.8%
Average <u>household</u> size	2.48	(X)	2.59
Average family size	3.00	(X)	3.14
Total housing units	108,942		
Occupied housing units	101,953	93.6	91.0%
Owner-occupied housing units	75,243	73.8	66.2%
Renter-occupied housing units	26,710	26.2	33.8%
Vacant housing units	6,989	6.4	9.0%

Madison County Health Needs Assessment & Community Health Plan Development Process

Social Characteristics	Number	Percent	U.S.
Population 25 years and over	170,432		
High school graduate or higher	143,600	84.3	80.4%
Bachelor's degree or higher	32,759	19.2	24.4%
<u>Civilian veterans</u> (civilian population 18 years and over)	30,142	15.5	12.7%
Disability status (population 5 years and over)	46,311	19.3	19.3%
Foreign born	3,286	1.3	11.1%
Male, Now married, except separated (population 15 years and over)	56,985	58.6	56.7%
Female, Now married, except separated (population 15 years and over)	57,247	52.7	52.1%
Speak a language other than English at home (population 5 years and over)	8,003	3.3	17.9%
Economic Characteristics	Number	Percent	U.S.
In labor force (population 16 years and over)	130,809	64.8	63.9%
Mean travel time to work in minutes (workers 16 years and over)	24.3	(X)	25.5
Median household <u>income</u> in 1999 (dollars)	41,541	(X)	41,994
Median family income in 1999 (dollars)	50,862	(X)	50,046
Per capita income in 1999 (dollars)	20,509	(X)	21,587
Families below poverty level	5,088	7.2	9.2%
Individuals below poverty level	24,774	9.8	12.4%
Housing Characteristics	Number	Percent	U.S.
Single-family owner-occupied homes	66,877		
Median value (dollars)	77,200	(X)	119,600
Median of selected monthly owner costs	(X)	(X)	

(X) Not applicable.

Source: U.S. Census Bureau, Summary File 1 (SF 1) and Summary File 3 (SF 3)

**US Census 2005 Demographic Profile Highlights for Madison County, IL
from American Community Survey Data Profile**

Note: The 2005 American Community Survey universe is limited to the household population and excludes the population living in institutions, college dormitories, and other group quarters.

General Characteristics	Estimate	Percent	U.S.	Margin of Error
Total population	258,567			*****
Male	125,923	48.7	49.0%	+/-685
Female	132,644	51.3	51.0%	+/-685
<u>Median age</u> (years)	36.9	(X)	36.4	+/-0.4
Under 5 years	16,651	6.4	7.0%	+/-136
18 years and over	196,259	75.9	74.6%	+/-240
65 years and over	34,420	13.3	12.1%	+/-429
One <u>race</u>	255,552	98.8	98.1%	+/-987
White	231,317	89.5	74.7%	+/-732
Black or African American	19,631	7.6	12.1%	+/-783
American Indian and Alaska Native	841	0.3	0.8%	+/-449
Asian	1,651	0.6	4.3%	+/-370
Native Hawaiian and Other Pacific Islander	0	0.0	0.1%	+/-266
Some other race	2,112	0.8	6.0%	+/-792
Two or more races	3,015	1.2	1.9%	+/-987
Hispanic or Latino (of any race)	5,089	2.0	14.5%	*****
Household population	258,567	100.0	100.0%	*****
Group quarters population	(X)	(X)	(X)	(X)
Average <u>household</u> size	2.43	(X)	2.60	+/-0.04
Average family size	2.93	(X)	3.18	+/-0.07
Total housing units	115,179			*****
Occupied housing units	106,550	92.5	89.2	+/-1,592
Owner-occupied housing units	79,870	75.0	66.9	+/-2,593
Renter-occupied housing units	26,680	25.0	33.1	+/-2,391

Madison County Health Needs Assessment & Community Health Plan Development Process

Vacant housing units	8,629	7.5	10.8	+/-1,592
Social Characteristics	Estimate	Percent	U.S.	Margin of Error
Population 25 years and over	171,921			+/-659
High school graduate or higher	(X)	87.7	84.2%	(X)
Bachelor's degree or higher	(X)	23.1	27.2%	(X)
<u>Civilian veterans</u> (civilian population 18 years and over)	27,888	14.3	10.9%	+/-1,823
Disability status (population 5 years and over)	34,145	14.2	14.9%	+/-2,348
Foreign born	4,575	1.8	12.4%	+/-1,180
Male, Now married, except separated (population 15 years and over)	56,373	56.8	55.9%	+/-2,135
Female, Now married, except separated (population 15 years and over)	54,146	50.0	51.0%	+/-2,116
Speak a language other than English at home (population 5 years and over)	N	100.0	19.4%	N
Economic Characteristics	Estimate	Percent	U.S.	Margin of Error
In labor force (population 16 years and over)	135,782	66.4	65.9%	+/-3,172
Mean travel time to work in minutes (workers 16 years and over)	24	(X)	25	+/-1.0
Median household <u>income</u> (in 2005 inflation-adjusted dollars)	47,350	(X)	46,242	+/-1,858
Median family income (in 2005 inflation-adjusted dollars)	57,022	(X)	55,832	+/-2,654
Per capita income (in 2005 inflation-adjusted dollars)	24,391	(X)	25,035	+/-924
Families below poverty level	(X)	7.2	10.2	(X)
Individuals below poverty level	(X)	10.5	13.3	(X)
Housing Characteristics	Estimate	Percent	U.S.	Margin of Error
Owner-occupied homes	79,870			+/-2,593
Median value (dollars)	108,900	(X)	167,500	+/-4,588
Median of selected monthly owner costs	(X)	(X)		(X)
With a <u>mortgage</u> (dollars)	1,075	(X)	1,295	+/-39
Not mortgaged (dollars)	356	(X)	369	+/-12

(X) Not applicable.

Source: U.S. Census Bureau, 2005 American Community Survey

Access to Care

In 1999, 8.7% of Madison County adults avoided going to a doctor because of cost and this number rose significantly in 2002 to 12.5% (IBRFSS). In 2002, only 73.8% of adults had a physical examination within the past year (this sentence is an Illinois stat not Madison County). In 1999, 90.4% of Madison County adults reported having a health care plan which dropped to 86.6% in 2002.

The IPLAN Data System Report (1998) showed that 8.4% of Madison County's population between the ages of 18 and 64 were uninsured. Although this is down from the years of 1996 and 1997, it may now be on the rise as represented from data trends from other sources. The State of Illinois offers the All-Kids insurance program for all families in Illinois. As of June 30, 2006, there were 41,277 Madison County children and adults enrolled in the All-Kids and Family Care program.

According to the St. Clair County Medical Society, which serves St. Clair and Madison counties, this area has lost over 165 physicians within the past two years due to the medical litigation crisis. These doctors have reportedly left the area, retired early, and/or quit practicing. The Illinois Civil Justice League found that 50% of all doctors that were sued in Illinois within the last four years were from Madison and St. Clair counties. According to the St. Clair County Medical Society by leaving a high litigation area, a physician can save 50-80% in annual malpractice insurance premiums. On January 8, 2005, the Daily Chronicle reported, "Forty-four percent of those living in southern Illinois have lost a doctor because he or she left a practice or moved a practice out of state to escape high malpractice premiums. That is nearly triple the statewide average and four times higher than in Chicago or the collar counties." On February 20, 2005, the Alton Telegraph reported that doctors who leave Madison County and go to Sangamon County cut their malpractice insurance rates by 50% and those who go to St. Louis, MO cut their rates by 75%. Multiple reports show that new doctors do not want to locate in Madison County.

The loss of physicians in Madison County has resulted in a loss of access to care. Many primary care physicians are not accepting new Medicare and Medicaid patients. The IPLAN Data System Report (2002) shows that the Medicaid enrollees to Medicaid physician vendors ratio is 121.2:1 in Madison County much higher than the state ratio of 82.3:1. When a primary care physician leaves the area the underserved clientele are unable to find another primary care physician. Specialized care patients are being sent out of state due to lack of specialty care physicians. New appointments are booked a year in advance for gynecological visits due to half of the OB/GYN doctors leaving the area (Alton Telegraph, 9/26/2004). Several studies report that economic viability requires local healthcare.

Madison County has one federally qualified healthcare center (FQHC) the Southern Illinois Healthcare Foundation, Inc. (SIHF). The sites located in Madison County are 550 Landmarks Blvd. in Alton, 2 Terminal Dr. Suite #8 in East Alton, and 2100 Madison Ave. in Granite City. SIHF offers services in pediatrics, OB/GYN, Internal Medicine, Family Medicine, Healthy Start, dental, and HIV services.

Madison County has five area hospitals. The services offered vary for each hospital. The names and locations are as follows:

- 1. Alton Memorial Hospital - 1 Memorial Dr. Alton, IL 62002**
- 2. Anderson Hospital - 6800 State Route 162 Maryville, IL 62062**
- 3. Gateway Regional Medical Center - 2100 Madison Ave. Granite City, IL 62040**
- 4. St. Anthony's Health Center - 1 St. Anthony's Way Alton, IL 62002**
- 5. St. Joseph's Hospital - 1515 Main St. Highland, IL 62249**

According to Illinois Department of Transportation, Madison County has 2,657.66 miles of road. The Illinois Secretary of State reports that of the 261,689 county citizens, 199,331 are licensed drivers. Madison County has public transportation through the Madison County Transit System.

IPLAN Access to Care Priority Data and Resources to Consider

Insurance Coverage Issues

The American Medical Association is building public and political support for initiatives that expand health insurance coverage through tax credits and insurance market reforms and that move toward a system of individually owned health insurance.

American College of Obstetricians and Gynecologists (ACOG) Resources on the Uninsured

The Commonwealth Fund

<http://www.cmwf.org>

Families USA

[http:// www.familiesusa.org](http://www.familiesusa.org)

Georgetown University Institute for Health Care Research & Policy

<http:// www.healthinsuranceinfo.net>

Kaiser Family Foundation

The Kaiser Commission on Medicaid and the Uninsured

<http://www.kff.org/about/kcmu.cfm>

National Academy of State Health Policy

<http://www.nashp.org>

The Robert Wood Johnson Foundation

<http://www.rwjf.org>

<http://www.covertheuninsured.com>

The Urban Institute

<http://www.urban.org>

Malpractice Crisis/Medical Liability Reform

American Medical Association (AMA)

As the AMA's top legislative priority, the AMA has been actively involved at the federal and state level to secure commonsense medical liability reform.

American College of Obstetricians and Gynecologists (ACOG)

***Washington, DC* -- ACOG strongly supports the "Fair and Reliable Medical Justice Act," S. 1337, introduced by Senators Michael Enzi (R-WY) and Max Baucus (D-MT). This legislation authorizes the US Secretary of Health and Human Services to award demonstration grants to states for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations.**

American Academy of Family Physicians

The American Academy of Family Physicians supports the following federal liability reforms:

- 1. \$250,000 limit on payments on "noneconomic damages,"**
- 2. Reducing awards by the amount of compensation from collateral sources,**
- 3. Allowing periodic payment of future damages at a defined award limit,**
- 4. Limiting attorneys' contingency fees,**
- 5. Replacing joint and several liability with proportionate liability among the defendants in a case,**
- 6. Reduce statute of limitations for commencing professional liability actions to one to three years after injury, with an absolute limit of six years for minors.**
- 7. Incentives for states to establish Alternative Dispute Resolution Systems, and**
- 8. An expert affidavit that must be provided by a specialist who possesses knowledge and expertise and practices in the same medical specialty as the defendant.**

American College of Physicians-What We Are Asking Lawmakers to Do:

- Co-sponsor legislation, "HEALTH ACT of 2002," H.R. 4200, to safeguard patient access to care through common sense reform.**
- Urge colleagues on the House Judiciary Committee and the House Energy & Commerce Committee to report this legislation as soon as possible.**
- Encourage the Senate to introduce and pass similar legislation.**

Addictions

In 2002, Illinois Behavioral Risk Factor Surveillance System reported that 21.6% of Madison County residents are at risk for acute/binge drinking while 7.8% of residents are at risk for chronic drinking. IBRFSS (2002) also reported that 28.6% of Madison County residents are current smokers compared with Illinois at 22.8% and an additional 2.6% of the county's population uses smokeless tobacco while Illinois is 2.1%. Of all Madison County residents 23.6% report being former smokers and 47.8% are non-smokers compared with the Illinois residents, which 22.9% are former smokers and 54.3% are non-smokers.

Data from the 2004 Illinois Youth Survey was analyzed for 8th, 10th, and 12th graders in the categories of 30-day use, perceived risk of harm, perceived adult disapproval, perceived peer disapproval, and mean age of initiation of use. (Data Tables, Appendix A)

Another alarming statistic comes from the IPLAN Data System Report that in the year 2002, 19.0% of mothers smoked during pregnancy which far exceeds Illinois' 10.0%.

The Illinois State Police (ISP) reports that methamphetamine grams seized in Madison County has increased from 161 grams in 1994 to 3,263 grams in the year 2004. The ISP also reports drug paraphernalia arrests in Madison County are up from 20 arrests in 1994 to 568 arrests in 2003. All drug violations in Madison County were up from 396 per 100,000 people in 1994 to 773 per 100,000 people in 2003.

The Illinois Criminal Justice Information Authority reports that controlled substances arrests were up from 324 in 1993 to 643 in 2003. Drug crimes were also on the rise from 638 in 1993 to 2,032 in 2003. Arrests for cannabis crimes were up from 295 in 1993 to 804 in 2003 while arrests for the Cannabis Control Act were up from 480 in 1993 to 801 in 2003.

Sexual Risk Behaviors

According to the Illinois Behavioral Risk Factor Surveillance System, in 2002, 4.3% of Madison County residents reported engaging in risky sexual activity.

Although the teen birth rate hit a record low in 2003 for the state of Illinois, Madison County's teen birth rate continues to be significantly higher than that of the state rate. During 2001, the teen birth rate for Madison County was 12.0% while the state average was 10.9%. In 2003, Madison County had a teen birth rate of 11.1% while the state average dropped to 9.7% (Statistics from Illinois Department of Public Health).

The following *Communicable Disease* information was collected by the Madison County Health Department during 2004...

Incidence Rate/100,000 population

Acquired Immunodeficiency Syndrome	2.317130157
Chlamydia	259.904766
Gonorrhea	102.7261036
Hepatitis B Acute	0.772376719
Hepatitis B Carriers	6.565202112
Hepatitis C	13.13040422
Human Immunodeficiency Virus (HIV)	5.792825393
Syphilis	3.475695236

According to an Illinois Department of Human Services press release from March 8, 2005, Governor Blagojevich announced that teen birth rates hit record lows in 2003 and the rates for the state of Illinois were down for the ninth consecutive year. Although this is good news for the state, Madison County teen birth rates continue to be much higher than the state rates for all of the last nine years. The state data from IDPH's health statistics compared to the county data is as follows:

	Illinois Teen Birth Rate	Madison County Teen Birth Rate
Year		
1994	13.0%	14.0%
1995	12.9%	16.2%
1996	12.7%	14.1%
1997	12.5%	13.6%
1998	12.4%	13.8%
1999	12.0%	13.4%
2000	11.4%	12.9%
2001	10.9%	12.0%
2002	10.3%	11.4%
2003	9.7%	11.1%
2004	9.9%	11.6%

Cardiovascular Health

According to the Illinois Behavioral Risk Factor Surveillance System, only 20.8% of Madison County residents ate five or more fruits and vegetables per day. With regards to body weight, 44.3% of Madison County residents are underweight or of normal weight while 31.4% are classified as overweight and 24.3% of the county's population is obese. Additionally, only 29% of Madison County residents meet the standard for moderate activity five times a week for at least 30 minutes and only 22.3% of the population meet the standard for vigorous activity of three times per week for at least 20 minutes. Overall, only 40.2% of Madison County residents get the recommended activity while 40.9% of the population gets insufficient activity and 18.9% report being inactive.

