May 2006

Champaign County Community Health Plan

Champaign Urbana Public Health District
Champaign County Public Health Department

Champaign County Community Health Plan

2006-2011

A Strategic approach to Community Health Improvement

For
Illinois Department of Public Health
Springfield, Illinois

May 2006

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Acknowledgements

The Champaign Urbana Public Health District would like to acknowledge and thank the many individuals and organizations that contributed their valuable time and expertise to this report. Special acknowledgement to Garry Bird, Mark Driscoll, Andrea Goldberg, Joel Goldberg and Julie Pryde for their assistance.

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Executive Summary

Purpose Statement

The Champaign County Community Health Plan provides a current portrait of the health assets and needs of the residents of Champaign County.

Illinois state law requires every local health department to participate in this process, called the Illinois Project for Local Assessment of Needs (IPLAN). This process must be conducted at minimum every five years. The detailed assessment and plan provides the foundation for evidence-based health planning and decision-making.

The essential elements of IPLAN are:

1. An organizational capacity assessment;
2. A community health needs assessment; and
3. A community health plan, focusing on a minimum of three priority health problems.

The Champaign County Community Health Plan was created using a model called "Mobilizing for Action through Planning and Partnership" (MAPP). This collaborative approach to community health planning was developed by the National Association of County and City Health Officials (NACCHO) in cooperation with the Public Health Practice Program Office and the federal Centers for Disease Control and Prevention (CDC). MAPP helps communities form effective partnerships that can better identify their unique circumstances and needs and use their resources wisely.

MAPP is a community-driven process. It is more intensive than other approaches in that it requires a high level of participation from community organizations and residents. This model employs a variety of methods to uncover community health trends,

identify gaps in care, evaluate assets and – most importantly – develop and implement a plan that successfully addresses community health needs.

The four components of MAPP

- The Community Health Status Assessment collects and analyzes health data and describes health trends, risk factors, health behaviors and issues of special concern.
- Community Themes and Strengths Assessment uses participants to make a list of issues of importance to the community, identify community assets and outline quality of life concerns.
- The Local Public Health System Assessment measures the local public health system's ability to conduct essential public health services.
- The Forces of Change Assessment identifies local health, social, environmental or economic trends that affect the community or public health system.

The Community Health Plan was initiated by the Champaign-Urbana Public Health District to determine locally relevant health priorities to better serve the residents of Champaign County. Public health issues demand collaborative and coordinated efforts to minimize service duplication and excess cost, and to be successful in intervention. This process provides both the community knowledge and support necessary for the identification and management of health problems.

The Health District convened a diverse group of health providers, civic leaders and community representatives to participate in this process. The goal is for all partners in the local public health system to work together to implement the recommendations outlined in this plan.

KEY FINDINGS

Part 1 Community Health Status Assessment

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM SURVEY

- The **lack of access to health care** was the most-often-cited public health problem in all of the assessments. Thirteen to 14 percent of county respondents in the Risk Factor Survey said they were **unable to see a doctor or fill a prescription** due to cost in the 12 months preceding the survey. This represents about 20,000 county residents. Over 22 percent of non-whites reported that they were unable to see a doctor due to cost, as compared to 10.7 percent of whites. Over 28 percent of non-whites and 10 percent of whites said they were unable to fill a prescription due to cost.
- Only 72.5 percent of non-whites had some **health care coverage**, as compared to 91.8 percent of whites.
- Non-whites (36.6 percent) were more likely than whites (22.7%) to report that they **could not afford a dentist** in the past year, even when they needed to see one.
- A larger proportion of non-whites (23.4 %) than whites (13.5 %) reported that they had 8-30 days in the past month when their **mental health** was "not good." Females (19.4 %) were more likely than males (8.5 %) to report that **physical, mental or emotional problems limited their activities**. Nearly one-third (30.4 %) of respondents said that they felt **depressed, sad or blue** more than two days per month.

