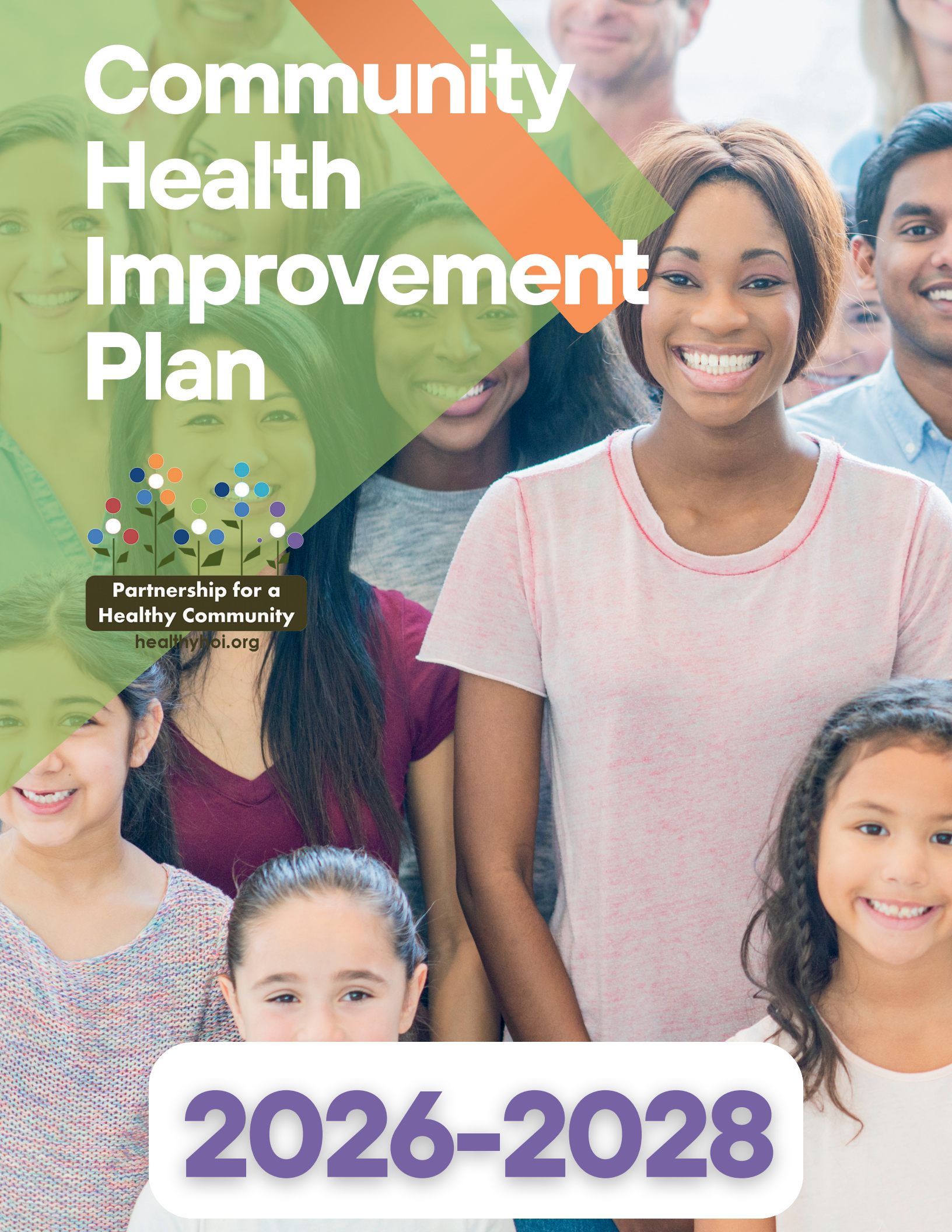
Community Health Improvement Plan



Partnership for a Healthy Community

healthyhoi.org

2026-2028

TABLE OF CONTENTS

Who are We?

MISSION

A community-driven partnership of public and private partners working together to address priority health issues in Peoria, Tazewell, and Woodford Counties of Illinois.

VISION

Our vision for the tri-county region will be a thriving community that is inclusive, diverse, and sustainable to ensure health equity and opportunity for well-being for all.

PARTNERSHIP FOR A HEALTHY COMMUNITY

The Partnership for a Healthy Community (PFHC) is a multi-sector community initiative working to improve population health in the tri-county region. The PFHC focuses on strengthening and aligning community efforts, leverage funding and supporting collaborative opportunities to drive health outcomes. To improve health in the tri-county region, the PFHC was formed in 2015 to develop a collaborative approach to the Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP).

The collaborative includes the regional health systems, local health departments, and community agencies. Since 2015, the Partnership for a Healthy Community has increased development and capacity to assist in creating a sustainable collaborative initiative to improve health.

PFHC Highlights:

- 2015 formation of a Board for the CHIP process for 2016-2019
- Initial Mission, Vision and Values created in January of 2016
- Partnership for a Healthy Community Bylaws in 2017
- Website in 2017
- 1st annual Report in 2017
- Two additional cycles of CHNA and CHIP – aligned
- 2026 marks the 4th Community Health Improvement Planning cycle of our Tri County team partners

PFHC Board

The PFHC has a board which has a reporting structure, bylaws, elections and appointments of officers. Members are elected to 3-year terms and are comprised of 5 representatives for the Region, Peoria, Tazewell and Woodford counties for a total of 20 members.

REGIONAL

Phil Baer
OSF Healthcare

Jill Dodaro
Carle Health

Dr. Sarah Donohue, PhD
U of I College of Medicine Peoria

Kate Green
Continuum of Care

Jennifer Zammuto
HOI United Way

PEORIA

Beth Crider
Retired Peoria ROE

Monica Hendrickson
Peoria City/County Health Department

Becca Mathis
Central Illinois Friends

Chris Setti
Greater Peoria Economic Development Council

Andrea Parker
Hult Center for Healthy Living

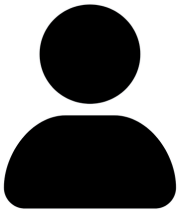
TAZEWELL

Rebecca Crumrine
U of I Extension

Amy Fox
Tazewell County Health Department

Amy Hubner
Pekin Public Schools District 108

Amanda Sutphen
OSF Healthcare



Vacant

WOODFORD

Amy Dewald
Woodford County Health Department

Sally Gambacorta
Carle Hospital Eureka

Autumn Jones
Woodford County Farm Bureau

Tricia Larson
Trillium Place

Craig Maynard
Illinois Wesleyan University

Dr. Sara Kelly, PhD

U of I College of Medicine Peoria

While not an official member of the PFHC Board, Dr. Sara Kelly, PhD is the lead of the PFHC Data Team and was an integral advisor in the Community Health Improvement Planning process.

A Look Back at the 2023-2025 CHIP

Rooted in findings from the latest Community Health Needs Assessment (CHNA) and shaped by community voices, the CHIP highlights three priority areas with the greatest impact on regional well-being. From 2022-2025 those were:

- **Healthy Eating - Active Living (HEAL)**
- **Obesity**
- **Mental Health**

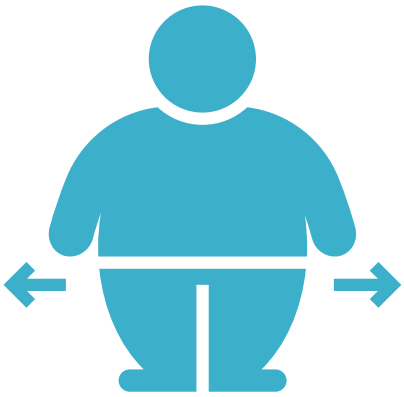
In these areas, the plan sets specific, measurable goals such as increasing access to nutritious foods and safe places for physical activity, reducing obesity among both teens and adults, and enhancing behavioral health support, including a 10% decrease in suicide deaths and a 10% rise in mental health treatment access.

The 2022–2025 Community Health Improvement Plan (CHIP) is a united, data-driven, and community-led blueprint for enhancing health and promoting equity across Peoria, Tazewell, and Woodford Counties. Created by the Partnership for a Healthy Community (PFHC), a coalition of hospitals, public health agencies, nonprofits, schools, and community partners, the CHIP reflects the region's collective commitment to building an inclusive, diverse, and sustainable Tri-County area where everyone can thrive.

The CHIP serves as both a strategic guide and a call to action, aiming to support cross-sector cooperation, influence policies and funding, and promote evidence-based solutions that reduce disparities and enhance quality of life.

By uniting partners around shared priorities and leveraging regional assets, the 2022–2025 CHIP outlined a path toward a healthier, more connected, and more resilient Tri-County community.

HEALTHY EATING - ACTIVE LIVING (HEAL)



OBESITY

MENTAL HEALTH

2023-2025 Highlights: HEAL

The HEAL Action Group leads regional efforts to increase access to nutritious foods, promote physical activity, and reduce obesity across Peoria, Tazewell, and Woodford Counties. HEAL focuses on creating equitable environments that enable all residents to make healthier choices. The group brought together partners from public health, food systems, education, and community organizations.

GROW A ROW

A signature effort of HEAL, the **Grow a Row** campaign encourages gardeners to donate produce to local food pantries. In the last three years, more than

69,000 pounds

of produce have been donated. The campaign continues to expand community engagement and directly supports food access for residents in need.

GARDENING GRANT PROGRAM

This program strengthens community gardens by funding infrastructure improvements, increasing production, and supporting the establishment of new garden sites. Grants help advance the group's garden capacity goals and expand sustainable access to local food.

2022-2025 HEAL GOALS

Increase community garden capacity by:	Increase adults reporting exercise at least 1 day per week from just:
10%	28%

HEALTHY BEHAVIORS

HEAL developed practical toolkits and educational resources related to gardening, nutrition, and physical activity. These accessible materials enhance community readiness and support evidence-based practices across the region.

HEAL-FSP

The **HEAL Food System Partners (HEAL-FSP)** collaborative is a multi-sector group dedicated to enhancing regional food system coordination. This effort encompasses shared communications, educational strategies, and two planned pilot projects that aim to enhance food access, support community development, and mitigate system-level fragmentation.

2023-2025 Highlights: Mental Health

2023-2025 MENTAL HEALTH GOALS

Reduce suicides in the Tri-County region by:	Increase the proportion of children and adults receiving treatment by:
10%	10%

OUTREACH EFFORTS

Campaigns and outreach efforts during this period have emphasized suicide prevention, resource awareness, and the importance of early intervention. Community trainings, school partnerships, and workplace education all contribute to a more informed and responsive support network, particularly for youth and high-risk groups. The action team is engaged in ongoing discussions related to resource coordination, data tracking, and strengthening cross-agency collaboration to align prevention and treatment strategies across the region.

The Mental Health Action Group of the Partnership for a Healthy Community (PFHC) leads regional efforts to strengthen mental health systems, expand access to care, and reduce suicide across Peoria, Tazewell, and Woodford Counties. Goals surrounded decreasing suicide and increasing the proportion of people receiving treatment. Addressing these gaps requires coordinated prevention efforts, crisis intervention capacity, and stronger community awareness.

EVIDENCE-BASED TRAININGS

One of the group's core efforts involves expanding access to evidence-based trainings such as Mental Health First Aid and QPR Suicide Prevention Gatekeeper Training. These programs equip residents, educators, parents, and frontline workers with skills to recognize warning signs, respond to crises, and connect individuals to appropriate care. The region also continues to support school-based trauma-responsive programming, strengthening early identification and support for youth experiencing mental health challenges.

ACCESS TO SERVICES

The group maintains a publicly available list of mental health and telepsychology providers, helping residents connect with local and virtual care options. This aligns with CHIP sub-priorities focused on improving telemedicine access and supporting culturally adaptive healthcare.The Mental Health Action Group also integrates its work with broader community programs that support behavioral health, suicide prevention, youth well-being, and community education.

2023-2025 Highlights: Obesity

The Obesity Action Group focuses on reducing obesity among adolescents and adults across Peoria, Tazewell, and Woodford Counties. The group collaborates with local health departments, schools, healthcare providers, and community organizations to implement evidence-based interventions that prevent obesity and related chronic diseases.

STRONG PEOPLE, HEALTHY WEIGHT

Targeting high-risk areas for obesity such as Northeast Peoria county, **Strong People Healthy Weight** is a

12 week

adult curriculum nutrition education with structured physical activity. Pilot results demonstrated improvements in participant weight, fitness, and blood pressure, signaling positive health impacts.

COLLABORATION WITH HEAL

Coordination with the HEAL Action Group, ensures environmental supports such as community gardens, healthy food access, and physical activity infrastructure reinforce obesity prevention goals. State-level collaboration, including alignment with initiatives such as the Illinois State Physical Activity and Nutrition (ISPAN), further strengthens the group's evidence-based and multi-sector approach.

2022-2025 OBESITY GOALS

Reduce adolescent obesity by:	Reduce adult women's obesity by:
1%	1%

WELL AND HEALTHY KIDS U

the Obesity Action Group has leveraged digital interventions and health coaching programs, including WELL and Healthy Kids U, which have reached hundreds of youth. These programs are expanding through partnerships with schools and universities, increasing access to education and behavioral support for healthy lifestyles. Additionally, the group is continuing work on a collaborative grant examining the impact of social media on youth obesity, and recently applied for an extension to broaden this initiative.

How Did We Get Here? The CHIP Process

PURPOSE

The Community Health Improvement Planning (CHIP) process is used to collaboratively address key health priorities in our community by identifying root causes, using data-driven strategies, and promoting health equity with input from our community and our partners. Mobilizing Action Through Planning and Partnerships or MAPP 2.0 was used as the guide to collect community data and develop value-based, people-centered interventions. Three assessments were used to gather the necessary data from primary and secondary sources:

ASSESSMENTS

COMMUNITY STATUS ASSESSMENT (CSA)

CSA informs MAPP and collects quantitative data on the status of your community such as demographics, health status, and health inequities. The PFHC developed a Tri-County Community Survey to identify health needs and health behaviors, including social determinants of health.

COMMUNITY CONTEXT ASSESSMENT (CCA)

The CCA centers on people and communities with lived experiences and lived expertise. It focuses on the views, insights, values, cultures, and priorities of those experiencing inequities firsthand. The CCA consisted of engaging various focus groups of specific populations to help understand health status and well-being, forces of change, built environment and access to care.

COMMUNITY PARTNER ASSESSMENT (CPA)

The CPA allows community partners involved in MAPP to look critically at their (1) individual systems, processes, and capacities; and (2) collective capacity as a network of community partners to address health inequities. The CPA was used to identify current and future actions to address health inequity at individual, systemic, and structural levels. The CPA assesses each PFHC partner's assets, resources, and strengths to improve community health, health equity, and advance community health improvement goals and strategies.

The findings from these assessments were then compiled into the Community Health Needs Assessment (CHNA).

These 3 assessments were supplemented with a variety of public health surveillance data to identify emerging trends and issues impacting community health and well-being. The data encompassed health behaviors, chronic disease prevalence, social determinants of health, and health inequities, as well as systemic factors such as power, privilege, and oppression that influence health outcomes in the Tri-County region of Central Illinois. A series of areas of concern were identified by the PFHC based on the assessment findings.

Community Prioritization

The MAPP 2.0 3 assessment process provided a structured approach for the PFHC to prioritize health issues for the 2026-2028 CHIP cycle. From the MAPP 2.0 assessments, the PFHC identified particular areas of concern that resulted in the development of 10 issue statements structured for community discussions and prioritization. These sessions involved reviewing raw data and summarizing key health issues affecting the Tri-County region. The Hanlon Method for Prioritizing Health Problems was used to guide this process. This method is widely recognized in public health for its systematic approach to evaluating and ranking health issues. As part of the comprehensive prioritization process, the PFHC applied the PEARL method, a key component of the Hanlon Method for Prioritizing Health Problems, to systematically evaluate a broad list of community health issues. The PEARL criteria—Propriety, Economics, Acceptability, Resources, and Legality—served as a screening tool to determine whether each issue was appropriate and feasible for public health intervention.

The PFHC held several community meetings in the Tri-County area to give community members and stakeholders an opportunity to rank the issue statements. Additionally, the PFHC, Tri-County health departments, OSF Saint Francis Medical Center, Carle Health, and the Community Conversations Group also participated in ranking issue statements.

Based on data collected from the assessments and the community prioritization process, three priority areas have been identified for the 2026-2028 CHIP Cycle:

Reduce food insecurity among youth, especially during school closures

Increase access to behavioral health services by improving navigation of services, particularly for youth and those with low income

Decrease suicidal ideation and self-harm behaviors among adolescents and young adults

The Priorities: Youth Food Insecurity

OUR FINDINGS

- 12,751 Tri-County youth are food insecure.
- Those who were younger, had lower household income, and unstable housing less often reported consumption of healthy fruits/vegetables.
- The most common reasons for not eating more fruits/vegetables were the lack of importance, dislike, and affordability.
- Youth report skipping meals or choose unhealthy options due to lack of time and money.
- Approximately half of the organizations reported food insecurity (through economic stability and built environment) as an issue that they focus much of their effort.

Youth Food Insecurity: The Data

12,751

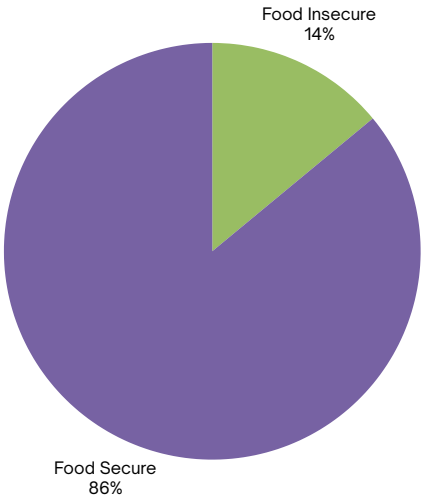
TRI-COUNTY YOUTH ARE AFFECTED BY FOOD INSECURITY

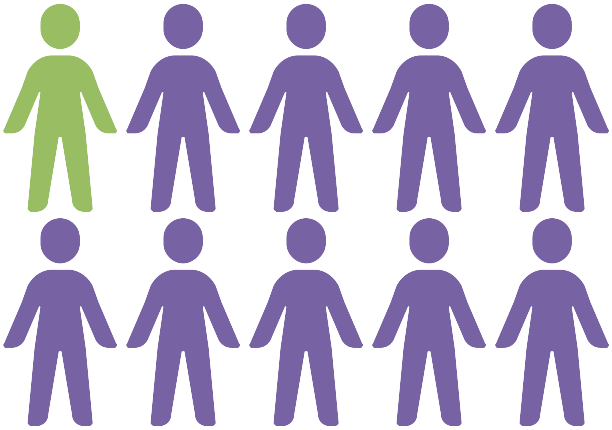
SOURCE: 2024 TRI-COUNTY CSA

THAT MAKES UP

14%

OF TRI-COUNTY YOUTH





WHICH MEANS MORE THAN

1 IN 10

DON'T KNOW WHERE THEIR NEXT MEAL WILL COME FROM

The Priorities: Access to Behavioral Health Services

OUR FINDINGS

- 30% of adults had unmet mental health treatment in the past year.
- Worse mental health was more common among those with unstable housing environments and minority populations.
- The most common barriers for seeking mental health treatment include cost, or no coverage under insurance, limited awareness of available treatment, and transportation.
- Shortage of mental health providers was an often-discussed issue.
- Lack of diverse providers and overall stigma around mental health among community members.
- Mental/behavioral health was one of the top topics that organizations specifically stated they were working on in the region (67%).
- Healthcare access/utilization are top issues addressed by organization in the community (72%).

Access to Behavioral Health Services: The Data

61,111

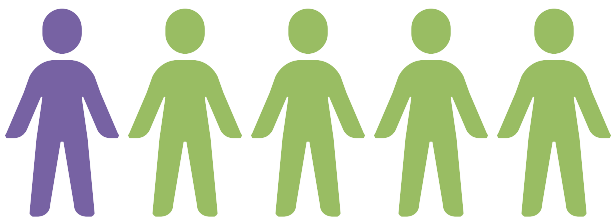
ADULTS IN THE TRI-COUNTY HAD A MENTAL HEALTH ISSUE IN PAST YEAR

SOURCE: 2024 TRI-COUNTY CSA

BUT ONLY

51%

OF RESPONDENTS TALKED WITH SOMEONE ABOUT IT



22%

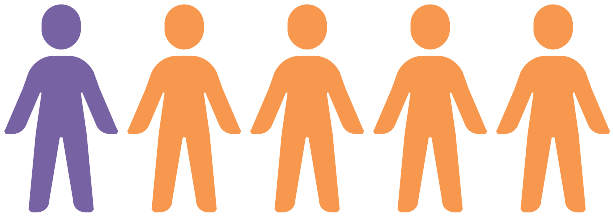
OF RESPONDENTS RATED MENTAL HEALTH AS THE MOST IMPORTANT HEALTH ISSUE. THAT'S THE HIGHEST IN THE ASSESSMENT

The Priorities: Suicidal Ideation and Self-Harm Behaviors In Young People

OUR FINDINGS

- 20% of high school students have seriously considered attempting suicide in the past year.
- Suicide mortality rate in the Tri-County region is higher than state.
- Low-income population and youth cited self-medication as a treatment for unmanaged mental health issues.
- Low-income population reported high levels of stigma and an overall lack of mental health treatment which contributes to accessing preventive care and other issues (i.e. substance use).
- Mental/behavioral health was one of the top topics that organizations specifically stated they were working on in the region (67%).

Suicidal Ideation and Self-Harm Behaviors in Young People: The Data

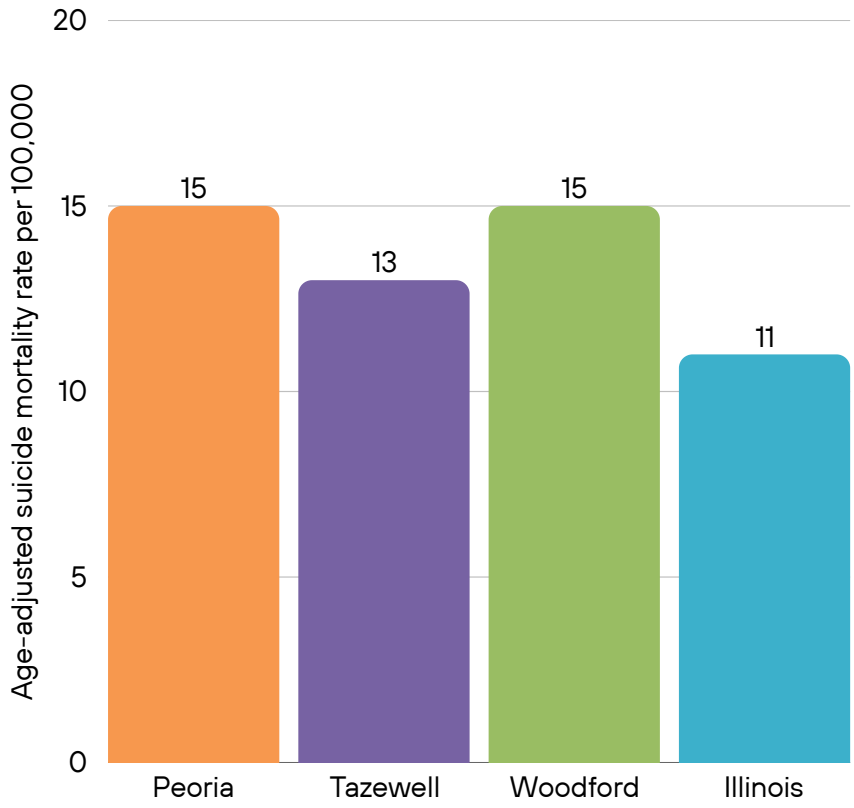


20%

OF HIGH SCHOOL STUDENTS HAVE SERIOUSLY CONSIDERED SUICIDE IN THE PAST YEAR

SOURCE: 2023 YRBSS

SUICIDE DEATHS FOR ALL COUNTIES IN THE TRI-COUNTY ARE HIGHER THAN ILLINOIS STATE AVERAGE



The Plan Moving Forward

Now that we have identified the priority health needs of our communities, it's time to get to work! **CHIP planning action teams** focusing on each priority area were formed to begin developing goals, interventions and strategies pertaining to the newly chosen health priorities. Each action team was made of representatives from numerous organizations and employed a:

Systems of Change Approach for Interventions

This approach prioritizes systems and structures, considers events and patterns, discovers root causes, emphasizes a shared vision, and facilitates the mental models for value based, people centered intervention. CHIP planning action teams were formed for each issue statement. The action teams held a series of meetings to that included discussions on current and future states, root causes of health inequities, data review, and community assets to develop intervention goals, objectives and strategies for the 2026-2028 CHIP cycle.

