Illinois Administrative Code Title 77, Chapter 1, Subchapter h, Part 600, Section 400 states that: Local Public Health Departments shall "Assess the health needs of the community by establishing a systematic needs assessment process that periodically provides information on the health status and health needs of the community."

# DeWitt County/Piatt County

Community Health Assessment and Plan

2018

**DeWitt-Piatt**
Bi-County Health Department
PREVENT • PROMOTE • PROTECT

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DeWitt and Piatt Counties Community Health Assessment and Plan

2018 – 2022

Mobilizing for Action through Planning and Partnerships:

A Strategic Approach to Community Health

For

Illinois Department of Public Health

Springfield, Illinois

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Dr. John Warner Hospital

Dewitt County/Clinton Emergency Management Agency

Kirby Medical Center

Monticello Rotary

Piatt County Board

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# Community Health Needs Assessment and Plan
## Summary of Process

**Statement of Purpose**

Public health departments throughout the United States currently focus on 10 core Essential Services. These core functions were expanded upon from three original core functions: Assessment, Policy Development, and Assurance. Originally identified by the Institute of Medicine, they become the foundation for every public health department in the country (Institute of Medicine, 1988). Throughout this paper, the concentration will center on the assessment function of public health in regards to the health of the populations within DeWitt and Piatt Counties.

As per the Illinois Administrative Code, every health department within the state must "assess the health needs of the community by establishing a systematic needs assessment process that periodically provides information on the health status and health needs of the community" (Illinois Department of Public Health, 2017). Community assessment is a crucial function for a public health department, as it aids in its responsibilities to monitor the local health status, but it also provides the opportunity to analyze and address health problems and hazards within the community. The DeWitt/Piatt Bi-County Health Department is then able to target these identified community health problems through the implementation of policies and plans. Through this assessment function, the public health system is provided with guidelines as to how more efficiently address health problems within each jurisdiction.

The objective of our department has been to construct an assessment process that would include as much participation as possible, as we desired community-wide contributions in regards to the health issues most affecting the community as a whole. Our department aimed to use the most comprehensive perspective of health as possible, as to include a large range of contributions from both area residents and also local service providers. Various factors influence health, shifting from individual behaviors and genetics, to larger scale environmental factors like physical and social environments, which a community may find themselves in.
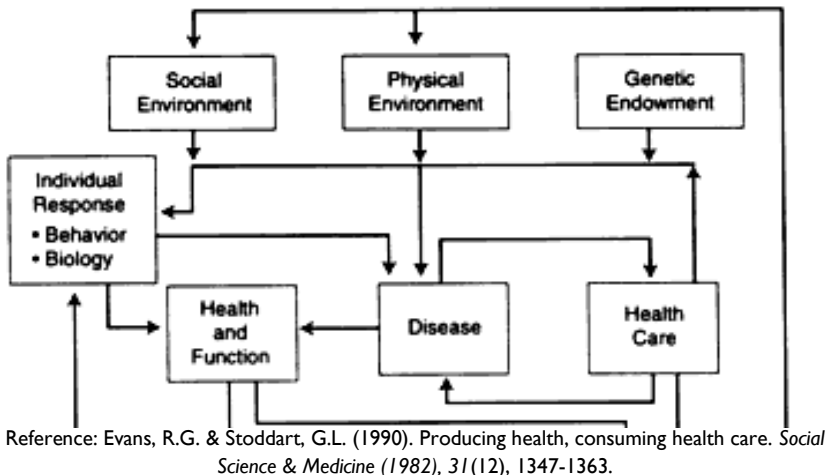
Health is a concept that encompasses both an individual's well-being and also their being devoid of illness. The Institute of Medicine produced a report in 1997 that recognized this fact in regards to health being a dynamic state, discussing how there is a wider recognition of this idea in many different settings (Institute of Health, 1997). Because of this idea, health is viewed as a combination of social and personal resources along with physical capabilities.

Additionally, this definition stresses the key contributions that affect health and come from areas outside of formal medical care and public health systems. Health is not solely dependent on medical care, but rather it is also determined by other factors as discussed before and could include individual behavior, genetic makeup, and social and economic conditions.

This is true for both individuals as well as populations.

The Health Field Model depicts the multiple determinants of health and the dynamic relationship of each one on another (Evans and Stoddart, 1994). The model links social environment, physical environment, genetic endowment, health care, disease, health and function, well-being, prosperity, and individual response (both behavioral and biological). This model provides a multidimensional perspective, which emphasizes the importance

**Figure 1 The Health Field Model**

Reference: Evans, R.G. & Stoddart, G.L. (1990). Producing health, consuming health care. *Social Science & Medicine (1982), 31*(12), 1347-1363.

of a population-based approach to community health issues. It also indicates the potential influences that both public and private entities, such as health care providers, public health agencies, and community organizations, can have on the health of a community. Additional stakeholders could include other government agencies, community organizations, and organizations and individuals in private industry. Other entities that may not be solely health-center such as schools, employers, social service and housing agencies, transportation and justice agencies, and faith communities all can influence the health of a community as well. Because of these interactions and influences that all affect health, the DeWitt/Piatt Bi-County Health Department elected to engage with a diverse audience throughout this assessment process.

**Community Participation Process**

The tutelage and frequent feedback for the key elements of this community assessment were supported by local community-based coalitions. The Clinton Area Chamber of Commerce, DeWitt County Coalition, Monticello Rotary, and the DeWitt and Piatt County Boards all provided community representation for both counties. These representatives came from local governments, churches, businesses, civic organizations, and health care providers. This diverse representation, working in collaboration with one another during multiple assessment processes, aided in the overall completion of the community assessment for our bi-county service area.

## Methodology

The DeWitt/Piatt Bi-County Health Department elected to use MAPP (Mobilizing for Action through Planning and Partnerships), an assessment model developed by the National Association of County and City Health Officials and the Centers for Disease Control and Prevention, to conduct the assessment. MAPP is a strategic planning tool that focuses on improving health throughout the community (National Association of County and City Health Officials, 2001). It is promoted by public health leadership and aids communities in prioritizing their community health issues and also in analyzing resources available to address them. There are four different assessment processes that are included in the MAPP Model. These processes each provide important understanding about challenges and

**Figure 2 MAPP Model**



Reference: National Association of County and City Health Officials. (2001). *Mobilizing for action through planning and partnerships.* Washington, D.C.: National Association of County and City Health Officials.

opportunities throughout the community. These processes include:

1. **Community Themes and Strengths Assessment**, which aids in identifying issues of interest for the community, community perceptions about quality of life, and also community assets.

2. **Local Public Health System Assessment**, which measures the capacity and performance of the local public health system—all the organizations and entities that contribute to the public's health.

3. **Community Health Status Assessment**, which analyzes data available about health status, quality of life, and risk factors that exist in the community.

4. **Forces of Change Assessment**, which identifies present or forthcoming forces affecting the community or local public health system.

Through the use of this assessment, local participants are able to determine strategic health issues within the community and then create goals and strategies to address these issues. The information collected is vital for the action cycle, because it is during this cycle that participants

plan for action, implement, and evaluate. Successfully conducting a MAPP assessment should create a sustainable community initiative that will conclusively end with overall community health improvement.

The Community Health Status Assessment included an extensive review and analysis of community specific data associated with demographic and socioeconomic characteristics, general health and access to care indicators, maternal and child health indicators, chronic disease indicators, infectious disease indicators, and environmental/occupational/injury data. This data was collected from sources such as the IPLAN data system, Behavioral Risk Factor Surveillance System (BRFSS), County Health Rankings, and other assessment results. After reviewing and analyzing community-specific data from these various sources, opinions were gathered from diverse audiences throughout the two county service area to complement the data collection.

Data that was reviewed and analyzed at this stage of the assessment process will be discussed throughout this report in more depth. A portion of the analysis included a compilation of data over time from the IPLAN, Behavioral Risk Factor Surveillance System, and County Health Rankings. This compilation is included as a Microsoft spreadsheet in the appendix. The indicators of particular interest are those with higher averages than that of the state, with a 1.0 reflecting an equal number between our communities and the state. The risk ratios, indicators with higher averages than that of the state overall, were given special attention throughout the assessment process as well. Another assessment and report published recently by the Kirby Medical Center in Monticello, IL was also reviewed and analyzed to ascertain if common themes existed throughout.

# Complete Results
## I.   Community Themes and Strengths Assessment

The Community Themes and Strengths Assessment is crucial to understanding opinions and concerns about quality of life within a community. Thoughts are collected from the community along with community assets to determine community health concerns and available assets to address them. The information collected from this assessment helps to provide an account of the community through the perspective of the community members themselves. Responses from this portion of the assessment were obtained primarily through focus groups that were coordinated as part of a local hospital assessment. The comments below collected from respondents summarize this assessment for each county in our jurisdiction:

## DeWitt County

### 1.   What do you feel is important in your community?

"Our community is built around the power plant and farming. Supporting local businesses is important and there is a definite sense of community life. Everyone knows each other and there is always accountability. Are you asking in terms of what I feel is important to change in our community?"

"Jobs and health"

"I feel it is important for our community to have access to medical, dental, vision and mental health providers, along with transportation needs."

"Be able to communicate with other health agencies or medical agencies/daycares and see if we can integrate ideas. Also, to have preventive health services available."

"I believe that programs that involve both youth and/ or seniors to give them a space to socialize, volunteer, and basically be out "among their friends" is important. The days of front porch sitting and talking with and helping neighbors needs to make a comeback."

"Most people I talk to are concerned with providing for their families"

### 2.   How do you perceive quality of life in your community?

"The quality of life here is somewhat poor. Many people have diabetes, obesity, and cardiac or drug problems. I strongly believe this is due to the lack of things to do here and a sense of being "stuck" in this rural life. There are plenty of folks who have good jobs at State Farm or the power plant and this definitely makes them happier, but in general, I think Clinton gets people down."