- More than one-quarter of male respondents were **at risk for acute / binge drinking**.
- **Smoking** in Champaign County has not increased or decreased since the late 1990s. The rate has remained steady around 20 percent, which is lower than the current state rate (22.2 percent), but is significantly higher than the target rate of 12 percent or less (Healthy People 2010).
- Nearly one in five females had been diagnosed with **asthma**.
- A larger proportion of non-whites (31.3%) than whites (11.1%) report that they are **at risk for injury due to failure to use a seatbelt**. Over 22 percent of males and 8.7 percent of females are at risk due to lack of seatbelt use.
- A majority (54.9%) of county residents believe they are **not getting enough exercise**, and nearly half of respondents report that they are either **overweight** (30.9%) or **obese** (17.1%).

OTHER DATA

- While **child poverty** is significantly lower in Champaign County than in Peoria County and in the state, it disproportionately burdens African-American children. African Americans make up only 11.2 percent of the population of the county, but black children account for nearly 47 percent of the children in poverty here.
- At least 11.8 to 14 percent of Champaign County residents have **no health insurance**.
- As of December 31, 2005, 23,293 Champaign County residents were **Medicaid** enrollees. Of these, 13,770 were less than 19 years of age.
- **Homelessness** has decreased since 1998 among adult males, but is increasing among women and children.

- Champaign-Urbana has a significantly higher rate (103.1 per 100,000 population) of **alcohol dependence syndrome hospitalizations** than either Peoria (42.3 per 100,000) or the state of Illinois (74.4 per 100,000). (*This higher rate could be attributed to Prairie Center and The Pavilion, both of which draw clients from a larger area*)
- Champaign County's rate of **child abuse and neglect** reports is significantly higher than that of the state of Illinois (40.5 per 1,000 children in Champaign County versus 30.0 for the state), a trend that has continued for years. There were 2,075 **domestic battery** reports to police in Champaign County in 2004. Of these, 1,313 led to charges against offenders and 660 orders of protection were issued.
- **Infant mortality rates** are higher in Champaign County (9.0 per 1,000 births) than in Peoria County (8.9) or in the state (8.0). Champaign-Urbana's infant mortality rate (12.1 per 1,000 births) is significantly higher than that of the county as a whole. **Neonatal mortality** and **post-neonatal mortality** rates are also highest in Champaign-Urbana. Rates of infant mortality, neonatal mortality and post-neonatal mortality are significantly higher for blacks than for whites, as are rates of **low birth weight and very low birth weight babies**. Black women are much less likely than white women to obtain **prenatal care in the first trimester** of their pregnancies. Public Health Vital Records indicate that about 28 percent of all Champaign County newborns are black.
- Most **vaccine-preventable diseases** have been on the decline in Champaign County in recent years, while some **sexually transmitted diseases**, such as **Chlamydia and Gonorrhea**, are much higher here than in the state as a whole, and have continued to rise.

- **Breast cancer rates** are higher in Champaign County (29.2 per 100,000 age adjusted population) than in the state (26.3).

KEY FINDINGS

Part 2: Assessment of Community Themes and Strengths

RECOMMENDATIONS OF ASSESSMENT TEAM

1) Increase availability of affordable and accessible health care
2) Broaden and enhance local employment opportunities;
3) Build collaborative partnerships between providers to make informed improvements to the system;
4) Work together to educate donors and philanthropists;
5) Create collaborative public education campaigns;
6) Set priorities based on need and work together to address regional or community issues;
7) Improve communication between providers and to the public;
8) Build trust and change attitudes between providers;
9) Capitalize on the diversity, educational resources and progressive thinking of the community to build a healthy and safe Champaign County.

TELEPHONE SURVEY

A series of structured and open-ended questions were asked through a telephone survey to gather comments on major quality-of-life issues as well as impressions of significant health problems and potentially risky behaviors

The purpose of the telephone survey was to gather perceptions from a representative sample of the adult (18+) Champaign County population regarding the quality of life and the quality of health care in the local community.