The following definitions and contexts were also identified and deemed essential during the planning process by each action team:

Youth Food Insecurity

Youth **-** individuals ages 0-18
Food insecurity - household-level economic and social condition of limited or uncertain availability of adequate and nutritious food.
School closures - any period of time outside a school setting, includes weeknights, weekends, holidays.

Access to Behavioral Health Services

Youth **-** ages 4-18
Low income **-** un-insured, under-insured, and those on Medicaid
Access **-** effectively engaging in care in a timely manner
Behavioral Health Care **-** any service targeted to improve mental health and/or substance use concerns

Suicidal Ideation and Self-Harm Behaviors in Young People

Young people **-** age range: 12-25 yrs
Suicidal thoughts **-** thinking about, considering, or planning suicide
Suicidal behaviors **-** engaging in behaviors with the intent to end own life
Self-harm **-** intentionally causing harm to own body

Youth Food Insecurity

GOAL

Empower and increase resiliency amongst youth and their families to improve access to adequate nutrition.

OBJECTIVES

1. Reduce the rate of youth screening positive for food insecurity by **1.5%** in the Tri-County by the end of December 2028
2. Increase the number of youth screened for food insecurity by **10%** in the Tri-County region by the end of December 2028.

Intervention Strategies	Tasks & Tactics	Evaluation Plan
Complete community assessment of nutrition resources for youth to develop a plan to address the gaps in food access.	1. Identify existing nutrition resources and preferences for youth 2. Identify gaps in nutrition resources 3. Compile collection of data around nutrition resources 4. Identify strategies to engage partners 5. Host conversation amongst partners and community members 6. Develop plan to address gaps	1a. Number of resources identified 2a. Number of gaps identified 3a. Establish baseline numbers and plan for ongoing stability 4a. Number of strategies identified & engagement plan developed 5a. Number of meetings held throughout cycle 6a. Report created that highlights gaps and plans to address them
Promote family stability by increasing food literacy and connecting families with sustainable food resources	1. Define roles of both individuals and organizations have in food security 2. Train identified organizations on food insecurity 3. Financial literacy training and connection to financial and nutrition assistance resources 4. Provide nutrition education opportunities for youth and families	1a. Increase number of partnerships between organizations and families 2a. Number of food insecurity trainings held 3a. Number of financial literacy trainings held 4a. Number of nutrition education trainings held
Promote awareness and advocacy around youth food insecurity to improve and sustain food access	1. Address gaps in utilization and availability of food resources 2. Develop or identify outreach strategies to improve community knowledge and perceptions of nutrition assistance programs 3. Develop communication processes among partners for continuity of care 4. Develop policy recommendations in support of legislation and/or potential funding applications	1a. Implementation of plan, including existing programs 2a. Strategies identified and carried out Increase participation in and knowledge on navigation of assistance programs 3a. Number of contacts made 3b. Number of organizations attended 4a. Number of policy recommendations

Access to Behavioral Health

GOAL

Improve access to and utilization of behavioral health resources for youth and low-income adults

OBJECTIVES

1. Increase the proportion of primary care visits that provide a mental health screening for Tri-County youth and low-income adults by **2%** by the end of December 2028.
2. Increase follow-up care after ED visits for behavioral health concerns among Tri-County youth by **5%** by the end of December 2028

Intervention Strategies	Tasks & Tactics	Evaluation Plan
Increase behavioral health (BH) family support	1. Identify existing family-centered community organizations and groups and evaluate their internal behavioral health resources	1a. Number of family-centered community spaces 1b. Catalog of organizations/groups Where are they? Where should they be? What do they provide/not provide? 1c. Gap assessment (tiered review) of resource availability and utilization of behavioral health programs/services
	2. Develop plans to increase family support	2a. Number of plans developed
Increase access to behavioral health (BH) services and programs	1. Identify existing BH resources in the Tri-County area	1a. Number of resources identified
	2. Create a public, dynamic, and centralized Tri-County directory of BH resources and programs	2a. Comprehensive directory created
	3. Identify a public, centralized location for a directory of resources, accessible to community members and providers	3a. Centralized location identified
	4. Develop a promotional campaign for directory	4a. Track number who access directory
Improve coordination of programs and services among BH providers	1. Educate stakeholders about System of Care principles & strategies	1a. Meeting products/number of stakeholders
	2. Integrate System of Care framework within previous & future BH PFHC activities	2a. Gap analysis (streamlining processes, expansion of services, hours, locations, workforce development, health literacy
	3. Educate key community leaders about coordination of BH services/programs	3a. Meeting products/number of presentations
	4. Develop a local behavioral health System of Care implementation policy	4a. Number of implementation policies developed

Suicidal Ideation and Self-Harm Behaviors in Young People

GOAL

Develop, encourage, and sustain a Tri-County region where adolescents and young adults live and feel supported, included, heard, and valued.

OBJECTIVES

1. Reduce suicide mortality rates among Tri-County adolescents and young adults by **1%** by the end of December 2028
2. Reduce the annual number of ED visits related to self-harm and behaviors among Tri-County adolescents and young adults by **2%** by the end of December 2028.

Intervention Strategies	Tasks & Tactics	Evaluation Plan
Strengthen family stability and reduce adversity across the lifespan	1. Assess diverse community settings, school SEL programs, and counseling services to identify gaps affecting family stability	1a. Number of assessments completed across settings 1b. % of identified gaps (categorized) 1c. Number of partners engaged in assessment process
	2. Provide linkages to behavioral health and supportive resources based on assessment findings and maintain a resource repository	2a. Number of families and programs connected to BH resources 2b. Number of resources added, updated, accessed in repository 2c. Increase in resource utilization over time
	3. Assess community awareness of brain development and create/disseminate education materials on coping and problem-solving	3a. Pre/post awareness survey results on brain development 3b. Number of educational materials created/number distributed 3c. Engagement metrics (event attendance, website/social media metrics)
	4. Develop and disseminate localized interventions on misinformation, social media, AI, etc. and promote realistic expectations and multiple paths to success for youth	4a. Number of interventions created and delivered 4b. Participation metrics for youth and adults 4c. Pre/post measures indicating understanding of materials
Expand behavioral health awareness, access, and workforce capacity	1. Provide suicide prevention and self-harm education and increase public understanding of identifying untreated mental health issues	1a. Number of suicide prevention/self-harm education sessions delivered 1b. Number of participants trained (youth, adults, families) 1c. Pre/post training surveys showing increased knowledge of warning signs and help-seeking behaviors 1d. Number or percent of referrals to mental health services following education

Suicidal Ideation and Self-Harm Behaviors in Young People

Intervention Strategies	Tasks & Tactics	Evaluation Plan
Expand behavioral health awareness, access, and workforce capacity (cont.)	2. Implement processes and surveys to identify gaps in behavioral health resources and disseminate accessible BH information	2a. Number of surveys distributed and percentage completed 2b. Number and type of BH gaps identified and documented 2c. Number of BH resource guides disseminate (digital or print) 2d. Number and/or % increase in resource inquiries or website traffic related to BH information
	3. Assess BH case coordination, develop warm-hand-off policies, and implement and evaluate the care coordination plan	3a. Number of partner organizations adopting warm-hand-off protocols 3b. Number of warm-hand-off referrals conducted 3c. Evaluations showing improved service navigation and reduced drop-off between referrals
	4. Conduct BH workforce assessment, develop a BH workforce plan, integrate it into broader workforce efforts, and implement staff self-care and training initiatives	4a. Number of workforce plan recommendations implemented 4b. Number of BH staff participating in self-care or wellness initiatives 4c. Number or % participation rates and pre/post training competency scores 4d. Number or % increase in BH workforce recruitment or retention metrics
	5. Assess BH policy gaps, develop needed policies, and advocate for improved BH communication and support systems	5a. Number of BH policies reviewed, identified, or drafted 5b. Number of advocacy activities completed (meetings, policy briefs, coalition actions) 5c. Number or % increase toward adoption, revision, or implementation of BH policies 5d. Number or % increase in BH communication systems (e.g., shared protocols, data-sharing agreements)
Enhance family wellbeing by increasing awareness of existing supportive networks and expanding equitable access to interventions that strengthen diverse families and backgrounds	1. Increase family connection and emotional awareness	1a. Number of family involvements or workshops conducted 1b. Attendance rates and participant demographics 1c. Pre/post surveys measuring improvement in family communication, emotional understanding and quality time 1d. Participant-reported increase in empathy, problem-solving, and emotional coping skills
	2. Develop or identify outreach strategies to improve community knowledge and perceptions of behavioral health programming	2a. Number of outreach strategies implemented 2b. Reach and engagement metrics 2c. Pre/post surveys assessing awareness and perceptions of nutrition assistance programs 2d. Number or % increase in program enrollment or utilization after outreach

Suicidal Ideation and Self-Harm Behaviors in Young People

Intervention Strategies	Tasks & Tactics	Evaluation Plan
Enhance family wellbeing by increasing awareness of existing supportive networks and expanding equitable access to interventions that strengthen diverse families and backgrounds (cont.)	3. Strengthen support networks across community touchpoints	3a. Number of partnerships established with community organizations (faith-based, recreational, cultural)
	4. Improve navigation of services using a 'No Wrong Door' approach	4a. Number of families successfully connected to services through multiple entry points 4b. % of inquiries resolved without referral failures 4c. Participant satisfaction surveys on ease of accessing services 4d. Number of staff trained on 'No Wrong Door' navigation protocols
	5. Reduce Mental Health Stigma through shared experiences	5a. Number of supportive group sessions or storytelling events conducted 5b. Attendance and demographic diversity of participants 5c. Pre/post surveys measuring changes in attitudes toward mental health and help-seeking behaviors 5d. Number of referrals to mental health services originating from group sessions
	6. Expand Awareness of and Access to Supportive Services	6a. Number of resource guides, digital tools, or outreach materials created and disseminated 6b. Number or % increase in the number of families accessing BH and community resources 6c. Engagement metrics (website hits, downloads, hotline calls) 6d. Participant-reported awareness and satisfaction with available resources

Evaluation & Monitoring

The Partnership for a Healthy Community (PFHC) Community Health Improvement Plan (CHIP) includes a comprehensive evaluation framework with both process and outcome indicators. These indicators will be monitored and updated regularly through data reports led by the PFHC Data Team. The PFHC Board will ensure accountability by reviewing progress and reporting results to the community. Indicator tracking will occur throughout the three-year cycle, with a focus on measuring changes in priority health issues and assessing the impact of implemented strategies.

Partnership for a Healthy Community Board reserves the right to amend this 2026-2028 Community Health Improvement Plan as needed to reflect changes with organizational capacity as well as changes in community focus. In addition, throughout the cycle, the acuity of health needs may become more significant and require amendments to the strategies and tactics developed to address the health need. Finally, in compliance with Internal Revenue Code Section 501(r), requirements for hospitals may refocus the limited resources the organization committed to the Plan to best serve the community.

Acknowledgements

Thank you!

To everyone who helped contribute to this Community Health Improvement Plan and process, we so appreciate your dedication to improving the health of our communities. This plan will serve as the foundation of creating a healthier Tri-County throughout the next 3 years. A special thank you to:

- Partnership for a Healthy Community Board Members
- 2023-2025 CHIP Action Teams and Co-Chairs
- 2026-2028 CHIP Planning Action Teams and Co-Chairs
- MAPP Steering Committee
- Community Conversations Group
- Bradley University
- University of Illinois College of Medicine (UICOMP)
- Tri-County Community Residents and Stakeholders
- Greater Peoria Healthcare Collaborative

And to the organizations that help make up the Partnership for a Healthy Community!

Partner Organizations

Bradley University
Carle Health
Center for Youth & Family Solutions
Central IL Friends
Chestnut Health Systems
Children's Home Association of Illinois
Economic Recovery Crops
Edge Counseling & Wellness
Eureka College
Gateway Foundation
Greater Peoria Economic Development Council
Heart of Illinois United Way
Heartland Health Services
Hult Center for Healthy Living
Methodist College
OSF Healthcare
Peoria City/County Health Department
Peoria County Sustainability
Peoria Heights Grade School
Peoria Park District
Peoria Parole Office
Peoria Regional Office of Education
Pekin School District 108
Phoenix Community Development Services
Southside Community Center
Solvera Health
STM Food
Tazewell County Health Department
Trillium Place
U of I Extension
U of I College of Medicine - Peoria
Veteran's Affairs
Woodford County Health Department

Contact Us

Email **HealthyHOI@WildApricot.org**

Website **HealthyHOI.org**

Facebook **Facebook.com/PartnershipForAHealthyCommunity**

Appendix A: Assessment Summaries

Partnership for a Healthy Community
healthyhoi.org

2025

Community Health Needs Assessment:

Partnership for a Healthy Community

PEORIA COUNTY

TAZEWELL COUNTY

WOODFORD COUNTY

Introduction

The Tri-County County Community Health-Needs Assessment is a collaborative undertaking by the Partnership for a Healthy Community to highlight the health needs and well-being of residents in Tri-County County.

Through this needs assessment, collaborative community partners, including Carle Eureka Hospital, Carle Health Methodist Hospital, Carle Health Pekin Hospital, Carle Health Proctor Hospital, Bradley University, Heart of Illinois United Way, Heartland Health Services, Hopedale Medical Complex, OSF Saint Francis Medical Center, Peoria City/County Health Department, Tazewell County Health Department and Woodford County Health Department have identified numerous health issues impacting individuals and families in the Tri-County County region. Several themes are prevalent in this health-needs assessment – the demographic composition of the Tri-County County region, the predictors for and prevalence of diseases, leading causes of mortality, accessibility to health services and healthy behaviors.

Results from this study can be used for strategic decision-making purposes as they directly relate to the health needs of the community. The study was designed to assess issues and trends impacting the communities served by the collaborative, as well as perceptions of targeted stakeholder groups.

In order to perform these analyses, information was collected from numerous secondary sources, including publicly available sources as well as private sources of data. Additionally, survey data from 2.329 respondents in the community were assessed with a special focus on the at-risk or economically disadvantaged population. Areas of investigation included perceptions of the community health issues, unhealthy behaviors, issues with quality of life, healthy behaviors, and access to medical care, dental care, prescription medications and mental-health counseling. Additionally, social drivers (determinants) of health (SDoH) were analyzed to provide insights into why certain segments of the population behaved differently.

Ultimately, the identification and prioritization of the most important health-related issues in the Tri-County County region were identified. The collaborative team considered health needs based on:

1. magnitude of the issue (i.e., what percentage of the population was impacted by the issue)
2. severity of the issue in terms of its relationship with morbidities and mortalities
3. potential impact through collaboration

Using a modified version of the Hanlon Method, the collaborative team prioritized three significant health needs:

- **Food insecurity among youth**
- **Access to behavioral health**
- **Suicidal and self-harm thoughts & behaviors**

Food Insecurity Among Youth

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

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

In Peoria County, the food insecurity rate stands at 14.5%, while Tazewell County reports a child food insecurity rate of 15.5%. Although specific data for Woodford County is limited, regional trends suggest similar challenges. These local rates exceed the Healthy People 2030 target of reducing household food insecurity to 6% and very low food security in children to 0.3%. This gap underscores the urgent need for coordinated, youth-focused interventions across the Tri-County area.

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

Access to Behavioral Health

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

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

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

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

Suicidal and Self-Harm Thoughts & Behaviors

Suicidal and Self-Harm Thoughts & Behaviors — ranging from ideation and planning to attempts—are serious public health concerns that require both preventative and clinical interventions to reduce risk and promote mental well-being.

In the Tri-County area of Peoria, Tazewell, and Woodford Counties, addressing suicide risk is especially urgent given disparities in healthcare access and mental health support. While 87% of residents report having a primary care provider (PCP), Black and Latino/a/x individuals and those experiencing housing instability are significantly less likely to have one, limiting early identification and intervention opportunities. Younger, higher-income, and more educated individuals more frequently use urgent care, which may not be equipped for sustained behavioral health support.

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

Collaborative Team

COLLABORATIVE TEAM

Phil Baer | OSF Healthcare System
Rebecca Crumrine | University of Illinois Extension
Amy Dewald | Woodford County Health Department
Jill Dodaro | Carle Health
Sarah Donohue | University of Illinois College of Medicine – Peoria
Amy Fox | Tazewell County Health Department
Sally Gambacorta | Carle Health
Kate Green | Home for All
Megan Hanley | Tazewell County Health Department
Monica Hendrickson | Peoria City/County Health Department
Tricia Larson | Carle Health
Leslie McKnight | Peoria City/County Health Department
Andrea Parker | Hult Center for Healthy Living
Chris Setti | Greater Peoria Economic Development Council
Amanda Sutphen | OSF Healthcare System
Jennifer Zummuto | Heart of Illinois United Way

FACILITATORS

Michelle A. Carrothers | OSF Healthcare System
Sara Kelly | University of Illinois College of Medicine – Peoria
Dawn Tuley | OSF Healthcare System
Dr. Laurence G. Weinzimmer (Principal Investigator) | Bradley University

Community Conversations Summary

Communities interviewed included:

- Cancer Patients
- Female (maternal health)
- LGBTQ+
- Low Income
- Male
- Minority
- Seniors
- Youth

When asked about insurance, most individuals said that they had health insurance but that it, and the cost of healthcare, was hard to afford, and many noted that it was hard to find physicians who accept Medicaid.

The results for each community are presented in their own sheet.

Listed below are the themes present in most conversations:

Some health issues nearly in every group included:

- Mental health is a top health issue
- Access to care is a top health issue

Health behaviors:

- Substance use was consistently mentioned as a problem

For social determinants of health, several issues commonly mentioned were:

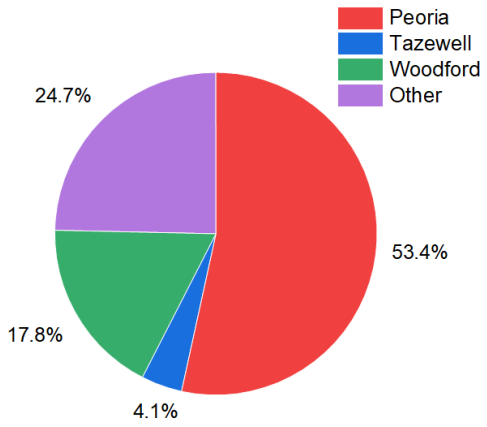
- Housing
- Safety
- Access to nutritious foods

Many people mentioned discrimination when discussing systems of power, privilege, and oppression.

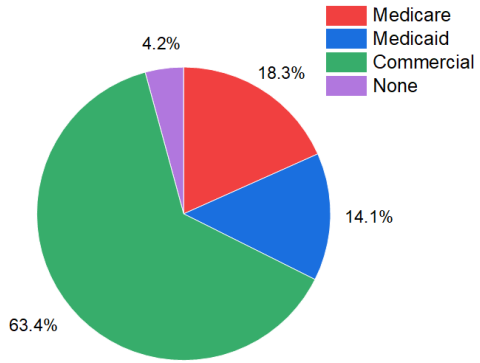
A lot of people mentioned opportunities to improve were health education.