"Not very good. people need better healthy lifestyles, lots of unemployed people"

"I feel the quality of life in our community is aging.   I also feel that the drugs affecting our families and community is taking a toll.   Our resources in reaching those affected by drugs is under development, but our ability to reach those in need is limited if the drug user declines the help of others."

"Many low-income residents in Dewitt County. Dewitt County is an older person community and we have financial issues. Because of these issues, the health status is poor."

"The quality of life could be improved in DeWitt county.   There are way too many young people walking the streets with no purpose.   Parents don't discipline their children for fear of being reported to the police. Older generations are being taken advantage of by scammers. Our world is falling apart."

"For most that I come in contact with quality of life is poor. They are struggling to financially support their family.   Since that is on their mind health issues generally take a back seat – miss appointments to make sure they are at work. Many are still undereducated as to the importance of good health and hygiene in their overall wellbeing. Unfortunately, this is being passed down to the next generation. Our community also has a large percentage of special needs students and even recently it was noted at the school board meeting that there is a critical shortage of teachers for this type of student. Many parents who have a child with special needs are struggling to receive the services that are needed since they are on Medicaid. They are trying to balance work and home and become easily overwhelmed.   They may have a lack of transportation to even get to appointments. Yet, there are others who do not want to exert themselves to make changes or they have just accepted this is the way it is and are teaching their children to just accept life in our area is just going to be this way. Drug addiction/alcohol issues are a common problem which results in angry and abusive behavior (I have seen this first hand in the clinic). Depression and anxiety are listed on at least half if not more of the medical histories that are filled out in the clinic. Even those that I speak with that seem to have a good job and a nice home and thus have a perceived good quality of life have mentioned anxiety about taking care of their family…uncertainty that their job will always be there."

3. **What assets do we have in this community that could help improve community health?**

"We have a strong agricultural sector and Good land and I could see that working to our advantage. There are like 5 gyms/fitness locations here which is great! We also have Weldon springs state recreation area and Clinton lake that offer people plenty of opportunity to get outdoors and move their bodies. Again, the people are the strongest asset. If they get behind something there is definitely a vivid discussion of it and almost everyone gets involved. If people need help paying for a surgery, there are grassroots fundraisers at the bars, in local businesses, etc. Oh! And we also have our own rural hospital so that's nice to have a hospital in town.

Schools, churches, health department, ymca, mental health center, and Bars...just kidding....”

“We do have access to medical, dental, vision, mental health along with transportation needs.   I am not sure of all that we have available to those who are addicted to drugs besides mental health and medical.”

“Fitness Centers, Friendship Center, Hopefully the Vault – teen center, Mental health, Health Dept – Dental clinic , Food banks such as American Legion, Assembly of God, Nazarene church, First Christian Church and DOVE”

“Food banks at churches, Friendship center, Peace Meal program for seniors, The Vault (not open yet), Most fast food places have coffee clubs that show up everyday, Youth Initiative. If each town or village could have a cleanup day where neighbors could help the neighbors that want the help, then maybe we would have less nuisance calls and more happy neighborhoods.”

“The Health Department is an asset to help provide education and a resource to go to find other services that are available for those who don’t have insurance or are on Medicaid especially since we do not have an HFS/Medicaid office in our county anymore.   WIC is also a great service that can help families who do want to provide healthy food for their families but just need that extra supplement.   We also have the Friendship Center for seniors that is a great resource for finding home help aides and community interaction.   Clinton does have family doctors from two sources and a hospital.   Although it would be nice to have a pediatrician again!”

## Piatt County

1. **What do you feel is important to your community?**

“Being prepared for any type of emergency (weather, disaster at a school, manmade, opioid crisis, pandemic, emerging infectious disease).”

“SAFETY, GOOD SCHOOLS, AND MULTIPLE OPTIONS FOR FAMILY ACTIVITIES AND RESOURCES.”

“Sharing ideas across organizations and agencies throughout the county is vital for our community.”

“Safety, education, and strong city leadership”

2. **How do you perceive quality of life in your community?**

“I believe my community has a pretty good perception of quality of life.”

“I FEEL LIKE IT IS GOOD,WE FEEL SAFE IN OUR TOWN, DON’T FEEL LIKE WE

HAVE TO WORRY TOO MUCH ABOUT CRIME, AND PLENTY OF OPTIONS FOR CHURCH INVOLVEMENT,AND WE HAVE GREAT SUPPORT FOR OUR SCHOOLS SPORTING EVENTS, BUT I WISH THERE WERE MORE OPTIONS FOR FAMILY ACTIVITIES IN OUR AREA, FOR EXAMPLE A "Y". FOR EXERCISE OPTIONS, AN INDOOR SWIMMING POOL,COMMUNITY GYM,CHILDREN'S GYMNASTICS CLASSES,TRAMPOLINES,INDOOR JUMP PARK ETC…INSIDE ACTIVITIES FOR ENERGY EXPENDATURE DURING INCLIMATE WEATHER FOR FAMILIES TO PARTICIPATE IN.- NOT MANY OPTIONS FOR ACTIVITIES IN LATE FALL AND WINTER HERE. I ALSO WISH THERE WERE MORE OPTIONS FOR COMMUNITY GATHERINGS/EVENTS TO BRING OUR COMMUNITY CLOSER AND TO IMPROVE OUR "SENSE OF COMMUNITY". ALSO, I WISH THERE WERE MORE OPTIONS FOR HEALTHIER EATING IN OUR AREA."

"I perceive quality of life in our community by maximizing one's ability to self-determine and live independently as long as it is safe to do so."

"I believe there are certain programs advertised within the community that aim at healthy lifestyles however, additional community outreach is needed as drug use, obesity, STD rates, and tobacco use rates remain high (county-wide)"

3. **What assets do we have in this community that could help improve community health?**

"Mental Health, community clinics and hospital, health department, schools, law enforcement. There are also regional assets available from the Regional Health Care Coalition."

"LOCAL FULL SERVICE HOSPITAL,MANY OPTIONS FOR LOCAL MEDICAL PROVIDERS, LOCAL MENTAL HEALTH FACILITIES, WOMEN AND PEDIATRIC RESOURCES FOR FAMILIES IN NEED, WE HAVE A VERY GENEROUS, PROSPEROUS COMMUNITY WILLING TO DONATE AS NEEDED. WE HAVE ALLERTON PARK AND MANY OTHER VERY NICE PARKS FOR INCREASED RECREATION FOR FAMILIES - THAT WE COULD UTILIZE MORE OF. -WE HAVE SEVERAL CHURCH OPTIONS AVAILABLE IN OUR AREA."

"In our community, we have Piatt County Cares Coalition that brings multiple social service agencies together to help assess and meet the needs of individuals in our community. The collaborative effort from various social service agencies (Faith in Action, Services for Seniors, A Small Hand, Community Action, Piatt County Mental Health, Prairieland Service Coordination, Ministerial Alliance, etc.) provides a safety net for people who might not qualify for some services they need. Communication between social service agencies and healthcare providers is key to improving community health. Thank you for providing the services that your agency provides to our community."

"We currently have a number of assets currently in place, it's just getting residents motivated.

Continue outreach and education. If one area could be improved it would be the services to senior citizens. Current assets in the community attempting to promote healthy lifestyles include:   Kirby Hospital, Piatt County Mental Health, Health Department, the U of I Extension Office, and local businesses attempting to promote healthy lifestyles (Yoga at Monarch and Allerton Park mansion)"

# II.   Local Public Health System Assessment

The Local Public Health System Assessment (LPHSA) focuses on the components, activities, competencies, and capacities of our local public health system. It also includes information about how the Essential Public Health Services that are being provided to our community. This assessment concentrates on the entire local public health system, including: all community organizations and entities that support and affect the community's health overall. The Essential Public Health Services Model is used during this assessment.

In 1994, the Core Public Health Functions Steering Committee formed this fundamental framework (Core Public Health Functions Steering Committee, 1994). This steering committee was comprised of U.S. Public Health Service Agency members, including those from National Association of County and City Health Officials (NACCHO) and also other important public health organizations. It was determined that the list of Essential Services should be included in every community's public health activities.

**The 10 Essential Public Health Services include the following:**

1. Monitor health status to identify community health problems.

2. Diagnose and investigate health problems and health hazards in the community.

3. Inform, educate, and empower people about health issues.

4. Mobilize community partnerships to identify and solve health problems.

5. Develop policies and plans that support individual and community health efforts.

6. Enforce laws and regulations that protect health and ensure safety.

7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.

8. Assure a competent public health and personal health care workforce.

9. Evaluate the effectiveness, accessibility and quality of personal and population-based health services.

10. Research new insights and innovative solutions to health problems.

Various assessment mechanisms were used during this assessment procedure. The assessment mechanisms aimed to accomplish four goals. These goals included:

A.  Compare local residents importance of the Essential Services of Public Health with staff members' ratings;

B.  Assess our system's capacity to provide these Essential Services analyzing both the Local Health Department capacity and the Local Public Health System overall and what strengths and weaknesses exist within local stakeholder organizations.

C.  Identify core concepts of our local health department's organizational capacity, along with an analysis of potential future challenges for the department; and

D.  Provide an agency specific assessment of strengths and weaknesses.

Each of these assessment mechanisms and their results are crucial to the completion of this assessment and are described as follows.

## A.    Essential Public Health Services Ranked by Importance

We asked community members to rank the Essential Services of Public Health to determine which services they believed to be most important. The results are provided in table 3 below, with the divisions between DeWitt County and Piatt County. These rankings were then averaged and compared to the DeWitt/Piatt Bi-County Health Department staffs' ratings of how well the department accomplishes each of these services for the community.