The Illinois Behavioral Risk Factor Surveillance System (2002) also showed that 29% of Madison County residents while the Illinois average is 24.5% have been told that their blood pressure is high and 74.2% of these residents (told have high blood pressure) are taking medication for high blood pressure compared with 71.3% of Illinois residents. Of the Madison County residents who had their cholesterol checked, 33.7% of this population was told that their cholesterol was high compared with 29.2% of Illinois residents who had their cholesterol checked and were told that their cholesterol was high.

The Illinois Community Health Information System (CHIS) data from the Illinois Department of Public Health reports that Diabetes is the 11th cause for hospitalization in Madison County.

IPLAN Data System Report also compares the coronary heart disease mortality rate for Madison County, which has a crude rate of 234.1/100,000 population and the crude rate for the state of Illinois which was 186.1/100,000 population in 2001. The premature rates during the same year for coronary heart disease mortality were Madison County 58.6/100,000 population and Illinois 37.4/100,000 population.

Cancer

The Illinois CHIS data from the Illinois Department of Public Health reports that cancer is the 7th leading cause of hospitalizations in Madison County and is equal to 2.8% of all hospitalizations.

IPLAN Data System Report shows that for the five years of 1996 through 2000, 48.4% of cervical cancer patients were diagnosed at late stage. The state rate of people diagnosed at late stage cervical cancer is 43.3%.

IBRFSS (2002) reports that only 41.5% of adults age 50 and older have had a sigmoidoscopy exam compared to the state average of 45.1% for Illinois adults age 50 and older. It is reported through IBRFSS that 31.3% of Madison County adults aged 50 and older have had a blood stool test compared to the state of Illinois rate of 40.1%. The colorectal cancer age-adjusted incidence rate for the five years of 1996-2000 was 58.1 for Madison County compared to the state rate of 51.6.

IPLAN also reports that the lung cancer incidence rate for Madison County is significantly higher at 65.2 per 100,000 population compared with the Illinois state rate of 54.6 per 100,000 population. Additionally, the lung cancer mortality rate in 2001, for Madison County was 67.6 per 100,000 population compared to the state rate of 54.2 per 100,000 population. The premature (<65) mortality rate for Madison County was 25.1 per 100,000 population and the state rate was 17.3 per 100,000 population.

Mental Health

The Illinois Behavioral Risk Factor Surveillance System (2002) stated that 62.8% of Madison County residents had no days within the last 30 days of “mental health not good”; 20.2% of the population reported one to seven days of “mental health not good”; while an additional 17% of the population reported 8-30 days of “mental health not good”. The report also noted that 57.2% of Madison County residents did not have any days in the past month when they felt depressed, sad or blue; yet, 16.5% of the population reported having one to two days of the past month feeling depressed, sad, or blue. An additional 26.3% of Madison County residents reported more than two days of the past month feeling depressed, sad, or blue.

The IPLAN Data System Report (2001) shows a crude suicide rate for Madison County as 13.5 per 100,000 people compared to the Illinois rate of 9.1 per 100,000 population.

According to the Illinois CHIS data, mental disorders are the fourth leading cause of hospitalizations (9.9%) in Madison County.

Older Adult Services

According to the U.S. Census Bureau (2000), 14.3% of Madison County’s population is 65 years of age and older.

The Illinois Behavioral Risk Factor Surveillance System (2002) reported that 23.6% of Madison County residents need help with personal or routine care, 14.1% of the population report having limited activities, and 5.1% of the population use special equipment. Additionally, 78.4% of Madison County residents report they have no days during the last 30 days when pain restricts their activities. Another 12% of residents report that they had one to seven days during the last 30 when pain has restricted their activities and 9.6% report that 8-30 of the previous 30 days pain has restricted their activities.

The Illinois Behavioral Risk Factor Surveillance System (2002) also showed that 30.6% of Madison County residents have been diagnosed by a doctor with arthritis compared to Illinois at 22.0% while 29.8% of Madison County’s residents report chronic joint symptoms and 43.5% of residents have been diagnosed with chronic joint symptoms and/or arthritis.

Asthma

The Illinois Behavioral Risk Factor Surveillance System (2002) reported that 14.0% of Madison County residents have been told by a doctor that they have asthma which is much higher than the state average of 10.7%.

Maternal and Child Health

The Illinois Kids Count published in 2005 states that during the year 2003, 2,205 children were tested for lead poisoning and of these children tested, 3.4% had high lead levels. With regard to licensed child care, there were 257 centers and homes in 1999 and the number fell to 234 in 2004. In 1999, 81.7% of licensed child cares accepted subsidies while that number rose to 90.6% in 2004. Of the licensed child care centers, 3.1% were accredited in 1999 while in the year 2004, 4.7% were accredited.

As stated in the *Addictions* section of this report, in 2002 the IPLAN Data System Report shows that while the Illinois rate for mothers who smoke during pregnancy is 10.0%, the rate for Madison County mothers who smoke during pregnancy is an alarming 19.0%.

As stated in the *Sexual Risk Behaviors* Section of this report, the teen birth rate in Madison County continues to surpass that of the Illinois rate every year. In 2004, the Madison County teen birth rate was 11.6% compared to the Illinois state rate of 9.9%.

Madison County has had a birth rate that has remained stable for the past 10 years with a ten-year average of 3353.3 births per year. The infant mortality rate for Madison County for the years 1999, 2000, 2001 (6.7 per 1,000 live births, 8.0 per 1,000 live births, and 6.4 per 1,000 live births) was significantly lower than the state average (8.3 per 1,000 live births, 8.3 per 1,000 live births, and 7.5 per 1,000 live births) for the same years. During the years 2002, 2003, and 2004, the infant mortality rate for Madison County (8.6 per 1,000 live births, 6.4 per 1,000 live births, and 9.7 per 1,000 live births) has significantly increased and surpassed the state averages for the same years (7.2 per 1,000 live births, 7.6 per 1,000 live births, and 7.3 per 1,000 live births).

Madison County has a Genetics program for this region of the state consisting of four components coordinated by the Madison County Health Department. A genetics clinic is held every other month with approximately 7-8 clients. SSM Cardinal Glennon Children's Hospital in St. Louis, MO partners with the health department to provide the genetics clinic. The health department partners with the Illinois Department of Public Health to follow up on abnormal blood test screenings on newborns and abnormal newborn hearing screenings for those parents that are difficult to locate. Sudden Infant Death Syndrome (SIDS) program conducts follow up with clients who have lost an infant to SIDS. The health department hosts a monthly SIDS support group for anyone affected by the unexpected loss of an infant.

As stated in the *Access to Care* section of this report, the State of Illinois offers the All-Kids insurance program for all families in Illinois. As of June 30, 2006, there were 41,277 Madison County children and adults enrolled in the All-Kids and Family Care program.

The Women, Infants, & Children (WIC) program and Family Case Management (FCM) program in Madison County are administered by Coordinated Youth and Human Services at offices located in Alton and Granite City. On a monthly basis, WIC services approximately 5,664 women and children (up to 5 years old). FCM averages 2,342 women and infants (up to 2 years old) monthly of which most of these clients are also served by WIC. In 2005, these programs included breast-feeding counselors with approximately 52% of women in the program breastfeeding from birth. This initiative provides additional support to help

mothers continue to decrease other health issues with their infants. WIC and FCM collect the number of prenatal visits for each client at each visit. WIC and FCM also track immunization rates for infants under the age of 2. Parents are asked to provide a shot record for every child under 3 years old. Children not up to date are referred to clinics to receive the immunizations. However, this data is self-reported by the clients and may not always reflect the true medical situation.

Environmental Issues

The American Lung Association reports in the “State of the Air: 2004” report that Madison County received a grade of F for the following categories: particle pollution (24 hour), particle pollution (annual), and high ozone days.

Madison County Health Department has a Lead Poisoning Prevention Program that is funded by the Illinois Department of Public Health (IDPH). The grant goal has two components. The first component is screening all children age 6 and under for lead poisoning risk with an IDPH assessment tool and collecting a blood lead sample if the child is determined to be at risk for lead poisoning. The second component is surveillance for and case management of all children age 6 and under with a blood lead level > 10ug/dL. All blood lead level laboratory reports for Madison County are reported to the Madison County Health Department. Case managing children with blood lead levels > 10ug/dL consists of educating the parents about lead hazards in the home and making recommendations for dietary changes and cleaning procedures that can reduce the potential for lead poisoning. The case manager works in conjunction with the environmental inspectors at IDPH to investigate the source of lead in the home. The nurse case manager will refer the case, if needed, to Madison County Community Development for assistance in removing the source of lead from the home.

Madison County has a lead abatement program administered by Madison County Community Development Community Development contracts with certified lead licensed risk assessment firms to assess the risk of lead based paint hazards in low-income housing units (built before 1978) and contracts with licensed, certified lead removal contractors to remediate any high risk lead based paint hazards to make the homes lead safe. Madison County Community Development also is under contract with members of the NL Industries/Taracorp Superfund Site Group to do lead based paint remediation in portions of Granite City, Madison, and Venice. This project was undertaken in connection with the settlement of an enforcement action taken by U.S. EPA.

Restaurants

As of December 2004, there were 1218 food establishments in Madison County. The Madison County Health Department reported to Illinois Department of Public Health that for the year of 2004 there were 313 re-inspections. The Madison County Health Department evaluated/investigated 14 foodborne illness complaints and 127 non foodborne illness complaints during the year of 2004.

WEBSITES FOR NON-COMMUNITY STATISTICAL DATA COLLECTED

Madison County QuickFacts (US Census Bureau) <http://quickfacts.census.gov/qfd/states/17/17119.html>

This site includes things such as population trends, age of residents, racial makeup of residents, graduate rates, housing within the county, average income of residents, and employment rates of residents.

Hospital Discharge Data

EMS Data Reporting System <http://app.idph.state.il.us/emsrpt/ind-hosp.asp>

This site includes the ability to search why people were hospitalized, length of stay in a hospital based on diagnosis, and much more. You can search by county, age of persons hospitalized, diagnosis, cost of stay, etc. This site also allows an individual to search mortality causes, traffic crash data, and the trauma registry.

Health Statistics

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

This site allows you to look at survey results for various health measures such as tobacco use, nutrition, diabetes, etc. and compare results from 1998 to 2002. This site is nice to begin to determine four year trends within the county. Sort by topic and/or county to determine prevalence data.

IPLAN Data System Report <http://app.idph.state.il.us/data/countyLevel.asp?menu=1>

This site has more detailed health indicators to select a search from but the information is often more dated than the data on IBRFSS. This site is also county specific.

Maternal and Child Health (KidCare) http://www.kidcareillinois.com/standards_kc.html

This site contains information and applications for insurance for children whose family income meets guidelines.

Voices for Illinois Children www.voices4kids.org/madison.pdf www.voices4kids.org/illinoiskidscount.htm

These sites contain demographic information on county children and economic, education, and health indicators that affect these children.

Illinois Criminal Justice Information Authority www.icjia.state.il.us

This site provides maps, data tables, and information on things such as DUI arrests, drug use trends, arrest rates, crime data, etc.

American Lung Association http://lungaction.org/reports/sota04_county.html?fcc=17119

This site provides ozone, particle pollution, and grade reports for Madison County's air quality.

Illinois Teen Births by County, 2002-2003 <http://www.idph.state.il.us/health/teen/teen0203.htm>

Fatality Analysis Reporting System (FARS)

<http://www.fars.nhtsa.dot.gov/queryReport.cfm?RequestTimeout=5000>

This site contains restraint usage among fatal crashes.

IPLAN Data Madison County needs to explore

(as of August 29, 2005)

2000 State and County Data unless otherwise specified

	Madison	Illinois	US	2010
Population	258,941	12,419,293		
Crude Death Rate/ 100,000	1035	855.8		
Black	782	837		
White	1967	892		
Population over 65 years	14.3%	12.1%		
Median Age (1990 data-latest for County)	33.9	32.8	32.9	
Medicaid/100.000 pop 65% of Black Medicaid Recipients are under age 21 years	14.0%	12.2%		
Colorectal Cancer Local Dx 5 year average 1996-2000 (high is good)	30.5%	35.1	42.2%	
Colorectal Mortality No significant difference by race	30.5	22.5	13.9	
Colorectal Incidence (age adjusted) 5 year average 1996-2000				
Total F	58.1	51.6	47.4	
Total M	75.6	72.1	65.4	
Black F	62.3	59.2	55.3	
Black M	59.5	75.9	71.5	
White F	57.6	50.3	47.0	
White M	76.2	71.3	65.3	
Lung Ca. Crude Mortality Total	75.7	54.9	54.9	44.9
Black	N=5	53.3	15.6	
Premature	22.5	18.0		
Lung Cancer Incidence (age adjusted 5 Year Average 1996-2000)				
Total	67.6	54.2		
Total F	65.2	54.6		
Total M	119.1	99.3	85.0	
Black F	64.2	60.2	55.4	
Black M	1317.7	133.4	123.6	
White F	65.1	4.4	53.6	
White M	118.3	95.7	83.5	
Prostate Cancer Incidence (age adjusted 5 year average)				
Black	245.0	227	276	
White	140.6	145.4	167.5	
Prostate Dx local stage T.	81.4	81.4		
Black	86.3	76.6		
White	80.8	81.9		
Mortality for both black and white is low compared to State				
Cervical Cancer late Dx T	48.4%	34.3%	41.5%	
Black	42.9	50.3	47.2	
White	42.9	41.5	40.2	
Coronary Crude Mortality T	253.7	194.6		166
Black	127.8	175.3		
White	267.1	206		
Premature	45	37.5		

	Madison	Illinois	US	2010
Cerebrovascular Mortality T	66	59.7		48
Black	56.2	49.2		
White	67.6	64		
Medicaid enrollees per 1 physician	120.4	73.1		
Low Birth Weight Total	7.6%	8.0%		
White	6.4%	6.5%		5%
Black	16.6%	14.1%		
Teen Birth (< 18 yr.) Overall	4.5%	4.18%		
Black	11.1%	9.7		
Smoking while pregnant	21%	10.9%		1%
Congenital Anomalies/100,000	414	310		
Alcohol Dependence Hospitalization /100,000 pop				
15-44 years	70.5	57.7		
45-64 years	65.1	73		
Hospitalization for Psychosis				
Age 15-44	1081.9	916.3		
Age 45-64	666.5	800.1		
Auto Crash Mortality	20	12.5		
Premature	19.7	11.7		
Hospitalizations Non-fatal hip	879.9	734.8		
Hip Female	1075	924.2		
Hip Male	469.7	423.7		
Hospitalization uncontrolled BP	42.86	102.7		
Per 100,000 population	N=111 N=12,750			
Gonorrhea/100,000 pop Total	100	199		
Black	925.2	917		
White	27	23.8		
Child Neglect & Abuse 2002 (per 1000 children)				
Reported	2,954			
Rate	36.9/1000	26.7/1000		
Indicated	1,030			
Unique	931			
Rate	13.9/1000	7.9/1000		

Behavioral Risk Factor Surveillance System for Adults
Risk Areas to Monitor
Madison Data 2002 - Illinois Data 2000
(many items are not included because questions are posed differently)

	Madison Unweighted Count	Illinois Unweighted Count
Respondents over age 65	19%	16.4%
Acute Binge Drinking	21.6%	15.7%
Chronic Drinking	7.8%	6%
Drinking & Driving	8.3%	1.8%
Told by Dr. have Asthma	14%	10.7%
Told they have high BP	29%	24.3%
Taking medication for high BP	74%	not given
Told they have > cholesterol	33.7	24.3
Have a health plan	86.6%	89.8%
Avoided Dr. due to cost	12.5%	7.2%
Believe they don't have a County H.D.	2.6%	
Had service at MCHD	17.5%	
Believe their health to be excellent/good	49.7%	55.5%
Days/year mental health not good (8-30)	17%	12.15%
Days/year mental health not good (8-30)	17.3	12.5
Days/year kept from usual activities (8-30)	13.3	12.5
Smoker	28.6%	21.1%
Former Smoker	23.6%	22.6
Smoked during pregnancy	20.1%	10.5
Overweight (lower is better)	31.4%	38.1%
Obese	24.3%	20.7
Now trying to lose weight	37%	39.1%
Women >40 had mammogram	90%	88.9%
Had Pap Smear	97.5%	93.1%

PRIORITY SETTING

Once qualitative and quantitative data were collected, the Core Team began the process of analyzing results, collapsing similar categories, and utilizing priority setting tools to determine the Health Priorities for the next five years. Throughout this process, the Core Team had extensive discussions about the results and feasible directions for Madison County. The methods used to set the Health Priorities are standard Public Health methods for priority setting and included the Hanlon Method and the PEARL Test (APEX, August 1996). The Hanlon Method addresses a rating of the size (actual statistical size) of the problem (Column A in Table A), rating of the seriousness of the health problems (Column B in Table A), rating the health problems for the effectiveness of available interventions (Column C in Table A), and then the score for the Hanlon Method which is calculated using the formula $(A+2B)C=\text{score}$ to determine rank (Column D in Table A), and rank of the identified health problems (Column E in Table A).