Most Important Quality of Life Issues in Champaign County

- Access to health care (58% of respondents mentioned it)
- Good schools (35%)
- Low crime / safe neighborhoods (29%)
- Good jobs / healthy economy (17%)
- Religious or spiritual values (13%)
- Parks and recreation (12%)
- Affordable housing (12%)
- Clean environment (11%)
- Strong family life (10%)
- Good place to raise children (8%)

Most Important Health Issues in Champaign County

- Cancer (29%)
- Heart disease and stroke (27%)
- Diabetes (17%)
- Affordable health care (14%)
- Mental health problems (11%)
- Child abuse and neglect (9%)
- Aging problems (9%)
- Domestic violence (8%)

- Drugs (8%)

Most Important Risky Behaviors in Champaign County

- Alcohol abuse (57%)
- Drug abuse (54%)
- Unsafe sex (33%)
- Tobacco use (26%)
- Obesity, being overweight (13%)
- Poor eating habits (11%)

UNITED WAY ASSESSMENT SURVEY

All groups interviewed (in a telephone survey, in focus groups and in personal interviews) ranked education and employment at the top of their concerns. Health care issues, support for families and the availability of resources to meet basic needs were next, followed by delinquency prevention and behavioral health care issues.

KEY FINDINGS

Part 3: Public Health System Assessment

ASSESSMENT TEAM FINDINGS

Members of the local public health system need:

- Better access to data on sentinel events (unnecessary disease, disability, or avoidable, untimely death) from the local primary care providers.
- Reliable data on social and mental health services and needs.
- Better monitoring of health problems, health hazards and health emergencies in the community.

- Better county-wide emergency preparedness planning.
- Improved collaboration and communication among members.
- More cooperative strategic planning.
- To use legislative tools to address community health problems when appropriate.
- A better appreciation of their role as members of the local public health system.
- Better data sharing.
- Improved workforce assessments to standardize measures of workforce competencies.
- A renewed commitment to developing public health leadership.
- Better participation in and utilization of community health assessments.
- More collaboration with university researchers on local public health issues.

KEY FINDINGS

Part 4: Forces of Change Assessment

ASSESSMENT TEAM FINDINGS

Six forces or trends were identified that currently affect or potentially could impact the availability or delivery of health services in Champaign County. They are:

- An aging population
- Changing demographics
- Changing governmental policies
- Disparities in health status
- Lack of a collaborative body for public health planning
- Shifting funding streams

A number of strategic issues emerged from the four parts of this collaborative assessment process. These can be summarized as follows:

How can the local public health system (the hospitals, clinics, public health departments and other providers of essential health and social services):

- Improve access to care
- Improve communications
- Create better data sharing tools and processes
- Reduce or eliminate disparities in health care availability and quality
- Build sustainable community health leadership
- Create a culture of collaboration among all members of the local public health system
- Use information technology to enhance collaboration and communication
- Collectively use the media and other outreach tools to increase public awareness of vital public health issues

And finally, members of the Community Health Status Assessment Team were invited to look at the assembled data and select the issues that they believed should be priorities for the local public health system in coming years. For a fuller description of each of these priorities, please see page 76.

IPLAN PRIORITIES

- **Access to Health Care**
- **Cancer**
- **Cardiovascular Disease**

- **Domestic Violence, Sexual Abuse, Elder Abuse and Child Abuse and Neglect**
- **Infant Mortality**
- **Mental Health**
- **Obesity**
- **Oral Health**
- **Sexually Transmitted Diseases**
- **Substance Abuse**

About Champaign County

Champaign County, the sixth largest county in the state of Illinois, lies in the central region, east of Bloomington (McLean County) and Decatur (Macon County) and west of Danville (Vermilion County). The 2000 population according to US census is 179,669. The three largest urban areas in the county are city of Champaign (population 67,518) city of Urbana (population 36,595) and village of Rantoul (population 12,857).