**Table 3: DeWitt County and Piatt County Rankings for the 10 Essential Public Health Services**

| Ten Essential Public Health Services—Ranked by Importance | | |
|:---:|:---:|:---:|
| **DeWitt County Rank*** | **Results** | **Piatt County Rank*** |
| 4 | 1. Monitor Health Status and understand health issues facing the community. | 5 |
| 5 | 2. Protect people from health problems and health hazards. | 3 |
| 2 | 3. Give people information they need to make healthy choices. | 2 |
| 7 | 4. Engage the community to identify and solve health problems | 7 |
| 8 | 5. Develop public health policies and plans. | 6 |
| 1 | 6. Enforce public health laws and regulations. | 9 |
| 3 | 7. Help people receive health services. | 1 |
| 6 | 8. Maintain a competent public health workforce. | 4 |
| 9 | 9. Evaluate and improve programs and interventions | 8 |
| 10 | 10. Contribute to and apply the evidence base of public health | 10 |

When combining the scores and creating averages, the most important services for the community members within our jurisdiction include the following:

- **Essential Service #7:** Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
- **Essential Service #3:** Inform, educate and empower people about health issues.
- **Essential Service #8:** Assure a competent public health and personal health care workforce.
- **Essential Service #2:** Diagnose and investigate health problems and health hazards in the community.

▪ **Essential Service #1:** Monitor health status to identify community health problems.

## B.   Local Public Health System Performance Assessment

Comparing the previous staff rankings with current rankings can help elucidate on potential improvements that have occurred within the department in the last five years, but can also identify any shortcomings or areas of further need. All staff members at the DeWitt/Piatt Bi-County Health Department were included in an organizational capacity survey. This included 3 different components: 1) 71 questions with a 5-point Likert-scale, 2) 4 open-ended questions, and 3) a ranking section with a 10-point Likert-scale for the 10 Essential Services.

For the section about the Essential Services, all staff members were asked to assess how well they felt the organization was performing each service with: 1 being "Services Fully Met" and 10 being "Services Not Met At All". Comparing these results with the local community members' rankings provides very important information. Further comparing the changes in staff members rankings over time can provide further insight into changes that have been made and other areas that could still use improvement.

**Table 4: Comparative Essential Service Ratings by DeWitt/Piatt Bi-County Health Department Staff from 2012 and 2017**

| Chief Concerns—Public Health System Assessment | | |
|---|---|---|
| **Health Department Staff Rating 2012** | **Essential Public Health Service** | **Health Department Staff Rating 2017** |
| **3.1** | 1. Monitor health status to identify community health problems. | **3.2*** |
| **3.1** | 2. Diagnose and investigate health problems and health hazards in the community. | **2.3** |
| **3.3** | 3. Inform, educate and empower people about health issues. | **4.5*** |
| **3.8** | 4. Mobilize community partnerships to identify and solve health problems. | **4.0*** |
| **3.6** | 5. Develop policies and plans that support individual and community health efforts. | **3.7*** |
| **3.2** | 6. Enforce laws and regulations that protect health and ensure safety. | **2.3** |
| **2.8** | 7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable. | **3.2*** |
| **4.4** | 8. Assure a competent public health and personal health care workforce. | **2.5** |
| **3.9** | 9. Evaluate the effectiveness, accessibility and quality of personal and population-based health services. | **3.8** |
| **3.9** | 10. Research new insights and innovative solutions to health problems. | **4.3*** |

Ratings from 1 "Services Fully Met" to 10 "Services Not Met At All".
* Indicates a rating that increased (worsened) in the past 5 years.

Areas of concern would include the Services that have received higher (worse) ratings than in the previous survey, indicating need to improve in those areas. Particular interest will be needed for those areas that have worsened in rating, but are still high in importance for community members. Although none of the Essential Services were given ratings higher than 5 out of 10, it is imperative to monitor scores that have gotten higher (worsened) over time. There were, however, several scores near the midpoint of the scale. The Essential Public Health Services that received the poorest scores in 2012 included:

- Essential Service #8: Assure a competent public health and personal health care workforce.

- Essential Service #9: Evaluate the effectiveness, accessibility and quality of personal and population-based health services.

- Essential Service #10: Research new insights and innovative solutions to health problems.

- Essential Service #4: Mobilize community partnerships to identify and solve health problems

Essential Service #8 was scored the lowest in 2012, with a 4.4 out of 10. This service, however, scored much better in 2017, receiving a 2.5 out of 10 and being one of the highest rated services in this round of surveys. Essential Service #9 received a score of 3.9 in 2012 and improved just slightly to receive a 3.8 in 2017. Essential Service #10 and #4, however, both worsened going from 3.9 and 3.8 to 4.3 and 4.0 respectively. This demonstrates potential need for improvement in these areas. Of these Essential Services, community members listed only Essential Service #8 in their most important services, and it did improve since the last survey.

This round of rankings, however, listed the following Essential Services as the lowest:

- Essential Service #3: Inform, educate and empower people about health issues.

- Essential Service #10: Research new insights and innovative solutions to health problems.

- Essential Service #4: Mobilize community partnerships to identify and solve health problems

- Essential Service #9: Evaluate the effectiveness, accessibility and quality of personal and population-based health services.

- Essential Service #5: Develop policies and plans that support individual and community health efforts.

Additionally, analyses were provided of local area stakeholders in terms of strengths (assets) and weaknesses (needs remaining) existing within the system overall. These analyses were conducted through Focus Group discussions co-facilitated between the DeWitt/Piatt Bi-County Health Department and Kirby Medical Center during the assessment period. The results of these focus groups discussions appear below:

## *Focus Group – Community Representatives*

Two different focus groups were assembled for this local assessment during this assessment period. The Community Representatives group was the first group addressed and was asked to first to identify any positive changes that they have witnessed in the delivery of healthcare and services within the community. Their responses included the following (Kirby Medical Center, 2016):

- Development of facilities

- Development of the Diaper Pantry, including school supplies and backpacks

- Increase area focus on wellness and related outreach from Kirby Medical Center

- New specialists at Kirby Medical Center

- Local transportation services have improved

- Local access to oncologists

- Local access to orthopedic services

After discussing these primary changes, the group was then prompted to describe any needs and concerns that they had in regards to the delivery of healthcare and services along with any general health issues in the community. Their responses included the following (Kirby Medical Center, 2016):

- Transportation to appointments

- Mental health

  o Pediatric Counseling

  o Access to Adult Counseling

  o Affordable transportation for mental health patients to healthcare

  o Youth Depression

  o Inpatient services for behavioral health, substance abuse, and depression patients

- Substance abuse
  - Alcohol
  - Heroin
  - Cocaine
  - Methamphetamines
  - Synthetics
  - Prescription drugs, including doctor shopping and selling medicine
- Substance abuse education for youth and adults
- Education for the community about the extent of the substance abuse issues
- Parent education on nitration and other wellness issues
- Continued expansion of local specialty services
  - Dialysis
  - OB/GYN services
  - Expanded orthopedics
  - Gerontologist
- Expanded access to physical therapy at Kirby Medical Center
- Assisted living
- Health education for youth and parents needs to be established area-wide
- Youth sports concussion review programs
- After school programs
- Nutrition education throughout the area
- Obesity among youth and adults
- Advocacy for seniors on health issues
- Community education about food allergies
- Expanded home health services in order to extend life at home
- Local services for veterans
- Care coordination for services and support outside the hospital
- Cooperation among groups and organizations around needs of underserved
- Better collaboration for utilizing faith community resources to address needs
- Local health service information clearinghouse
- Baseline wellness exams for youth

- Opportunities for indoor recreation for adults and youth

- Indoor aquatic recreation and therapy

- Mentoring for youth

- Weekend convenient care

## *Focus Group – Medical Professionals and Partners*

The second group included various medical professionals and partners from within the community. The group was first asked to report any positive changes they have observed in the delivery of healthcare and services over the past years, the same question was asked of the community members. Their responses included the following (Kirby Medical Center, 2016):

- New assisted living facility

- Increased recognition of mental health as a local issue

- Wellness and preventive care

- Expanded specialty services through Christie Clinic, including surgery and dermatology

- Strong relationship among Kirby Medical Center and the schools

- Silver Sneakers program

- Kirby Derby and similar programs

- Full spectrum of options for senior living

- Memory care facility

- Local pre- and post-operative care and therapy can be obtained at Kirby Medical Center

- Quick Care

- Expanded collaboration and services for wellness in outlying areas

- Expanded services at the nursing home, including respite care, portable x-ray, and electronic medical records

- Strong support for seniors

- Improvements at mental health center, including expanded cooperation with Kirby Medical Center

- New clinic and pharmacy being built in Cerro Gordo

- Strengthened collaboration between Kirby Medical Center and Carle Clinic

- Hospitalist program is helping to keep patients in the community

- Electronic medical records
- Continuum of care has increased
- Transportation is better

Similarly to that of the Community Representative group, this group was also asked a second question. They were to identify any existing needs and concerns regarding the delivery of healthcare and services and overall health issues in the community. They responded with the following (Kirby Medical Center, 2016):

- More transportation availability locally and outside of area
- Before and after appointments
    - Availability to meet calls for appointments
    - Services in outlying areas
    - Better coordination with schools on public transportation resources
    - Local services information source, possibly like 411
- Cooperation to remove redundancy in healthcare
    - Patient care literacy to help with understanding access, cost, and billing issues
- Expanded Quick Care hours
- More access to local psychiatrists
- Expanded mental health nursing services
- Expanded substance abuse resources
    - Prevention
    - Outreach of services
- Improve electronic health information exchange
- Include nursing homes in information sharing
- Better educate patients on patient home care and their role
- More opportunities and encouragement for recreation and exercise
- Education on end-of-life
- Resources for vision care for youth
- Education to change patient behavior
- Increase access to mental health and primary care
- Increase collaboration on information
- Improve physician efficiency by delegation of EMR responsibilities to mid-levels

# C.    Organizational Capacity Assessment

The main responsibility of a local health department is to protect and enhance a community's health status. The capacity within an agency greatly determines its ability to provide these services. In an article by G.P. Mays, et al., it was reported that local health departments were responsible for an average 67% of total effort contributed towards the 20 public health activities (2004). Assurance activities saw 80% contribution by a local health department, 60% towards assessment activities, and 58% towards policy development tasks. All of these activities heavily relied upon the capacity of local health departments.