Community Conversations: Demographics

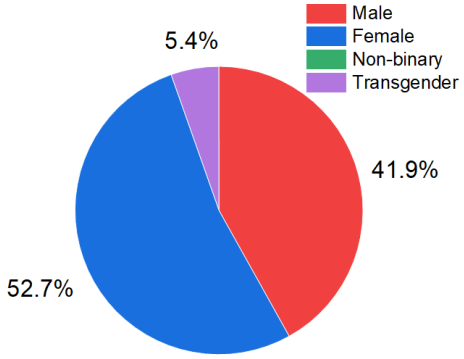
County



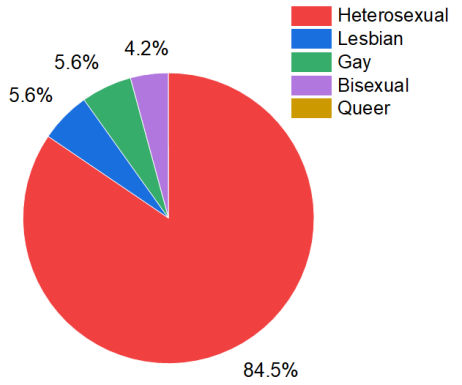
Insurance



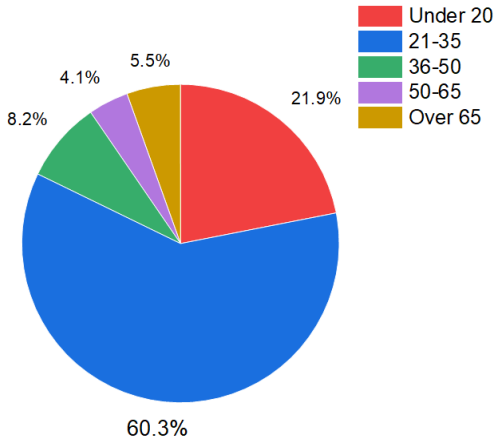
Gender



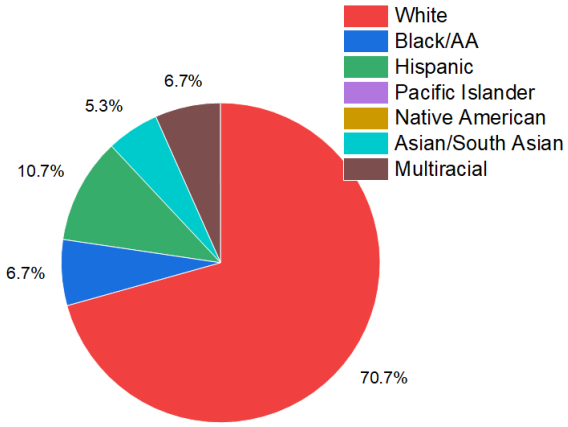
Sexual Orientation



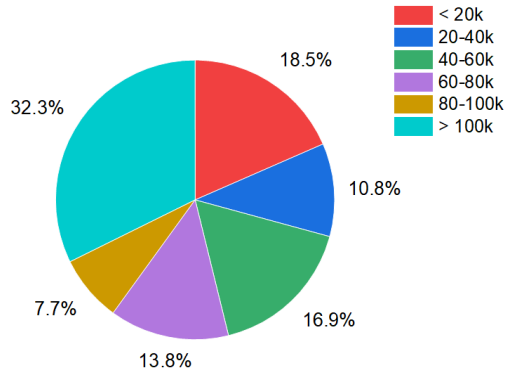
Age



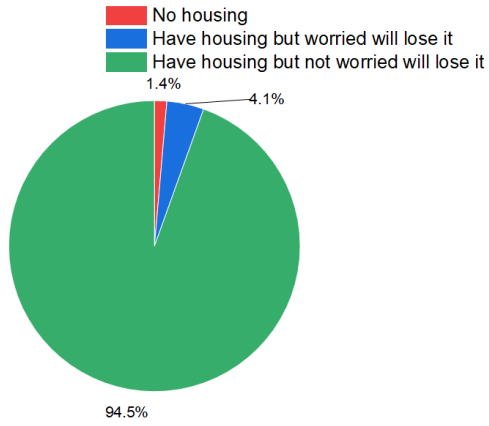
Race/Ethnicity



Income



Stable Housing



COMMUNITY PARTNER ASSESSMENT

2025

Partnership for a Healthy Community

EXECUTIVE SUMMARY

OVERVIEW

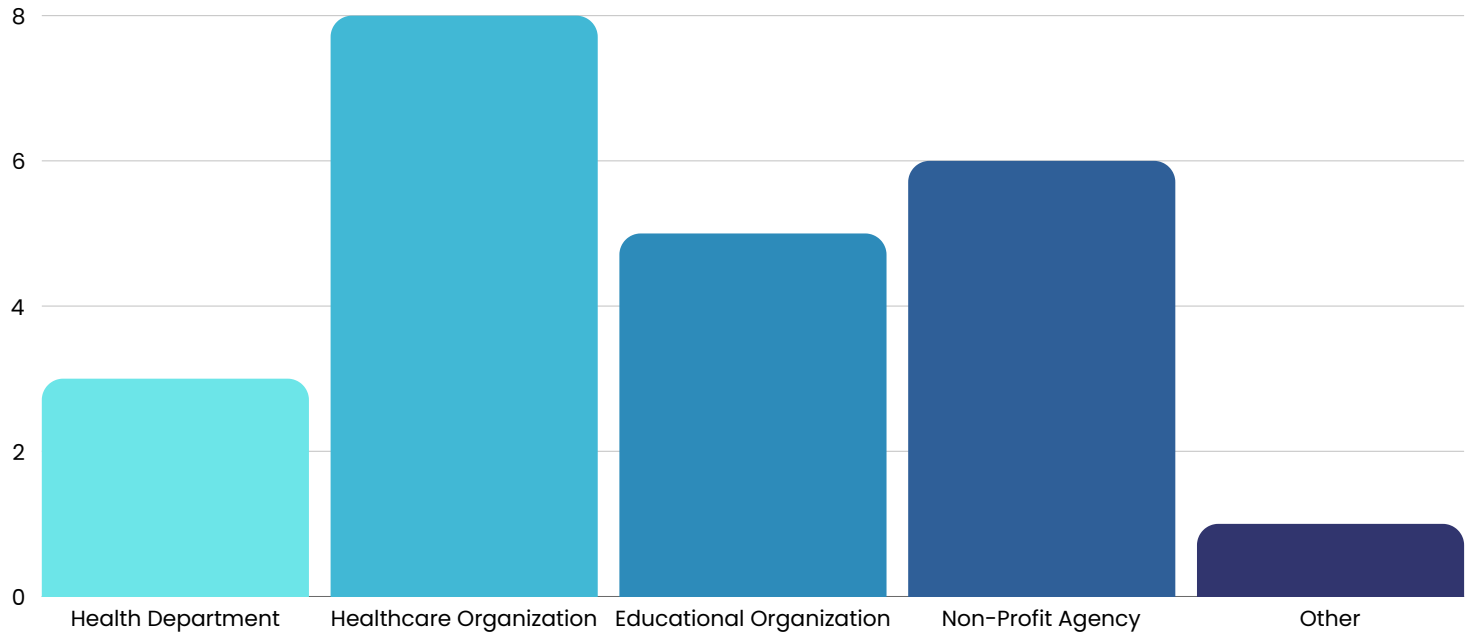
The **Community Partners Assessment (CPA)** evaluates various domains to understand how participating organizations address community health and overall well-being. This report specifically focuses on their commitment to health equity and related concepts.

Representatives from **18 organizations** completed the survey. The survey explored their community work, the populations they serve, the focus of their organizations, and the strategies they employ. The CPA is divided into the following sections:

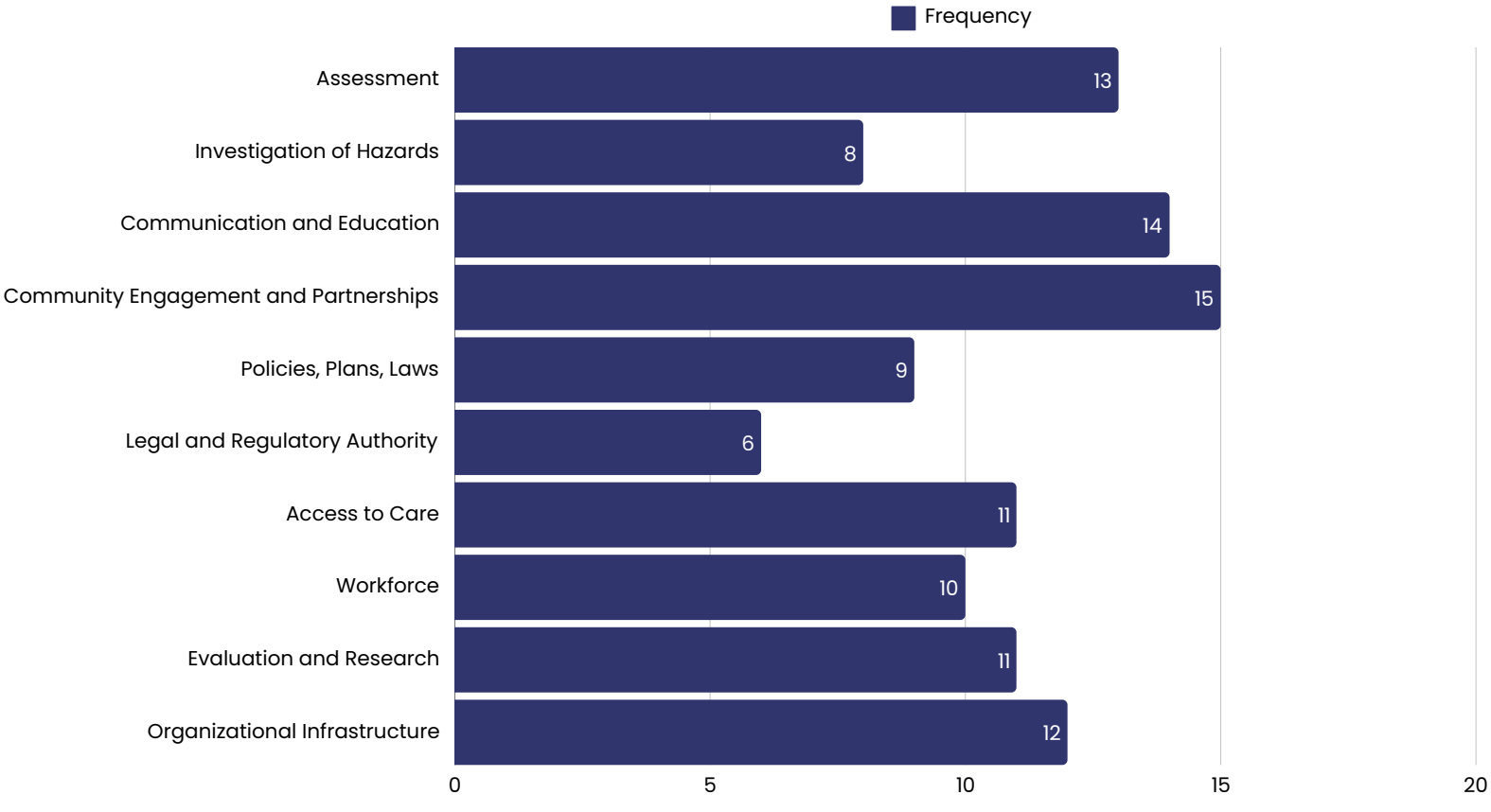
- **DESCRIPTION OF ORGANIZATION**
- **FOCUS OF ORGANIZATIONS**
- **POPULATIONS SERVED**
- **SHARED GOALS**
- **COMMUNITY ENGAGEMENT**
- **DATA COLLECTION**
- **COMMUNICATION**

DESCRIPTION OF ORGANIZATIONS

Types of organizations that completed the CPA

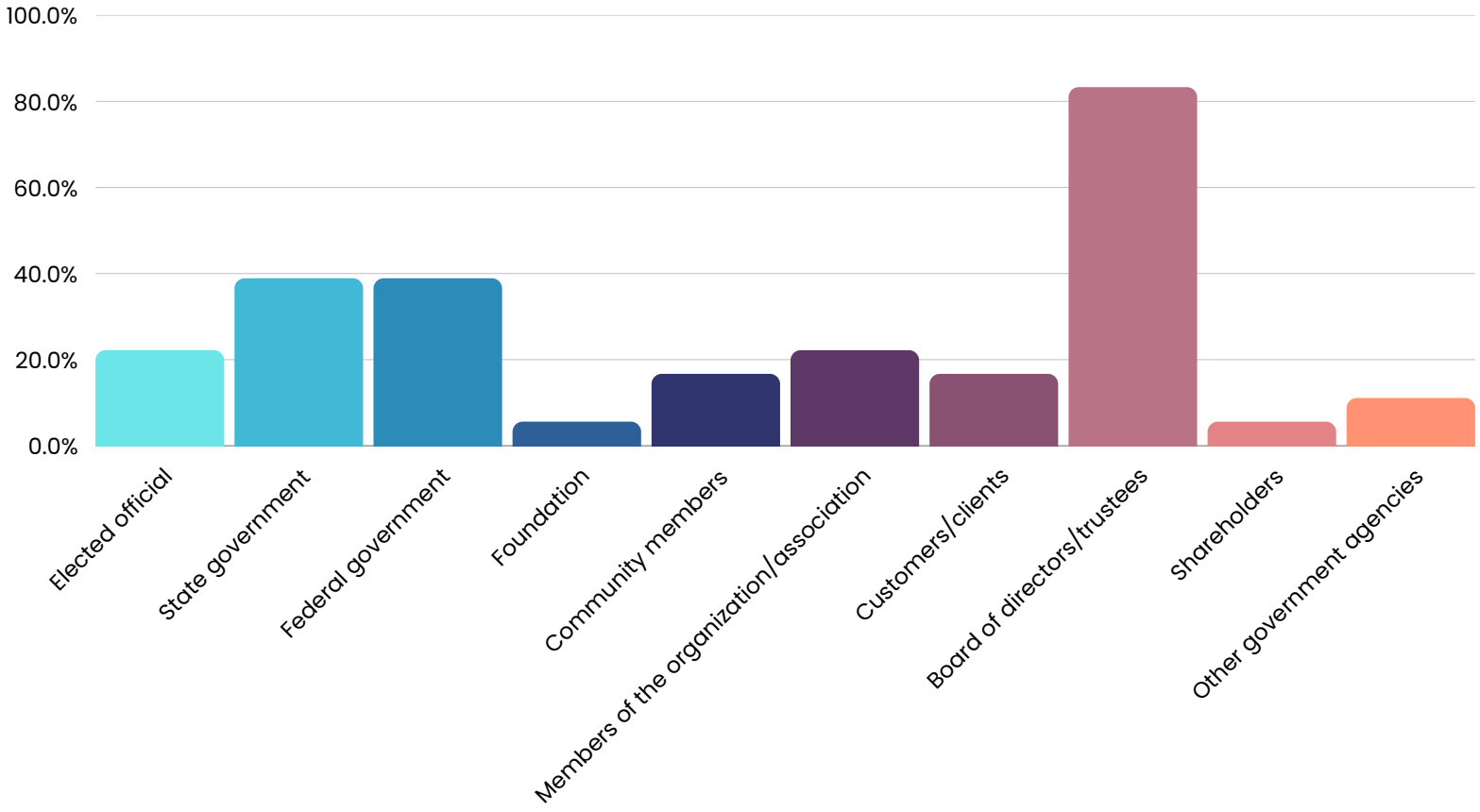


Regular activities reported by organizations

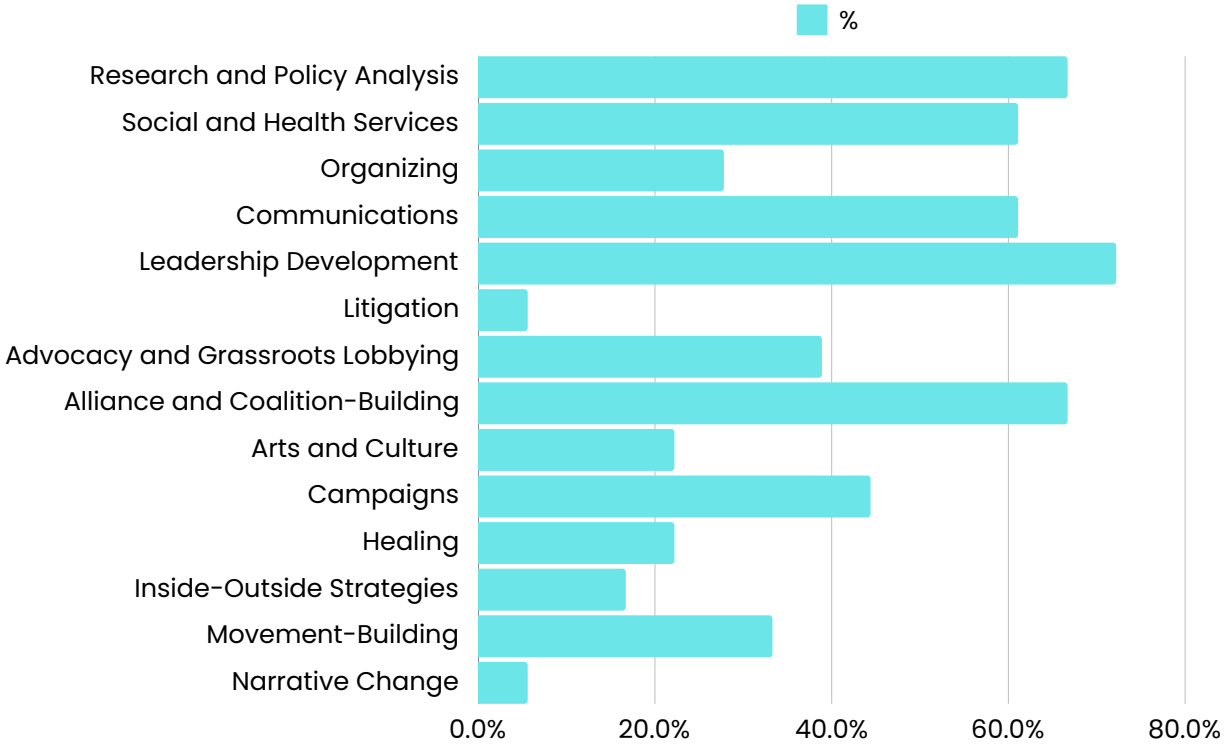


DESCRIPTION OF ORGANIZATIONS

Organization reports to



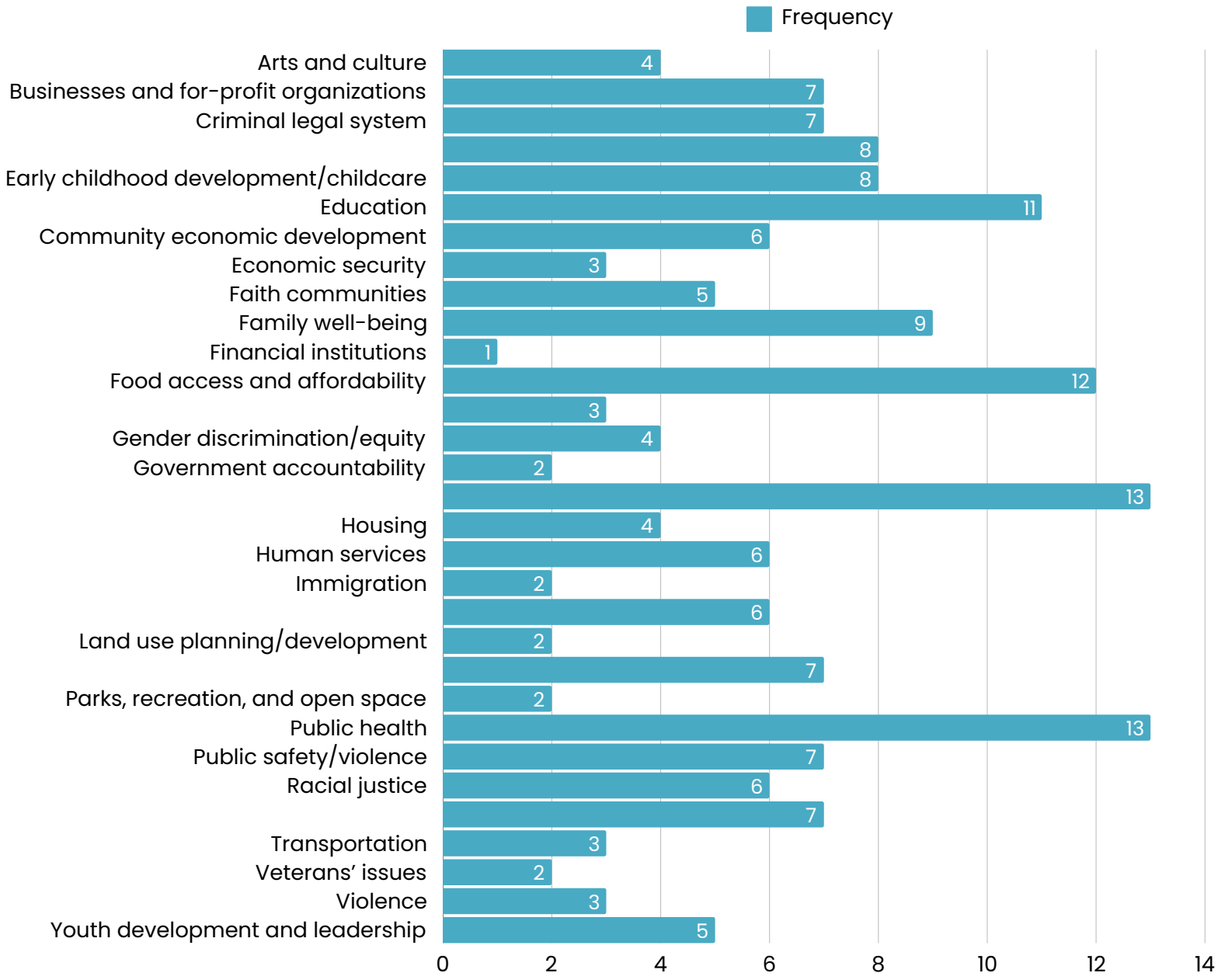
Organization strategies reported



Research and Policy Analysis: Gathering and analyzing data to create credibility and inform policies, projects, programs, or coalitions. **Social and Health Services**: Providing services that reach clients and meet their needs (including clinical and healthcare services). **Organizing:** Involving people in efforts to change their circumstances by changing the underlying structures, decision-making processes, policies, and priorities that produce inequities. **Communications:** Messaging that resonates with communities, connects them to an issue, or inspires them to act. **Leadership Development:** Equipping leaders with the skills, knowledge, and experiences to play a greater role within their organization or movement. **Litigation:** Using legal resources to reach outcomes that further long-term goals. **Advocacy and Grassroots Lobbying**: Targeting public officials either by speaking to them or mobilizing constituents to influence legislative or executive policy decisions. **Alliance and Coalition-Building**: Building collaboration among groups with shared values and interest. **Arts and Culture**: Nurturing the multiple skills of an individual through the arts and encouraging connection through shared experiences. **Campaigns**: Using organized actions that address a specific purpose, policy, or change. **Healing**: Addressing personal and community trauma and how they connect to larger social and economic inequalities. **Inside-Outside Strategies:** Coordinating support from organizations on the "outside" with a team of like-minded policymakers on the "inside" to achieve common goals. **Movement-Building**: Scaling up from single organizations and issues to long-term initiatives, perspectives, and narratives that seek to change systems. **Narrative Change**: Harnessing arts and expression to replace dominant assumptions about a community or issue with dignified narratives and values.

DESCRIPTION OF ORGANIZATIONS

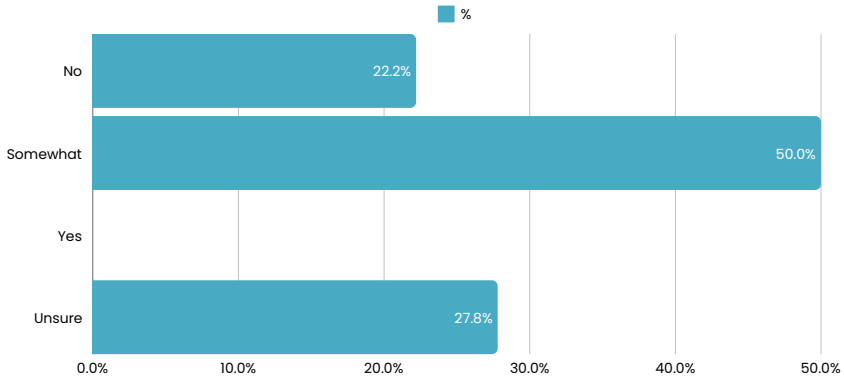
Issues that organizations work on in the community



The most common issues worked on include: healthcare access/utilization, public health, and food access and affordability.