Champaign County, Illinois is located in the heart of East Central Illinois, at Latitude 40.14030 North, Longitude 88.19610 West. With Interstates 57 and 74 intersecting in the County, Chicago, Illinois is approximately 2 hours north; St. Louis, Missouri is approximately 3 hours south-southwest; and Indianapolis, Indiana is approximately 2 hours east.

Champaign County is home to the University of Illinois (which includes about 625 acres in both Champaign and Urbana; student enrollment is ~40,000), Parkland College, and two major regional hospitals, Carle Foundation Hospital and Provena Covenant Medical Center. Carle Foundation Hospital is a 300-bed teaching hospital and the region's only level 1 trauma hospital. Champaign County has significant educational,

governmental, technological, light industrial and agricultural assets. Champaign County comprises 1,008 square miles, the majority of which are devoted to agriculture.

The Champaign-Urbana Public Health District, the primary local health department in the county, serves the cities of Champaign and Urbana and – via a contractual agreement with the Champaign County Public Health Department – provides all Public Health services, except child dental care, to the rest of Champaign County. The Public Health District was formed via a voter referendum in 1937 to provide services to Champaign-Urbana residents, now provides services to residents of Champaign-Urbana as well as the rest of Champaign County(through a contractual agreement). With a staff of 105 full time employees, the Health District provides preventive and diagnostic services in a wide array of healthcare areas. The Health District also provides food, water and septic inspections, and an array of other environmental health services.

Urbana-Champaign is the home of the University of Illinois-College of Medicine. The college provides first year medical education for one hundred twenty-five students, one hundred of whom go on to Rockford or Peoria for the second through the fourth year. The twenty-five who remain in the community are predominantly enrolled in the combined MD/PhD program. The College of Medicine also sponsors an internal medicine residency program. The residents and, to a lesser extent, the medical students do provide medical care to the residents of the community in the context of their principal mission, namely, learning the art and science of medicine. This academic endeavor sponsored by the University of Illinois serves as a magnet to attract physicians to practice in the community. The presence of a medical school in a community leads to an enhanced quality of care, as physicians who are interested in academic affiliation

locate their practices in the community (*Joseph Goldberg, MD, University of Illinois, College of Medicine, 2006*)

The Frances Nelson Community Health Center in Champaign is the only Federally Qualified Health Center in the county which provides primary medical services, prenatal program, immunizations, health education, and social services to medically under-served and uninsured adults and children of Champaign County

(*NOTE: For purposes of analyzing trends in Champaign County, the authors of this report compared health measures here to those of Peoria County, which is demographically similar to Champaign County.*)

MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP)

PART 1: Community Health Status Assessment

The population of Champaign County increased slightly since 1990. The greatest change was a drop in the white population of 5.9% and an increase of 1.6% in black population. Champaign has a very low proportion of Hispanics, only 2.9% as compared to 12.3% for the State of Illinois. Even the county's proportion of elderly residents (9.7%) is lower than the State average of 12.1%.

The percentage of educated people is significantly higher in Champaign when compared to Peoria or the state average. There is a significant difference in the median household income. The median household income for the state is 20% higher than for Champaign residents.