A local public health system assessment must include comprehensive assessments of the capacities, challenges, and strategic orientation of the local health department as well. For this assessment, the DeWitt/Piatt Bi-County Health Department surveyed its staff to ascertain opinions about agency strengths and weaknesses and also to provide additional information for future strategic planning purposes. The design used for this survey was adapted from a model used by the state of Texas to conduct biennial assessments for their various forms of government. The model is discussed in "Reinventing Texas Government", a text written by Michael Lauderdale (1999). The role of this survey for our agency was to provide ongoing feedback for improvement of functions.

The instrument used to determine organizational capacity included 71 questions on a 5-point Likert scale, with 1 being "Strongly agree" and 5 being "Strongly disagree". These questions focused on topics surrounding agency services, employee benefits, and available resources, among others. The second part of the survey included 4 open-ended questions to provide suggestions for agency improvement. This provided staff members with the opportunity to include as many or as few suggestions as they saw fit. The third and last part of the survey, as discussed above, was the component with the 10 Essential Services. The staff members rated each essential service on a 10-point Likert scale from 1 being "Services Fully Met" to 10 "Services Not Met At All". All surveys were anonymous and were completed within a two-week window.

**Results**

Derived from the model used in Texas, any question that received a mean score of 3.0 or higher was indicative of more negative than positive perceptions by staff members (Lauderdale, 1999). Any question that received a mean score of 4.0 or higher is indicative of an area that may be of considerable concern for the agency and may require prompt attention. Comparatively, however, any question with a score of 2.0 or lower is indicative of an area that should be considered within the strengths of the agency.

*Agency Strengths*

Many reported strengths of the agency included staff members' benefits, organizational human resources, and abilities to collaborate with entities outside of the health department.

**Specific Items Receiving Highest Rating (Items receiving a score of "Strongly Agree" or "Agree"):**

| **Item** | **Score** |
|---|---|
| 64. I am satisfied with the sick leave benefit offered by my employer. | 1.00 |
| 65. I am satisfied with the vacation benefit offered by my employer. | 1.00 |
| 60. Sexual harassment is not tolerated in this organization. | 1.14 |
| 5. We know who our customers are. | 1.29 |
| 9. Every employee is valued. | 1.29 |
| 22. We work well with the public. | 1.43 |
| 41. Employees feel safe working in this organization. | 1.43 |
| 42. Employees feel that they work in pleasant surroundings. | 1.43 |
| 59. I am confident that any ethics violation I report will be properly handled. | 1.43 |
| 67. I am satisfied with the dental insurance benefit offered by my employer. | 1.43 |

*Agency Weakness/Growth Areas*

There were no questions that received a mean score of 4.0 or above, but rather the highest score was 3.43. This is just above neutral and indicative that on average, staff members view this specific issue slightly more negatively than positively. Our agency is dedicated to improving itself, and will continue to survey staff on a routine basis. This will aid in determining improvements and areas that may need further improvement.

**Specific Items Receiving Poorest Rating:**

The following items were the only two questions with a mean score between 3.00 and 4.0:

| **Item** | **Score** |
|---|---|
| 7. Average work is rewarded the same as excellent work. | 3.43 |
| 14. Information and knowledge are shaped only in this organization. | 3.14 |

*Summary of Comments Provided in Open-Ended Questions*

The second component of this survey included 4 open-ended questions to provide staff members with the opportunity to share their opinions that may otherwise be constricted within a Likert-scale format. These questions were developed with the advise of agency directors and are reflective of previously used survey questions. The exact questions and received responses have been included below:

**72. What barriers exist today that prevent the Health Department from performing its core functions, if any?**

"Lack of nurses to cover 2 offices."

"Community knowledge. Does the community really understand the services provided by the health department?"

"The unreliability of the internet creates a huge barrier in not only our core functions, but our day-to-day jobs. If our office can't complete daily tasks without encountering internet issues, then our agency as a whole cannot meet our core functions successfully. Also, I think social media creates a barrier for our health department by allowing anyone in the public to be able to put information out into the community that might not always be accurate. This can often cause the public to feel as if the health department isn't handling the situation because they haven't been informed from our office, but rather a citizen with a public platform to post and say anything."

"We often have poor internet access and problems with our Cornerstone program which leaves us unable to perform daily core functions for our clients, not just occasionally, but often."

"Increasing responsibilities from IDPH to LHDs. Too many requirements for each core program. Limited staff and increasing responsibilities and expectations at state level make quality of work difficult."

**73. Considering how we deliver services, I think the Health Department should put more thought into….**

"Training staff."

"Advertisement. We need to get the word out about what the Health Department does as a whole. Focus on different topics and promoting each department at the Health Department."

"Our office should put more thought into working with other entities in our community so that we may help the people in our communities with resources. Building a closer relationship with the doctor's offices so infants, women and children can be referred to our WIC program by their doctor. Showing the client that their doctor supports and encourages their enrollment in the WIC program. Building better relationships with programs that we refer our clients to (and often people who walk into our office looking for help), giving them an easier transition from our

office to the one they will go to after seeing us. Helping to close the gap so they don't feel as if they're constantly being shuffled from one place to the next with no assistance."

"I feel we should put more thought into the cleanliness of our clinic. We are consistently seeing clients with contagious conditions or illnesses and also handling and collecting bodily fluids such as blood and urine for testing we do. We also have dead bugs throughout our clinic that our clients children are touching and sometimes trying to eat off the floor."

"I believe we have an excellent staff that is open to expanding services beyond normal expectations. No changes or additional thought should be put into our services."

## 74. What things about the Health Department are most in need of change?

"Teach front line staff how to do more of the dental office manager's job such as turning the screen gray once the patient has left. The dental office manager is constantly on the go."

"Would like to have focus groups that promote each department, that way the employees have a better understanding of the Health Department as a whole unit. How can each department help one another? Support one another and promote one another?"

"Better communication between the two offices. Making sure when changes are put into place information is relayed to each office at the same time. Consistency between the offices is also an issue. Are the same forms being used? Are clients told the same information at each office by the staff? Also, toggling back and forth between computers to use a program that is web-based (Cornerstone). This seems to cause more problems and takes longer to complete a task that if the system was being used on one computer only."

"Internet services improved, outside of building needs repaired and re-done/updated and the cleanliness of the inside of clinic improved."

"Keeping up to date with changes that occur at the state level to keep in compliance with the LHPG. No other changes are necessary considering we provide a number of services that expand beyond our expectations."

## 75.   If I could change one thing about the way the Health Department conducts business it would be….

"Have more available times to do flu/immunization clinics especially in August, September and October."

"To have a closer relationship with the pediatricians in our community."

"To make sure both of our offices are working toward being more connected with each other and our communities we serve. Being more involved with the public and letting them know our offices care and are here to help them and their families with our services we provide."
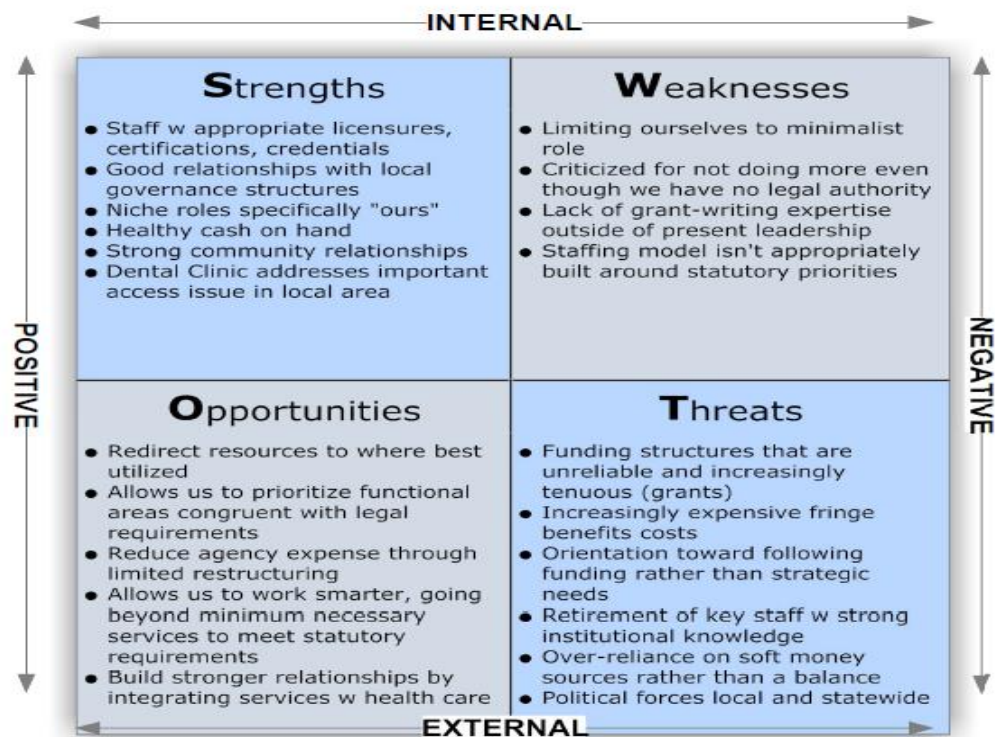
"Nothing, I feel like we do a great job."

"This is a fantastically operated health department with an amazing and hard working staff that is willing to work together when needed. I do not believe any change is necessary except for possibly the expansion of educational outreach in the public and schools (e.h., sexual education, etc.)."