Then the Core Team applied the PEARL Test which requires a Yes or No response to each of the following five areas in the Data Ranks Table (Table A) labeled as follows: P-Propriety, E-Economics, A-Acceptability, R-Resources, and L-Legality. For any health problem that received a No in any column there were two options which included either dropping the health problem from further consideration or to assess the possibility of correcting the reason for the No. The only health problem receiving any No judgments for the PEARL Test was Environmental Issues for the factors of Propriety and Resources. It was determined by the Core Group that the issues raised in relation to Environmental Issues were on a regional or federal level and could not be sufficiently addressed at the county level at this time nor were resources accessible on any scale to make an impact on the environmental concerns raised in the collective data. The final column in Data Ranks Table (Table A) contains the number of community responses as related to the Community Response Surveys. This number was not included in the calculation; however, it was the initial determining factor for the top health problems to review in the statistical data and part of the discussions to determine seriousness and interventions. Community perception is a substantial factor in developing interventions, identifying root causes, and gaining community support and engagement for behavior change to occur.

The Illinois Department of Public Health requires at least three health priorities to be established within each designated health jurisdiction for the next five years. The process of Health Priority Setting for Madison County was a role of the Core Team and it included: review of the community response data, review of the statistical data, review of other supporting data such as the 2005 Madison County Youth Forum recommendations (Appendix B) and MCPCH Respiratory Committee Smoking in Restaurants Community Survey Results (Appendix C), discussions of existing resources and interventions and their effectiveness, discussion of identified gaps in service to meet or enhance health issues, discussions of the resources and/or lack of resources to meet or enhance health issues, completion of Data Ranks Worksheets by Core Team members, discussions on the Hanlon and PEARL Test components, a discussion regarding the issue of Access to Care, and final determination of the 2007-2012 Madison County Community Health Priorities.

Initially, there were 103 categories from the Community Response Surveys. These categories were collapsed by the Core Team into fifteen categories with each category receiving at least a total of ten community responses. The Core Team determined that all

fifteen health problems listed in the Data Ranks Table (Table A) should be concentration areas for Madison County over the next five years and should receive some level of attention. The committee felt that this final list was a reflection of the community perceptions frequently supported by statistical data and upheld through two standardized processes. At any point in program and service planning, consideration should be given to incorporating as many of the health problem areas as possible. However, fifteen is too many in which to concentrate on a broader, more collaborative scale. The Core Team engaged in further discussion to try to accommodate addressing as many of the fifteen as possible by the cross-over effect that many of the identified health problems have within the health field and Madison County. Therefore, the Core Team combined Addictions with Smoking/Tobacco to form the *ADDICTIVE BEHAVIORS* priority, STD-related issues with Maternal and Infant Care to form the *SEXUAL RISK BEHAVIORS* priority, and Obesity-related issues with Cardiovascular Disease to form the *CARDIOVASCULAR HEALTH* priority. All three areas reflect both prevention and treatment approaches that are vital for addressing these health concerns. These three priority areas can address a more collaborative approach in Madison County especially through comprehensive program development and seeking additional large-scale grant funding.

COMMENTS ON ACCESS TO CARE

Clearly, Access to Care was the top health concern from the Community Response Surveys with 1,436 responses, but it needed to be examined. Community perceptions of health problems are driven by multiple factors which often include: personal or family experiences, occupations, geographical residence, media influence, community norms, social campaigns, and many other factors. At the time of survey dissemination in the community, a substantial campaign was in progress in Madison and St. Clair Counties to address the issue of physicians leaving the counties in part due to criminating increases in medical malpractice insurance. The Core Team acknowledged that while Access to Care is a significant health concern for Madison County; however, they concluded that there are many more facets in the Access to Care issue in addition to physician flight that impact county residents. After extensive discussion and review of the Access to Care data listed below, the Core Team noted that a) there are multiple layers that contribute to some of the underlying Access to Care issues that are beyond the scope or ability to be addressed at the county level b) there are multiple individual factors that affect Access to Care c) there exists multiple opportunities that may not have been specifically noted by community members but are known to exist that could be applied in Madison County to address some Access to Care issues (e.g. increase countywide enrollment in the KidCare program) d) there are a number of existing opportunities within each of the three designated priorities areas to address Access to Care concerns. Therefore, the Core Team has requested that at least one objective and/or intervention strategy under each of the three health priority areas address an Access to Care issue for that health concern.

Table A.

DATA RANKS PRIORITY SETTING TABLE

as of September 30, 2005

Madison County

N=1473 surveys (with up to 5 responses per survey)

Health Problems	A-Size	B-Seri.	C-Interv.	D-Score (A+2B)C	E-Rank	P	E	A	R	L	# of responses
Access to Care	10	8	8	208	1	Y	Y	Y	Y	Y	1436
Addictions	9	10	7	203	2	Y	Y	Y	Y	Y	439
STD-related issues	5	8	9	189	3	Y	Y	Y	Y	Y	276
Obesity-related issues	10	8	7	182	4	Y	Y	Y	Y	Y	505
Cardiovascular Disease	10	10	6	180	5	Y	Y	Y	Y	Y	241
Smoking/Tobacco	8	10	6	168	6	Y	Y	Y	Y	Y	263
Cancer	9	9	6	162	7	Y	Y	Y	Y	Y	341
Mental Health	7	6	7	133	8	Y	Y	Y	Y	Y	173
Maternal and Infant Care	6	5	8	128	9	Y	Y	Y	Y	Y	247
Older Adult Services	9	9	4	108	10	Y	Y	Y	Y	Y	70
Asthma	9	8	4	100	11	Y	Y	Y	Y	Y	101
Communicable Diseases	5	3	9	99	12	Y	Y	Y	Y	Y	259
Child Health	5	2	6	54	13	Y	Y	Y	Y	Y	145
Environmental Issues	10	3	3	48	14	N	Y	Y	N	Y	306
Restaurants	1	2	8	40	15	Y	Y	Y	Y	Y	89

2007-2012 Madison County Community Health Priorities

1: Addictive Behaviors

Focus – alcohol, tobacco, and methamphetamine

2: Sexual Risk Behaviors

Focus- STD's, HIV, education, testing, teen pregnancy and sexuality, maternal and infant care

3: Cardiovascular Health

Focus – obesity, exercise, nutrition, eating issues, heart-related issues

At least ONE intervention will need to address Access to Care for each Health Priority

COLLAPSED SUBCATEGORIES OF COMMUNITY RESPONSES

with at least 10 community responses after collapsing

- 1) **Access to Care [Access to Care, Access to Care/Insurance Issues, Lack of Physicians/Malpractice, Affordable Health Care/Insurance, Dental Care, Affordable Prescriptions, Transportation]**
- 2) **Addictive Behaviors [Tobacco (Smoking/Tobacco, Teen Smoking, Second Hand Smoke), Drug Abuse, Alcohol/Drugs, Alcohol Abuse, Alcohol Use (underage), Gambling, Drug Dealers, Needle Exchange]**
- 3) **Sexual Risk Behaviors [STD's, AIDS, Maternal and Infant Care (Teen Births/Pregnancy Education, Maternal Care/Infant Mortality, Birth Control/Premarital Sex, Parenting Skills, Women's Health, Abortion)]**
- 4) **Cardiovascular Health [Obesity/Nutrition, Cardiovascular Issues (Cardio including Cholesterol, BP, and stroke) Diabetes, Exercise, Nutrition/Diet/Exercise, Fitness/Wellness, Eating Disorders]**
- 5) **Cancer Prevention and Detection [Cancer, Breast, Prostate, Lung, Colon, Skin, Ovarian]**
- 6) **Mental Health [Mental Health including ADHD and suicide, Depression, Anxiety, Stress, Counseling, Bedwetting]**
- 7) **Older Adult Services [Elder Care, Alzheimer's Disease, Hospital and Nursing Home Quality/Access, Arthritis]**
- 8) **Asthma/Allergies**
- 9) **Communicable Disease Prevention and Management [Vaccines/Immunizations, Flu/Respiratory, Flu/Immunizations, Communicable Diseases, Hepatitis, TB, SARS, Coughs and Colds, Handwashing]**
- 10) **Child Health Issues [Child Health Issues, Lead, Autism, Head Lice, Daycare/Childcare Issues, Well Child Care, Tay Sachs, Deafness]**
- 11) **Environmental Issues [Air Quality, Environment/Water, Pollution, West Nile Virus, Vector Issues, Chemicals on grass/food, Asbestos, Bird Flu]**
- 12) **Restaurant Cleanliness (food safety)**
- 13) **Issues of Violence [Domestic Violence/Abuse/Gangs/Rape, Child Abuse, Bullying/Peer Pressure, Violence, Guns]**
- 14) **Vehicle Safety (includes vehicles, bikes, etc)**
- 15) **Housing and Employment [Community Infrastructure, Shelter/Affordable Housing, Unemployment/Cost of Living, Homeless, Housing Issues]**
- 16) **Pets/Strays/Animals**
- 17) **Adequate Training of Health Care Personnel**

DISCUSSION OF HEALTH PRIORITIES WITH COMMITTEES

The Public Health Administrator presented the 2007-2012 Health Priorities to the Madison County Board of Health Advisory Committee on January 5, 2006. The Health Advisory Committee unanimously supported the three new priority areas and recommended passage to the Madison County Board of Health.

The MCPCH Chairs Committee was presented with the new health priorities at their meeting in December 2005. They discussed the standing MCPCH committees and the creation of new committees for the new priority areas. MCPCH decided to support five committees at this time based upon past priority areas, new priority areas, interest in the health concern, and attendance that include: Addictive Behaviors Committee, Sexual Risk Behaviors Committee, Cardiovascular Health Committee, Cancer Committee, and Motor Vehicle Committee. The Respiratory Committee had three focus areas which were tobacco, asthma, and influenza. The MCPCH Chairs determined that tobacco would be addressed under the Addictive Behaviors Committee, asthma is already being addressed by the Asthma Coalition for the Greater St. Louis Metro-East, and influenza was being addressed sufficiently by the health department, hospitals, physician offices, and nursing care facilities. Therefore, members of the Respiratory Committee would be invited to join one of the other MCPCH committees or the Asthma Coalition for the Greater St. Louis Metro-East to continue to meet these needs for Madison County. After two attempts during the past five years to resurrect the Falls Committee, the MCPCH Chairs Committee agreed to disband the Falls Committee due to lack of interest and decreased participation.

The Public Health Administrator presented the proposed health priorities to the Madison County Board of Health – Health Department Committee at the December 14, 2005 meeting. A discussion of the process to reach health priorities goals resulted. At their January 11, 2006 meeting, the Madison County Board of Health – Health Department Committee unanimously approved a resolution adopting the three stated health priorities as the 2007-2012 Madison County Health Priorities (Appendix D). On June 21, 2006, the Madison County Board of Health approved a resolution to approve and adopt the 2007-2012 Madison County Health Needs Assessment and Community Health Plan (Appendix E).

COMMENTS ON THE DEVELOPMENT OF OBJECTIVES AND STRATEGIES

The next phase of the process entailed the development of a Community Health Plan to address the health priorities. From the Community Stakeholders Meetings and continuing community contacts, additional participants were recruited to participate in MCPCH Committees to develop and implement the Community Health Plan over the next five years. All five committees provided objectives and strategies to address the identified health concerns over the next five years. This document was produced and available for any interested party in Madison County to use to facilitate improving the quality of life for this county.

IV. PRIORITY ONE – ADDICTIVE BEHAVIORS

REDUCE THE RATE 30-DAY USE OF SUBSTANCES BY ADOLESCENTS

INCREASE THE NUMBER OF TREATMENT AND RECOVERY SERVICES

A. RATIONALE

Utilization of the Hanlon Method and PEARL test for Priority Setting in combination with statistical data and community response yielded addictive behaviors as the first health priority area for Madison County to address over the next five years. Subcategory areas from the Community Health Assessment to be considered over the next five years for the Addictive Behaviors priority were determined to include: tobacco (smoking/tobacco, teen smoking, secondhand smoke), drug abuse, alcohol/drugs, alcohol abuse, alcohol use (underage), gambling, drug dealers, and needle exchange. Objectives and program strategies will be developed and implemented based on these results.

The U.S. Department of Health and Human Services reported in their document, *Healthy People 2010: National Health Promotion and Disease Prevention Objectives*, that tobacco use and substance abuse are two of the top ten leading health indicators for

this ten year period. These ten leading health indicators shape the overall picture of health for individuals and the nation. Each indicator embodies a degree of the following components: behavioral choices, environmental influence and impact, economic issues, social conditions, access to care issues, and interfacing with the health care system. Addictive behaviors exacerbate burdens to individuals and to society within each of these component areas unless the behaviors are prevented or eliminated. Tobacco use and substance abuse perpetuate economic hardships and business impacts, human development issues, productivity levels, attachment to schools and community, generational and genetic health concerns, insurance costs, public health and safety, and individual health ailments which weigh down the health care systems, increase insurance costs to society, impact family members, and compromise an individual's quality of life. Several long term health ailments can result from tobacco use and substance abuse some of which include: a variety of cancers, heart disease, oral health issues and diseases, mental and emotional issues, and sexual risk, and stress. By implementing interventions to target risk factors, contributing factors, and to enhance protective factors, influence over multiple health concerns can occur.

According to Healthy People 2010 Objective 26-09a, the national target the age by 2010 for average age of first use of alcohol for lifetime users is 16 years old with a baseline of 13 years old. According to 2004 data from the Illinois Youth Survey, Madison County adolescents begin regular use of alcohol at age 12.5 years, first time use of tobacco at age 11.3 years, and first time use of marijuana at age 12.3 years. By 2012, Madison County will strive to reduce by 10% the 30-day use rates of gateway substances in adolescents in 8th, 10th, and 12th grades (Baseline: Illinois Youth Survey Data, 2004). Utilization of scientifically-based, logical programs and approaches to lifestyle behavior change has been successful for the field of tobacco use and substance abuse. Therefore, Madison

County will implement comprehensive programs and opportunities to impact behavior change for individuals and communities.