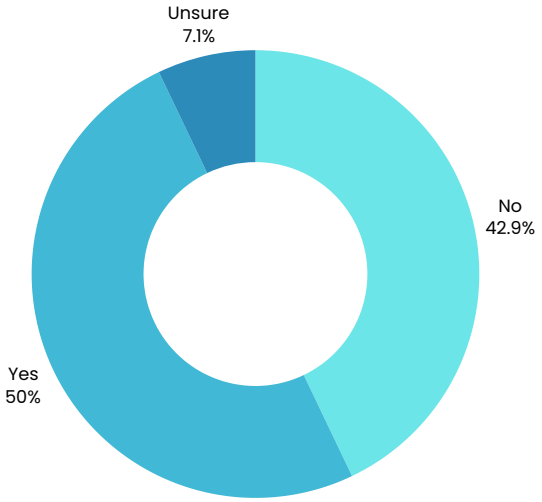
DESCRIPTION OF ORGANIZATIONS

Work with other populations

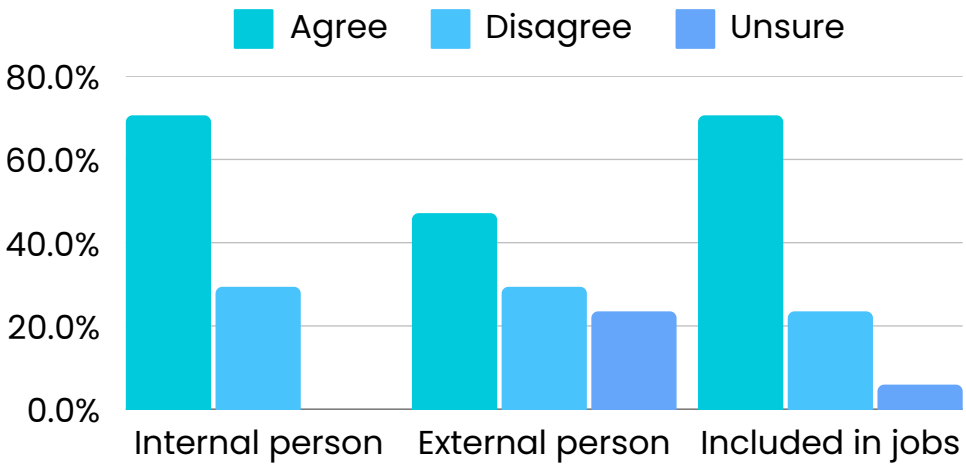


Organizations also reported serving other marginalized populations including: unsheltered persons, persons who use drugs, those who perform sex work, and those facing other daily stressors.

Administrative/frontline staff reflect the demographics of the community served

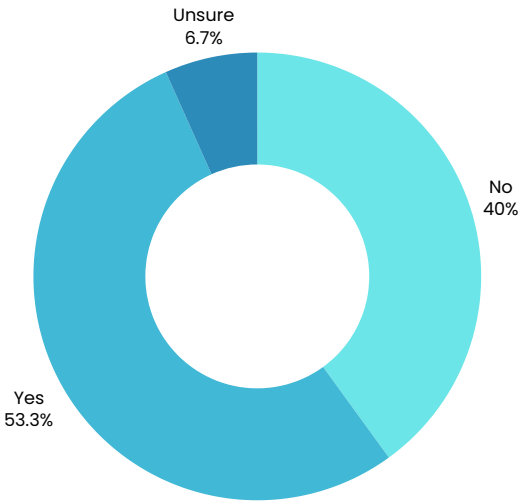


Diversity, equity, and inclusion among organizations



70.6% (n=12) reported they had at least one person internally dedicated to addressing this issue
47.1% (n=8) reported they had at least one person externally dedicated to addressing this issue
70.6% (n=12) state that advancing equity/addressing inequities is included in all or most of the job requirements

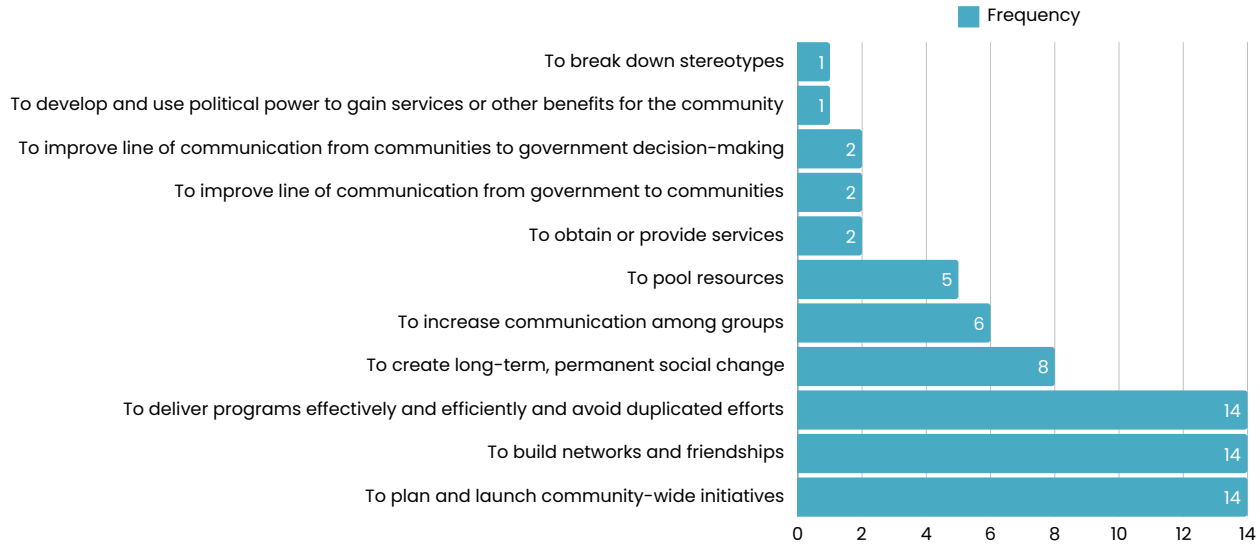
Management of the organization reflects the demographics of the population served



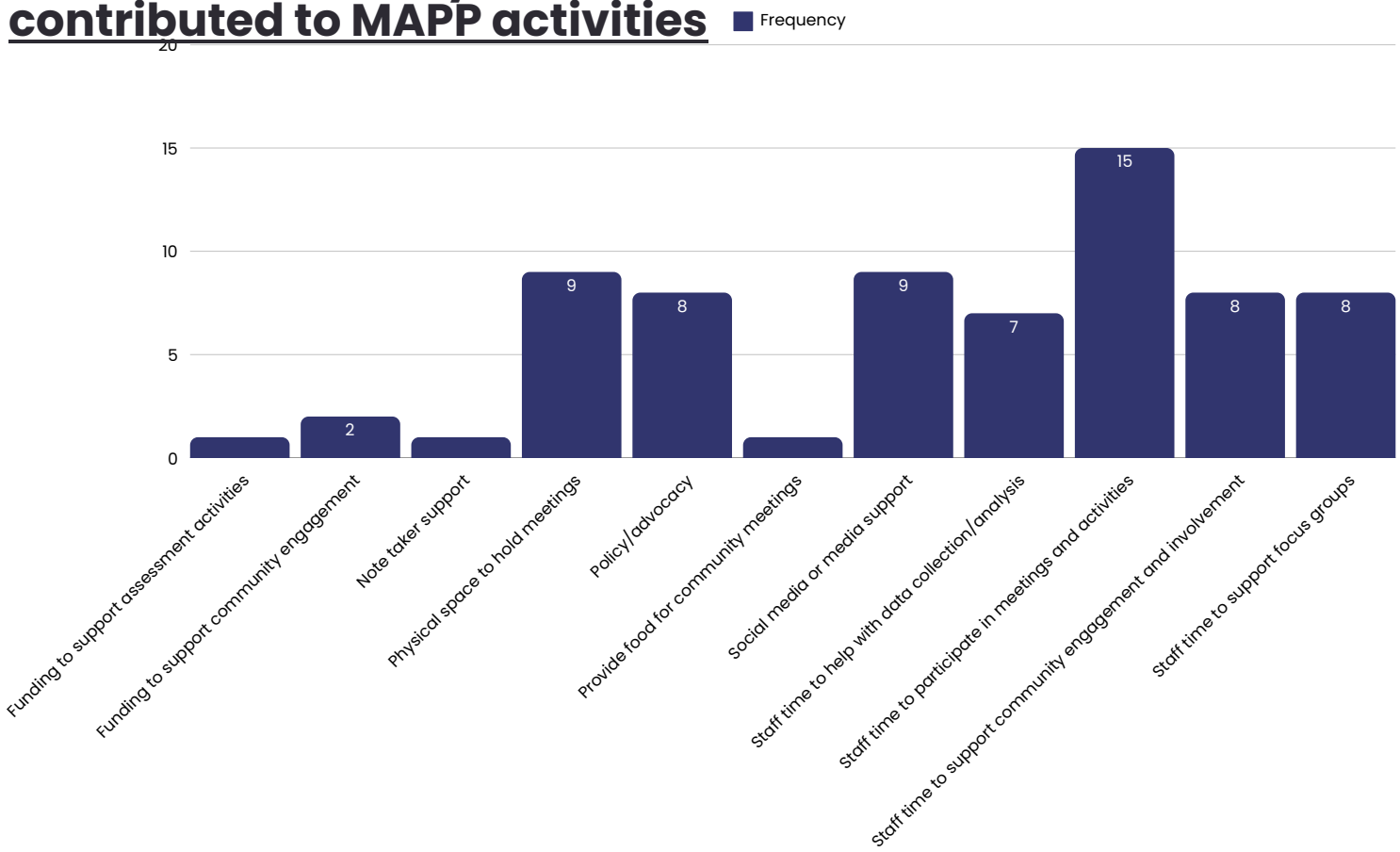
Approximately half of these organizations report management or staff reflecting the demographics of the population served

FOCUS OF ORGANIZATIONS

Top 3 reasons in joining the community health improvement partnership

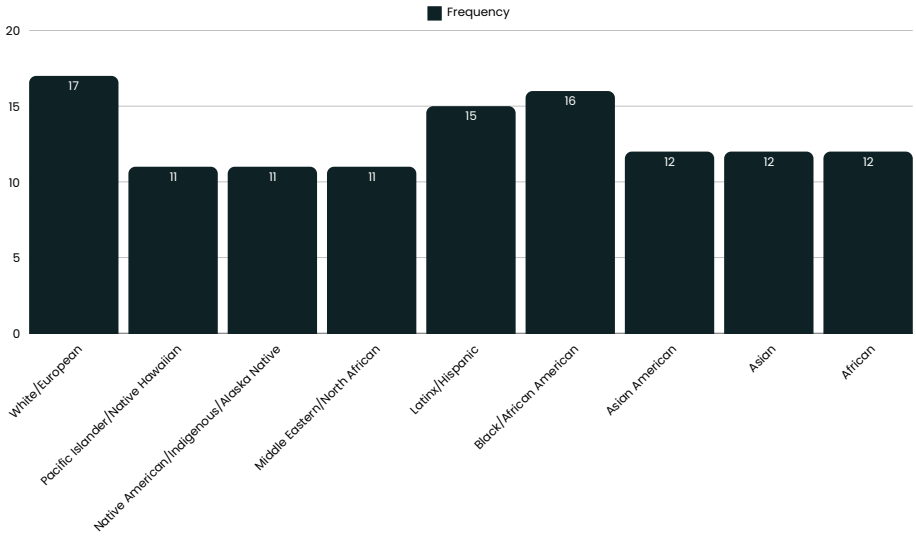


Resources that may be contributed to MAPP activities

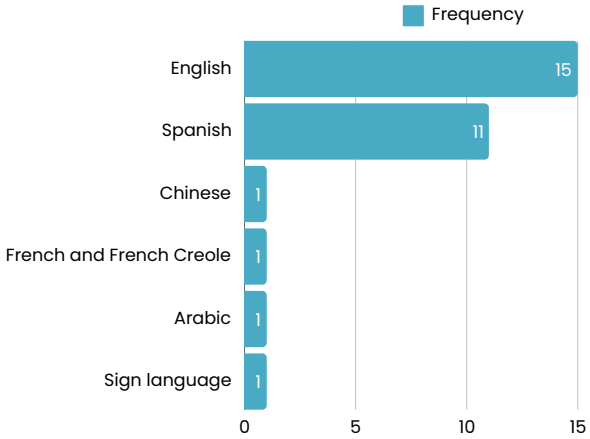


POPULATIONS SERVED

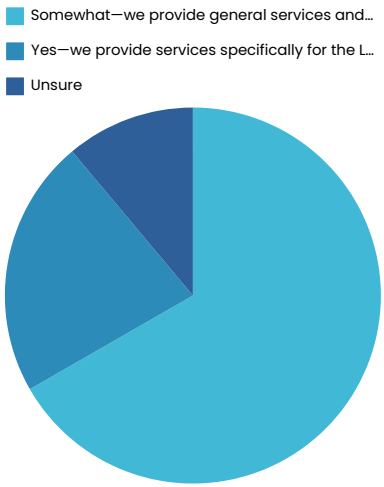
Racial/ethnic populations organizations work with who completed CPA



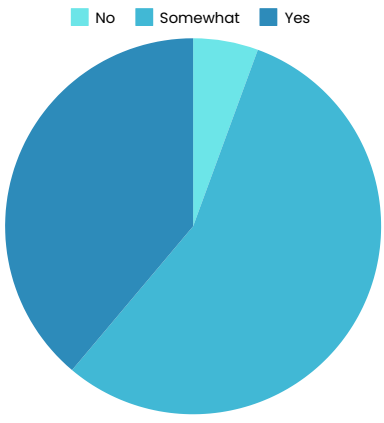
Languages spoken at organizations

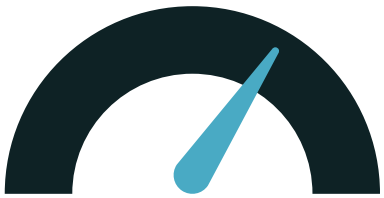


Organizations that provide services for transgender, non-binary, and other members of the LGBTQIA+ community



Organizations that offer services specifically for people with disabilities



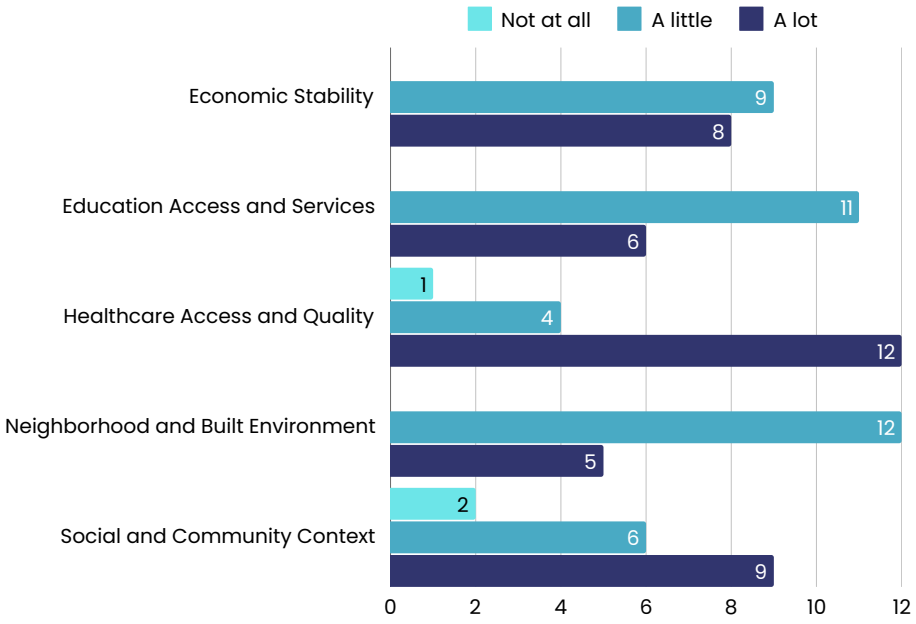


67% of organizations report working with immigrants, refugees, asylum seekers, and other populations who speak English as a second language

83% of organizations report access to interpretation and translation services

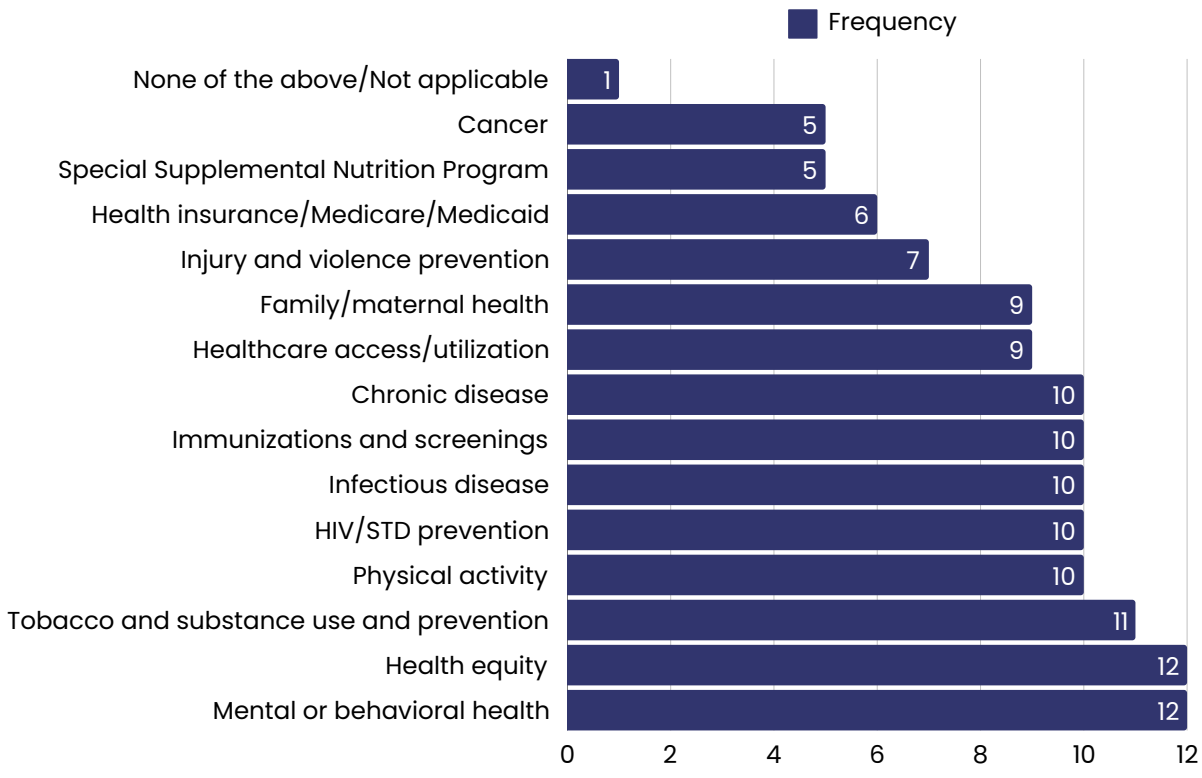
SHARED GOALS

Amount that the organizations focus on the following issues



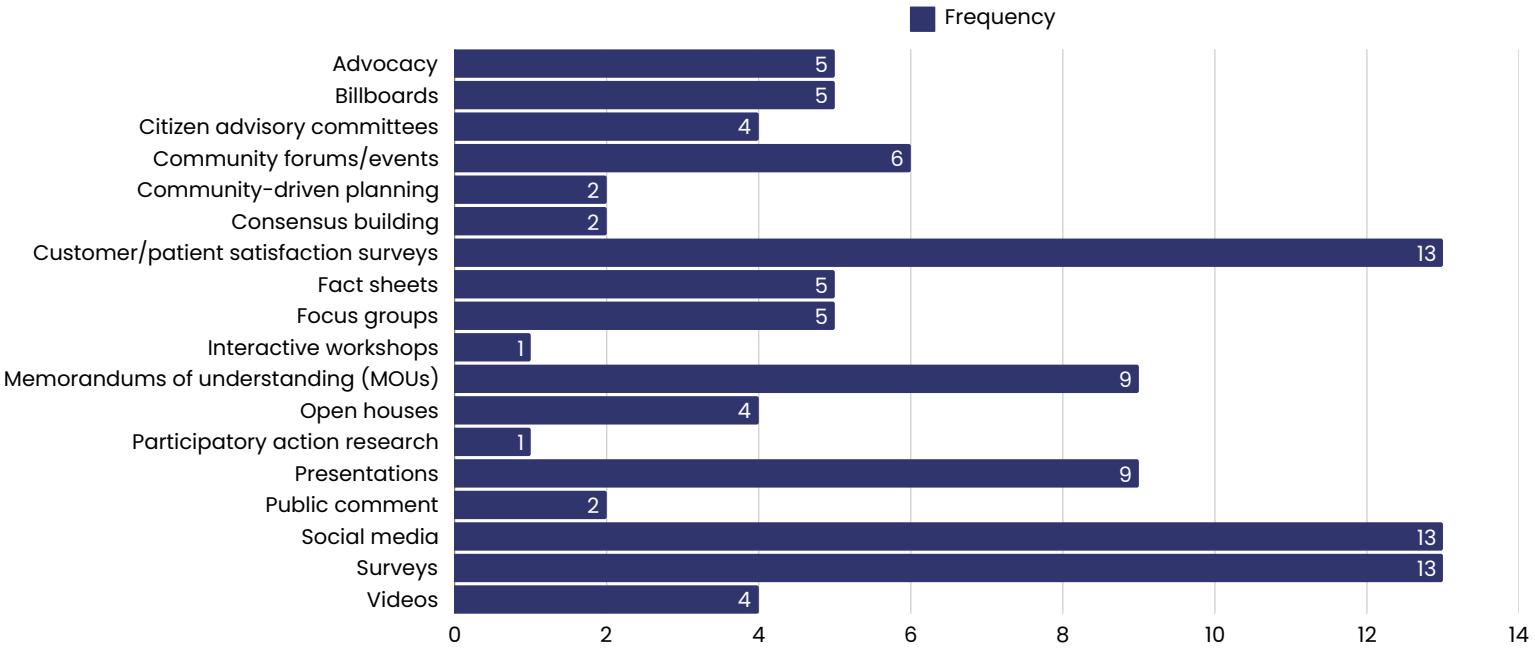
E**conomic Stability**: The connection between people's financial resources—income, cost of living, and socioeconomic status—and their health. This includes issues such as poverty, employment, food security, and housing stability.
Education Access and Services: The connection of education to health and well-being. This includes issues such as graduating from high school, educational attainment in general, language and literacy, and early childhood education and development.
Healthcare Access and Quality: The connection between people's access to and understanding of health services and their own health. This includes issues such as access to healthcare, access to primary care, health insurance coverage, and health literacy.
Neighborhood and Built Environment: The connection between where a person lives—housing, neighborhood, and environment—and their health and well-being. This includes topics like quality of housing, access to transportation, availability of healthy foods, air and water quality, and public safety.
Social and Community Context: The connection between characteristics of the contexts within which people live, learn, work, and play, and their health and well-being. This includes topics like cohesion within a community, civic participation, discrimination, conditions in the workplace, violence, and incarceration

Specific topics that organizations work on in the Tri-County region



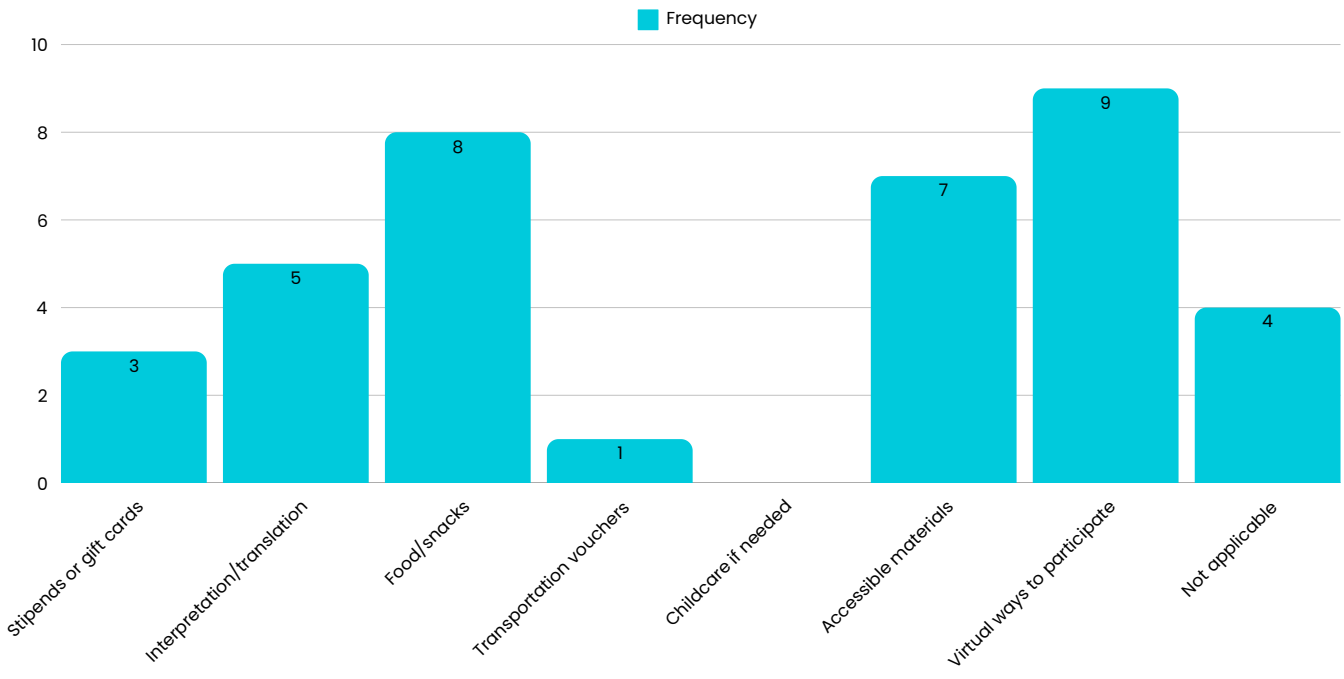
COMMUNITY ENGAGEMENT

Most common methods of community engagement reported by organizations

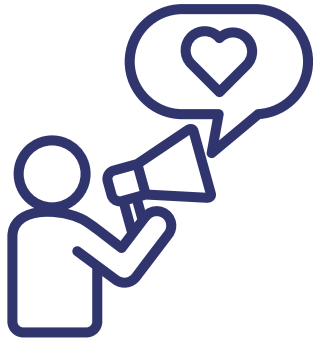


The following methods of community engagement were not reported: community organizing, house meetings, polling, open planning forums with citizen polling, and participatory budgeting.