D.

# SWOT Analysis

A SWOT Analysis is a structured planning method to evaluate the strengths, weaknesses, opportunities and threats involved in a project or venture. The analysis below pertains to the DeWitt/Piatt Bi-County Health Department.

INTERNAL

**S**trengths
- Staff w appropriate licensures, certifications, credentials
- Good relationships with local governance structures
- Niche roles specifically "ours"
- Healthy cash on hand
- Strong community relationships
- Dental Clinic addresses important access issue in local area

**W**eaknesses
- Limiting ourselves to minimalist role
- Criticized for not doing more even though we have no legal authority
- Lack of grant-writing expertise outside of present leadership
- Staffing model isn't appropriately built around statutory priorities

POSITIVE / NEGATIVE

**O**pportunities
- Redirect resources to where best utilized
- Allows us to prioritize functional areas congruent with legal requirements
- Reduce agency expense through limited restructuring
- Allows us to work smarter, going beyond minimum necessary services to meet statutory requirements
- Build stronger relationships by integrating services w health care

**T**hreats
- Funding structures that are unreliable and increasingly tenuous (grants)
- Increasingly expensive fringe benefits costs
- Orientation toward following funding rather than strategic needs
- Retirement of key staff w strong institutional knowledge
- Over-reliance on soft money sources rather than a balance
- Political forces local and statewide

EXTERNAL

# III. Community Health Status Assessment

The Community Health Status Assessment is critical for understanding the health concerns and needs of the community. Through this assessment, it is possible to understand the community's health status as a whole, with a strong portrayal provided from collected quantitative data. It is also an essential component of the MAPP process. This stage provides detailed information about specific health issues that the community is facing (e.g. high rates of heart disease or low numbers of community members with health insurance). These foundational data are collected from a number of different sources, and are subsequently analyzed to identify community health issues. These data are then compared with state data to determine differences in health status across the different levels. This activity is primarily lead by local health departments, as they have the core capacity to lead.

The bulk of data collection is often completed by a few smaller organizations, but including community perspective is also crucial for this assessment, as it provides qualitative information about health status within the community. The Appendices include summaries of collected data from these assessments.

The National Association of County and City Health Officials (NACCHO) split this assessment into six different steps. These steps include:

**Step 1- Prepare for the Community Health Status Assessment**

This assessment required a subcommittee to oversee the tasks involved in this component of the MAPP process. The subcommittee would also be responsible for overseeing all related activities. Representation was not restricted to business leaders or heads of organizations, but rather various representatives from diverse backgrounds contributed to the participation. This diversity provided important perspective for the committee. The DeWitt/Piatt Bi-County Health Department also provided the resources needed to assist with this process. These resources included the computer hardware and software that was used to collect and analyze data, resources for copying and printing materials, and additional staff support.

**Step 2 – Collect data for the core indicators on the CHSA indicator list**

Being often an arduous task, data collection was somewhat simplified at this step because the health department provided the subcommittee with any available data from IDPH and other government sources. It's crucial to analyze data trends and be able to compare time-varying data. This helps in determining if any trends have increased or decreased over time, and provides the opportunity to compare data across communities and over time. These data were also compared to state data over time. The Appendices include several spreadsheets that include the trending health status of these communities over the last 15 years. These spreadsheets cover a number of core indicators and provide an overview of the community's health.

**Step 3 – Identify locally-appropriate indicators and collect the data**

Various other indicators are also crucial for understanding the health status of a

community. Outside of IDPH datasets, these additional datasets were compiled and analyzed:

- IPLAN Data—Illinois Department of Public Health.
- Behavioral Risk Factor Surveillance System Data—Illinois Department of Public Health
- County Health Rankings
- Kirby Medical Center Community Needs Assessment

**Step 4 – Organize and analyze the data; develop a compilation of the findings; and disseminate the information.**

After collecting the various data, health department staff who possess expertise in epidemiology will lead in the analyses. These staff members will also have computer skills and statistical experience to aid in analysis. Computer-based resources are provided by the health department and were used to:

- Enter, analyze, and transmit community data;
- Gather and analyze national and state data;
- Translate assessment data into relevant, comprehensible, and community-specific terms.

Further comparisons were made with state data to highlight any issues or concerns within the community's health status. Specific spreadsheets were created for the IPLAN data, as well as the Behavioral Risk Factor Surveillance System data.

**Step 5 – Establish a system to monitor the indicators over time**

This data has been continually collected and updated, and will continue to be monitored over time. This ongoing observation will help aid in following trending health concerns for years to come. The local health department, or one other comparative entity should take the lead in managing and reviewing the data for any consequential changes.

**Step 6 – Identify challenges and opportunities related to health status**

This phase in the assessment provides a list of important influencing factors for the community's health status overall. This data was critical for understanding the health concerns within our two-county jurisdiction. All data were examined and analyzed to identify any challenges for the community's health status. Opportunities to improve health status within the community were also derived from these data analyses. Health related risk and any contributing factors were also determined using this data. All data was updated and compared to previously collected data, spanning time and geographic location. The largest ongoing challenge is that of economic disparities existing between the two counties within our jurisdiction.

# Significant Findings

The overall health of the population of our two-county jurisdiction is very good, but the intent of this assessment is to determine and analyze specific statistics that fall just outside of the scope of good health. Several different data sources were reviewed in preparation for this assessment. The following data were reflective of areas where either Piatt or DeWitt County had significant health concerns, demonstrated by exceedingly high rates of each specific problem when compared to the state averages:

**Piatt County:**

Leading Causes of Mortality—Diseases of Heart[*]

Leading Causes of Mortality—Malignant Neoplasms

Leading Causes of Mortality—Cerebrovascular Diseases

Leading Causes of Mortality—Diabetes Mellitus

Leading Causes of Mortality—Chronic Lower Respiratory Diseases

Premature Death[+]

Percentage of the Population Obese

Percentage of the Population with Sedentary Lifestyle

Seldom/Never Use Seat belts

No Flu Shot in the past 12 months

No Pneumonia Shot

Never had PSA Test

Diagnosed with Coronary Health Disease

Last Routine Checkup > 1 Year

Last Pap smear > 1 Year

Use Special Equipment due to Health

Lack of Primary Care Physicians

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[*] Leading Causes of Mortality by county collected from IDPH data (2011)

[+] Data from County Health Rankings & Roadmaps (2010-2014)

Preventable Hospital Stays

Lack of Dentists

**DeWitt County:**

Leading Causes of Mortality—Diseases of Heart[*]

Leading Causes of Mortality—Malignant Neoplasms

Leading Causes of Mortality—Chronic Lower Respiratory Diseases

Leading Causes of Mortality—Alzheimer's Disease

Leading Causes of Mortality—Cerebrovascular Diseases

Premature Death[+]

Low Birth Weight[+]

Percentage of the Population Obese

Percentage of the Population with Sedentary Lifestyle

Teen Birth Rate

Lack of Primary Care Physicians

Preventable Hospital Stays

Driving to Work Alone

Days Health Kept from Work (8-30)

Last Routine Checkup > 1 Year

Told have Coronary Heart Disease

Told had Heart Attack

Told Diabetic

Seldom/Never Use Seat belts

---

[+] Data from County Health Rankings & Roadmaps (2010-2014)

Uses Smokeless Tobacco

At-Risk for Chronic Drinking

Last Mammogram > 1 Year

Last Clinical Breast Exam > 1 Year

Last Pap smear > 1 Year

No Flu Shot in the past 12 months

No Pneumonia Shot

No Procto/Sigmoidoscoty (≥50 years old)

Diagnosed with Arthritis by Physician

Diagnosed with Asthma by Physician

Activities Limited by Impairment

Use Special Equipment due to Health

Overall the data collected for our two-county jurisdiction provides a depiction of good health, but there is need to focus on the statistics that still reside outside of the criterion of good health. Several different sources were consulted to collect and analyze data for the community health status assessment. The Appendices consist of several spreadsheets with organized data including:

- Detailed year-by-year (1990—2006) data from the IPLAN;
- Leading Causes of Death from Illinois Department of Public Health (IDPH)
- County Health Rankings; and
- Behavioral Risk Factor Surveillance System (BRFSS).

These data are the main source of information used during this assessment process. In the spreadsheets, areas of concern were those which had higher rates than that of the state of Illinois. They are indicated in red text. These spreadsheets allow trend analysis and will provide opportunity for future trend analysis to monitor health concerns over time. Any health outcomes that have persistently poor scores will greatly influence local health priorities.

# IV. Forces of Change Assessment

The Forces of Change Assessment provides insight into what is currently and also has the ability to affect the health of our community or the local public health system as a whole. It identifies any specific threats or opportunities for change. The product of this assessment will provide a specific, yet comprehensive, list of key forces of change along with their potential impact. This is especially important for taking into consideration the broader contextual environment surrounding communities and their local public health systems. Various aspects of the environment can directly and indirectly cause changes. These influencing factors can include, but are not limited to: state and federal legislation, new and fast-paced technological advances, organizational changes for health care services, any new shift in the economy or in employment status, and also changes within family structures and gender roles. They are extremely important as they affect the overall health and quality of life of community members, along with how effective the local public health system is at ensuring good health for the community.

This assessment included interactions with various local social service agencies and coalition members. These communications, primarily at coalition meetings and through email interactions, provided insight into which forces and trends are impacting the general health of the community.