Various data sources were analyzed to help establish the priorities and develop the community plan which included the data that follows. In 2002, Illinois Behavioral Risk Factor Surveillance System reported that 21.6% of Madison County residents are at risk for acute/binge drinking while 7.8% of residents are at risk for chronic drinking. IBRFSS (2002) also reported that 28.6% of Madison County residents are current smokers compared with Illinois at 22.8 % and an additional 2.6% of the county's population uses smokeless tobacco while Illinois is 2.1%. Of all Madison County residents 23.6% report being former smokers and 47.8% are non smokers compared with the Illinois residents which 22.9% are former smokers and 54.3% are non smokers. Another alarming statistic comes from the IPLAN Data System Report that in the year 2002, 19.0% of mothers smoked during pregnancy which far exceeds Illinois' 10.0%. The Illinois State Police reports that methamphetamine grams seized in Madison County has increased from 161 grams in 1994 to 3,263 grams in the year 2004. The ISP also reports drug paraphernalia arrests in Madison County are up from 20 arrests in 1994 to 568 arrests in 2003. All drug violations in Madison County were up from 396 per 100,000 people in 1994 to 773 per 100,000 people in 2003. The Illinois Criminal Justice Information Authority reports that controlled substances arrests were up from 324 in 1993 to 643 in 2003. Drug crimes were also on the rise from 638 in 1993 to 2,032 in 2003. Arrests for cannabis crimes were up from 295 in 1993 to 804 in 2003 while arrests for the Cannabis Control Act were up from 480 in 1993 to 801 in 2003.

Madison County objectives for achieving five year outcomes reflect and support *Healthy People 2010 Objectives*. The following are ten year Healthy People 2010 Focus Areas concurrent with the five year county objectives and interventions outlined in this plan for tobacco use and substance abuse (as defined by Healthy People 2010): Focus Area 01- Access to Quality Health Care, Focus Area 07-Educational and Community-Based Programs, Focus Area 26-Substance Abuse, and Focus Area 27-Tobacco Use.

B. RISK AND CONTRIBUTING FACTORS ANALYSIS

The risk and contributing factors identified as most often associated with addictive behaviors included: physical trauma, temperament, early initiation of use, early aggressive behavior, past trauma or abuse, poor self-concept, lack of commitment to societal values or norms, poor parent supervision and monitoring, poor attachment to parents, tolerant parental attitudes, parental substance use and/or abuse, family conflict, discipline and expectation issues, living arrangements, peer substance use, peer pressure/peer rejections, perceptions of normative use by peers, academic failure, community and neighborhood characteristics, availability and accessibility of substances, lack of commitment to schools, community laws and norms favorable toward substance use, economics of the community, anti-social behavior, poor parenting skills, and invincibility attitude (An Overview of Risk and Protective Factors, The Alberta Youth Experience Survey, 2002; MCPCH Addictive Behavior Committee, 2006). It was determined that adolescents and pre-adolescents need to remain as the focus for primary prevention initiatives. Parents, schools, communities, and law enforcement

were recognized as significant factors in this continuum. After consideration of these risk and contributing factors, focus for objectives and intervention strategies was placed on: increasing general knowledge, attitudes, and skills related to substance use and abuse prevention; building life skills; improving self-concept; implementing media campaigns; implementing social norms campaigns; targeting parents and schools with education and initiatives; continuing to build a comprehensive peer leadership program across geographical and age demographics; increase smoking cessation attempts; impact the age of initiation for alcohol and tobacco use; continue to develop policies that enhance the environmental influences on substance use and/or abuse; maintain compliance of local merchants in regard to sales of alcohol and tobacco products; continue to provide and increase programs for substance abuse-related treatment and recovery; and continue to collaborate with local, county, regional, and state organizations to provide comprehensive substance abuse prevention, treatment, and recovery services for Madison County as related to addictive behaviors.

C. OUTCOME OBJECTIVES

1. By June 2012, reduce by 10% the 30-day use rates of gateway substances in adolescents in 8th, 10th, and 12th grades. (Baseline: alcohol=20% 30-day use rate, tobacco=8% 30-day use rate, marijuana=7% 30-day use rate, Illinois Youth Survey Data, 2004)
2. By June 2012, increase the number of agencies, organizations, or programs (e.g. AA, Al-Anon, Alateen) offering addictive behavior-related services to impact the access to addiction treatment and recovery services by at least five additional services. (Baseline not available)

D. IMPACT OBJECTIVES:

1. By December 2009, reduce adolescent use of alcohol by 5% by increasing the proportion of adolescents who disapprove of substance use/abuse and increasing the proportion of adolescents who report that adults/parents disapprove of their use of alcohol. (Baseline: Illinois Youth Survey Data, 2004-see Appendix A)
2. By December 2009, reduce adolescent use of tobacco in grades 9-12 by 5% by decreasing the illegal sale rates to minors and increasing the proportion of adolescents who disapprove of substance use/abuse. (Baseline: Illinois Youth Survey Data, 2004-see Appendix A; Madison County Health Department Data; Illinois Department of Public Health Data)
3. By December 2009, reduce adolescent use of marijuana by 5% by increasing the proportion of adolescents who disapprove of substance use/abuse. (Baseline: Illinois Youth Survey Data, 2004-see Appendix A)

E. INTERVENTIONS:

- 1. By January 2007, re-establish the Madison County Underage Drinking Initiative Coalition to focus on local policy issues.**
- 2. By January 2007, community agencies and organizations will continue to coordinate compliance checks with local law enforcement and peer leaders.**
- 3. By January 2007, community agencies and organizations will continue to provide life skill education (e.g. decision making, communication, conflict resolution, stress management, self-concept, self-esteem, etc.) as a prevention strategy decreasing alcohol, tobacco, and drug use, abuse, and initiation.**
- 4. By January 2007, the Madison County Partnership for Community Health Addictive Behaviors Committee will collaborate with the Metro-East Coalition Against Methamphetamine (MECAM) to work toward strategic goals established by MECAM to impact issues related to methamphetamine in Madison County.**
- 5. By February 2007, Madison County Health Department will continue to coordinate opportunities for smoking cessation.**
- 6. By February 2007, Madison County Health Department will continue to work with local universities, schools, organizations, businesses, and communities to prevent and decrease tobacco use.**
- 7. By June 2007, community agencies and organizations will continue to provide peer leadership opportunities for children and adolescents as a prevention strategy addressing contributing factors for addictive behaviors.**
- 8. By June 2007, community agencies and organizations will continue to provide scientifically accurate information to local news media about alcohol, tobacco, and other drugs to ensure the quality and content of the messages that the local news media supply to the region.**
- 9. By June 2007, community agencies and organizations will continue to build relationships with local news media to increase the accuracy in reporting relevant to addictive behavior stories.**
- 10. By September 2007, community agencies and organizations and coalitions will focus on local policy issues related to tobacco.**
- 11. By January 2008, community agencies and organizations will implement a social norms campaign to change parental, peer, and community acceptance of underage drinking.**
- 12. By December 2008, community agencies and organizations and programs will continue to provide treatment and recovery opportunities in Madison County.**

- 13. By December 2008, schools and community agencies and organizations will provide alcohol, tobacco, and other drug information and education for students, parents, administration, faculty, and staff.**
- 14. By January 2011, conduct at least five media/social marketing campaigns to increase awareness and education targeting alcohol, tobacco, and other drug related issues and perceptions.**
- 15. By January 2011, community agencies and organizations and programs will advocate for additional services to support, enhance, and/or expand treatment and recovery opportunities offered in Madison County.**

F. RESOURCES AVAILABLE (governmental and nongovernmental):

Several community resources exist to assist with the development of this committee and the execution of this strategic plan which include: Madison County Health Department, Madison County Partnership for Community Health (MCPCH), Madison County hospitals, Madison County schools, Chestnut Health Systems, Southern Illinois University Edwardsville School of Nursing, Lewis & Clark Community College, Coordinated Youth and Human Services, Southern Illinois University Edwardsville Department of Kinesiology and Health Education, Southwestern Illinois College, InTouch PSA 16, Olin Corporation, Madison County Community Development, Good Samaritan House, Prevention First Incorporated, Illinois Department of Human Services (IDHS), Illinois Department of Public Health (IDPH), Substance Abuse Prevention Program (SAPP) Grant from IDHS, Illinois Tobacco-Free Communities Grant from IDPH, Madison County Sheriff's Department, Madison County State's Attorney's Office, Madison County Board of Health Chairman, Madison County law enforcement agencies, Madison County merchants

V. PRIORITY TWO – SEXUAL RISK BEHAVIORS

REDUCE THE RATE OF GONORRHEA REDUCE THE RATE OF CHLAMYDIA

A. RATIONALE

Utilization of the Hanlon Method and PEARL test for Priority Setting in combination with statistical data and community response yielded sexual risk behaviors as the second health priority area for Madison County to address over the next five years. Subcategory areas from the Community Health Assessment to be considered over the next five years for the Sexual Risk Behaviors priority were determined to include: STD's, AIDS, and maternal and infant care (teen births/pregnancy education, maternal care/infant mortality, birth control/premarital sex, parenting skills, women's health, abortion). The Madison County Partnership for Community Health Sexual Risk Behaviors Committee determined the health problems related to sexual risk behaviors to include: teen pregnancy, STD's/STI's, sexually abusive relationships, date rape/rape, low self-esteem, sexual harassment, internet addictions, and maternal/child problems (poor prenatal care, drug use, STD transmission). Objectives and program strategies will be developed and implemented based on these results.

The U.S. Department of Health and Human Services reported in their document, *Healthy People 2010: National Health Promotion and Disease Prevention Objectives*, that responsible sexual behavior is one of the top ten leading health indicators for this ten year period. These ten leading health indicators shape the overall picture of health for individuals and the nation. Each indicator embodies a degree of the following components: behavioral choices, environmental influence and impact, economic issues, social conditions, access to care issues, and interfacing with the health care system. Sexual risk behaviors perpetuate a myriad of other physical, mental, emotional, social, spiritual and economical burdens to individuals and to society unless the behaviors are prevented or eliminated. Healthy People 2010 identifies Focus Areas related to sexual risk behaviors including: family planning, HIV, maternal and infant and child care, and sexually transmitted diseases. In addition, data and research often justify a link between alcohol, tobacco, and other drug use to an individual's willingness to engage in other risky behaviors such as sexual risks. Sexual risk behaviors can create economic hardships, human development issues, impact productivity levels, compromise attachment to schools and community, generational and genetic health concerns, insurance costs, public health and safety, and potential spread of infectious diseases within the community compromising quality of life for that individual and many others. By implementing interventions to target risk factors, contributing factors, and to enhance protective factors, influence over multiple health concerns can occur.

According to Healthy People 2010 Objective 25-01, the national target is by 2010 for only 3% of the people ages 15-24 years that attend STD clinics to have Chlamydia. According to the 2001 IPLAN Data System information, 99.2/100,000 population of Madison County had gonorrhea and 205.2/100,000 population had Chlamydia. According to 2005 Madison County provisional data, 147.91/100,000 population of Madison County had gonorrhea and 299.68/100,000 population had Chlamydia. The focus of the community plan objectives entails reversing the trend of increased prevalence incidence of

gonorrhea and Chlamydia. By 2012, Madison County will strive to reduce the rate of gonorrhea to less than 100/100,000 population (Baseline: IPLAN Data System, 2001; 147.91/100,000 population, Madison County provisional data, 2005) and reduce the rate of Chlamydia to less than 220/100,000 population (Baseline: 205.2/100,000 population, IPLAN Data System, 2001; 299.68/100,000 population, Madison County provisional data, 2005). Therefore, Madison County will implement interventions to address the prevention of, treatment of, and access to care for sexually transmitted diseases through comprehensive and collaborative programming.

As part of the data analysis, community responses and various data sources were examined, reviewed, and discussed. Some of the highlights from the statistical investigation follow. According to the Illinois Behavioral Risk Factor Surveillance System, in 2002, 4.3% of Madison County residents reported engaging in risky sexual activity. Although the teen birth rate hit a record low in 2003 for the state of Illinois, Madison County's teen birth rate continues to be significantly higher than that of the state rate. During 2001, the teen birth rate for Madison County was 12.0% while the state average was 10.9%. In 2003, Madison County had a teen birth rate of 11.1% while the state average dropped to 9.7% (Statistics from Illinois Department of Public Health). In 2004, following were incidence rates per 100,000 population for specific infectious diseases: Acquired Immunodeficiency Syndrome 2.317130157; Chlamydia 259.904766; Gonorrhea 102.7261036; Hepatitis B Acute 0.772376719; Hepatitis B Carriers 6.565202112; Hepatitis C 13.13040422; Human Immunodeficiency Virus (HIV) 5.792825393; and Syphilis 3.475695236.

Madison County objectives for achieving five year outcomes reflect and support *Healthy People 2010 Objectives*. The following are ten year Healthy People 2010 Focus Areas concurrent with the five year county objectives and interventions outlined in this plan for Sexual Risk Behaviors (as defined by Healthy People 2010): Focus Area 01-Access to Quality Health Care, Focus Area 07-Educational and Community-Based Programs, Focus Area 09-Family Planning, Focus Area 13-HIV, Focus Area 16-Maternal and Infant and Child Care, Focus Area 25-Sexually Transmitted Diseases. Two other focus areas indirectly impact the risk of sexual behaviors which include: Focus Area 26-Substance Abuse and Focus Area 27-Tobacco Use.

B. RISK AND CONTRIBUTING FACTORS ANALYSIS

The risk factors identified as most often associated with sexual risk behaviors included: promiscuity (sex at a young age, sex early in relationships) and unprotected sex. Contributing factors included: low socioeconomic status; drug abuse; lack of adult supervision; being a victim of abuse; negative peer influence (pressure to have sex, fit in); neglect; unhealthy attitudes about sex; lack of education regarding sexuality; and lack of available health and support services. Other contributing factors included: failure to utilize available resources (cost); negative social and cultural environments (lack of connection to trusted adults and lack of communication about sexuality within families); lack of structured community activities; lack of access to birth control/condoms; lack of comprehensive sexuality education (STD's/STI's), lack of support from community/school administrations, as well as poorly trained teachers; inadequate/inappropriate media coverage (movies, TV, internet porn, chat rooms, blogs); and invincibility attitude. It was determined that adolescents and pre-

adolescents were not receiving adequate information or opportunities to build positive decision making skills to prevent and/or avoid risky sexual behaviors. Families and schools were recognized as significant factors in this continuum. After consideration of these risk and contributing factors, focus for objectives and intervention strategies was placed on increasing the number of STD testing sites; increasing general knowledge, attitudes, and skills related to STD prevention; building life skills; improving the partner notification process; continued monitoring of STD rates; continued counseling, testing, and outreach for high risk populations; working with the media; implementing a social norms campaign; and collaborating with the schools and State Board of Education regarding state standards for health education, especially the components related to sexual risk behaviors.

C. OUTCOME OBJECTIVE:

1. By June 2012, reduce the rate of gonorrhea to less than 100/100,000 population. (Baseline: 99.2/100,000 population, IPLAN Data System, 2001; 147.91/100,000 population, Madison County provisional data, 2005)
2. By June 2012, reduce the rate of Chlamydia to less than 220/100,000 population. (Baseline: 205.2/100,000 population, IPLAN Data System, 2001; 299.68/100,000 population, Madison County provisional data, 2005)

STRATEGIES TO MEET 1 & 2:

Partner with local schools and area clinics to increase education and access to treatment of STD's

Provide schools and agencies with a list of people available to do STD education.