Things offered by organizations at community meetings



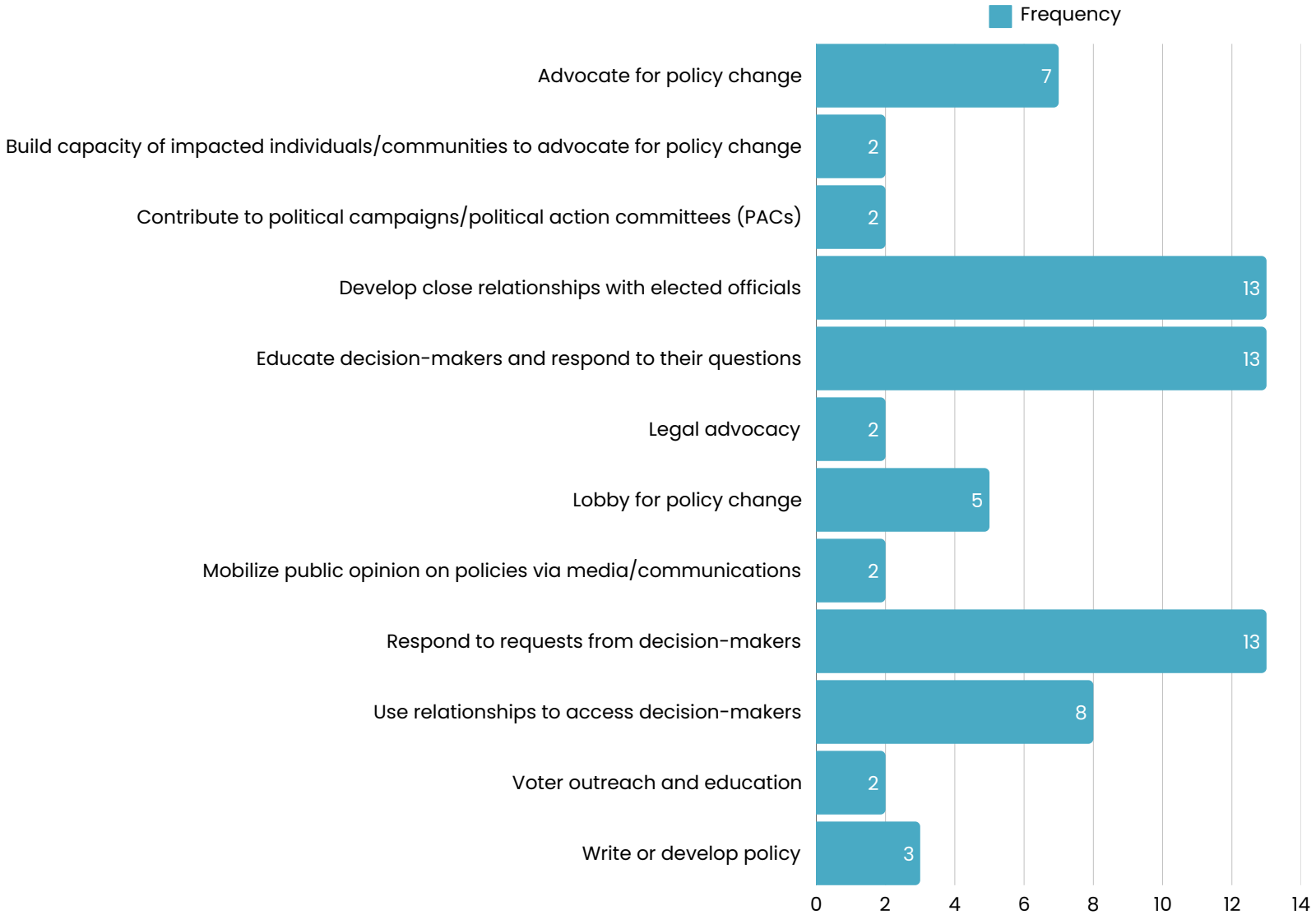
COMMUNITY ENGAGEMENT



The top three types of policy/advocacy work reported were:

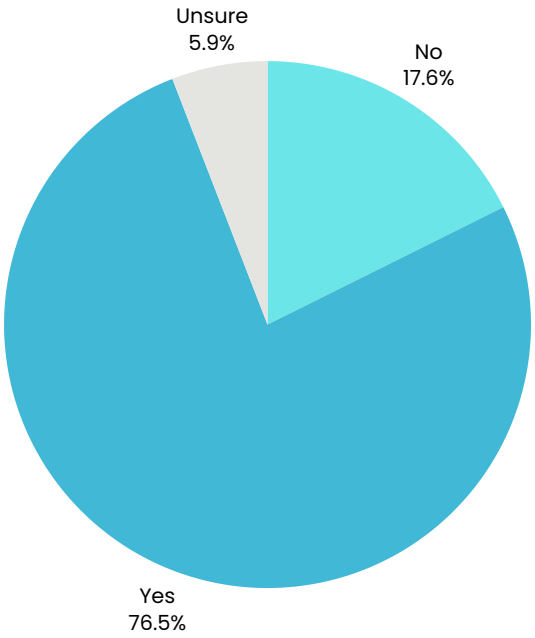
1. Develop close relationships with elected officials
2. Educate decision-makers and respond to their questions
3. Respond to requests from decision-makers

Policy/advocacy work reported by organizations

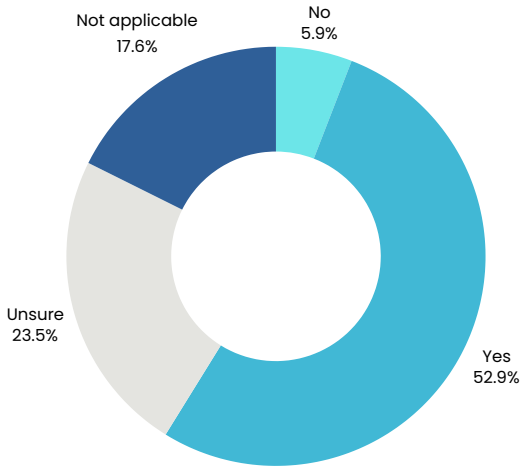


DATA COLLECTION

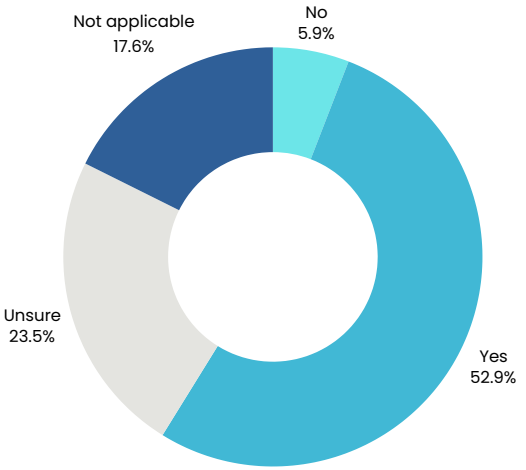
Organization conducts assessments



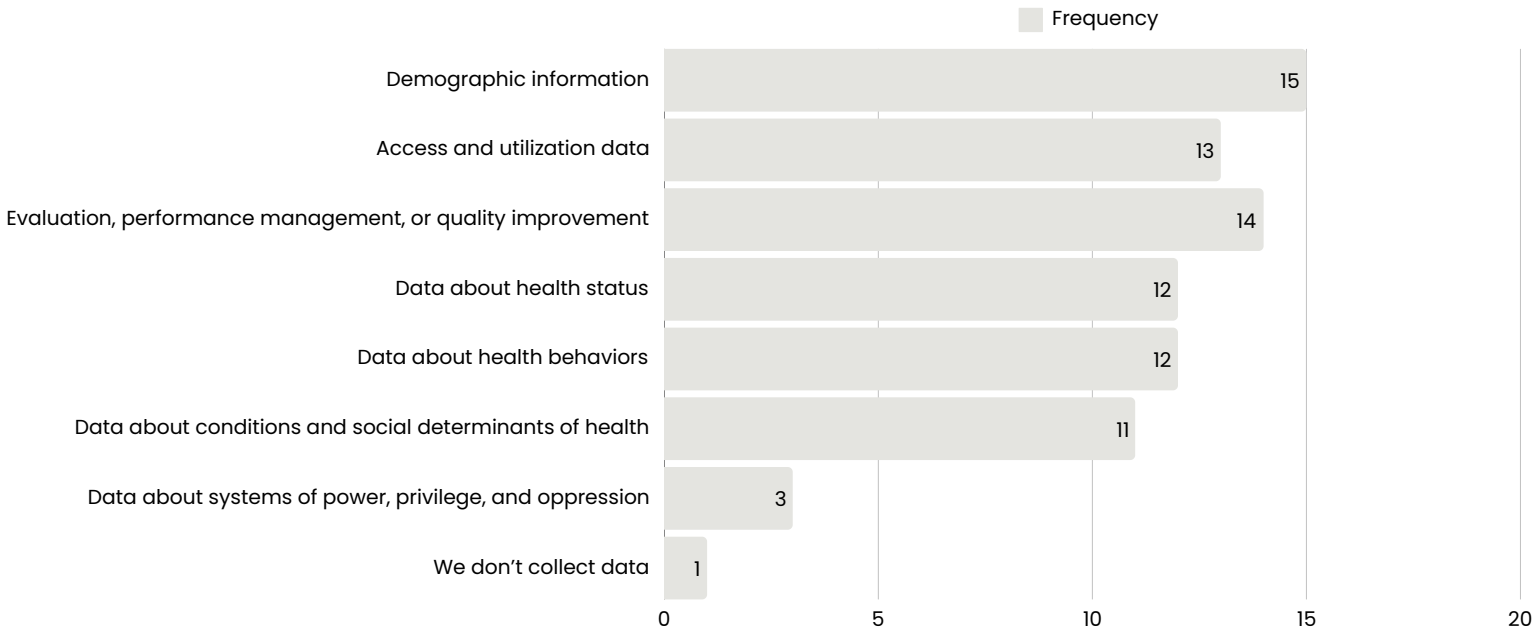
Able to share assessments with MAPP collaborative



Able to share other data collected with MAPP collaborative

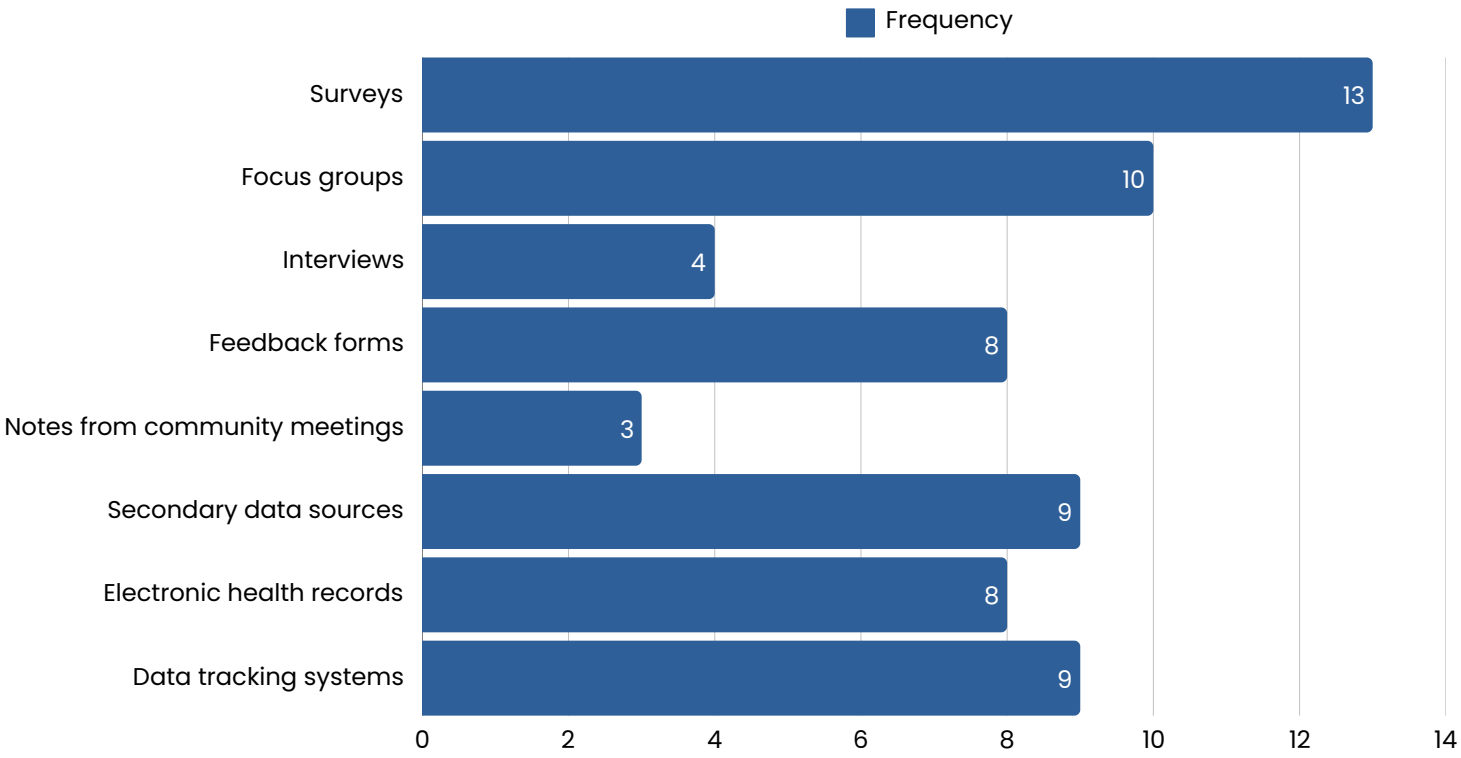


Types of data collected by organizations

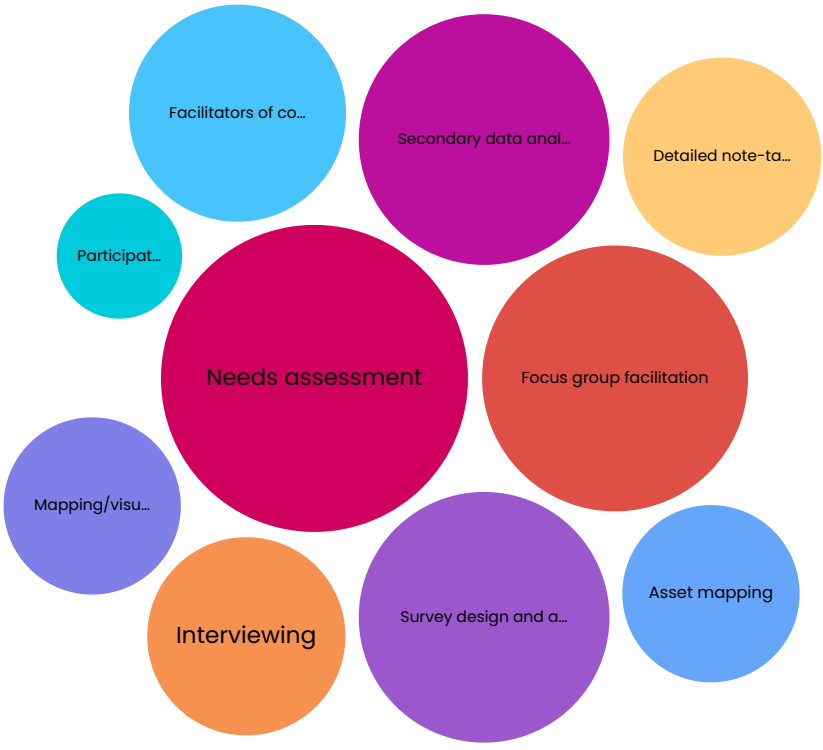


DATA COLLECTION

Method of data collection by organizations

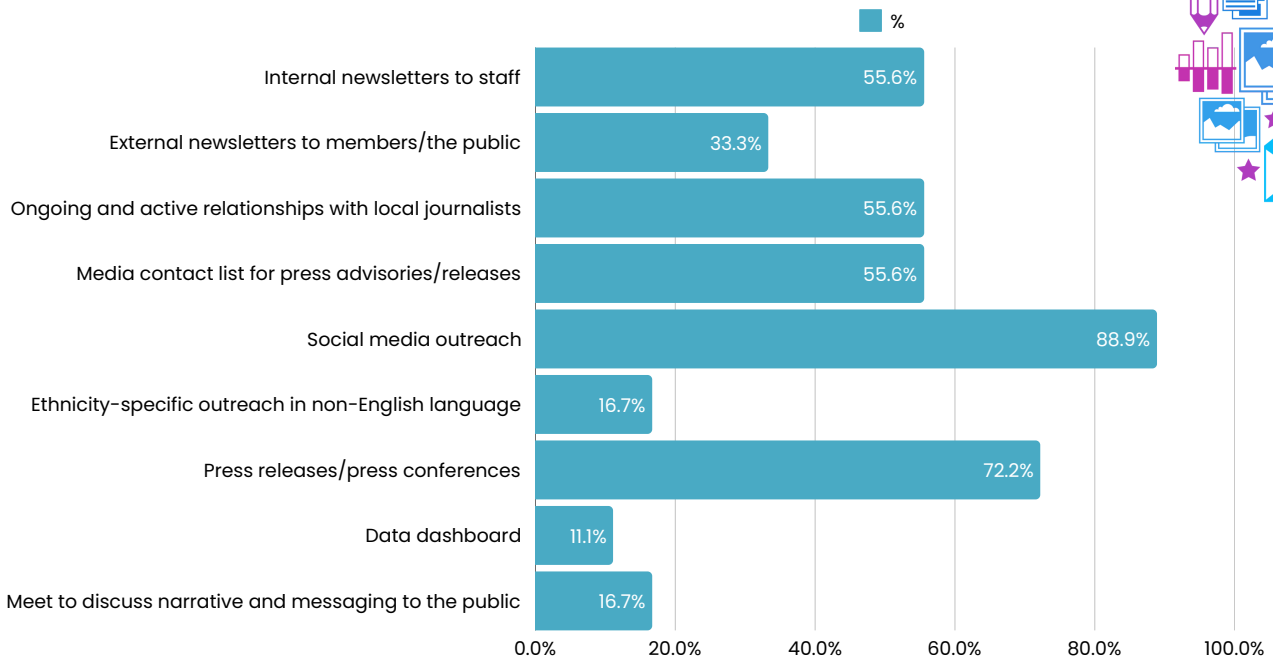


Data skills in organization

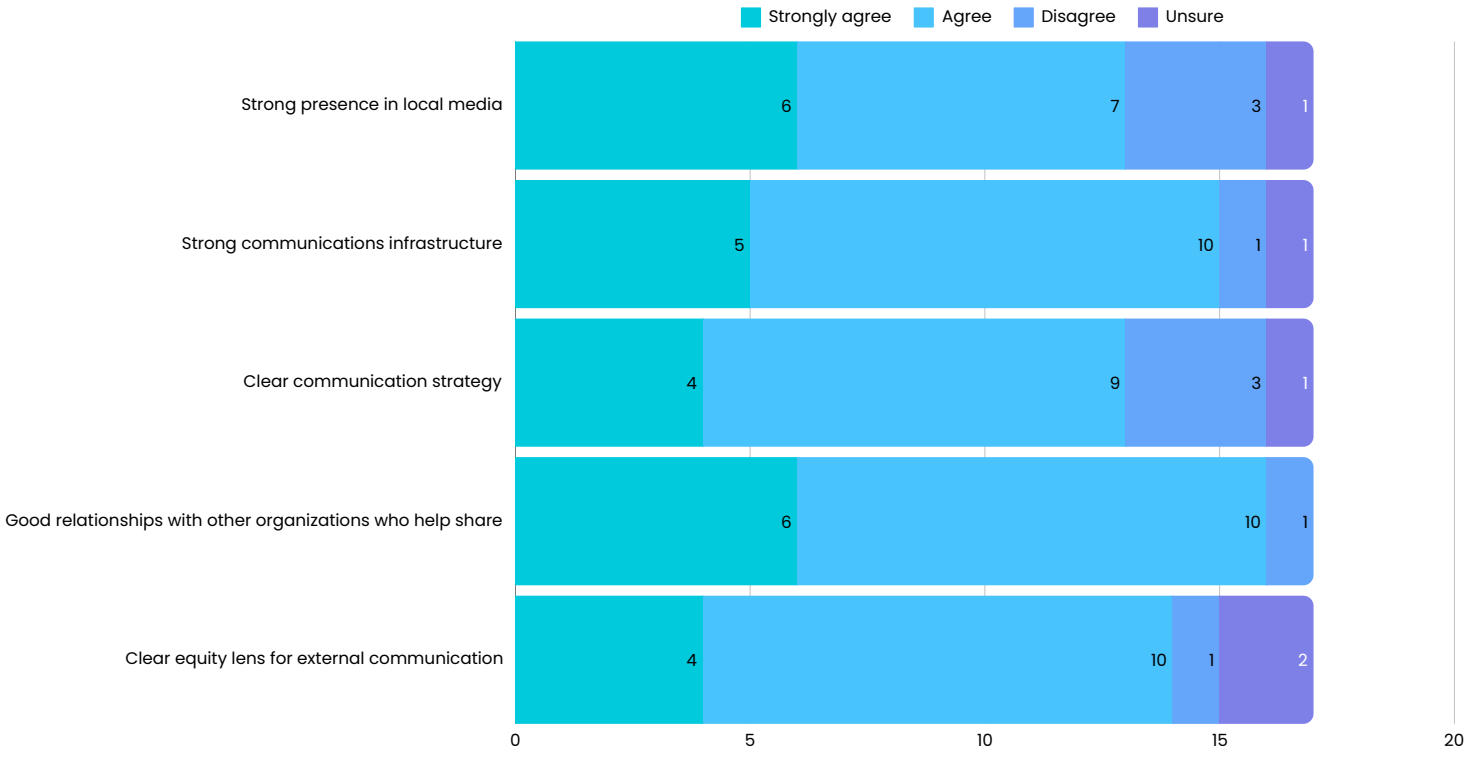


COMMUNICATION

Types of communication methods used by organizations



Describing communication among organizations



Thank You

If you have any questions, please don't hesitate to contact us.