## Findings:

The received feedback was organized into several categories of forces and trends that are considered important contributing forces of change both now and into the future for DeWitt and Piatt counties. These categories include:

- Economic trends and related challenges
- Changes in the Health Care System prompted by legislative action/inaction
- Aging of the population and related issues
- Environmental Conditions

### *Economic Trends and Related Challenges*

Concern was expressed in regards to both the current losses in funding and also future financial instability. These current losses in funding have been experienced by our network of social service providers within DeWitt and Piatt counties, and are of concern because of their direct impact on services offered and capacities of the local health system. Some concerns were connected to the lack of cost of living adjustments in conjunction with having to provide the same level of services without the aid of increased funding. There was also concern around the growing demand for certain services. Medicaid populations without our two-county jurisdiction

have been growing but there has been no new or supplementary funding to help counteract these increasing demands. Some respondents also voiced concern around the political contentiousness in state legislature. All of these concerns are of the utmost importance as they could culminate causing serious negative impacts in the future.

### Health Care Reform (the Affordable Care Act)

Several respondents also acknowledged the impact of the Affordable Care Act and ever-changing healthcare platform. There is need to monitor the potential direct changes that could occur to local services because of this legislation. Further concern was expressed in regards to the increased financial dependence on government with the deteriorating conditions of the economy.

### Environmental Conditions

This category of concern was mostly focused around the introduction of chemical toxins into the community. This was directly related to the pending Clinton Landfill permit request. The landfill is requesting a permit to accept hazardous waste, but the landfill's location above the Mahomet natural aquifer has turned the issue quite controversial. This aquifer provides water resources to around 750,000 local residents, from various surrounding counties. The controversy surrounds the possibility of aquifer contamination, severely affecting surrounding communities water supplies and health status. The concern has been shared with the state senators, in hopes of improving the situation.

# V. Community Health Plan and Strategies

### *Results and Findings*

As a result of the four assessment processes, our agency has identified the following priorities (in no particular order):

- Mental Health
- Chronic Disease
- Aging in Place
- Transportation
- Single Information Source

## 1.   *Mental Health*

The Illinois State Health Improvement Plan (SHIP) contains a framework surrounding three main health priorities, the first being mental health (Illinois Department of Public Health, 2016). This plan provides the state's summary of health status priorities and strategies for public health system improvement. It is a component of Healthy Illinois 2021, and the priorities of our community have some overlap with the priorities discussed in-depth in SHIP. Mental health is an important health concern throughout the state of Illinois, as well as within our community.

SHIP prioritizes this health concern partially due to the fact that in 2014, "one of five young adults in Illinois – ages 18 to 24 – reported experiencing poor mental health for more than one week in a month," (2016). Additionally, there were 39,501 children and adolescents who sought care from the Illinois public mental health system during 2013. Behavioral health problems, relating to mental health, alcohol, and substance abuse problems, have also been reported to contribute to a large number of emergency department visits.

In the discussions from our focus groups throughout our service area, concern was raised around the topic of access to mental/behavioral health services, especially among youth. According to the CDC, in any given year 1 in 5 Americans will experience a mental illness (Centers for Disease Control and Prevention, 2018). Mental health and physical health are often directly related and can influence one another. Mental illnesses, like anxiety and depression, can greatly affect an individual's ability to maintain good physical health. Comparatively, chronic diseases and other physical health issues can have an equally as detrimental affect on a person's mental health. These influences can also act as a cycle, feeding negatively off of each other.

Currently the model for understanding mental health and mental disorders focuses on the

interaction between social, environmental, and genetic factors of individuals throughout their lives. Behavioral health researchers focus on risk factors and protective factors; the factors that predispose individuals to mental illness and those that protect individuals against developing them. The successful prevention of mental, emotional, and behavioral (MEB) disorders relies heavily on interdisciplinary strategies and approaches due to these diverse influencing factors.

There has been a lot of research and increased understanding surrounding mental/behavioral health and MEB. Some of the developments have included understanding the commonality of MEB, identifying the greatest opportunities for prevention, and the importance of implementing interventions that are relevant to the target audiences. All of this progress supported the significance of understanding protective factors. Healthy People 2020 lists several applicable health objectives, including (U.S. Department of Health and Human Services, 2018):

MHMD-1:     Reduce the suicide rate.

MHMD-2:     Reduce suicide attempts by adolescents.

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

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

MHMD-5:     Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral.

MHMD-6:     Increase the proportion of children with mental health problems who receive treatment.

MHMD-7:     Increase the proportion of juvenile residential facilities that screen admissions for mental health problems.

MHMD-8:     Increase the proportion of persons with serious mental illness (SMI) who are employed.

MHMD-9:     Increase the proportion of adults with mental health disorders who receive treatment.

MHMD-10:    Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders.

MHMD-11:    Increase depression screening by primary care providers.

MHMD-12:    Increase the proportion of homeless adults with mental health problems who receive mental health services.

Our objectives for mental health align with the goals described in SHIP. From our assessments, it was very evident that there was a concern in regards to access to mental/behavioral health services. Additional need for better access to care for depression and anxiety were identified as health concerns for our community, with further focus for education centered on young people and the issues that they face.

These objectives bring our agency a unique opportunity to work in collaboration with local partners to improve access to services, enhance our delivery system, and create better referral systems that will overall better serve our community.

## Outcome Objective:

3.      **(Developmental) Increase the proportion of adults with mental health disorders who receive treatment by 2023.**

## Impact Objective:

1.1      **(Developmental) Increase depression screening by primary care providers by 2021.**

## Intervention Strategy:

1.1.1.      **The DeWitt/Piatt Bi-County Health Department will screen clients for depression and develop a referral system with local mental health providers beginning in 2019.**

Many of our clients fall within underserved populations; it is imperative that we work in collaboration with our local mental/behavioral health providers to increase screening measures. Through increasing screening measures and linking clients with local resources when needed, our agency can aid in ensuring the provision of adequate treatment for those suffering from mental health issues.

## *2.   Chronic Disease and Related Risk Factors:*

Chronic disease is a health priority for our community, and is also recognized as a priority by SHIP because two of the leading causes of death in the state of Illinois are chronic diseases: heart disease and malignant neoplams (cancer) (2016). Both of these diseases are leading causes of death in the state and in our community specifically. The goals defined in SHIP, included (Illinois Department of Public Health, 2016):

- Increase opportunities for active living;
- Increase opportunities for healthy eating;
- Increase opportunities for tobacco-free living; and

- Increase opportunities for community-clinical linkages.

There were three specific needs related to chronic disease and its prevention that were identified from the focus groups within our community. These included:

- Need to merge community resources and services with chronic disease management;
- Need for competent support groups and other ways of providing support for people who face chronic illness; and
- Need for increased access to personal case management.

The most successful interventions are focused around the opinions of the community, working to address their biggest concerns. One focus should be on the the task of merging community resources and services with chronic disease management.

## Outcome Objective:

2. **(Developmental) Increase community-clinical linkages to improve chronic disease management by 2023.**

## Impact Objective:

2.1 **(Developmental) Increase the proportion of persons suffering from chronic disease who have access to community resources and services by 2021.**

## Intervention Strategy:

2.1.1 **The DeWitt/Piatt Bi-County Health Department will train at least 2 staff members to implement the Chronic Disease Self-Management Program in local settings to DeWitt and Piatt County residents by 2019.**

This intervention will support many older community members by assisting them to better manage their chronic conditions. The Chronic Disease Self-Management program will offer assistance for individuals who suffer from chronic diseases. It will improve their quality of life and increase their self-efficacy. Additionally, this program is based off of the program developed by Stanford University's Patient Education Research Center.

*3. Aging in Place*

Home health care services that aid in extending life at home, along with the inclusion of well checks and creative uses of technology were also considered extremely important within our community. It is important to ensure quality of life for everyone, especially underserved populations that may have lack of access to health care. Aging in place focuses on four main components surrounding access; coverage, services, timeliness, and workforce. There are 3 distinct steps that are required to aid in this area. Those include:

- Gaining entry into the health care system.

- Accessing a health care location where needed services are provided.

- Finding a health care provider with whom the patient can communicate and trust.


It is crucial to have access to health care services, especially later in life when health may be deteriorating. There are disparities in access that affect individuals and have been identified as a concern in our community. A number of barriers affect access to health services, including, cost, lack of insurance coverage, and lack of service availability. The lack of access to health care can leave individuals facing a number of unmet health needs, delays in receiving appropriate and necessary care, and inability to access preventive services.


## Outcome Objective:

**3.      (Developmental). Increase access to home health care services by 2023.**

## Impact Objective:

**3.1      (Developmental) Expand nurse navigator and discharge nurse programs by 2021.**

## Intervention Strategy:

**3.1.1      The DeWitt/Piatt Bi-County Health Department will work in collaboration with local partners to increase discharge nurse programs by 2019.**


## *4. Transportation*

Our community currently has access to some public transportation services. The Piattran provides community members with rides to appointments, but has need for further sustainability. There was concern in regards to a barrier of access that exists currently for some individuals. Additionally, there is need to discuss the community's ability to sustain local public transportation services. The Piattran transportation services is crucial for many community members to access health care, but has potential to improve its services. There is need to make it

more flexible and accessible to the community members. The main focus, however, was on sustaining the existing services.

## Outcome Objective:

**4.      (Developmental). Increase access to medical transportation services by 2023.**

## Impact Objective:

**4.1     (Developmental) Improve sustainability of local Piattran services by 2021.**

## Intervention Strategy:

**4.1.1    The DeWitt/Piatt Bi-County Health Department will work in collaboration with local partners to make Piattran services more efficient and accessible for community members by 2019.**


## *5. Single Information Source*

The last priority for our health department addresses the concern of having a single source information center. Many community stakeholders brought up the concern about having a single information source where community members can seek information and find help in locating local medical and community services. This center would also be an available asset to help them in understanding how to access the available local services. The main concept and overarching theme that was being brought up surrounded the idea of "Forging Community".