Utilize STD teaching aids to assist with STD education (i.e., videos, handouts), network with local agencies, schools on resources available through the health department.

D. IMPACT OBJECTIVES:

1. By June 2012, demonstrate a 10% increase in knowledge, skills, and attitudes of participants receiving general STD education.

STRATEGY:

Find or develop a tool that can be used to assess baseline STD knowledge in the community.

Use assessment findings to identify true areas of need and then progress with the development of strategies to meet identified needs (i.e., education, access to treatment).

2. By June 2012, advocate for the addition of one STD testing site in Madison County. (Baseline is 2 testing sites in Madison County, 2006)

STRATEGY:

STD testing sites are costly. Review existing sites and develop a plan to obtain an additional testing site.

E. INTERVENTIONS:

1. By January 2007, establish a functional community coalition under MCPCH addressing Sexual Risk Behaviors.

STRATEGY:

This goal has been met through the development of the Madison County High Risk Sexual Behavior Committee

2. By January 2007, Madison County Health Department will continue to provide access to adequate treatment of people affected by exposure to STD's by providing medications for those meeting criteria.

STRATEGY:

Educate the public regarding current STD treatment sites.

Disseminate information regarding STD testing and treatment sites to the public through the media of radio, flyers, and newspapers during the next year.

Network with local charities (Catholic Charities), and pharmacies about medication programs that maybe available to assist clients with medication costs.

3. By January 2007, Madison County Health Department will continue to provide counseling to patients exposed to STD's and continue to educate these patients on risks, transmission, treatment options, and prevention.

STRATEGY:

Continue the educational services offered by the 2 existing STD testing sites and refer clients to other local health care providers and agencies as needed.

Collaborate with local pharmacies on distributing information on STD's counseling sites and services available.

Review current partner notification practices at the two local STD clinics in Madison County, and make suggestions for change if indicated.

Inform local health care providers of resources available to assist providers/clients with better partner notification and treatment.

4. By January 2007, Madison County Health Department will continue to provide anonymous and confidential HIV counseling, testing, and referral services.

STRATEGY:

This goal is already met through the Madison County Health Department

5. By January 2007, Madison County Health Department will continue to provide STD risk reduction interventions for at risk populations.

STRATEGY:

See strategies listed for items 1-4.

6. By January 2007, MADCAP will continue to provide group prevention and support for individuals at high risk for HIV.

STRATEGY:

Provide HIV positive clients and families with a list of local support groups to help coping with HIV in their lives (Bethany Place, Effort for AIDS).

- 7. By January 2007, collaborate with schools and the State Board of Education regarding state standards for health education, especially the components related to sexual risk behaviors.**

STRATEGY:

Review local, state and federal regulations regarding sexual risk behavior education (e-mail site responsibleSexEd.org)

Encourage the incorporation of AIDS education in sex education at the local level

Incorporate findings into local sexual risk reduction education.

- 8. By February 2007, this MCPCH Committee will identify specific issues relevant to the sexual risk behaviors subcategories, incorporate additional strategies countywide to achieve the outcome objectives, and identify specific interventions that this committee can contribute to achieve the outcome objectives.**

STRATEGY:

Subcategories have been identified and strategies are currently being developed to meet community needs (see list of subcategories).

- 9. By March 2007, Madison County Health Department will increase awareness of their availability to assist with partner notifications supporting the two existing STD testing sites or any physician's offices.**

STRATEGY:

Review current partner notification practices at the two local STD clinics in Madison County, and make suggestions for change if indicated.

Inform local health care providers of resources available to assist providers/clients with better partner notification and treatment (i.e., clinical site visits, mailings and other media campaigns)

- 10. By June 2007, Madison County Health Department will assist with improving STD partner notification through training and education regarding STD testing and treatment, and partner notification.**

STRATEGY:

Utilize Title 10 Training resources for clinicians working in the areas STD clinics.

Review government standards and regulations regarding the notification of partners with STD's.

Review partner notification procedures of local STD clinics, offer guidance as needed.

- 11. By June 2008, community agencies and organizations will continue to provide scientifically accurate and factual information to local news media about STD's to ensure the quality and content of the messages that the local news media supply to the region.**

STRATEGY:

MCPCH will provide local health care providers and community agencies a list of services that can be utilized to provide the public with factual and evidenced based information related to sexuality.

Encourage local health care agencies and the community to call, e-mail or fax to the Madison County Health Department any concerns over information that they feel is inaccurate or potential inaccurate (i.e., this can be done through the identified media campaigns listed above).

- 12. By September 2009, community agencies and organizations will continue to provide peer leadership opportunities, life skill education (e.g. decision making, communication, stress management, conflict resolution, self-esteem, self-efficacy, etc.) as a prevention strategy impacting STD transmission.**

STRATEGY:

In place are religious groups, YMCA's, Teen Reach, Peer Groups, Latch Key Programs, Chestnut Health Services, Coordinated Youth Services, Camp Success, after school programs, and Health Department Training programs to enhance life skills development throughout the lifespan.

- 13. By September 2009, community agencies and organizations will continue to provide peer leadership opportunities for children and adolescents as a prevention strategy impacting STD transmission.**

STRATEGY:

In place are religious groups, YMCA's, Teen Reach, Peer Groups, Latch Key Programs, and Health Department Training programs.

- 14. By September 2009, schools will continue to meet state criteria and grant directives related to STD education, prevention, and treatment.**

STRATEGY:

Provide schools with information on state and local regulations regarding STD educations, prevention and treatment.

Provide schools with information regarding STD education, programs offered through the Madison County Health Department.

- 15. By December 2009, explore options to increase access to care for men in the general population to receive STD testing.**

STRATEGY:

Implement media campaign to include specific resources available to men (i.e., medications available at Madison County Health Department).

Explore funding for STD testing and treatment of men

- 16. By September 2011, schools and/or community agencies and organizations will provide STD information and education for students and/or parents.**

STRATEGY:

MCPCH will offer a list of sound evidence-based resources, and speakers to schools and/or community agencies and organizations in order to provide education on sexuality education to the public.

- 17. By December 2009, conduct at least three media campaigns to increase awareness and education about STD-related issues.**

STRATEGY:

Organize media campaigns through newspapers, web pages, radio and community announcements (i.e., churches, community groups and agencies).

Identify a social need related to sexuality and develop a social marketing campaign.

G. RESOURCES AVAILABLE (governmental and nongovernmental):

Several community resources exist to assist with the development of this committee and the execution of this strategic plan which include: Madison County Health Department, Madison County Partnership for Community Health (MCPCH), Madison County hospitals, Madison County schools, Southern Illinois Health Care Foundation-Alton, Madison County Urban League-Madison, Madison County AIDS Program (MADCAP), Lewis & Clark Community College Teen Parent Services (TPS) Program, Coordinated Youth and Human Services, Chestnut Health Services, Oasis Women's Center, and Southern Illinois University Edwardsville.

VI. PRIORITY THREE – CARDIOVASCULAR HEALTH

REDUCE THE PREMATURE DEATH RATE FROM CARDIOVASCULAR DISEASE

A. RATIONALE

Utilization of the Hanlon Method and PEARL test for Priority Setting in combination with statistical data and community response yielded cardiovascular disease as the third health priority area for Madison County to address over the next five years. Subcategory areas to be considered over the next five years for Cardiovascular Health priority were determined to include: Obesity/Nutrition, Cardiovascular Issues (Cardio including Cholesterol, BP, and stroke), Diabetes, Exercise, Nutrition/Diet/Exercise, Fitness/Wellness, and Eating Disorders. Objectives and program strategies will be developed and implemented based on these results.

The U.S. Department of Health and Human Services reported in their document, *Healthy People 2010: National Health Promotion and Disease Prevention Objectives*, that heart disease is the leading cause of death in the U.S., killing approximately 500,000 people each year. African Americans are at a disproportionately higher rate of coronary heart disease. Although the mortality rate from coronary heart disease has declined over the past three decades, it remains one of the primary health concerns and preventable conditions. Several risk factors for heart disease are also common for stroke, cancer, and some respiratory disease. By implementing interventions to target risk factors, influence over multiple health concerns can occur.

IPLAN Data System Report reports that the 2001 coronary heart disease mortality rate for Madison County was a crude rate of 234.1/100,000 population as compared to state of Illinois crude rate which was 186.1/100,000 population. The crude rates for premature coronary heart disease mortality were Madison County 58.6/100,000 population and Illinois 37.4/100,000 population. Healthy People 2010 Objectives target an age-adjusted rate of 166/100,000 population for coronary heart disease mortality. By 2012, Madison County will strive for a crude premature heart disease mortality rate of 55/100,000 population under age 65. Preventive lifestyle behavior change approaches have been deemed successful for decreasing the incidence of premature heart disease. Therefore, Madison County will implement comprehensive opportunities targeting heart disease risk factors producing favorable behavior change.

Other data sources were analyzed to help establish the priorities and develop the community plan which included the data that follows. According to the Illinois Behavioral Risk Factor Surveillance System, only 20.8% of Madison County residents ate five or more fruits and vegetables per day. With regards to body weight, 44.3% of Madison County residents are underweight or of normal weight while 31.4% are classified as overweight and 24.3% of the county's population is obese. Additionally, only 29% of Madison County residents meet the standard for moderate activity five times a week for at least 30 minutes and only 22.3% of the population meet the standard for vigorous activity of three times per week for at least 20 minutes. Overall, only 40.2% of Madison County residents get the recommended activity while 40.9% of the population

gets insufficient activity and 18.9% report being inactive. The Illinois Behavioral Risk Factor Surveillance System (2002) also showed that 29% of Madison County residents while the Illinois average is 24.5% have been told that their blood pressure is high and 74.2% of this county's residents are taking medication for high blood pressure compared with 71.3% of Illinois residents. Of the Madison County residents who had their cholesterol checked, 33.7% of this population was told that their cholesterol was high compared with 29.2% of Illinois residents who had their cholesterol checked and were told that their cholesterol was high. The Illinois CHIS data from the Illinois Department of Public Health reports that Diabetes is the 11th cause for hospitalization in Madison County.

Madison County objectives for achieving five year outcomes reflect and support *Healthy People 2010 Objectives*. The following are ten year national Focus Areas concurrent with the five year county objectives and interventions for heart disease: Focus Area 01- Access to Quality Health Care, Focus Area 07-Educational and Community-Based Programs, Focus Area 12-Heart Disease and Stroke, Focus Area 26-Substance Abuse, and Focus Area 27-Tobacco Use.

B. RISK AND CONTRIBUTING FACTORS ANALYSIS

The risk factors identified as most often associated with cardiovascular disease (heart disease) included: high cholesterol, obesity, smoking, hypertension, stress, age/family history, and sedentary lifestyle. Contributing factors included: nutrition, no hormone replacement therapy, medication non-compliant, lack of education/knowledge, lack of activity/exercise, tobacco advertising, food choice/preference, early tobacco addiction, tobacco availability, peer/adult modeling, genetics, occupational stress, family dynamic stress, poor coping skills, food advertising, food availability, choices, knowledge, motivation, economics, fear (hormone replacement therapy), transportation, misinformation, community safety (exercise), available time, preferred leisure activity, convenience, physical limitation, self-efficacy, and poor stress management skills.

After consideration of these risk and contributing factors, focus for objectives and intervention strategies was placed on smoke free public places, monitoring of blood pressure rates, education, weight maintenance programs, and awareness and involvement of the community in physical activity.

C. OUTCOME OBJECTIVE:

18. By 2012, reduce the premature death rate from cardiovascular disease to no more than 55/100,000 population under age 65. (Baseline: 58.6/100,000 population under age 65-crude data from Madison County 2001. 37.4/100,000 population under age 65-crude data from Illinois 2001)

D. IMPACT OBJECTIVES:

1. By December 2009, the number of food service establishments inspected by the Madison County Health Department who receive “smoke-free” certification will increase by 20%. (Baseline: 112 in 2005, IDPH Smoke Free Restaurants website)
2. By December 2009, decrease the number of Madison County adults who report they have never had their blood pressure check to 10% (Baseline: 12.2%)
3. By December 2010, all Madison County hospitals will be totally “smoke-free”. (Baseline: 0, 2005 hospital smoking policies)

E. INTERVENTIONS:

1. By December 2008, update the Madison County Healthy Dining Restaurant Guide Survey and place on the Madison County Health Department website.
2. By December 2008, present (2) two Jazz Up Your Heart Seminars in conjunction with Madison County hospitals.
3. By December 2008, revamp the Beat-the-Odds Weight Maintenance program.
4. By January 2009, increase the number of blood pressure screening sites in Madison County.
5. By January 2010, collaborate with the Illinois Department of Public Health Wellness Van to bring the service to (2) two underserved areas.
6. By December 2011, increase by 10% participation in the annual Madison County WALKDAY sponsored by Madison County Partnership for Health (MCPCH) and Madison County Government (Baseline: 7,213 in 2005)

H. RESOURCES AVAILABLE (governmental and nongovernmental):

Numerous community resources (staff and funding possibilities) exist to assist in the development and execution of this strategic plan which include: Illinois Tobacco Free Communities Grant, Madison County Health Department, Madison County Partnership for Community Health (MCPCH), American Heart Association, Madison County Regional Office of Education, American Lung Association, University of Illinois Extension, Alton Memorial Hospital, Anderson Hospital, St. Anthony's Health Center, Gateway Regional Medical Center, St. Joseph's Hospital, Southern Illinois University Edwardsville School of Nursing, Southern Illinois University Edwardsville Department of Kinesiology and Health Education, and Madison County schools.

VII. EXISTING PRIORITY AREA – CANCER

NO INCREASE IN THE OVERALL CANCER MORTALITY RATE

A. RATIONALE

Utilization of the Hanlon Method and PEARL Test for Priority Setting in combination with statistical data and community response yielded cancer as the fifth health priority area for Madison County to address over the next five years. Although cancer was ranked seventh, the community response suggests that cancer continues to be a health concern in Madison County. In addition, this health priority has a functioning coalition that has a desire to continue collaborating to maintain the rate of cancer in Madison County. Subcategory areas from the Community Health Assessment to be considered over the next five years for the Cancer priority were determined to include: lung cancer, prostate cancer, colorectal cancer and breast and cervical cancer. Objectives and program strategies will be developed and implemented based on these results.

The U.S. Department of Health and Human Services reported in their document, *Healthy People 2010: National Health Promotion and Disease Prevention Objectives*, that cancer is the second leading cause of death in the U.S., killing approximately 552,200 people each year. African Americans have a disproportionately higher mortality rate for cancer than any other race. Although cancer mortality rates have experienced slight decline over the years, the decline varies by gender, race, ethnicity, and type of cancer. Even with some minimal progress, cancer remains one of the primary health concerns and is, in some cases, a preventable condition in the U.S. It's estimated that as much as 50% or more of cancer can be prevented through smoking cessation and improved dietary habits. Several risk factors for cancer such as tobacco use and obesity are also common for heart disease, stroke, and some respiratory diseases. Therefore, by implementing interventions to target the risk factors associated with cancer, Madison County will see a reduction in prevalent diseases with similar risk factors.

Vital Statistics Illinois reported that the 2001 overall cancer mortality rate for Madison County was a crude rate of 227.9/100,000 population compared to the state crude rate of 197.7/100,000 population. Healthy People 2010 Objective 3-1 targets a reduction in the overall cancer death rate to 159.9/100,000 population with a baseline of 202.4/100,000 population in 1998 (age adjusted to the year 2000 standard population). By 2012, there will be no increase in the overall cancer mortality rate in Madison County (Baseline: 227.9/100,000 population, Vital Statistics Illinois, 2001). Madison County can sustain the current mortality rate by increasing early detection efforts with consideration for the increasing mortality rates due to the aging population. With the focus on primary prevention and early detection initiatives, Madison County will curtail any future increases in mortality rates and detect rate reduction over an extended period of time.