PREPARED BY:

PFHC Data Team

skelly88@uic.edu

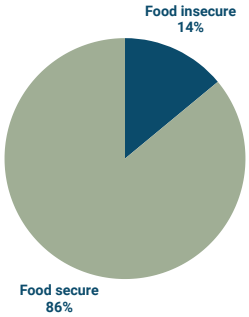
Appendix B: Issue Statements

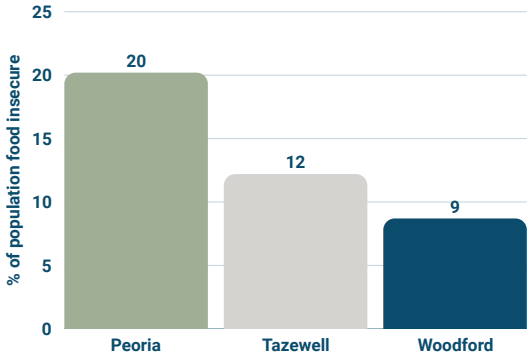
Partnership for a Healthy Community
healthyhoi.org

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

Partnership for a Healthy Community

12,751 TRI-COUNTY YOUTH ARE FOOD INSECURE





Community Status Assessment

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

Community Context Assessment

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

Community Partner Assessment

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

Programs that improve food insecurity among youth:

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

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

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

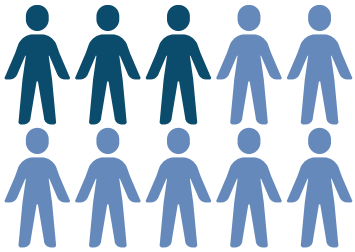
Partnerships with local stores: focus on building capacity among corner stores to include healthy foods can improve food insecurity among youth

REFERENCES:

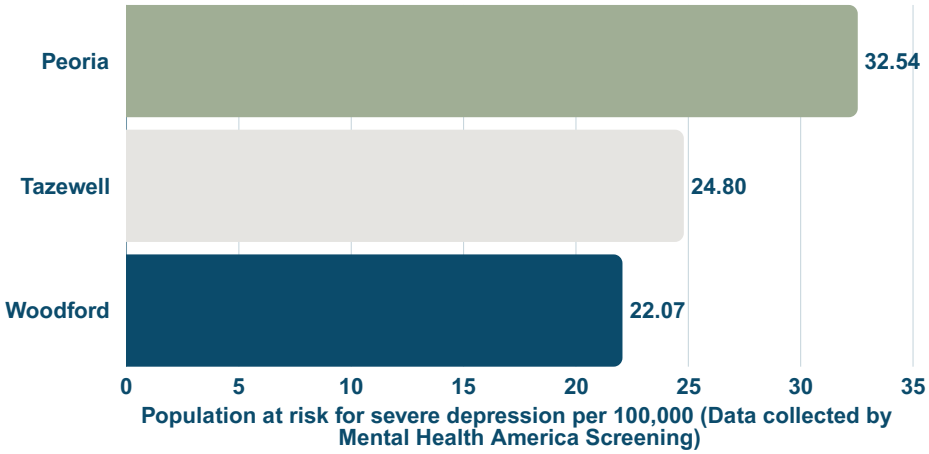
1. Holley, C. E., & Mason, C. (2019). A systematic review of the evaluation of interventions to tackle children's food insecurity. Current nutrition reports, 8, 11-27.
2. Engelhard E, Hake M. Food Security Evidence Review. Feeding America. August 2020. Available at: https://www.feedingamerica.org/sites/default/files/2020-12/Food%20Security%20Evidence%20Review%20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

INCREASE ACCESS TO BEHAVIORAL HEALTH CARE FOR YOUTH AND THOSE WITH LOW INCOME

Partnership for a Healthy Community



30% of adults had unmet mental health treatment in the past year (2023 NSDUH)



Community Status Assessment

- Worse mental health was more common among those with unstable housing environments and minority populations.
- The most common barriers for seeking mental health treatment include cost, or no coverage under insurance, limited awareness of available treatment, and transportation

Community Context Assessment

- Shortage of mental health providers
- Lack of diverse providers and overall stigma around mental health among community members

Community Partner Assessment

- Mental/behavioral health was one of the top topics that organizations specifically stated they were working on in the region (67%).
- Healthcare access/utilization are top issues addressed by organization in the community (72%).

Programs that improve access to behavioral health care for youth and those with low income:[1-2]

Awareness and anti-stigma campaigns: Interventions that focus on reducing stigma and increasing mental health literacy can improve help-seeking behavior and reduce misconceptions surrounding mental and behavioral health

Community health worker programs: utilizing trained laypersons to provide outreach and navigation for mental health services in the community can improve engagement in treatment for low-income communities

School-based programs: focus on programs that are grounded in social and emotional learning can improve emotional regulation among youth. Specific programs noted in the literature include: Positive behavioral interventions and supports (PBIS) and Cognitive Behavioral Intervention for Trauma in School (CBITS)

Integrated health care: co-locating mental health services within primary care offices can improve access to those with low-income, including families and youth in need

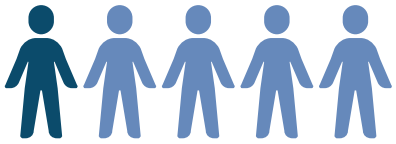
REFERENCES

1.Petersen, I., Evans-Lacko, S., Semrau, M., Barry, M. M., Chisholm, D., Gronholm, P., Egbe, C. O., & Thornicroft, G. (2016). Population and community platform interventions. In V. Patel, D. Chisholm, T. Dua, R. Laxminarayan, & M. E. Medina-Mora (Eds.), Mental, neurological, and substance use disorders: Disease control priorities (3rd ed., Vol. 4, pp. 247–263). The International Bank for Reconstruction and Development / The World Bank. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4904839/

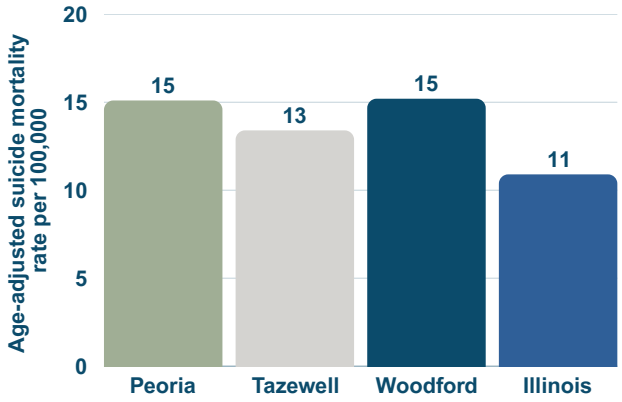
2. Mullen, J. N., Levitt, A., & Markoulakis, R. (2023). Supporting individuals with mental health and/or addictions issues through patient navigation: a scoping review. Community Mental Health Journal, 59(1), 35-56.

DECREASE SUICIDAL THOUGHTS/BEHAVIORS AND SELF-HARM RELATED ADMISSIONS FOR ADOLESCENTS AND YOUNG ADULTS

Partnership for a Healthy Community



20% OF HIGH SCHOOL STUDENTS HAVE SERIOUSLY CONSIDERED ATTEMPTING SUICIDE IN THE PAST YEAR (2023 YRBSS)



Community Status Assessment

- Suicide mortality rate in the Tri-County region is higher than state.

Community Context Assessment

- Low-income population and youth cited self-medication as a treatment for unmanaged mental health issues.
- Low-income population reported high levels of stigma and an overall lack of mental health treatment which contributes to accessing preventive care and other issues (i.e. substance use).

Community Partner Assessment

- Mental/behavioral health was one of the top topics that organizations specifically stated they were working on in the region (67%).

Programs that decrease suicidal thoughts/behaviors and self-harm behaviors among adolescents and young adults:[1-4]

Community awareness campaigns: focus on raising awareness about mental health and suicide prevention by focusing on reducing stigma and encouraging help-seeking. These campaigns can be done through community events, social media campaigns, and public service announcements (PSAs)

Cognitive-Behavioral Therapy (CBT): providing CBT which is a structured, evidence-based therapy that helps individuals identify and change negative thought patterns and behaviors. CBT can help underlying issues such as depression and/or anxiety that are often linked to suicide/self-harm

Peer support programs: focus on the influence of peers to provide support and promote positive coping strategies, resulting in a sense of belonging and understanding

REFERENCES:

1. Aoun, J., Spodenkiewicz, M., & Marimoutou, C. (2024). Scoping review on prevention of suicidal thoughts and behaviors in adolescents: methods, effectiveness and future directions. Frontiers in child and adolescent psychiatry, 3, 1367075.
2. Schlichthorst, M., Ozols, I., Reifels, L., & Morgan, A. (2020). Lived experience peer support programs for suicide prevention: A systematic scoping review. International journal of mental health systems, 14, 1-12.
3. Büscher, R., Torok, M., Terhorst, Y., & Sander, L. (2020). Internet-based cognitive behavioral therapy to reduce suicidal ideation: a systematic review and meta-analysis. JAMA network open, 3(4), e203933-e203933.
4. Tarrier, N., Taylor, K., & Gooding, P. (2008). Cognitive-behavioral interventions to reduce suicide behavior: a systematic review and meta-analysis. Behavior modification, 32(1), 77-108

Appendix C: CHNA Data

Selected CHNA Data

Food insecurity among youth

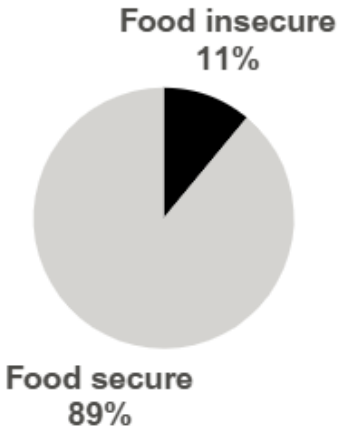
National target data

1. *Reduce household food insecurity and hunger*

Baseline: 11.1% of households were food insecure

Target for 2030: 6.0% of households

When comparing local rates to national targets for reducing household food insecurity, it is critical to implement coordinated, youth-focused interventions across the region.

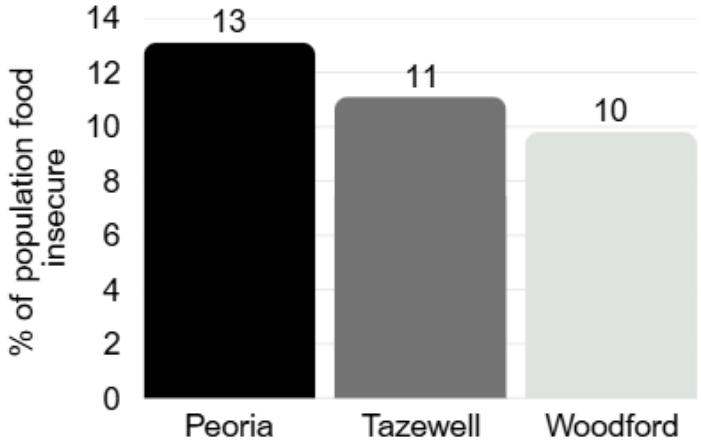


Community Status Assessment Data

In the Tri-County region, 14% of residents are food insecure. Approximately 20% of Peoria residents, 12% of Tazewell, and 9% of Woodford residents are food insecure. Those who were younger, had lower income, and reported unstable housing less often reported consumption of healthy fruits/vegetables. The most common reason reported for not eating more fruits/vegetables were the lack of importance, dislike, and affordability of them. (Community Status Assessment)

The proportion of residents reporting they go hungry 1-2 days a week has doubled since the last cycle, up from 3% to 6% among Tri-County residents.

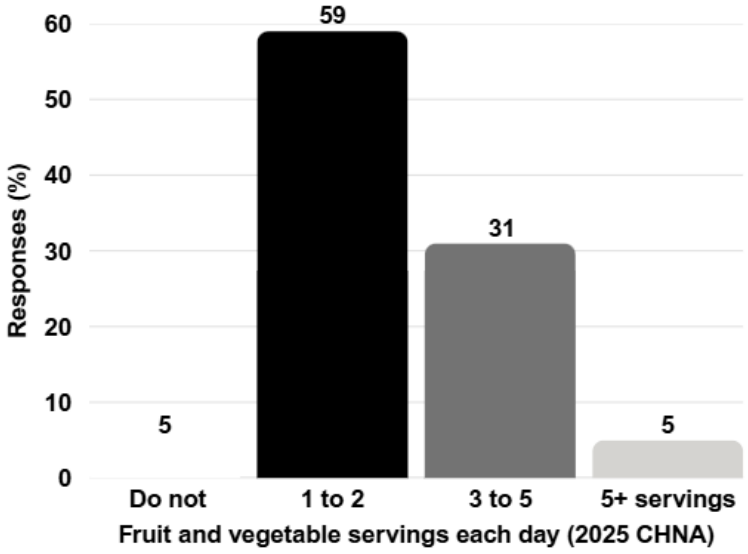
Prevalence of hunger tends to be higher for Black people and those with an unstable housing environment. Prevalence of hunger tends to be less likely White people, those with higher education, those with higher income, and residents of Woodford County



Expanding access to nutritious foods by strengthening and aligning community resources across the regional food system could help address this issue based on local qualitative data from the Community Context Assessment

- Youth reported skipping meals or chose unhealthy options due to lack of time and money
- Tri-County residents also reported they would like more places to get a good hot meal, more food pantries/food drives
- LGBTQ and minorities report poor eating is driven from poverty

A majority of residents (64%) reported low or no consumption of fruit or vegetables each day. The most common reasons across the region was the lack of importance, dislike of the fruit/vegetables, and the affordability of them as well.



Social Drivers and MAPP 2.0

Consumption of fruits and vegetables tended to be more likely for women, older people, those with higher education, and those with higher income. Consumption of fruits and vegetables tends to be less often reported among those with an unstable housing environment. It is essential that everyone has access to food and drink necessary for living healthy lives. Food insecurity exists when people don't have physical and economic access to sufficient, safe and nutritious food that meets their dietary needs for a healthy life.

Access to behavioral health

National target data

1. *Increase the proportion of adolescents and adults who are screened for depression*

Baseline**:** 8.5% of primary care office visits included screening for depression in persons aged 12 years and over (2016 National Ambulatory Medical Care Survey)

Target for 2030: 13.5%

2. *Increase the proportion of children with mental health problems who get treatment*

Baseline**:** 70.7% of children aged 4 to 17 years with mental health problems received treatment (2019 National Health Interview Survey)

Target for 2030: 79.3%

3. *Increase the proportion of adults with depression who get treatment*

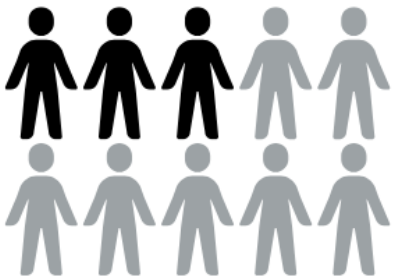
Baseline**:** 60.8% of adults aged 18 years and over with depression received treatment in the past year (2021 National Survey on Drug Use and Health)

Target for 2030: 13.5%

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

Community Status Assessment Data

Age-adjusted depression prevalence among adults is 22.7 in Peoria County, 23.5 in Tazewell County, and 23.1 in Woodford County (Source: CDC Places, 2022 report). National surveillance estimates that 23% of adults have experienced a mental health issue in the past year and 30% of adults had unmet mental health treatment needs in the past year (2023 NSDUH). Poor mental health was more common among residents with unstable housing and those in minority populations. Moreover, the most common barrier for seeking treatment reported among Tri-County residents was cost, lack of insurance support, limited awareness of available treatment, and transportation to get to treatment Based on 2025 CSA data, 14% report poor mental health which is down from 16% in 2022.



30% of adults had unmet mental health treatment in the past year (2023 NSDUH)

There is a shortage of mental health providers in the Tri-County region compared to state and national estimates. Due to the limited supply of providers, a higher proportion of residents are not able to access these systems. Addressing these disparities will require coordinated strategies that enhance provider availability and improve system navigation for those seeking behavioral health services.

Based on data from the Community Context Assessment, access to behavioral

healthcare was impacted by long wait times and difficulty finding providers that accept Medicaid. Minority populations also reported a need for support navigating healthcare systems including behavioral healthcare. Additionally, a lack of diverse providers and overall stigma around mental health providers contribute to the unmet mental health treatment needs of residents.

Social Drivers

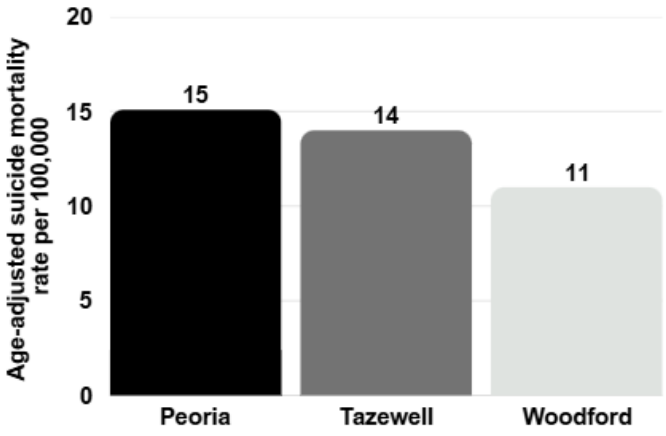
Residents who reported depression, anxiety, and stress was higher among women, younger people, those with lower income, and those who reported unstable housing. Similarly, perceptions of mental health tend to be lower for Black people, LatinX people, and those with an unstable housing environment.

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

Suicide and self-harm

National target data

1. *Reduce the suicide mortality rate*
   Baseline: 14.2 suicides per 100,000 population (2018)
   Target for 2030: 12.8 per 100,000
2. *Reduce suicide attempts by adolescents*
   Baseline: 7.4 suicide attempts per 100 population of students in grades 9 through 12 in the past year (2017)
   Target for 2030: 1.8 per 100



Community Status Assessment Data

Suicide mortality rates are 15 per 100,000 in Peoria County, 14 per 100,000 in Tazewell County, and 11 per 100,000 in Woodford County (Data Source: 2019-2023 National Center for Health Statistics-Mortality Files) . These suicide mortality rates are higher than State of Illinois for all counties in the Tri-County region.

Social Drivers

Improving system navigation, early intervention, and strengthening integration of behavioral health into primary care and community settings may help reduce the overall suicide mortality rate in the region, especially among adolescents and young adults.

Appendix D: PFHC Intervention Spreadsheets

Partnership for a Healthy Community
healthyhoi.org

Partnership for a Healthy Community-CHIP Intervention Worksheet

CHIP Action Team: Food insecurity among youth	
Goal:	***Empower and increase resiliency amongst youth and their families to improve access to adequate nutrition.***
Objective 1:	Reduce the rate of youth screening positive by 1.5% for food insecurity among households with children in the Tri-County by the end of December 2028. Data Source: OSF (Point Person: Amanda Sutphen)
Objective 2:	Increase the number of youth screened for food insecurity by 10% in the Tri-County region by the end of December 2028.*** Data Source: OSF (Point Person: Amanda Sutphen)

Intervention Strategies

Strategy 1: Complete community assessment of nutrition resources for youth to develop a plan to address the gaps in food access.