## Outcome Objective:

**5.      (Developmental). Provide a single sources information center to community members about healthcare and community services by 2023.**

## Impact Objective:

**5.1     (Developmental) Increase community participation and solidarity by creating and maintain a single source information center by 2021.**

## Intervention Strategy:

**5.1.1    The DeWitt/Piatt Bi-County Health Department will work in collaboration with local partners to develop a sustainable budget for the Single-Source program by 2019.**

# Appendices

**I. Piatt County Health Rankings & Roadmaps (2017 updates)**

**II. Dewitt County Health Rankings & Roadmaps (2017 updates)**

**III. Piatt BRFSS (Round 4 updates: 2014)**

**IV. Dewitt BRFSS (Round 4 updates: 2014)**

**V. Piatt County Community Health Report Card (IPLAN) (no updates since 2006)**

**VI. Dewitt County Community Health Report Card (IPLAN) (no updates since 2006)**

**VII. Piatt County Leading Causes of Death (IDPH) (2008-2011 new spreadsheet)**

**VIII. Dewitt County Leading Causes of Death (IDPH) (2008-2011 new spreadsheet)**

**IX. Illinois State Leading Causes of Death (IDPH) (2008-2011 new spreadsheet)**

**X. Capacity Org Survey (Piatt-Dewitt Bi-County HD – responses from 2017)**

# References

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## Results and Findings

When determining and prioritizing the health needs of the community, both qualitative and quantitative data was gathered and analyzed. Things considered by the representatives included the estimated feasibility and effectiveness of possible interventions; the burden, scope, severity, or urgency of the health needs; the health disparities associated with these health needs; the importance the community places on addressing the health needs; and other community assets and resources that could be leveraged through strategic collaboration in the community to address the health needs.

Several potential health needs or issues were determined from this process discussed above. These needs and issues were taken into consideration when identifying priorities for the Implementation Strategy.

As a result of the four assessment processes, our agency has identified the following priorities (in no particular order):

- Mental Health
- Chronic Disease
- Aging in Place
- Transportation
- Single Information Source

On February 23, 2016 the steering committee met to discuss the results collected from the focus groups and summarize additional secondary data. After reviewing and discussing all of the information and data, this committee prioritized these five significant health needs facing the community. The identified needs were:

## I.  Mental Health

Issues related to mental health were identified, along with the focus on identification and diagnosis of many health concerns, particularly for youth. Need for better access to care for depression and anxiety were identified, in addition to the need for education centered on young people and the issues that they face.

In addition to mental health concerns, improved substance abuse prevention was

identified as a serious need. Community involvement and local support were seen as critical to address this health concern, along with recovery support and increased education to bring heightened awareness to these topics.

In discussions spurred during the focus groups across our service area, it was very evident that there was a concern in regards to access to mental/behavioral health services. The National Institute of Mental Health (NIMH) discusses the prevalence of mental illness in the United States, saying that one in six U.S. adults live with a mental illness (NIMH, 2017). There were an estimated 44.7 million adults in the United States living with a mental illness in 2016. In the state of Illinois, suicide was the cause of 1,041 deaths in 2011 (IPLAN, 2017). And according to the Center for Disease Control and Prevention (CDC), suicide accounted for 44,965 deaths in 2016 (CDC, 2017).

This brings a unique opportunity for our agency to work in collaboration with local partners to improve access to services, enhance our delivery system, and create better referral systems that will overall better serve our community.

## *2.   Chronic Disease and Related Risk Factors:*

There were three specific needs related to chronic disease and its prevention that were identified from the focus groups. These included the need to merge community resources and services with chronic disease management, the need for competent support groups and other ways of providing support for people who face chronic illness, and also the need for increased access to personal case management.

According to the CDC, chronic disease causes the majority of deaths the United States, being responsible for 7 of 10 deaths each year (CDC, 2018). The most common chronic diseases include heart disease, stroke, cancer, diabetes, and arthiritis. They are all some of the most preventable of all health problems in the U.S.

These leading causes of death cause numerous deaths that could be prevented. Data collected from the Illinois Department of Public Health determined some leading causes of deaths throughout the state, with apparent chronic diseases far higher on the chart than other causes of deaths.

In 2011, the leading causes of death in DeWitt County included (Illinois Department of Health, 2018):

- Malignant neoplasms (26.8%)

- Diseases of heart (25.5%)

- Chronic lower respiratory diseases (5.7%)

- Alzheimer's disease (5.7%)
- Cerebrovascular diseases (5.1%)
- Accidents (4.5%)
- Influenza and pneumonia (3.2%)
- Nephritis, nephrotic syndrome and neprhosis (1.9%)
- Diabetes mellitus (1.3%)
- Septicemia (1.3%)
- Chronic liver disease and cirrhosis (1.3%)
- All other causes (17.8%)

Comparatively the leading causes of death in Piatt County in 2011, included (Illinois Department of Health, 2018):

- Diseases of heart (26.6%)
- Malignant neoplasms (24.3%)
- Cerebrovascular diseases (7.5%)
- Diabetes mellitus (5.2%)
- Chronic lower respiratory diseases (3.5%)
- Intential self-harm (suicide) (3.5%)
- Accidents (2.9%)
- Alzheimer's disease (1.2%)
- Influenza and pneumonia (1.2%)
- Nephritis, nephrotic syndrome and neprhosis (0.6%)
- Septicemia (0.6%)
- All other causes (23.1%)

These unrelenting conditions plague our counties, the state, and the nation. They cause many individuals to suffer lifelong disability, lower quality of life, crippling health care costs, and ultimately death, all that could have been prevented. There are four main health risk behaviors—lack of physical activity, poor nutrition, use of tobacco, and excessive alcohol consumption—that are often responsbile for much of this burden of disease.

**Table 2. Leading Causes of Death in the State of Illinois, DeWitt County, and Piatt County in 2016**

| | State of Illinois N(%) | DeWitt County N(%) | Piatt County N(%) |
|---|---|---|---|
| *All deaths* | <u>107041</u> | <u>189</u> | <u>176</u> |
| *Diseases of heart* | 25017 (23.4) | 46 (24.3)* | 44 (25.0)* |
| *Malignant neoplasms* | 24396 (22.8) | 39 (20.6) | 49 (27.8)* |
| *Cerebrovascular diseases* | 5660 (5.3) | 9 (4.8) | 8 (4.5) |
| *Chronic lower respiratory diseases* | 5632 (5.3) | 13 (6.9)* | 14 (8.0)* |
| *Accidents* | 5506 (5.1) | 8 (4.2) | 10 (6.3)* |
| *Alzheimer's disease* | 3878 (3.6) | 19 (10.0)* | 2 (1.1) |
| *Diabetes mellitus* | 2782 (2.6) | 4 (2.1) | 5 (2.8)* |
| *Influenza and pneumonia* | 2518 (2.4) | 5 (2.6)* | 4 (2.3) |
| *Nephritis, nephrotic syndrome and nephrosis* | 2177 (2.0) | 2 (1.1) | 2 (1.1) |
| *Septicemia* | 1704 (1.6) | 2 (1.1) | 3 (1.7)* |

\* Indicates county's percentage of death higher for that cause of death than the state percentage.

Data collected from Illinois Department of Public Health. *More Detailed Death Statistics.* Retrieved January 9, 2018, from http://www.dph.illinois.gov/data-statistics/vital-statistics/death-statistics/more-statistics.

## 3.   *Aging in Place*

Another health concern that was noted involved home health care services to aid in extending life at home, along with the inclusion of well checks and creative uses of technology. Health equity requires access to extensive, high quality health care services. It's important to ensure quality of life for everyone. Aging in place focuses on four main components surrounding access; coverage, services, timeliness, and workforce. There are 3 distinct steps that are required to aid in this area. Those include:

- Gaining entry into the health care system.
- Accessing a health care location where needed services are provided.
- Finding a health care provider with whom the patient can communicate and trust.

Access to health care is crucial to an individual's health and can impact it in many ways. It can directly affect overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of certain health conditions; overall quality of life; preventable death; and also life expectancy. Disparities in access exist and affect both individuals and society as a whole. Lack of access or limited access to health care can negatively affect an individual's quality of life and deprive them of their full potential.

There are a number of barriers that affect access to health services. Some of these barriers can include cost, lack of insurance coverage, and lack of service availability. With little or no access to health care individuals can be faced with a number of unmet health needs, delays in receiving appropriate and necessary care, inability to access preventive services, and also they are faced with the possibility of having a number of preventable hospital visits.

## 4.  *Transportation*

Another concern identified by these groups included the need for sustainable local public transportation services. These services could help address several concerns, including a barrier of access for some individuals. There is need to discuss the community's ability to sustain local public transportation services. Additionally, there was discussion about various ways to improve the current public transportation services, making it more flexible and accessible to the community members. The main focus, however, was on sustaining the existing services.

## 5.  *Single Information Source*

The last consequential need that the focus groups discussed was surrounding a single source information center. Focus groups, as well as health department staff members all brought up the concern about having a single information source where community members can seek information and find help in locating local medical and community services. This center would also help them understand how to access the various available services. During the various discussions, the main concept that was being brought up surrounded the idea of "Forging Community". The overarching theme of the discussions and the key to addressing all of the needs and concerns that had been identified and prioritized was to focus on this idea of "Forging Community".

## Resources Available to Meet Priority Health Needs

After identifying these core concerns and needs, several resources have also been identified as community assets to aid in addressing the concerns and helping meet these needs. There are a number of resources within or affiliated with Kirby Medical Center, the Medical Center located in Piatt County, but there are also a several other resources available outside of the Medical Center.