Healthy People 2010 Objective 3-2 targets a reduction in the lung cancer mortality rate to 44.9/100,000 population with an age adjusted baseline of 57.6/100,000 population in 1998. According to the Illinois Project for Local Assessment of Needs Data System (IPLAN), the lung cancer mortality rate in 2001 for Madison County was 67.6 compared to the state rate of 54.2. IPLAN also reports that the lung cancer incidence rate for Madison County

is significantly higher at 65.2 compared with the Illinois state rate of 54.6. Healthy People 2010 states that “cigarette smoking is the most common risk factor for lung cancer, accounting for 68-70% of lung cancer deaths among females and 88-91% of lung cancer deaths among males”. Support is strong for prevention efforts to delay initial smoking and address additional risk factors before they cause disease. Prevention education and preventative lifestyle behavior change approaches such as smoking cessation have been deemed successful for decreasing the incidence of lung cancer. Therefore, by 2012, the Madison County Partnership for Community Health (MCPCH) Cancer Committee and the MCPCH Addictive Behaviors committee will work in conjunction to reduce the incidence of lung cancer by increasing awareness about the risks of smoking/exposure to secondhand smoke, the benefits of smoke-free restaurants and the benefits of smoking cessation.

IPLAN states that the 2000 mortality crude rate for breast cancer was 29.1/100,000 for Madison County and 32.2/100,000 for the state. Healthy People 2010 Objective 3-3 targets a reduction in breast cancer mortality to 22.3/100,000 females with a baseline of 27.9/100,000 females in 1998 (age-adjusted to the year 2000 standard population). IPLAN also shows that for the five years of 1996 through 2000, 48.4% of Madison County cervical cancer patients were diagnosed at late stage compared to 43.3% of the state cervical cancer patients. Healthy People 2010 Objective 3-4 targets a reduction in mortality from cancer of the uterine cervix to 2/100,000 females with a baseline of 3.0/100,000 females in 1991 (age adjusted to the year 2000 standard population). Evidence supports early detection screenings and education as effective approaches for decreasing the death rates of breast and cervical cancer. The recent decrease in deaths from breast cancer in white females is attributed to greater use of breast cancer screenings; but deaths due to breast cancer in African American females continue to increase. When cervical cancer is detected early survival is almost 100 percent. Therefore, Madison County’s primary approach to sustaining the overall cancer mortality rate will be to increase early detection breast and cervical cancer screening opportunities and access for all women in Madison County.

Healthy People 2010 Objective 3-5 targets a reduction in the colorectal cancer mortality rate to 13.9/100,000 with a baseline of 21.2/100,000 in 1998 (age adjusted to the year 2000 standard population). IPLAN Data System reported that the 2001 colorectal cancer mortality rate for Madison County was a crude rate of 22.3/100,000 population as compared to the state of Illinois crude rate which was 21.8/100,000 population. Colorectal cancer is the second leading cause of cancer-related deaths in the United States. Illinois Behavioral Risk Factor Surveillance System (IBRFSS) reports that only 41.5% of adults age 50 and older have had a sigmoidoscopy exam compared to the state average of 45.1% for Illinois adults age 50 and older. IBRFSS also reported that 31.3% of Madison County adults aged 50 and older have had a blood stool test compared to the state of Illinois rate of 40.1%. The use of early detection screenings such as the sigmoidoscopy and the fecal occult blood tests (FOBT) has shown a reduction in colorectal deaths. Due to the success of these screenings, MCPCH Cancer Committee will work to increase colorectal cancer screening services in Madison County.

Healthy People 2010 Objective 3-7 targets a reduction in the prostate cancer mortality rate to 28.8 deaths/100,000 males with a baseline of 32/100,000 males in 1998 (age

adjusted to the year 2000 standard population). Prostate cancer is the third leading cause of cancer death in men. Digital rectal examination (DRE) and the prostate-specific antigen (PSA) test are two screening methods used for the early detection of prostate cancer. In order to maintain and/or reduce the number of deaths due to prostate cancer, Madison County Health Department will increase the number of uninsured and underinsured men that are educated and screened for prostate cancer.

Madison County objectives for achieving five year outcomes reflect and support Healthy People 2010 Objectives. The following are ten year Healthy People 2010 Focus areas concurrent with the five year county objectives and interventions outlined in this plan for cancer: Focus Area 3-1 Reduce Overall Cancer Deaths, Focus Area 3-2 Reduce Lung Cancer Deaths, Focus Area 3-3 Reduce Breast Cancer Deaths, Focus Area 3-4 Reduce Cervical Cancer Deaths, Focus Area 3-5 Reduce Colorectal Cancer Deaths, Focus Area 3-7 Reduce Prostate Cancer Deaths, Focus Area 3-12 Increase Colorectal Cancer Screening, Focus Area 3-11 Increase Pap tests, Focus Areas 3-13 Increase Mammograms, Focus Area 27-Tobacco Use, Focus Area 27-5 Increase Smoking Cessation by Adults, and Focus Area 27-7 Increase Smoking Cessation by Adolescents.

Various data sources were analyzed to help establish the priorities and develop the community plan which included the data that follows. According to Vital Statistics Illinois 2001, the premature (<65) mortality rate for Madison County was a 5-year average (1997-2001) of 25.1/100,000 and the state rate was 17.3/100,000. IPLAN reports that the colorectal cancer age-adjusted incidence rate for the five years of 1996-2000 was 58.1 for Madison County compared to the state rate of 51.6. The Illinois Hospital Association Community Health Information System (CHIS) from the Illinois Department of Public Health reports that cancer is the 7th leading cause of hospitalizations in Madison County and is equal to 2.8% of all hospitalizations.

B. RISK AND CONTRIBUTING FACTORS ANALYSIS

The risk factors identified as most often associated with cancer (primarily lung, prostate, colorectal, breast and cervical) included: age, a family history of certain cancers, use of tobacco products, exposure to second hand smoke, obesity, diet, lack of exercise, exposure to radiation or other cancer causing agents. Contributing factors included: socioeconomic status, environmental/air quality, screening history, educational level, attitudes/health beliefs, physical inactivity, nutrition, lack of knowledge (risk factors, prevention strategies, and available screening services), use and exposure to smoke, fear, and transportation. The risk factors identified specifically for breast cancer include: early onset of menopause and older than 35 at birth of first child.

After consideration of these risk and contributing factors, focus for objectives and intervention strategies was placed on early detection through screening for prostate, colorectal, breast and cervical cancer, education and community awareness of cancer especially lung, prostate, colorectal, breast and cervical, and community awareness regarding the benefits of smoke-free public places.

C. OUTCOME OBJECTIVES:

1. By June 2012, there will be no increase in the overall cancer mortality rate in Madison County. (Baseline 2001: 227.9/100,000 population, Vital Statistics Illinois)

D. IMPACT OBJECTIVES:

1. By June 2012, the Madison County Partnership for Community Health (MCPCH) Cancer Committee will work in conjunction with the MCPCH Addictive Behaviors Committee to reduce the incidence of lung cancer in Madison County by increasing awareness about the cause and effect between smoking and lung cancer. (Baseline 2001: 67.6/100,000 population)
2. By June 2012, the MCPCH Cancer Committee will work to increase colorectal cancer screenings at hospitals in Madison County. (Baseline: To be established in 2006)
3. By June 2012, increase the number of uninsured and underinsured men screened for prostate cancer through the Prostate and Testicular Cancer Awareness and Screening Program at Madison County Health Department. (Baseline: To be established in 2006)
4. By June 2012, increase opportunities and resources for all women to access screening and early detection programs for breast and cervical cancer through the Illinois Breast and Cervical Cancer Program (IBCCP), screening services funded by the Susan G. Komen Foundation, and other non-profit organizations as evidenced by adding 2 new resources. (Baseline 2001: one organization (IBCCP)/Baseline 2006: two organizations [IBCCP and Komen])
5. By June 2012, the MCPCH Cancer Committee will increase by 3 school districts the number of county middle and high schools who administer the Centers for Disease Control and Prevention's (CDC) Youth Risk Behavior Survey (YRBS). (Baseline 2006: 3 school districts in the last 5 years.)

E. INTERVENTIONS:

1. By July 2006, MCPCH Cancer Committee members will volunteer to approach, educate, and solicit participation of middle and high schools in Madison County in the 2005 YRBS survey by selecting school districts to recruit.
2. By August 2006, MCPCH Cancer Committee members will help solicit school participation by assembling YRBS packets for distribution to schools.
3. By January 2007, the MCPCH Cancer Committee will work in collaboration with the MCPCH Addictions Committee to educate policy makers about the benefits of smoke-free restaurants.

- 4. By January 2007, the MCPCH Cancer Committee will identify and promote colorectal cancer screening programs and providers in Madison County.**
- 5. By March 2007, the MCPCH Cancer Committee will collaborate with Madison County Health Department to produce public service announcements and press releases to promote Colorectal Cancer Awareness Month**
- 6. By October 2007, increase awareness and knowledge of the general community regarding prostate cancer and the importance of early detection.**
- 7. By June 2008, provide prostate cancer screening services at Madison County Health Department to reach a yearly total of 250 uninsured or underinsured men with a focus on men 50 and older and men 40 and older at high risk for prostate cancer.**
- 8. By March 2010, the MCPCH Cancer Committee will develop community education pamphlets or power point presentations about colorectal cancer for community awareness purposes.**
- 9. By March 2010, the MCPCH Cancer Committee will work in collaboration with Madison County Health Department to provide colorectal cancer screening (using fecal occult blood test [FOBT] patient mail-in kits) for distribution during Colorectal Cancer Awareness Month.**
- 10. By October 2010, increase general public awareness about breast and cervical health and about early detection and cancer screening programs via media outlets such as billboards, public service announcements, press releases, purchased advertising in newspapers, on television, and on radio.**
- 11. By December 2010, the MCPCH Cancer Committee will collaborate with the MCPCH Addictions Committee to promote awareness and recognition observances such as The Great American Smokeout, Kick Butts Day, etc.**
- 12. By June 2012, conduct enrollment and awareness days regarding all breast and cervical cancer screening programs (IBCCP, Komen) available through Madison County Health Department by onsite education in businesses and workplaces; at hospital health and wellness fairs; and in community settings such as Wal-Marts, Kmart, strip malls, housing developments, and places where groups of women live or congregate.**
- 13. By June 2012, enroll 500 women per year into the IBCCP program through Madison County Health Department.**
- 14. By June 2012, enroll 100 women per year into Komen and/or other breast and cervical cancer screening programs.**

-
- 15. By June 2012, continue to recruit new providers (including MDs, nurse practitioners, nurses, surgeons, laboratories, and mammography facilities) to facilitate achieving a high quality level of care for Madison County women.**
 - 16. By June 2012, continue to provide professional education and resources to providers (including MDs, nurse practitioners, nurses, surgeons, laboratories, and mammography facilities) to assure they have up-to-date guidelines and algorithms to facilitate achievement of a high quality level of care for Madison County women.**
 - 17. By June 2012, MCPCH Cancer Committee members will volunteer to approach, educate, and solicit participation of middle and high schools in the biannual YRBS surveys in 2007, 2009, and 2011.**

VIII. EXISTING PRIORITY AREA – MOTOR VEHICLE CRASH RELATED INJURY/DEATH

REDUCE THE RATES OF DEATHS AND HOSPITALIZATION FOR UNINTENTIONAL INJURIES DUE TO MOTOR VEHICLE CRASHES

A. RATIONALE

Utilization of the Hanlon Method and PEARL test for Priority Setting in combination with statistical data and community response did not yield unintentional injuries and/or deaths caused by motor vehicle crashes as a health priority area for Madison County. However, based on statistical analysis alone, motor vehicle crashes continue to be a serious health issue in Madison County. Based on Illinois Crash Facts and Statistics, motor vehicle crashes in Illinois were at a slow decline, from 443,293 in 2001 to 437,289 in 2003. Madison County did not fit this profile. This is indicated by an increase in crashes, from 7,842 crashes in 2001 to 8,353 crashes in 2003. According to the Illinois Department of Public Health statistics, unintentional injury is the fifth leading cause of death in Illinois. Motor vehicle crashes cause 38% of all unintentional injury deaths. For Madison County over the last few years, motor vehicle crashes have attributed to 45% of all unintentional injury deaths. When ranked by specific ages, motor vehicle crashes are the leading cause of death for age 2 and every age 4 through 33. With these statistics, the motor vehicle crash will continue to be an area addressed by Madison County for the next five years. Objectives and program strategies will be developed and implemented based on these results.

The U.S. Department of Health and Human Services reported in their document, *Healthy People 2010: National Health Promotion and Disease Prevention Objectives* that unintentional injuries are the fifth leading cause of death in the U.S., killing approximately 100,000 people each year, and the leading cause of death for people aged 1 to 34. Healthy People 2010 Objectives target a rate of 9.2/100,000 population for motor vehicle mortality. According to the Illinois Project for Local Assessment of Needs (IPLAN), Madison County's 2001 motor vehicle crashes crude mortality rate was 20.0/100,000, whereas the rate for Illinois was 12.5/100,000 population. By 2011, Madison County will strive for a crude motor vehicle mortality rate of 14.4/100,000 population. (Baseline = 20.0/100,000 population IPLAN 2001)

In an effort to specifically address the influence of alcohol in motor vehicle fatalities, Madison County will implement specific interventions to reduce the rate of alcohol-related motor vehicle deaths to the state's rate by 2011. According to the IPLAN, Madison County's 1996 alcohol-related motor vehicle death rate was 5.5/100,000 compared to the Illinois rate of 4.1/100,000 population. (Baseline = 5.5/100,000 population IPLAN 1996, their latest available statistic)

B. RISK AND CONTRIBUTING FACTORS ANALYSIS

The risk factors identified as most often associated with unintentional injury related to motor vehicle crashes include: driver inexperience, unrestrained or improperly restrained

occupants, impaired judgment, environmental influence on motor vehicle issues, age, disease process, physical impairment, cognitive abilities, and chemical alterations. Contributing factors include: lack of knowledge regarding restraint issues and road conditions, consistency in enforcement of seat belt laws, age/developmental stage, emotional status, chemical impairment, vehicular conditions, lack of education regarding crash dynamics, employment status, multiple demands on income and financial concerns, confusing information about restraint use, impaired senses, slow response time, altered mental status, prescription/non-prescription medication use, alcohol and other drug abuse, weather, roadway design, poor vehicle maintenance, health and wellness status, fitness level, lifestyles, lack of inadequate/inappropriate medical care, and distraction within vehicle.

After consideration of these risk and contributing factors, the focus for objectives and intervention strategies was placed on child-passenger restraint, education, and behavior changes, with particular emphasis placed on the lack of perception of harm by many motor vehicle occupants.

C. OUTCOME OBJECTIVES

1. By 2011, reduce the deaths caused by motor vehicle injuries to no more than 14.4/100,000 population. (Baseline: 20.0/100,000 population IPLAN 2001)
2. By 2011, reduce the rate of alcohol-related motor vehicle deaths to 4.1/100,000 population. (Baseline: 5.5/100,000 population IPLAN 1996)

D. IMPACT OBJECTIVES

1. By 2009, increase the use of driver restraint to 85%. (Baseline: 75% MCPCH Motor Vehicle Committee 2006)
2. By 2010, increase the use of booster seats for children ages 4 to 8 to 70%. (Baseline: 20% NHTSA 2004)

E. INTERVENTIONS

Note: Several of these interventions are ongoing annually.