	Tasks/Tactics	**Evaluation Plan**
	Identify existing nutrition resources and preferences for youth	- # of resources identified
	Identifying gaps in nutrition resources	- # of gaps identified
	Compile collection of data around nutrition resources	- Establish baseline numbers and plan for ongoing stability
	Identify strategies to engage partners	- # of strategies identified - Engagement plan developed
	Host convening/conversation amongst partners and community members	- # of meetings held throughout the cycle
	Development of plan to address gaps	- Report created, highlighting gaps and plan for addressing them

Strategy 2: Promote family stability by increasing food literacy and connecting families with sustainable food resources

	Tasks/Tactics	**Evaluation Plan**

	Defining the roles that both individuals and organizations have on food security	- Increase number of partnerships between organizations and families
	Training on food insecurity for the identified organizations	- # of trainings held
	Financial literacy training and connection to available financial and nutrition assistance resources	- #of trainings held
	Provide nutrition education opportunities for youth and families	- # of educations held
Strategy 3: Promote awareness and advocacy around youth food insecurity to improve and sustain food access		
	Tasks/Tactics	**Evaluation Plan**
	Addressing gaps in utilization and availability of food resources	- Implementation of plan- including existing programs
	Develop or identify outreach strategies to improve community knowledge and perceptions of nutrition assistance programs	- Strategies identified and carried out - Increase participation in nutrition assistance programs - Navigation
	Develop communication processes among partners for continuity in care	- Number of contacts made - Number of organizations attended
	Develop policy recommendations in support of legislation and/or potential funding applications	- Number of policy recommendations

***: This will heavily rely on strong support from our entire healthcare system.

Partnership for a Healthy Community-CHIP Intervention Worksheet

CHIP Action Team: Behavioral Health Access and Navigation		
Goal:	***Improve access and utilization of behavioral health resources for youth and low-income adults.***	
Objective 1:	Increase the proportion of primary care visits that provide a mental health screening by 2% among youth and low-income adults in the Tri-County region by the end of December 2028. Data Source: OSF (Point Person: Amanda Sutphen)	
Objective 2:	Increase follow up care after ED visit for behavioral health concerns among youth by 5% in the Tri-county region by the end of December 2028. Data Source: Carle (Point Person: Tricia Larson), Heartland (Point Person: Nicole Hartzler)	
Intervention Strategies		
Strategy 1: Increase behavioral health family support		
	Tasks/Tactics	**Evaluation Plan**

	- Identify existing family centered community organizations and groups and their internal behavioral health resources	- # of family centered community spaces, catalog of organizations and groups
		  o Where are they/where do they need to be?
		  o What do they provide/not provide?
		- gap assessment (tiered review) of resource availability and utilization of behavioral health programs and services

	Develop plans to increase family support based off gap assessment findings	- # of plans developed
Strategy 2: Increase access to behavioral health services and programs		
	Tasks/Tactics	**Evaluation**
	Identify existing BH resources in the Tri-County area	- # of MH/BH resources
	Identify a public centralized location for the directory accessible to community members and providers	- Centralized location identified

	Create a public Tri-County centralized, dynamic directory of BH resources and programs	- Comprehensive directory created
	Develop a promotional campaign for behavioral health directory	- Track access to directory
Strategy 3: Improve coordination of services and programs among behavioral health providers.		
	Tasks/Tactics	**Evaluation Plan**
	Educate stakeholders about System of Care principles and strategies	- Meeting minutes, sign in sheets, presentations - # of stakeholders
	Integrate System of Care framework within previous and future BH PFHC activities	- Gap analysis (streamlining processes, expansion of services, hours, location, and meet patients where they're at., workforce development, and health literacy)
	Educate key leaders in the community about coordination of BH services and programs	- # of presentations developed and implemented - Meeting minutes, sign in sheets, agendas, presentations
	Develop a local behavioral health System of Care implementation policy	- Number of implementation policies developed

Partnership for a Healthy Community-CHIP Intervention Worksheet

CHIP Action Team: Youth Suicide and Self-Harm		
Goal:	***Develop, encourage, and sustain a Tri-County region where adolescents and young adults live and feel supported, included, heard, and valued.***	
Objective 1:	Reduce suicide mortality rates by 1% among adolescents and young adults in the Tri-County region by the end of December 2028. Data Source: CDC WISQARS and IDPH Vital Records	
Objective 2:	Reduce the annual number of ED visits related to self-harm and behaviors by 2% among adolescents and young adults in the Tri-County region by the end of December 2028. Data Source: Carle (Point Person: Tricia Larson), Heartland (Point Person: Nicole Hartzler), OSF (Point Person: Amanda Sutphen)	
Intervention Strategies		
Strategy 1: Strengthen Family Stability & Reduce Adversity Across the Lifespan		
	Tasks/Tactics	**Evaluation Plan**
	Assess diverse community settings, school SEL programs, and counseling services to identify gaps affecting family stability.	- # of assessments completed across settings - % of identified gaps (categorized) - # of partners engaged in assessment process
	Provide linkages to behavioral health and supportive resources based on assessment findings and maintain a resource repository.	- # of families & programs connected to BH or supportive resources - # of resources added, updated, and/or accessed in repository - Increase in resource utilization over time
	Assess community awareness of brain development and create/disseminate educational materials on coping and problem-solving.	- Pre/post awareness survey results of brain development - # of educational materials created/# distributed

		- Engagement metrics (event attendance, website views/clicks/shares/downloads)
	Develop and disseminate localized interventions on misinformation, social media, and AI, and promote realistic expectations and multiple paths to success for youth.	- # of interventions created and delivered - # participation for youth and adults - Pre/post measures indicating understanding of material
	Identify and advocate for policies that support family stability.	- # of policies reviewed, identified, and/or drafted for improvement - # of advocacy actions completed - # of policy changes adopted or advanced
Strategy 2: Expand Behavioral Health Awareness, Access & Workforce Capacity		
	Tasks/Tactics	**Evaluation Plan**
	Provide suicide prevention and self-harm education and increase public understanding of identifying untreated mental health issues.	- # of suicide prevention/self-harm education sessions delivered. - # of participants trained (youth, adults, families). - Pre/post training surveys showing increased knowledge of warning signs and help-seeking behaviors. - # or % of referrals to mental health services following education efforts. -
	Implement processes and surveys to identify gaps in behavioral health resources and disseminate accessible BH information.	- # of surveys distributed and percentage completed. - # & type of BH gaps identified and documented. - # of BH resource guides disseminated (digital or print).

		- # and/or % in resource inquiries or website traffic related to BH information.
	Assess behavioral health care coordination, develop warm-hand-off policies, and implement and evaluate the care coordination plan.	- # of partner organizations adopting warm-hand-off protocols. - # of warm-hand-off referrals conducted. - Evaluations showing improved service navigation and reduced drop-off between referrals.
	Conduct BH workforce needs assessment, develop a BH workforce plan, integrate it into broader workforce efforts, and implement staff self-care and training initiatives.	- # of workforce plan recommendations implemented. - # of BH staff participating in self-care or wellness initiatives. - # or % participation rates and pre/post training competency scores. - # or % in BH workforce recruitment or retention metrics.
	Assess BH policy gaps, develop needed policies, and advocate for improved BH communication and support systems.	- # of BH policies reviewed, identified, or drafted. - # of advocacy activities completed (meetings, policy briefs, coalition actions). - # or % toward adoption, revision, or implementation of BH policies. - # or % improvements in BH communication systems (e.g., shared protocols, data-sharing agreements).

Strategy 3: Enhance family wellbeing by increasing awareness of existing supportive networks and expanding equitable access to interventions that strengthen diverse families and backgrounds.		
	Tasks/Tactics	**Evaluation Plan**
	Increase Family Connection & Emotional Awareness	- # of family involvement events or workshops conducted. - Attendance rates and participant demographics. - Pre/post surveys measuring improvement in family communication, emotional understanding, and quality time spent together. - Participant-reported increase in empathy, problem-solving, and emotional coping skills.
	Develop or identify outreach strategies to improve community knowledge and perceptions of behavioral health programming	- # of outreach strategies implemented (flyers, social media campaigns, workshops, community meetings). - Reach and engagement metrics (e.g., social media clicks, event attendance). - Pre/post surveys assessing awareness and perceptions of nutrition assistance programs. - # or % increase in program enrollment or utilization after outreach.
	Strengthen Support Networks Across Community Touchpoints	- # of partnerships established with community organizations (faith-based, recreational, cultural).

		- # of support programs or activities offered through these touchpoints. - Engagement metrics (attendance, repeat participation). - Participant-reported increase in access to support networks.
	Improve Navigation of Services Using a 'No Wrong Door' Approach	- # of families successfully connected to services through multiple entry points. - % of inquiries resolved without referral failures. - Participant satisfaction surveys on ease of accessing services. - # of staff trained on 'No Wrong Door' navigation protocols.
	Reduce Mental Health Stigma Through Shared Experiences	- # of supportive group sessions or storytelling events conducted. - Attendance and demographic diversity of participants. - Pre/post surveys measuring changes in attitudes toward mental health and help-seeking behaviors. - # of referrals to mental health services originating from group sessions.
	Expand Awareness and Access to Supportive Resources	- # of resource guides, digital tools, or outreach materials created and disseminated. - # or % increase in the number of families accessing behavioral health and community resources.

		- Engagement metrics (website hits, downloads, hotline calls). - Participant-reported awareness and satisfaction with available resources.

Appendix E: Carle Health Intervention Spreadsheets

Carle Health Methodist Hospital

Actions	Anticipated Impacts	Committed Resources	Measuring Our Impact	Planned Collaborations
Establish annual food drive to collect and donate food items to youth-serving organizations and families in need.	Youth in our community will have increased access to food through efforts led by and collaborated with Carle Health Methodist Hospital.	•Carle Health Methodist Hospital Senior Leadership •Carle Health Senior Leadership •Carle Health Methodist Hospital Behavioral Health Leadership •Carle Health Methodist Hospital Behavioral Health Providers •Carle Health Methodist Hospital Spiritual Care •Carle Health Public Relations/Marketing	Amount of food donated through food drives and partnerships with community organizations. Donation dollars provided to community organizations decreasing food insecurity among youth, including specific partnerships through: • Peoria Public Schools Foundation Weekend Snack Pack Program • Heart of Illinois Big Brothers Big Sisters Youth Mentoring Program – Lunch Buddies • 5-year commitment to Salvation Army for Food Pantry Support	•Trillium Place •Hult Center for Healthy Living •Peoria, Tazewell, and Woodford County Health Departments
Develop and implement a standardized process to screen patients for food insecurity at key clinical locations and provide inclusive, equitable nutrition and food resource materials to individuals identified as in need.	Patients at clinical locations will be increasingly screened for food insecurity and referred to appropriate resources.		Number of referrals from screenings for food insecurity.	
Provide individualized nutrition education to youth through the WELL program, offering evidence-based sessions that include fruit and vegetable education, cooking demonstrations, and culturally responsive curriculum.				
In partnership with Carle Health West Region, implement targeted, community-based, youth-centered nutrition education initiatives across the tri-county region by 2028, with program activities beginning by December 2026.			Number of youth centered, community-based nutrition education initiatives led by and collaborated on with Carle Health Methodist Hospital.	

Carle Health Pekin Hospital

Actions	Anticipated Impacts	Committed Resources	Measuring Our Impact	Planned Collaborations
Establish annual food drive to collect and donate food items to youth-serving organizations and families in need.	Youth in our community will have increased access to food through efforts led by and collaborated with Carle Health Pekin Hospital.	•Carle Health Pekin Hospital Senior Leadership •Carle Health Senior Leadership •Carle Health Pekin Hospital Behavioral Health Leadership •Carle Health Pekin Hospital Behavioral Health Providers •Carle Health Pekin Hospital Spiritual Care •Carle Health Public Relations/Marketing	Amount of food donated through food drives and partnerships with community organizations. Donation dollars provided to community organizations decreasing food insecurity among youth, including specific partnerships through: • Peoria Public Schools Foundation Weekend Snack Pack Program • Heart of Illinois Big Brothers Big Sisters Youth Mentoring Program – Lunch Buddies • 5-year commitment to Salvation Army for Food Pantry Support	•Trillium Place •Hult Center for Healthy Living •Peoria, Tazewell, and Woodford County Health Departments
Develop and implement a standardized process to screen patients for food insecurity at key clinical locations and provide inclusive, equitable nutrition and food resource materials to individuals identified as in need.	Patients at clinical locations will be increasingly screened for food insecurity and referred to appropriate resources.		Number of referrals from screenings for food insecurity.	
Provide individualized nutrition education to youth through the WELL program, offering evidence-based sessions that include fruit and vegetable education, cooking demonstrations, and culturally responsive curriculum.				
In partnership with Carle Health West Region, implement targeted, community-based, youth-centered nutrition education initiatives across the tri-county region by 2028, with program activities beginning by December 2026.			Number of youth centered, community-based nutrition education initiatives led by and collaborated on with Carle Health Pekin Hospital.	

Carle Health Proctor Hospital

Actions	Anticipated Impacts	Committed Resources	Measuring Our Impact	Planned Collaborations
Establish annual food drive to collect and donate food items to youth-serving organizations and families in need.	Youth in our community will have increased access to food through efforts led by and collaborated with Carle Health Proctor Hospital.	•Carle Health Proctor Hospital Senior Leadership •Carle Health Senior Leadership •Carle Health Proctor Hospital Behavioral Health Leadership •Carle Health Proctor Hospital Behavioral Health Providers •Carle Health Proctor Hospital Spiritual Care •Carle Health Public Relations/Marketing	Amount of food donated through food drives and partnerships with community organizations. Donation dollars provided to community organizations decreasing food insecurity among youth, including specific partnerships through: • Peoria Public Schools Foundation Weekend Snack Pack Program • Heart of Illinois Big Brothers Big Sisters Youth Mentoring Program – Lunch Buddies • 5-year commitment to Salvation Army for Food Pantry Support	•Trillium Place •Hult Center for Healthy Living •Peoria, Tazewell, and Woodford County Health Departments
Develop and implement a standardized process to screen patients for food insecurity at key clinical locations and provide inclusive, equitable nutrition and food resource materials to individuals identified as in need.	Patients at clinical locations will be increasingly screened for food insecurity and referred to appropriate resources.		Number of referrals from screenings for food insecurity.	
Provide individualized nutrition education to youth through the WELL program, offering evidence-based sessions that include fruit and vegetable education, cooking demonstrations, and culturally responsive curriculum.				
In partnership with Carle Health West Region, implement targeted, community-based, youth-centered nutrition education initiatives across the tri-county region by 2028, with program activities beginning by December 2026.			Number of youth centered, community-based nutrition education initiatives led by and collaborated on with Carle Health Proctor Hospital.	

Carle Health Methodist Hospital				
Actions	Anticipated Impacts	Committed Resources	Measuring Our Impact	Planned Collaborations
Recruit behavioral health providers to add capacity within the community	Wait times from referral to initial appointment will decrease.	•Carle Health Methodist Hospital Senior Leadership •Carle Health Senior Leadership •Carle Health Methodist Hospital Behavioral Health Leadership •Carle Health Methodist Hospital Behavioral Health Providers •Carle Health Methodist Hospital Spiritual Care •Carle Health Public Relations/Marketing	Number of net new behavioral health providers employed by Carle Health Methodist Hospital and Carle Health on an annualized basis.	•Trillium Place •Hult Center for Healthy Living •Peoria, Tazewell, and Woodford County Health Departments
Provide education and training related to mental health and substance use and the available resources for patients of Carle Health Methodist Hospital	People residing in the service area will have a greater understanding and recognition of behavioral health needs, the available resources, and opportunities to access care.		Number of Mental Health First Aid Trainings provided by Carle Health Methodist Hospital and Carle Health.	
Partner with Carle Health Trillium Place Young Minds Center to increase behavioral health capacity, and to help our communities understand such availability	Youth, their families, and individuals with low income will have greater access to behavioral health services.			
Provide financial support for community organizations engaging is efforts to increase access to behavioral health services.	The utilization of available mental health and substance use services will increase.		Donation dollars provided to community organizations improving behavioral health access among youth, including specific partnerships through: The Children's Home Association of Illinois Behavioral Health Program	

Carle Health Pekin Hospital				
Actions	Anticipated Impacts	Committed Resources	Measuring Our Impact	Planned Collaborations
Recruit behavioral health providers to add capacity within the community	Wait times from referral to initial appointment will decrease.	•Carle Health Pekin Hospital Senior Leadership •Carle Health Senior Leadership •Carle Health Pekin Hospital Behavioral Health Leadership •Carle Health Pekin Hospital Behavioral Health Providers •Carle Health Pekin Hospital Spiritual Care •Carle Health Public Relations/Marketing	Number of net new behavioral health providers employed by Carle Health Pekin Hospital and Carle Health on an annualized basis.	•Trillium Place •Hult Center for Healthy Living •Peoria, Tazewell, and Woodford County Health Departments
Provide education and training related to mental health and substance use and the available resources for patients of Carle Health Pekin Hospital	People residing in the service area will have a greater understanding and recognition of behavioral health needs, the available resources, and opportunities to access care.			
Partner with Carle Health Trillium Place Young Minds Center to increase behavioral health capacity, and to help our communities understand such availability	Youth, their families, and individuals with low income will have greater access to behavioral health services.		Number of Mental Health First Aid Trainings provided by Carle Health Methodist Hospital and Carle Health.	
Provide financial support for community organizations engaging is efforts to increase access to behavioral health services.	The utilization of available mental health and substance use services will increase.			

Carle Health Proctor Hospital				
Actions	Anticipated Impacts	Committed Resources	Measuring Our Impact	Planned Collaborations
Recruit behavioral health providers to add capacity within the community	Wait times from referral to initial appointment will decrease.	•Carle Health Proctor Hospital Senior Leadership •Carle Health Senior Leadership •Carle Health Proctor Hospital Behavioral Health Leadership •Carle Health Proctor Hospital Behavioral Health Providers •Carle Health Proctor Hospital Spiritual Care •Carle Health Public Relations/Marketing	Number of net new behavioral health providers employed by Carle Health Proctor Hospital and Carle Health on an annualized basis.	•Trillium Place •Hult Center for Healthy Living •Peoria, Tazewell, and Woodford County Health Departments
Provide education and training related to mental health and substance use and the available resources for patients of Carle Health Proctor Hospital	People residing in the service area will have a greater understanding and recognition of behavioral health needs, the available resources, and opportunities to access care.			
Partner with Carle Health Trillium Place Young Minds Center to increase behavioral health capacity, and to help our communities understand such availability	Youth, their families, and individuals with low income will have greater access to behavioral health services.		Number of Mental Health First Aid Trainings provided by Carle Health Methodist Hospital and Carle Health.	
Provide financial support for community organizations engaging is efforts to increase access to behavioral health services.	The utilization of available mental health and substance use services will increase.			

Carle Health Methodist Hospital				
Actions	Anticipated Impacts	Committed Resources	Measuring Our Impact	Planned Collaborations
Deliver education and training grounded in evidence-based practices that support suicide prevention and awareness strategies, including Mental Health First Aid (MHFA), Question, Persuade, Refer (QPR), and Assessing and Managing Suicide Risk (AMSR).	Increased mental health literacy and stigma reduction in the community	•Carle Health Methodist Hospital Senior Leadership •Carle Health Senior Leadership •Carle Health Methodist Hospital Behavioral Health Leadership •Carle Health Methodist Hospital Behavioral Health Providers •Carle Health Methodist Hospital Spiritual Care •Carle Health Public Relations/Marketing	Number of Mental Health First Aid trainings offered by Carle Health Hospital network and Carle Health West Region.	•Trillium Place •Hult Center for Healthy Living •Peoria, Tazewell, and Woodford County Health Departments
Implement structured program presentations coordinating with training & community events to increase awareness of available behavioral health resources, spanning prevention through crisis intervention	Improved timely access to crisis intervention resources.		Number of educational events focused on suicide prevention, hosted by or collaborated on by Carle Health Methodist Hospital.	
Collaborate with community partners to host joint training and educational sessions, fostering shared participation among providers, team members, and community organizations (e.g., churches, agencies, schools) to strengthen awareness, trust, and knowledge of local resources				
Analyze data aligned with best practices to ensure timely and culturally responsive approaches in addressing the needs of target populations and expand programmatic interventions across the four hospital networks in the Tri-County region	Increased use of evidence-based suicide prevention practices among community organizations.			

Carle Health Pekin Hospital				
Actions	Anticipated Impacts	Committed Resources	Measuring Our Impact	Planned Collaborations
Deliver education and training grounded in evidence-based practices that support suicide prevention and awareness strategies, including Mental Health First Aid (MHFA), Question, Persuade, Refer (QPR), and Assessing and Managing Suicide Risk (AMSR).	Increased mental health literacy and stigma reduction in the community	•Carle Health Pekin Hospital Senior Leadership •Carle Health Senior Leadership •Carle Health Pekin Hospital Behavioral Health Leadership •Carle Health Pekin Hospital Behavioral Health Providers •Carle Health Pekin Hospital Spiritual Care •Carle Health Public Relations/Marketing	Number of net new behavioral health providers employed by Carle Health Pekin Hospital and Carle Health on an annualized basis.	•Trillium Place •Hult Center for Healthy Living •Peoria, Tazewell, and Woodford County Health Departments
Implement structured program presentations coordinating with training & community events to increase awareness of available behavioral health resources, spanning prevention through crisis intervention	Improved timely access to crisis intervention resources.		Number of educational events focused on suicide prevention, hosted by or collaborated on by Carle Health Pekin Hospital.	
Collaborate with community partners to host joint training and educational sessions, fostering shared participation among providers, team members, and community organizations (e.g., churches, agencies, schools) to strengthen awareness, trust, and knowledge of local resources				
Analyze data aligned with best practices to ensure timely and culturally responsive approaches in addressing the needs of target populations and expand programmatic interventions across the four hospital networks in the Tri-County region	Increased use of evidence-based suicide prevention practices among community organizations.			

Carle Health Proctor Hospital				
Actions	Anticipated Impacts	Committed Resources	Measuring Our Impact	Planned Collaborations
Deliver education and training grounded in evidence-based practices that support suicide prevention and awareness strategies, including Mental Health First Aid (MHFA), Question, Persuade, Refer (QPR), and Assessing and Managing Suicide Risk (AMSR).	Increased mental health literacy and stigma reduction in the community	•Carle Health Proctor Hospital Senior Leadership •Carle Health Senior Leadership •Carle Health Proctor Hospital Behavioral Health Leadership •Carle Health Proctor Hospital Behavioral Health Providers •Carle Health Proctor Hospital Spiritual Care •Carle Health Public Relations/Marketing	Number of Mental Health First Aid trainings offered by Carle Health Hospital network and Carle Health West Region.	•Trillium Place •Hult Center for Healthy Living •Peoria, Tazewell, and Woodford County Health Departments
Implement structured program presentations coordinating with training & community events to increase awareness of available behavioral health resources, spanning prevention through crisis intervention	Improved timely access to crisis intervention resources.		Number of educational events focused on suicide prevention, hosted by or collaborated on by Carle Health Proctor Hospital.	
Collaborate with community partners to host joint training and educational sessions, fostering shared participation among providers, team members, and community organizations (e.g., churches, agencies, schools) to strengthen awareness, trust, and knowledge of local resources				
Analyze data aligned with best practices to ensure timely and culturally responsive approaches in addressing the needs of target populations and expand programmatic interventions across the four hospital networks in the Tri-County region	Increased use of evidence-based suicide prevention practices among community organizations.			

Appendix F: OSF Healthcare Intervention Spreadsheets

OSF Healthcare Saint Francis Medical Center

Youth Food Insecurity

Actions	Timeline / Milestone	Impact Measurement (*Process Indicator*)	Potential Collaborations/Partners
Expand Gardens of Hope community outreach efforts	2026- 9,669 persons served 2027- 10,152 persons served 2028- 10,659 persons served	Increase number of persons served by 5% each year. (FY24 Baseline: 9,209 persons served)	St. Ann's Catholic Church, University of Illinois Extension, Tazewell County Health Department & HEAL food system partners
Increase Gardens of Hope produce harvested	2026- 12,991+ pounds 2027- 13,250+ pounds 2028- 13,515+ pounds	Increase produce harvested annually by 2% (FY24 Baseline: 12,737 pounds)	St. Ann's Catholic Church, University of Illinois Extension, Tazewell County Health Department & HEAL food system partners
Implement food insecurity screenings and resources at school physicals provided in the community	2026- Establish baseline 2027- Baseline + increase 3% 2028- 2027 + increase 3%	Increase food insecurity screenings provided at community school physicals annually by 3% (Baseline: TBD)	PCCEO, Friendship House, Dream Center, Mosaic Christian Church, Bartonville Christian Church, New Beginnings Worship Center, St. Ann's Catholic Church, Southside Christian Academy, OSF Medical Group-Pediatrics, Dunlap School District & Tazewell County Head Start
Provide OSF representation on PFHC's youth food insecurity action team	2026- .1 FTE committed 2027- .1 FTE committed 2028- .1 FTE committed	Commit .1 FTE annually to the PFHC action team	PFHC

OSF Healthcare Saint Francis Medical Center

Behavioral Health Access & Navigation

Actions	Timeline / Milestone	Impact Measurement (*Process Indicator)*	Potential Collaborations/Partners
Increase outpatient Behavioral Health encounters	2026- 18,843 encounters 2027- 19,220 encounters 2028- 19,604 encounters	Increase outpatient behavioral health encounters annually by 2% (FY24 Baseline: 18,474	OSF Medical Group & Heartland Health Services
Expand OSF Strive to serve individuals aged 6+ (previous aged 14+)	2026- 2,292 encounters 2027- 2,338 encounters 2028- 2,385 encounters	Increase OSF Strive encounters annually by 2% (FY24 Baseline: 2,247 encounters)	Peoria Public Schools, OSF Medical Group, Heartland Health Services, Center for Prevention of Abuse, Peoria Police & community partners
Increase referrals to OSF Behavioral Health Navigation during central region community events	2026- 1,546 referrals 2027- 1,577 referrals 2028- 1,609 referrals	Increase referrals to OSF Behavioral Health Navigation annually by 2% (FY25TD Baseline: 1,516 referrals)	Head start programs, Friendship House, Dream Center, Faith Based Organizations, OSF Medical Group Pediatrics and local school districts
Provide OSF representation on PFHC's behavioral health access and navigation action team	2026- .1 FTE committed 2027- .1 FTE committed 2028- .1 FTE committed	Commit .1 FTE annually to the PFHC action team	PFHC

OSF Healthcare Saint Franics Medical Center

Youth Suicide and Self Harm

Actions	Timeline / Milestone	Impact Measurement (*Process Indicator*)	Potential Collaborations/Partners
Implement behavioral health/suicide screenings at school physicals in the community	2026- Establish baseline 2027- Baseline + increase 3 % 2028- 2027 + increase 3%	Increase outpatient behavioral health/suicide screenings annually by 3% (Baseline: TBD)	Head start programs, Friendship House, Dream Center, Faith Based Organizations, OSF Medical Group Pediatrics and local school districts
Implement behavioral health/suicide screenings on the OSF Care-A-Van	2026- Establish baseline 2027- Baseline + increase 3 % 2028- 2027 + increase 3%	Increase outpatient behavioral health/suicide screenings annually by 3% (Baseline: TBD)	Friendship House, Dream Center, Bartonville Christian Church, Salvation Army, Pathway Ministries, St. Paul's Episcopal Church, & Sophia's Kitchen
Provide suicide prevention education and awareness to the community	2026- 2 events 2027- 3 events 2028- 4 events	Provide suicide prevention education and awareness events annually	Friendship House, Dream Center, Mosaic Christian Church, Bartonville Christian Church, St. Ann's Catholic Church, Sophia's Kitchen, Other faith-based organizations, & local school districts
Provide OSF representation on PFHC's youth suicide and self-harm action team	2026- .1 FTE committed 2027- .1 FTE committed 2028- .1 FTE committed	Commit .1 FTE annually to the PFHC action team	PFHC

Appendix G: CHIP Action Team Tasks & Timelines

Partnership for a Healthy Community
healthyhoi.org

Group: Food Insecurity

Goal: Empower and increase resiliency amongst youth and their families to improve access to adequate nutrition.