**Resources Within or Affiliated with Kirby Medical Center**

*Kirby Medical Group has three locations: Monticello, Atwood, and Cerro Gordo, with services including (Kirby Medical Center, 2018):*

1. Family and Internal Medicine

- Primary care
    - Prevention and health screenings
    - Family medicine
    - Pediatric and adolescent care
    - Geriatric care
    - Women's health
    - Men's health
    - Internal medicine
    - School and sports physicals
- Kirby Quick Care Walk-In Clinic
- Workplace wellness
- Medically-supervised weight loss services
- Mental health services
- Behavioral medicine program
- Allergy testing immunotherapy
- Specialty care

2. Emergency

- Emergency Department
- Ambulance
- CareLink

3. Therapies

- Physical therapy
- Occupational therapy
- Speech therapy
- Cardiac rehabilitation
- Pulmonary rehabilitation
- Women's health therapy services
- Pulmonary function testing

4. Surgery

- General surgery
- Orthopedic surgery
- Cataract surgery
- Gastroenterology
- Gynecological procedures
- Spine injections
- Cosmetic and reconstructive plastic surgery
- Podiatric surgery

5. Sleep Center

6. Inpatient Care

- Acute care and hospitalists
- Swing bed/transitional care

7. Diagnostic Imaging

- 64-slice Computed Tomography (CT) scanning
    - Magnetic Resonance Imaging (MRI)
    - Bone Densitometry
    - Digital mammography
    - Positron Emission Tomography/Computed Tomography (PET/CT)
    - Vascular ultrasound screening
        - Ankle Brachial Index (ABI) – identifies the presence of Peripheral Vascular Disease (PVD)
        - Carotid artery – detects narrowing in the arteries that supply blood to the brain
        - Abdominal aorta – evaluates the abdominal aorta for wall weakness or dilation
    - General ultrasound
    - Cardiovascular ultrasound
    - General x-ray

8. Laboratory

- Hematology

- Chemistry
- Immunohematology
- Urinalysis
- Serology
- Microbiology
- Phlebotomy
- Urine Drug Screening

9. Food and Nutrition Services

- Registered dietitian
- Nutrition therapy in the areas of:
  - Cardiovascular disease, including high cholesterol, hypertension, anticoagulation therapy, and congestive heart failure)
  - Diabetes
  - Gastrointestinal issues
  - Food allergies
  - Kidney disease
  - Nutritional management of cancer
  - Prenatal and postnatal nutrition
  - Sports nutrition
  - Weight loss/gain
- Assessment of nutritional status
- Implementing appropriate nutritional interventions
- Follow-up care (monitoring and evaluation)
- Chronic disease prevention program

10. Mental Health Counseling

- Depression
- Anxiety
- Bipolar Disorder
- Post Traumatic Stress Disorder (PTSD)
- Addiction and related issues
- Self-harm

- Grief or loss

11. Urology/Gynecology

12. Fresh Start Weight Loss

13. Oncology Clinic

14. Community Services

- Neighborhood medic program
- Adopt-A-Medic Program
- CPR program
- Emergency preparedness information at your fingertips
- Thomas Dixon Memorial Scholarship
- The Kirby Foundation

**Community Organizations, Health Partners, and Government Agencies**

There were a number of other organizations and resources outside of Kirby Medical Center. The organizations that were identified as current or potential partners for addressing these mentioned health needs and related issues include:

- Kirby Foundation Board
- Faith In Action
- Piattran
- University of Illinois Extension
- Carle
- Christie Clinic
- Dr. John Warner Hospital
- Churches
- Meals on Wheels
- Nursing homes and senior housing
- Local governments
- Schools
- Law enforcement
- Emergency Management Agency

## Results

## Implementation Strategy

The implementation strategy to address the mentioned health needs was developed through a meeting of the hospital's Community Advisory Committee of the governing board. This committee has diverse representation through its community members who come from various backgrounds including public health, mental health, physicians, and hospital senior leadership. The needs assessment was reviewed and significant needs were identified along with supporting documents. Potential next steps were examined, along with possible internal and external resources that are currently available to address the current prioritized needs.

For each of the five categories, the group discussed possible steps and intentions by stakeholders were identified. The anticipated influence of these actions was also weighed with consideration to the resources intended to commit to these actions. The plan, once finalized, will be evaluated by periodic review of measurable outcome indicators, along with the annual review.

The following include the process by which identified needs will be addressed (Kirby Medical Center, 2016):

1.      MENTAL HEALTH

The identified issues surrounding mental health included access to identification and diagnosis of mental health concerns, particularly among youth. There was also significant need identified for better access to care for depression and anxiety. This need included further urgency for education focused on youth and the situations that they are being confronted with.

Improved substance abuse prevention was also identified, along with the need for community involvement and support for this issue. Additionally, increased availability for addicts to seek local support for recovery and overall education were also determined important. The group members also brought up the concern of creating increased awareness about the implications of further legalization and heightened availability of marijuana.

*Actions intended to be taken in order to address the health need:*

- Explore a collaboration with Piatt County Mental Health to address local needs for services in mental health, substance abuse, and other areas
- Explore expanding mental health counseling to the Cerro Gordo Clinic
- Explore expanding mental health services at Kirby Medical Center
- Explore community coalition involvement with schools to develop a community plan to identify mental health, substance abuse, and other issues faced by youth and to provide education around those issues and activities for youth that will promote mental health and substance abuse avoidance

- Monitor progress of the actions above by observing changes in numbers served
- Improve effectiveness of medication reconciliation

*Anticipated impact of these actions:*

- Creation of a collaborative effort among healthcare providers and the community to address these issues
- Identify, coordinate, and promote available local services
- Expand access to mental health services at Kirby Medical Center

*Programs and resources Kirby Medical Center plans to commit to address the health need:*

- Administration
- Community Advisory Committee

*Planned collaboration between our agency and other facilities or organizations:*

- Kirby Medical Center
- Dr. John Warner Hospital
- Piatt County Mental Health
- IMPACT Community Coalition
- Schools

2.  CHRONIC DISEASE

There were three significant needs under the scope of chronic disease prevention. These included relating community assets and services to chronic disease management, efficient support groups and other forms of communication for people who face chronic illness, and increased access to personal case management.

*Actions intended to be taken to address the health need:*

- Grow and develop a nurse navigator program for Medicare patients to provide annual wellness visits and screening; coordinated case management for inpatient and after-care; and outpatient case management for home services, appointment and other needs
- Expand discharge nurse services to provide education before release and provide post-release follow-up
- Create and grow a wellness initiative; first for employees, then for the public

- Educate the public about nurse navigator and discharge nurse services

- Monitor progress of the actions above by observing changes in numbers served

- Enhance the Neighborhood Medic program providing for well check home visits by Kirby Medical Center's Emergency Medical Services

*Anticipated impact of these actions:*

- Expanded care coordination

- Expanded home services

- Improved communication between patients and providers

- Increased wellness education and activities for staff and area youth

*Programs and resources Kirby Hospital plans to commit to address the health need:*

- Nurses

- Clinics

- Wellness Director

- Wellness Committee

*Planned collaboration between our agency and other facilities or organizations:*

- University of Illinois Extension

- Kirby Medical Center

- Dr. John Warner Hospital

- Schools

- Senior services

- Adult services

- Community working with youth

3.     AGING IN PLACE

There was also a need in our jurisdiction to increase home health services, enabling community members to have extended life at home. This while flourishing with well checks and creative and new uses of technology.

*Actions intended to be taken to address the health need:*

- Expand nurse navigator and discharge nurse programs
- Promote use of CareLink medic alert services
- Support community efforts by Meals on Wheels, Faith In Action, and other senior service providers as appropriate and collaborate to enhance services
- Monitor progress of the actions above by observing changes in numbers served
- Therapy home environmental visits

*Anticipated impact of these actions:*

- Increase opportunities for seniors to age at home longer
- Increase healthcare contacts with seniors at home
- Sustain and improve community-based services for seniors at home

*Programs and resources Kirby Medical Center plans to commit to address the health need:*

- Kirby Medical Group
- Clinic Director
- Nurse Navigator
- Kirby EMS

*Planned collaboration between our agency and other facilities or organizations:*

- Kirby Medical Center
- Dr. John Warner Hospital
- Meals on Wheels
- Faith In Action
- Other senior service providers
- CareLink program

4. TRANSPORTATION

Concerns were also raised in regards to local public transportation services. Sustainability of current services is the most important need discussed, but there was also discussion focused around the improvement of public transportation, preferably making it more flexible and accessible for community members.

*Actions intended to be taken to address the health need:*

- Reduce stress on public transportation system by providing increased home healthcare
- Explore arrangements with Piattran that will increase flexibility for appointments, fill specific voids in local transportation, and help sustain Piattran through advertising that will generate matching funds for Piattran

*Anticipated impact of these actions:*

- Improved flexibility in public transportation availability for healthcare related services
- Reduced need for transportation for healthcare appointments and related special arrangements and down-time

*Programs and resources Kirby Medical Center plans to commit to address the health need:*

- Administration
- EMS
- Case management
- Marketing

*Planned collaboration between our agency and other facilities or organizations:*

- Kirby Medical Center
- Dr. John Warner Hospital
- Piattran
- Other villages and communities

5.     SINGLE INFORMATION SOURCE

The fifth need identified by the groups was in regards to a single information source. There is a significant concern regarding a single source information center where community members would be able to find information, get assistance in locating local medical and community services, and also learning about how to access these health services.

*Actions intended to be taken to address the health need:*

- Explore the viability of renewing and expanding a web-based information sharing program for healthcare providers and community service providers previously begun
- Explore alternative services to provide single source information to citizens about

healthcare and community services

- Monitor progress of the actions above by observing numbers served through new information resources
- Develop a sustainable budget pro forma for the Single-Source program

*Anticipated impact of these actions:*

- Improved communication among providers resulting in better coordination of services for patients and others
- Easier access healthcare and community information
- Improved access to local health and community services

*Programs and resources Kirby Medical Center plans to commit to address the health need:*

- Administration

*Planned collaboration between our agency and other facilities or organizations:*

- Kirby Medical Center
- Dr. John Warner Hospital
- Healthcare and services providers
- Community service providers
- Community groups