1. By September 2009, vehicle safety information will be provided for at least 10 community events.
2. By January 2010, develop and implement public awareness activities in observance of 3-D Month.

3. By May 2009, 100 safe driving sessions will be offered annually targeting students enrolled in county Driver Education programs.
4. By May 2009, 30 "Learning to CARE" educational programs will be offered for fourth grade students in Madison County.
5. By May 2011, annually promote media-based traffic education programs that include: EMSC Week, SAFE KIDS Week, Buckle Up America! Week, Child Passenger Safety Awareness Week, Drive Safely Work Week, National Stop on Red Week.
6. By January 2008, Madison County Youth Board will implement a community/school awareness program re: distracted driving.
7. By January 2009, will have documentation of 100 proper car seat checks/installations.
8. By January 2009, will participate in 3 alcohol and/or tobacco server/seller compliance checks.

F. RESOURCES AVAILABLE (governmental and nongovernmental)

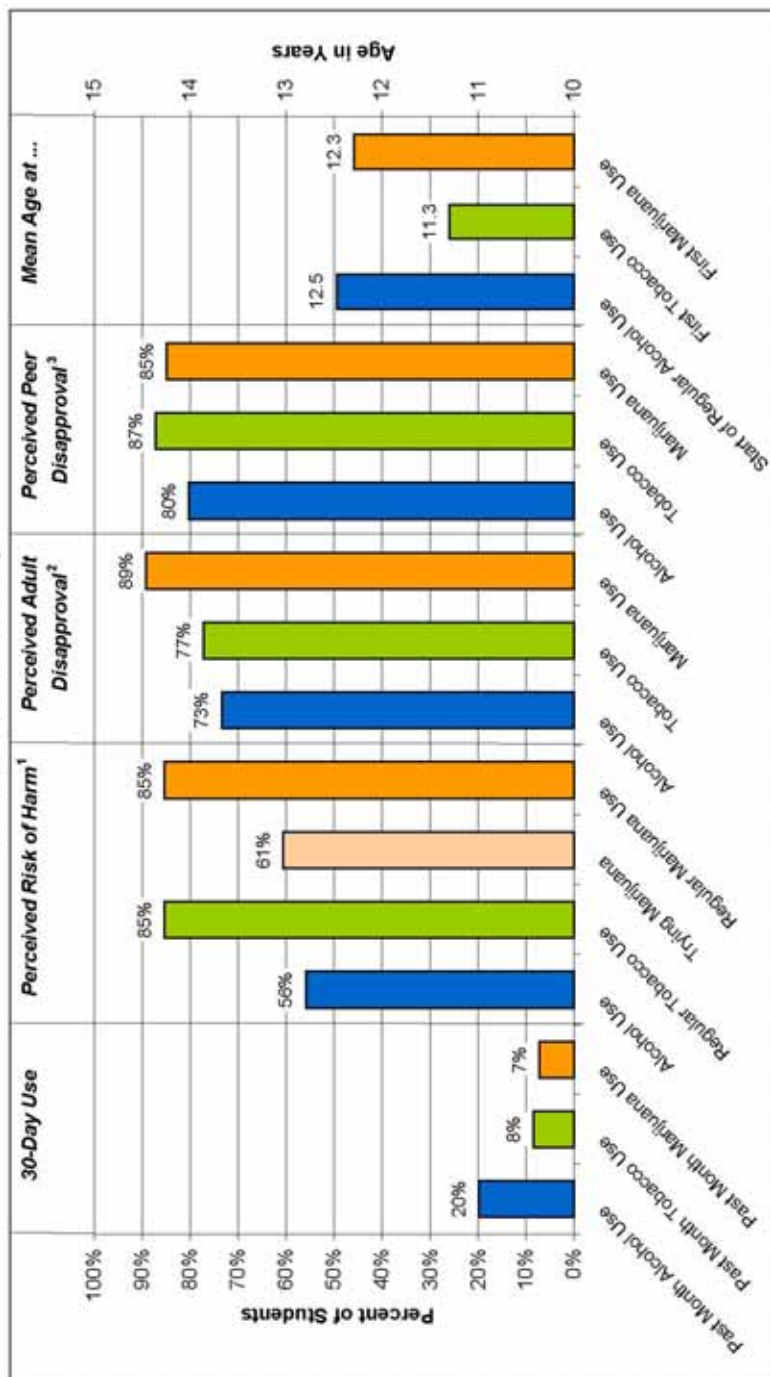
Numerous community resources exist to assist in the development and execution of this strategic plan which include: Local Public Health Tax, Madison County Health Department, Madison County Partnership for Community Health, Illinois Department of Human Services, Illinois Department of Transportation, Illinois Department of Public Health, Emergency Medical Services for Children Region 4, Alton Memorial Hospital, Anderson Hospital, Gateway Regional Medical Center, St. Joseph's Hospital, Saint Anthony's Hospital, Madison County Regional Office of Education, Chestnut Health Systems, school districts, local law enforcement agencies, local fire districts, EMS providers, Illinois State Police, SIUE School of Nursing, physicians and related health care providers, churches/church groups, youth organizations, Madison County Coroner's Office, National Highway Traffic Safety Administration.

G. BARRIERS:

With any initiative that involves change, barriers exist and need to be considered in the planning and implementation processes. Potential barriers to achieving the reduction of injuries and deaths occurring due to motor vehicle crashes include: level of parent education on safety issues, lack of consistent enforcement of existing occupant protection laws, lack of enforcement and prosecution of existing impaired driving laws, lack of public information regarding vehicle safety issues, insensitivity to level of concern, increase in population of the county, increase in vehicle miles traveled, increase in issuance of driver licenses in county, increase in new roadways, increase in traffic signals, and insufficient of program funding.

APPENDIX A –ILLINOIS YOUTH SURVEY DATA
www.illinoisyouthsurvey.org

057 Madison County 8th Grade (642 Students)
2004 Illinois Youth Survey



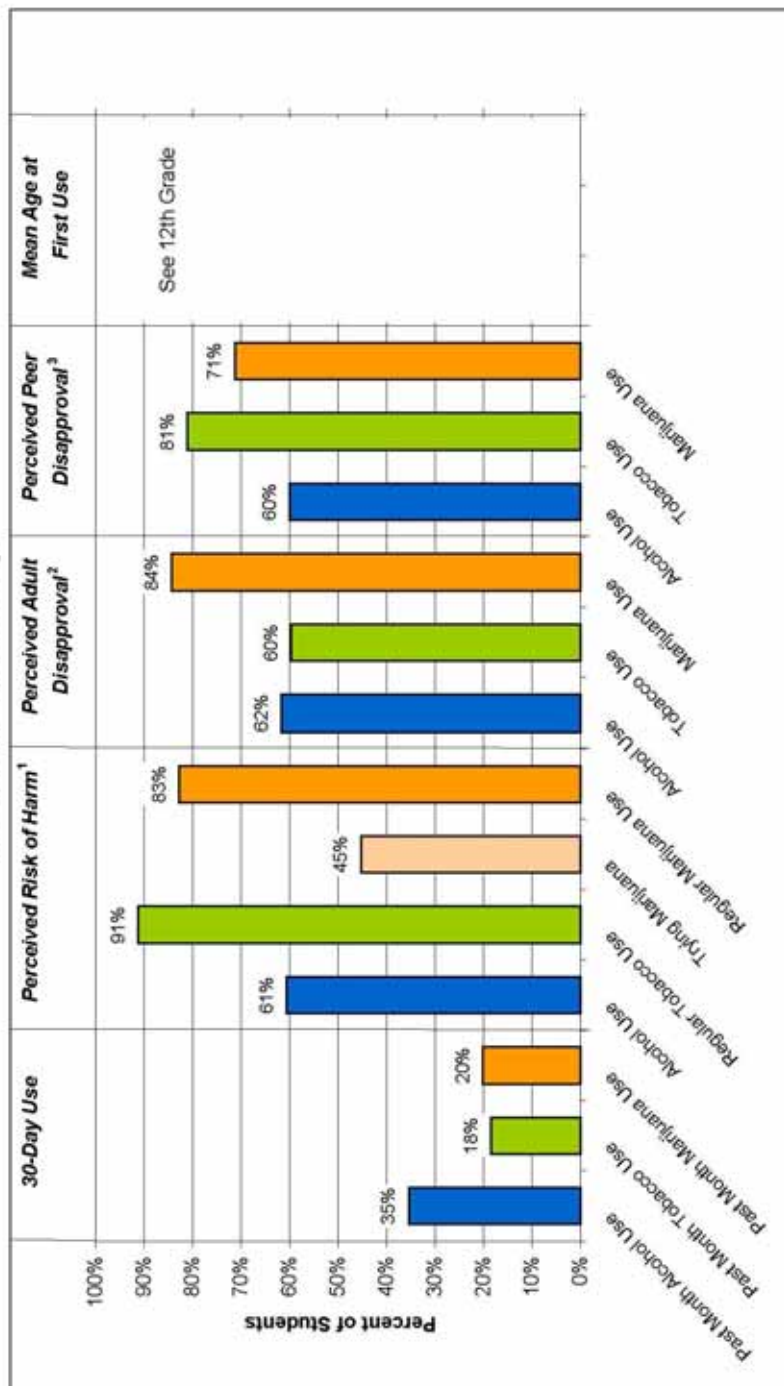
¹Perceived Risk of Harm: Percent who responded "Moderate Risk" or "Great Risk" of harm.

²Perceived Adult Disapproval: Percent who responded "Wrong" or "Very Wrong" attitude of neighborhood adults toward youth use of substance.

³Perceived Peer Disapproval: Percent who reported "Little Chance" or "No Chance" of appearing cool if used substance.

APPENDIX A –ILLINOIS YOUTH SURVEY DATA
www.illinoisyouthsurvey.org

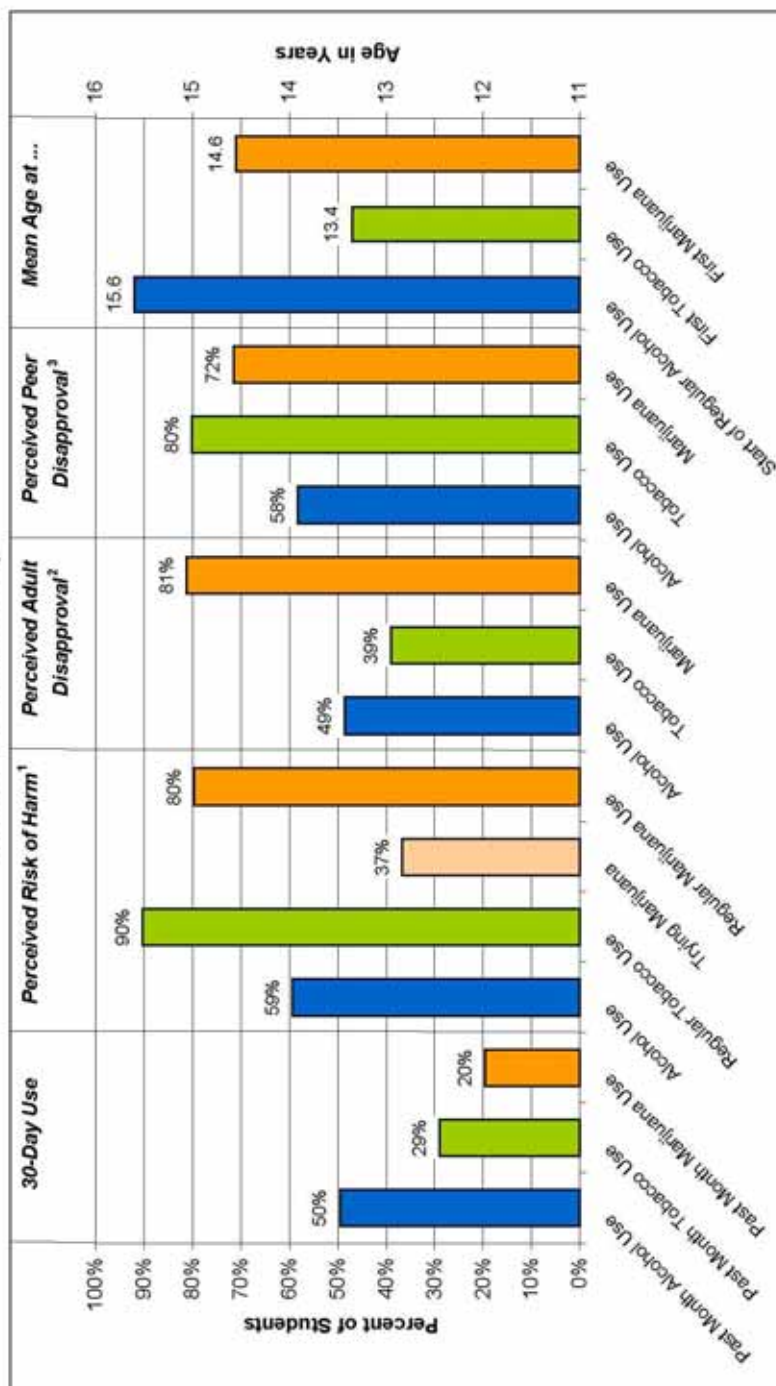
**057 Madison County 10th Grade (516 Students)
 2004 Illinois Youth Survey**



¹ Perceived Risk of Harm: Percent who responded "Moderate Risk" or "Great Risk" of harm.
² Perceived Adult Disapproval: Percent who responded "Wrong" or "Very Wrong" attitude of neighborhood adults toward youth use of substance.
³ Perceived Peer Disapproval: Percent who reported "Little Chance" or "No Chance" of appearing cool if used substance.

APPENDIX A –ILLINOIS YOUTH SURVEY DATA
www.illinoisyouthsurvey.org

**057 Madison County 12th Grade (453 Students)
 2004 Illinois Youth Survey**



¹ Perceived Risk of Harm: Percent who responded "Moderate Risk" or "Great Risk" of harm.

² Perceived Adult Disapproval: Percent who responded "Wrong" or "Very Wrong" attitude of neighborhood adults toward youth use of substance.

³ Perceived Peer Disapproval: Percent who reported "Little Chance" or "No Chance" of appearing cool if used substance.

APPENDIX B – 2005 MADISON COUNTY YOUTH FORUM ISSUES AND RECOMMENDATIONS

Topic: Alcohol, Tobacco, and Other Drugs

Issue and Problem Statement:

- Availability and Access: Alcohol, tobacco and other drugs are readily available to young people. This access enables experimentation and continued usage resulting in dependency and/or other health problems.
- Law Policies: Laws and policies are inconsistent among communities and across schools within the county. This encourages students to go to communities where it is easier to access and the risk of being caught is reduced. Schools that lack strict policies also see increased use by students who do not fear consequences.
- Addiction/Rehab: Very few quality rehab programs exist to help deal with the consequences of addiction. Young people are often mixed in with older adults creating a support climate in which the person may feel alienated. The reason for use and abuse need to be identified and addressed as many youth are using and abusing for deeper reasons.
- Community Norms: Communities continue to model alcohol use, yet expect young people not to engage in similar behaviors. Block parties and summer festivals glamorize alcohol to young people and have a greater impact than fear tactics and threats. The message about use is different among parents, schools, law enforcement, government, business, and the general community in the county leading youth to be confused. Additionally the social norms vary on what is and is not acceptable and tolerated.