Planning Cycle: 3 Years (January 1, 2026 – December 31, 2028)

Objective 1: Reduce the rate of youth screening positive by 1.5% for food insecurity among households with children in the Tri-County by the end of December 2028.
Objective 2: Increase the number of youth screened for food insecurity by 10% in the Tri-County region by the end of December 2028.

Similar baseline data: Food insecurity is 14.5% in Peoria County and 15.5% in Tazewell County; Woodford County data is unavailable but likely similar according to regional trend (Source: CHNA, 2025)

These objectives are based on guidance from Healthy People 2030. In particular, the following objective:

1) **Objective NWS-01: Reduce household food insecurity and hunger**
   Baseline: 11.1% of households were food insecure
   Target for 2030: 6.0% of households

Tentative Plan

Task Group / Objective	Supporting Strategy	Year 1 (2026)	Year 2 (2027)	Year 3 (2028)
Phase 1: Foundation & Planning	Strategy 1			
1.1 Community Assessment & Planning	S1: Assessment/Plan	Jan - Mar		
1.2 Engage & Convene Partners	S1: Convening	Apr - Sept	Apr -Sept	Apr - Sept
Phase 2: Action & Food Literacy	Strategy 2			
2.1 Partnership/Role Definition	S2: Define Roles	Jan - Mar		
2.2 Capacity Building (Trainings)	S2: Trainings	Apr - Sept	Apr - Sept	Apr - Sept
2.3 Food Literacy Education	S2: Education	Apr-Dec	Jan-Dec	Jan-Sept
Phase 3: Program Scaling & Advocacy	Strategy 3			
3.1 Outreach & Utilization Improvement	S3: Outreach/Gaps	Oct - Dec	Jan-Dec	Jan-Dec
3.2 Policy Awareness & Communication	S3: Advocacy/Comms		Apr-Dec	Jan-Dec

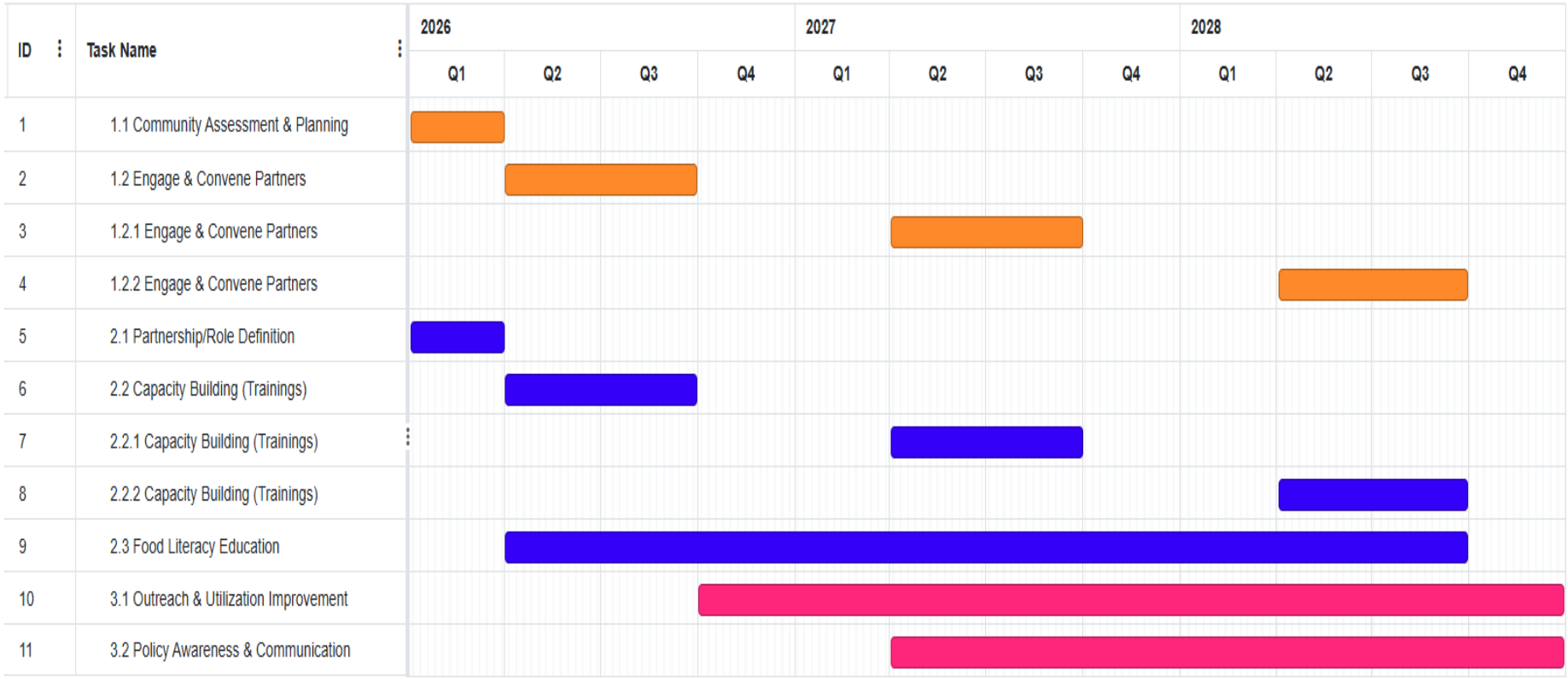


Figure 1: Project Timeline

CHIP Action Team: Behavioral Health Access and Navigation

Goal: Improve access and utilization of behavioral health resources for youth and low-income adults.

Planning Cycle: 3 Years (January 1, 2026 – December 31, 2028)

Objective 1: Increase the proportion of primary care visits that provide a mental health screening by 2% among youth and low-income adults in the Tri-County region by the end of December 2028.
Objective 2: Increase follow up care after ED visit for behavioral health concerns among youth by 5% in the Tri-county region by the end of December 2028.

Similar baseline data: Age-adjusted depression prevalence among adults is 22.7 in Peoria County, 23.5 in Tazewell County, and 23.1 in Woodford County (Source: CDC Places, 2022 report)

These objectives are based on guidance from Healthy People 2030. In particular, the following objectives:

1) **Objective MHMD-08: Increase the proportion of adolescents and adults who are screened for depression**
   Baseline**:** 8.5% of primary care office visits included screening for depression in persons aged 12 years and over (2016 National Ambulatory Medical Care Survey)
   Target for 2030: 13.5%
2) **Objective MHMD-03**: **Increase the proportion of children with mental health problems who get treatment**
   Baseline**:** 70.7% of children aged 4 to 17 years with mental health problems received treatment (2019 National Health Interview Survey)
   Target for 2030: 79.3%
3) **Objective MHMD-05**: **Increase the proportion of adults with depression who get treatment**
   Baseline**:** 60.8% of adults aged 18 years and over with depression received treatment in the past year (2021 National Survey on Drug Use and Health)
   Target for 2030: 13.5%

Tentative Plan

Task Group	Supporting Strategy	2026	2027	2028
Phase 1	**Strategy 1**	**Jan - Dec**		
1.1 Conduct Family/Community Resource Mapping & Gap Assessment	S1: Increase BH Family Support	Jan - Dec	Jan - Dec	
1.2 Develop Family Support Action Plans	S1: Increase BH Family Support	Jan - Dec	Jan - Dec	Jan - Mar
Phase 2	**Strategy 2**			
2.1 Inventory & Locate Tri-County BH Resources	S2: Increase access to BH services and programs	Jan - Dec		
2.2 Create & Maintain Dynamic BH Directory	S2: Increase access to BH services and programs	Mar - Dec	Jan - Dec	Jan-Mar
2.3 Design & Execute Directory Promotional Campaign	S2: Increase access to BH services and programs	April - Dec	Jan - Dec	Jan - Dec
Phase 3	**Strategy 3**			
3.1 Educate Stakeholders on System of Care (SOC)	S3: Improve coordination of services and programs	Mar - Dec	Jan - Dec	Jan - Dec
3.2 Integrate SOC Framework & Conduct Gap Analysis	S3: Improve coordination of services and programs	Mar - Dec	Jan - Dec	Jan - Dec

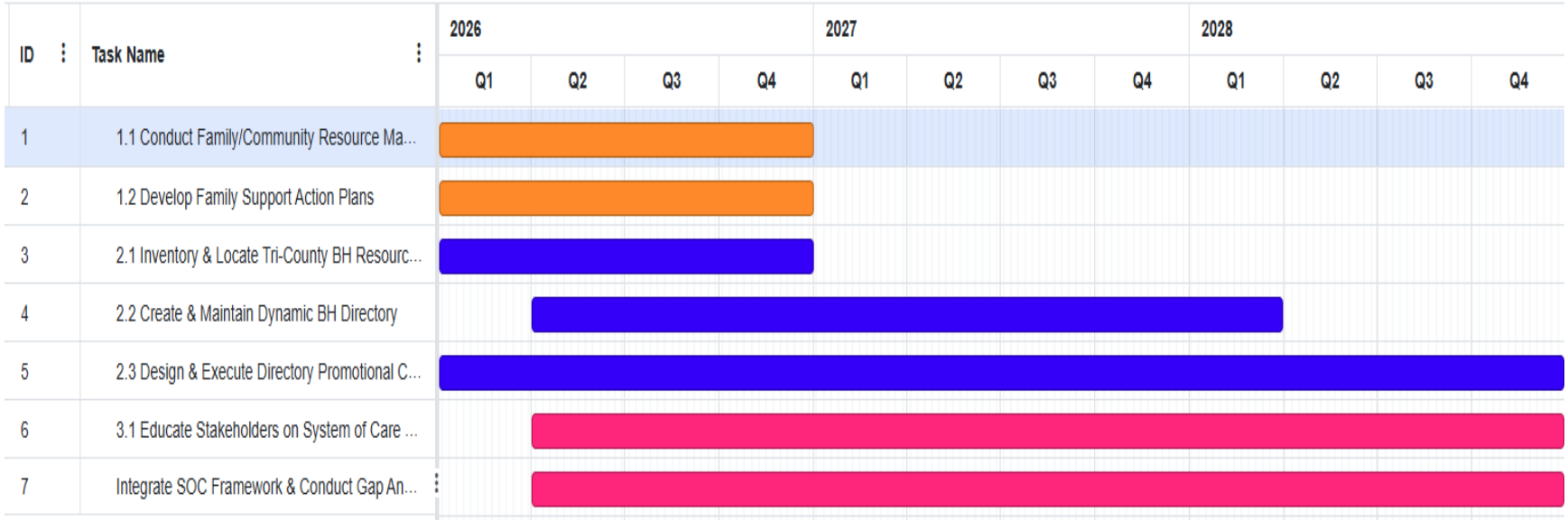


Figure 1: Project Timeline

Group: Suicide

Goal: Develop, encourage, and sustain a Tri-County region where adolescents and young adults live and feel supported, included, heard, and valued

Planning Cycle: 3 Years (October 1, 2025 – December 31, 2028)

Objective 1: Reduce suicide mortality rates by 1% among adolescents and young adults in the Tri-County region by the end of December 2028.
Objective 2: Reduce the annual number of ED visits related to self-harm and behaviors by 2% among adolescents and young adults in the Tri-County region by the end of December 2028.

Similar baseline data: Suicide mortality rates are 15 per 100,000 in Peoria County, 14 per 100,000 in Tazewell County, and 11 per 100,000 in Woodford County (Data Source: 2019-2023 National Center for Health Statistics-Mortality Files)

These objectives are based on guidance from Healthy People 2030. In particular, the following objectives:

1) **Objective MHMD-01: Reduce the suicide rate**
   Baseline: 14.2 suicides per 100,000 population (2018)
   Target for 2030: 12.8 per 100,000
2) **Objective MHMD-02: Reduce suicide attempts by adolescents**
   Baseline: 7.4 suicide attempts per 100 population of students in grades 9 through 12 in the past year (2017)
   Target for 2030: 1.8 per 100

Tentative Plan

Task Group	Supporting Strategy	2026	2027	2028
Phase 1	**Strategy 1**			
1. Assess Gaps & Establish Resource Base	S1: Stability & Adversity Reduction	Jan - June		
2. Develop & Deliver Educational Materials	S1: Stability & Adversity Reduction	Apr- Dec	Jan - Dec	
3. Advocate for Family Stability Policies	S1: Stability & Adversity Reduction	July - Dec	Jan - Dec	Jan -Dec
Phase 2	**Strategy 2**			
4. Implement Prevention Training & Resource Dissemination	S2: Awareness & Workforce	Jan - Dec	Jan - Dec	Jan - Sept
5. Optimize Care Coordination & Policies	S2: Awareness & Workforce	July - Dec	Jan - Dec	Jan - Dec
6. Build & Support BH Workforce	S2: Awareness & Workforce	Apr - Dec	Jan - Dec	Jan - Sept
Phase 3	**Strategy 3**			
7. Strengthen Family Connection & Stigma Reduction	S3: Family Wellbeing & Outreach	July - Dec	Jan - Dec	Jan - Dec

8. Build Community Partnerships & Support Networks	S3: Family Wellbeing & Outreach	July - Dec	Jan - Dec	Jan - June
9. Optimize Service Navigation & Outreach	S3: Family Wellbeing & Outreach	Apr - Dec	Jan - Dec	Jan - Dec
10. Expand Awareness and Resource Access	S3: Family Wellbeing & Outreach	July - Dec	Jan - Dec	Jan - Dec

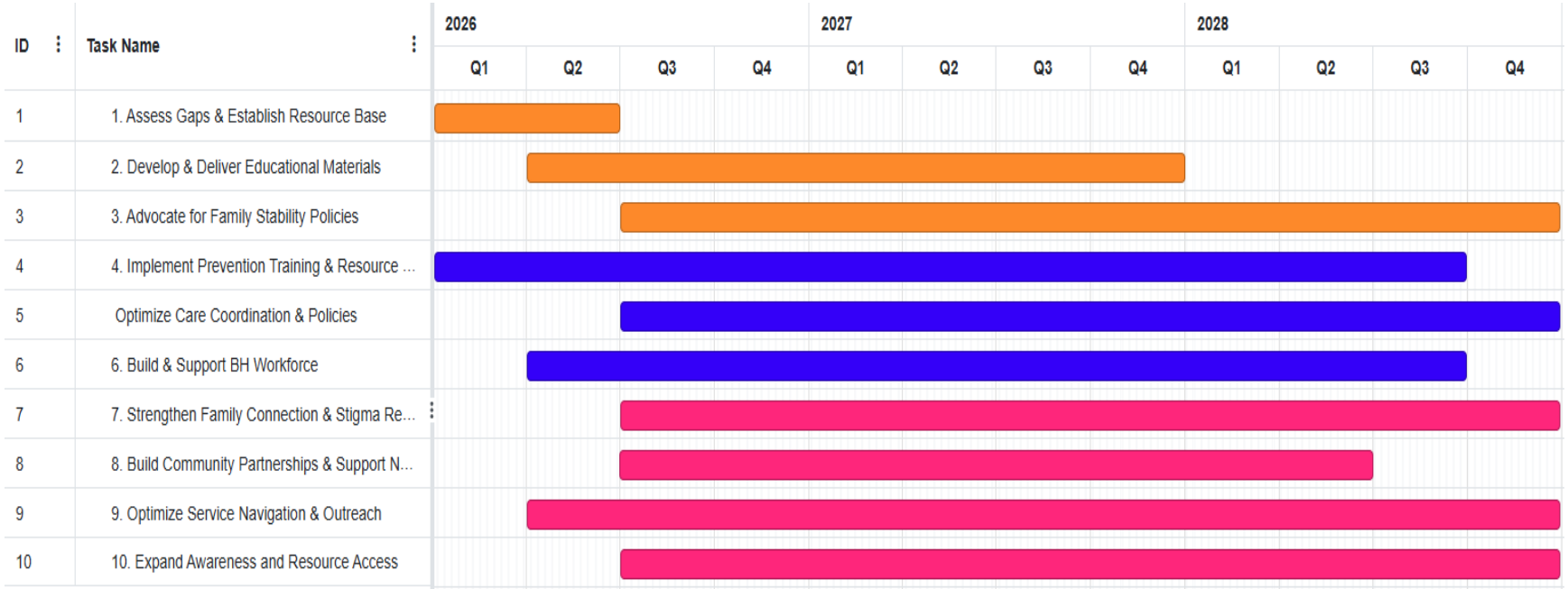


Figure 1: Project Timeline

Appendix H: CHIP Planning Action Team Committee Members

Partnership for a Healthy Community
healthyhoi.org

Food Insecurity Action Team

*Denotes action team chairperson

Dr. Keji Akin-Olugbemi - U of I College of Medicine - Peoria
Betsy Ayers - Hult Center for Health Living
Beth Beachy - Tazewell County Health Department
Maria Bosma - Bradley University
Dr. Amy Christison - U of I College of Medicine - Peoria
Michelle Compton* - Peoria City/County Health Department
Rebecca Cottrell - Peoria County Sustainability
Rebecca Crumrine - U of I Extension
Sue Cupples - STM Food
Carline Ehrett - Tazewell County Health Department
Amy Fox - Tazewell County Health Department
Sally Gambacorta - Carle Health
Kelly Gibler - Children's Home Association of Illinois
Kate Green - Heart of Illinois United Way
Dawn Harris Jeffries
Dorsey Hill - Economic Recovery Corps
Sara Kelly - U of I College of Medicine - Peoria
Hanna Landis - OSF Healthcare
Erin Luckey - Woodford County Health Department
Miracle McClendon - Tazewell County Health Department
Leslie McKnight - Peoria City/County Health Department
Jordan Meeks - OSF Healthcare
Andrea Parker - Hult Center for Healthy Living
JD Raucci - Tazewell County Health Department
Rachel Sabella - Peoria County Sustainability
Joanne Upchurch - Carle Health
Shanita Wallace - Tazewell County Health Department
Paul Wilkins* - Woodford County Health Department
Valerie Wolfe - Tazewell County Health Department

Access to Behavioral Health Action Team

*Denotes action team chairperson

Bethanie Albrecht* - Woodford County Health Department
Dr. Keji Akin-Olugbemi - U of I College of Medicine - Peoria
Tyler Antram - Carle Health
Christina Burden - OSF Healthcare
Michele Carmichael
Amber Clark - Veteran's Affairs
Allysen Classen - Heartland Health Services
Christopher Cox - Peoria Parole Office
Keith Downes - OSF Healthcare
James Flurer - U of I College of Medicine - Peoria
Sally Gambacorta - Carle Health
Kate Green - Heart of Illinois United Way
Megan Hanley - Tazewell County Health Department
Joyce Harant - Peoria Park District
Robin Henry - Solvera Health
Dawn Harris Jeffries
Nate Johnson - Carle Health
Kathy Karl
Sara Kelly - U of I College of Medicine - Peoria
Rebecca Kidd - Molina Healthcare of Illinois
Tricia Larson - Trillium Place
Audrey LeaMasters - Edge Counseling & Wellness
Jan Leonard - Heart of Illinois United Way
Angella Lewis
Irene Lewis-Wimbley - Southside Community Center
Dawn Lochbaum - OSF Healthcare
Kati Manning - Molina Healthcare of Illinois
Leslie McKnight - Peoria City/County Health Department
Kirsten Miller - Peoria Heights Grade School
Joanie Montoya - Carle Health
Erica Mutchler - Tazewell County Health Department
Kunle Ogunjesa - U of I College of Medicine - Peoria
Molly Pilgreen - Phoenix Community Development Services
Tabatha Poppenga - Methodist College
Jodi Rinaldo - Heartland Health Services
Regina Siscoe - Heartland Health Services
Betty Sours - Center for Youth & Family Solutions
Lisha Streitmatter - Peoria City/County Health Department
Shanita Wallace - Tazewell County Health Department
Leslie Wilson* - Tazewell County Health Department

Suicidal Ideation and Self-Harm Behaviors in Young People Action Team

*Denotes action team chairperson

Dr. Keji Akin-Olugbemi - U of I College of Medicine - Peoria
Payton Beach - Hult Center for Healthy Living
Tim Bromley - OSF Healthcare
Michele Carmichael
Amber Clark - Veteran's Affairs
Matt Collins* - Carle Health
Christopher Cox - Peoria Parole Office
Amy Dewald - Woodford County Health Department
Stacie Ealey - Tazewell County Health Department
James Flurer - U of I College of Medicine - Peoria
Sally Gambacorta - Carle Health
Jonathan Gauerke - Gateway Foundation
Kate Green - Heart of Illinois United Way
Megan Hanley - Tazewell County Health Department
Monica Hendrickson* - Peoria City/County Health Department
Robin Henry - Solvera Health
Hannah Jordan - Veteran's Affairs
Sara Kelly - U of I College of Medicine - Peoria
Tricia Larson - Trillium Place
Audrea LeaMasters - Edge Counseling & Wellness
Angella Lewis
Dawn Lochbaum - OSF Healthcare
Sydney Meuth - Southside Community Center
Kirsten Miller - Peoria Heights Grade School
Joanie Montoya - Carle Health
Molly Pilgreen - Phoenix Community Development Services
Amy Roberts - Peoria City/County Health Department