Notes:

- There needs to be stricter carding policies for places that sell alcohol and tobacco. We need to increase the amount of compliance checks that are happening to assure that the stores and sellers are complying with the checking ID's and the law. Give praise to the stores that are following the rules.
- There needs to be a standard county policy regarding underage drinking and drug use. They need to target the athletes as well. It seems that a lot of times the policies don't apply to the athletes, especially depending on the season.
- Parents and Law Enforcement need to be working together and supporting each other.
- Sheriff Hertz made the statement regarding the meeting that came out of last year's youth forum regarding school policies and underage drinking and drug use issues. He said that he would follow up on that and see whatever happened to that.
- Tobacco policies need to be looked at, the best way to address this issue is at the state level, similar to alcohol policies.
- The issue of athletes using was brought up again. Stating that there is not follow through regarding athletes using.
- Also more enforcement of Zero Tolerance Law. We need to increase awareness on this issue and what the consequences are.
- We should implement breathalyzers at dances or any school event and follow through with enforcing.
- Sheriff Hertz commented that the anonymous tip line has led to successful disbursement of parties. If the students know of places that are selling to minors, call the tip line and provide that information. It is not being a snitch it is a saving lives issue.
- Jeff Parker stated that he liked the idea of setting a standard through the county. He suggested that talking to the athletic directors would be a first step. We also need to make sure that counseling is part of the program.
- Schools need to implement peer leadership and peer mediation groups in the schools to increase awareness on ATOD issues.
- We need to reiterate the importance of enforcement of underage drinking issues.

- We need to establish campaigns to show that the community is alcohol free, instead of having homecomings hosted by beer companies.
- Maybe schools can establish a newsletter, website, or message board to discuss ATOD issues and help find out the deeper reasons youth are using and what services need to be made available to them.
- Parents need to walk the talk

Topic: Sexual and Social Health**Issue and Problem Statement:**

- Sex Education: students do not receive adequate comprehensive sexuality education in schools, as abstinence only programs have been proven ineffective.
- Media: The media has created too much of an obsession with body image and sexuality causing insecurity, unhealthy exercise and eating behaviors along with dangerous sexual behaviors.
- Teen Pregnancy: Teen pregnancy continues to be a major epidemic in the United States with one in three sexually active teens becoming pregnant. Schools and families do not do an adequate job in providing students with the needed skills and knowledge (beyond abstinence) to effectively reduce the likelihood of becoming a teen parent.
- Peer Pressure: Peer pressure impacts student's sexual and social behaviors in a significant way. This pressure comes not only from immediate friends but also from pressure drawn from the media (TV/movies/magazines/internet). Skills and education for coping with peer pressure tend to be simplistic and limited.

Notes:

- We need to add more comprehensive sexuality education programming to our schools.
- We need to include common STD information, if not all STD information.
- Birth control options should be included.
- Mental and emotional aspects of sex and becoming sexually active.
- Social pressure: teachers need to teach us ways to handle this. There is so much pressure about having sex and it is not even discussed.
- The class should be broken up for part of the time to and taught by a same sex teacher to get into more in-depth conversations.
- Look at the virginity pledges. A study was shown that they were effective in the beginning and then when they started having sex, they showed that those who signed actually had a decreased number using protection
- Look at all of the cartoons geared towards adults (Simpson's and Family Guy), Laguna Beach on MTV and the shows on the WB
- We need to increase awareness with PSA's on the harmful effects of the media.
- We need to go a step further then PSA's we need to pay attention to the ads that are being shown throughout the show and write a letter to the advertisers and explain the impact they are having by supporting that.
- We need to educate the adults on the goal of sexuality education, which is education on life long sexuality.
- We need to urge schools to hire Health Educators
- There are too many followers and not enough leaders, It is time to step up and be the person you know you are
- Stress is a major factor in teen's lives today! We need to spend some time thinking of how we can all deal with this together.
- Parents need to be actively involved in sex education. We need to use the agencies to teach parents how to talk to their kids about sex. Too much hypocrisy! Media, etc. Use experts to talk about that and use the parents to teach values. Help educate parents as to what is going on.
- Establish Peer Counseling Groups
- There should be workshops help for everyone talking about teen pregnancy.

Topic: Personal Health and Safety**Issue and Problem Statement:**

- Lack of eating: Too many students do not get enough calories, suffer nutritionally and sometimes develop eating disorders.
- Violence: Violence is a major part of the lives of young adults. Exposure through the media leads to thinking, which implies violence acceptable and at times appropriate. Violence within relationships, date rape and threats of violence all have the potential for severely impacting the health and well being of individuals now and dwell into their future. Verbal and emotional abuse are prevalent; however, often difficult to identify, report, or to know how to cope with it when it happens to you or a friend.
- Distracted Driving: Cell phones, eating, car stereos, speeding, not paying attention, and other distractions severely increase the likelihood that young drivers may be involved in an automobile accident. Students sometimes think they're invincible and Laws and Driver Education have not always helped.
- Internet Chat Groups: Many students are subjected to the dangers of Internet safety including; misuse or inappropriate sharing of personal information, bullying; manipulations; and the development of potentially dangerous relationships.

Notes:

- Coaches do not give enough time to eat. Schools out at 2:30 and coaches want you there by 2:45.
- We need to bring in dieticians/nutritionist to talk about healthy eating habits and living.
- Lunchtime food is not cooked well; we need to be offered healthier food choices.
- There needs to be more emphasis on health classes in school
- Teen helpline needs to be made available to kids in this county. With trained people manning the phones. PL can increase awareness of the line and emotional issues.
- Use functioning peer leader groups to do peer mediation and conflict resolution
- Stricter dress codes and enforcement of dress codes.
- Teachers must send to the students to administrators. The dress MUST be disruptive to the educational process in order for it to be addressed.
- Peer Leaders need to be change agents. They need to establish the norm of acceptable behavior regarding violence. What are acceptable things to say, ways to act, etc?
- Gossip leads to a lot of the violence in schools.
- Schools should offer a club fair for incoming students. This will increase awareness on the different clubs and organization opportunities that are offered in schools assist them in becoming a part of positive school programs (teach tolerance.org).
- We need to do channel 1 PSA's regarding both chat room dangers and distracted driving.
- Sheriff Hertz will contact his friend with ISP to do a PSA on distracted driving

Topic: Mental and Emotional Health**Issue and Problem statement**

- Self Esteem: Too many high school students are not happy with whom they are and lack the self esteem desirable in young adults. This is manifested in risky health behaviors, trouble with interpersonal relationships, and a variety of other health problems.
- Depression: Today more and more students are suffering from the effects of depression, be it short term or chronic. Linked to many stressors they face, students need to learn how to prevent and cope with the effects of depression as well as how to help others who suffer.
- Stress: Today more than ever, the demands upon young people often overwhelm their capacity to cope. These stressors include pressures from peers, parents, and educators and from young adults themselves. These problems manifest in depression and suicide, drug use, risky sexual behaviors,

interpersonal problems and other emotional conflicts. Preventive education about stress and suicide is often limited and too often a reaction to a tragedy. There is also a lack of support systems of adults for teens to talk with to help them cope with their stressors, discuss difficult issues, and turn to for resources as well as lack of support systems on a continuing basis after as tragedy occurs.

- Coping with Loss: Loss is a common experience for many students. Death, divorce, relationship breakups and other losses can overwhelm a student's capacity to cope. Minimal education is given to students on ways to more effectively deal with loss and minimal support exists to help them through these difficult times.

Notes:

- Mix It Up Day?
- There needs to be a health education reform, this seems to be the reoccurring theme.
- We need to bridge the communication gap between everyone (administration, parents, teachers, etc.)
- We need to provide workshops on these topics and other topics such as financing college, stress management, communication strategies, etc.
- We should have coping awareness week, just like red ribbon week. We can do announcements, speakers, bulletin boards, etc.
- We need to increase awareness of this issue.
- Offer the "Bridge" monthly family nights
- Adults need to remember to let kids be kids!
- The students need to remember you are the one who controls the choices you make. Focus on making good choices, but listen to yourself. We all have an idea of what is right and wrong. Make the right choices to help move you along in the right direction. There are a lot of things out of our control but some of these issues that have been brought up tonight are within your control. Make good and healthy choices when you have the opportunity to choose.
- You are all here for a reason. You all have the opportunity to be leaders. It is the time to push for a change!!

Updates:

- Sheriff Hertz spoke to his ISP contact and they have scheduled the students to perform in a PSA that will be shown on cable network and channel 1. Each school will receive a free copy of the tape.
- Sheriff Hertz has appointed to staff members from the Madison County Sheriff's Department to be mentors/liaisons to the MCYB. The youth board can call on these detectives with any issues that might arise. They each have a specialty area. One specializes in cyber safety and the other specializes in ATOD adolescent issues and sexual assault.

APPENDIX C – MCPCH CUSTOMER RESTAURANT SURVEY RESULTS

Customer Restaurant Survey -393 surveys were completed, however, some individuals did not answer all of the questions. This is reflected as the question responses do not add up to 393. Surveys were distributed by a news release, phone calls, general community events, health fairs and a radio interview on WBGZ/Alton.

YES	NO	Do you smoke?
39	354	
YES	NO	If you are a smoker, would you still eat in a smoke-free restaurant?
79	27	
YES	NO	If you are a smoker, would you continue to come to this restaurant if it was smoke-free?
85	25	
YES	NO	If you are a non-smoker, would you eat in a restaurant with a smoking environment? (almost all survey respondents stated that they eat in restaurants with smoking environments, but only sit in the non smoking section.)
203	138	
YES	NO	If you are a non-smoker, would you prefer eating in a smoke-free restaurant?
346	8	
YES	NO	Would you support a law making all restaurants smoke-free?
325	56	
YES	NO	Are you concerned about getting any disease related to smoke or second-hand smoke such as lung cancer, emphysema or heart disease?
318	70	
YES	NO	Are you concerned about the health-risks of being in a smoking environment?
326	53	
YES	NO	If you wanted to let a restaurant know your opinion of their smoking environment, which of the following ways would you probably use? Please circle all that apply.
		*Comment cards 304
		*Tell the staff 186
		* Tell the manager 124
		*Other 76

Miscellaneous Telephone Comments - 2005 Customer Smoking Survey

- Great survey
- I hope filling out this survey helps
- I do not go unless the non smokers can be in their own room. Consequently, I do not eat out a lot.
- I have tried to let restaurants know my opinion about the smoking, but nothing works.
- I seek out restaurants that are smoke free.
- I wouldn't go to a restaurant that had an environment that I disliked such as when smoking is permitted in all sections of the restaurant.
- I tell the owner if I am unhappy about the smoking.
- I would make a phone call to the restaurant to complain about the smoking, 3 comments
- I am enrolled in Freedom From Smoking classes at St. Anthony's Hospital.
- I would write a letter to the restaurant to complain about the smoking. 4 comments
- I would use a petition.
- I do not patronize restaurants that allow smoking. 5 comments
- I leave if the smoking is too bad. 3 comments
- We eat at Fazoli's in Alton a lot because it is smoke free.
- We eat in the non smoking areas of restaurants, but we don't go to bars because of the smoking.
- I do eat in restaurants with smoking sections, but I prefer not to. I get choked up from being around the smoke for a long time and it aggravates me when I am trying to eat a meal.
- I complain to restaurants online if possible.
- I have been smoke-free for 28 years.
- We don't patronize smoky restaurants.
- We do everything that we can to inform restaurants about our opinions about their smoking environment. Then, I don't patronize them at all.-I won't go to Steak N Shake.
- The Deluxe Diner in Roxana has no non smoking section at all.
- I have been smoke-free for 17 years.
- I feel that people don't have the right to endanger the lives of others.
- I walked out of Los Tres Amigos (Wood River)-there is no divider between smoking and non smoking.
- I quit smoking 20 years ago.
- My husband and I travel to California-I wish things were like that here.
- I travel to Ravanelli's restaurant in Granite City because it is all non smoking.
- I avoid certain restaurants because of smoke. I avoid all bars.
- If restaurants go non smoking, I will cut down on the number of times I eat out.
- We would go to bars, piano bars, etc., if they were non smoking. Bars would increase their business if they went smokefree.
- I already have heart disease from smoking. 2 comments
- I have COPD from smoking. (pulmonary disease)

APPENDIX D – BOARD OF HEALTH RESOLUTION FOR HEALTH PRIORITIES

D-1

A Resolution Establishing Assessment Priorities for the 2007-2012 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, 2001 to June 2, 2006 in part by utilizing the process known as the Illinois Project for Local Assessment of Needs (IPLAN); and

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

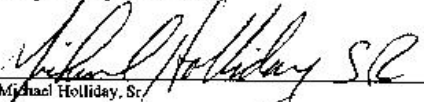
WHEREAS, the assessment process involving core members and stakeholders from various agencies, offices, faith-based organizations, community associations, schools, universities, hospitals, and other partners within the public health system of Madison County has been ongoing since May, 2004; and

WHEREAS, the next 5-year Madison County Community Health Plan (2007-2012) will be developed to establish objectives and strategies for intervention of at least three priority health needs identified in the IPLAN assessment process; and

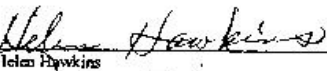
WHEREAS, the Board of Health Advisory Committee and Health Department Committee recommend the acceptance of the IPLAN assessment findings which identify several priority health needs;

NOW, THEREFORE, BE IT RESOLVED that the Madison County Board of Health establishes the health priorities of *Addictive Behaviors, Sexual Risk Behavior, and Cardiovascular Health* for the 2007-2012 Madison County Community Health Plan, and that the Public Health Administrator is hereby authorized to apply with Illinois Department of Public Health for certification renewal.

Respectfully Submitted,

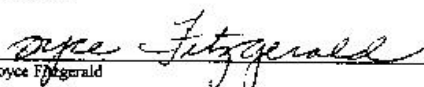

Michael Holliday, Sr.

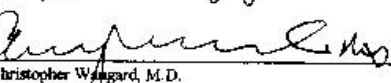

Kent Scheibel


Helen Hawkins


Jeff Kuhn


Mark Burris


Joyce Fitzgerald


Christopher Waligard, M.D.

Health Department Committee

JUNE 21, 2006

A RESOLUTION ADOPTING THE 2007-2012 MADISON COUNTY
COMMUNITY HEALTH PLAN

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

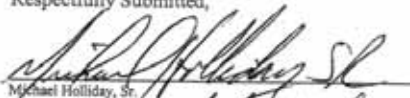
WHEREAS, the Madison County Board of Health adopted the health priorities of *Addictive Behaviors, Sexual Risk Behavior, and Cardiovascular Health* for the 2007-2012 Madison County Community Health Plan, on January 18, 2006; and,

WHEREAS, the Madison County Community Health Plan has been prepared by stakeholders from various agencies, offices, faith-based organizations, community associations, schools, universities, hospitals, and other partners within the public health system of Madison County and establishes objectives and strategies for intervention for the adopted health priorities; and

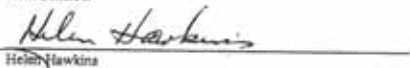
WHEREAS, the Board of Health Advisory Committee and Health Department Committee recommend the adoption of the Plan;

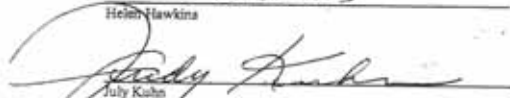
NOW, THEREFORE, BE IT RESOLVED that the Madison County Board of Health adopts the 2007-2012 Madison County Community Health Plan.

Respectfully Submitted,


Michael Holliday, Sr.

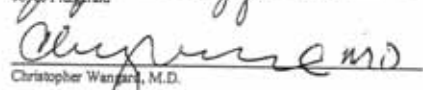

Kent Scheibel


Helen Hawkins


Judy Kuhn


Mark Burris


Joyce Fitzgerald


Christopher Wanzel, M.D.

Health Department Committee