Demographic Characteristics		CC 2000	CC 2000	CC 1990	CC 1990	Peoria 2000	Peoria 2000	IL 2000	IL 2000	Source
		#	%	#	%	#	%	#	%	
General Characteristics										
Total Population	**% Change from 1990-2000**	**179,669**		**173,025**		**183,433**		**12,419,293**		**US Census**
Male	**-0.2**	90,306	50.3	87,492	50.5	88,196	48.1	6,080,336	49.1	
Female	**+0.2**	89,363	49.7	85,533	49.5	95,237	51.9	6,338,957	51.0	
Median age (years)		28.6				36.0		34.7		
Under 5 years	**-1.0**	10,417	5.8	11,847	6.8	12,612	6.9	876,549	7.1	
18years and over	**+0.9**	141,850	79.0	135,259	78.1	137,324	74.9	9,173,842	73.9	
65 years and over	**+1.0**	17,470	9.7	15,129	8.7	25,981	14.2	1,500,025	12.1	
One Race		176,094	98.0			180,371	98.3	12,184,277	98.1	
White	**-5.9**	141,536	78.8	146,506	84.7	145,602	79.4	9,125,471	73.5	
Black or African American	**+1.6**	20,045	11.2	16,559	9.6	29,532	16.1	1,876,875	15.1	
American Indian and Alaska Native	**0.00**	433	0.2	331	0.2	411	0.2	31,006	0.2	
Asian		11,592	6.5			3,041	1.7	423,603	3.4	
Native Hawaiian and Pacific Islander		72	0.0			51	0.0	4,610	0.0	
Some other races		2,416	1.3			1,734	0.9	722,712	5.8	
Two or more races		3,575	2.0			3,062	1.7	235,016	1.9	
Hispanic or Latino (Any race)	**+0.9**	5,203	2.9	3,485	2.0	3,827	2.1	1,530,262	12.3	
Household population	**+2.1**	164,831	91.7	155,008	89.6	176,553	96.2	12,097,512	97.4	
Group quarters population	**-2.1**	14,838	8.3	18,017	10.4	6,880	3.8	321,781	2.6	
Average Household size		2.33		2.43		2.43		2.63		
Average family size		2.96				3.01		3.23		
Total Housing Units		75,280	100.0	68,416	100.0	78,204		4,885,615		
Occupied	**+0.4**	70,597	93.8	63,900	93.4	72,733	93.0	4,591,779	94.0	

housing units										
Owner occupied	**+4.8**	39,329	55.7	34,857	50.9	49,249	67.7	3,088,884	67.3	
Renter occupied	**+1.9**	31,268	44.3	29,043	42.4	23,484	32.3	1,502,895	32.7	
Vacant	**-0.4**	4,683	6.2	4,516	6.6	5,471	7.0	293,836	6.0	

Demographic Characteristics		**CC 2000**	**CC 2000**	**CC 1990**	**CC 1990**	**Peoria 2000**	**Peoria 2000**	**IL 2000**	**IL 2000**	**Source**
		#	%	#	%	#	%	#	%	
Social Characteristics										
	% Change from 1990-2000	**179,669**		**173,025**		**183,433**		**12,419,293**		**US Census**
Population 25yrs and over	**+0.6**	100,559	56.0	95,971	55.4	118,498		7,973,671		
High school graduate and over	**+3.5**	91,487	91.0	83,974	87.5	99,342	83.8	6,493,228	81.4	
Bachelors degree or higher	**+3.9**	38,202	38.0	32,726	34.1	27,661	23.3	2,078,049	26.1	
Population 65 and over		16,721	100.0	15,129	100.0	24,336	100.0	1,416,418	100.0	
With disability		6,683	40.0			9,351	38.4	573,878	40.5	
Employment Status (16yrs and over)		145,926	100.0	138,979	100.0	142,372	100.0	9,530,946	100.0	
Unemployment	See next page for unemployment numbers									
Families below poverty level	**1999**	2,750	6.9	3,130		4,708	10.0	244,303	7.8	
Median Household income		37,780		35,630		39,978		46,590		
Special Populations										
Migrant persons	**+1.9**	14,389	8.0	10,554	6.1	5,825	3.2	1,529,058	12.3	**US Census**
Homeless persons										
Non English speaking persons	**+2.8**	19,914	11.8	14,562	9.0	10,185	6.0	2,220,719	19.2	

Socioeconomic Measures

EMPLOYMENT & INCOME

Percent Unemployed

	1990	2004	% Change	Source
Champaign County	2.9%	4.5%	+1.6%	Bureau of Labor Statistics
Peoria County	5.2%	6.2%	+1.0%	Bureau of Labor Statistics
Illinois	6.3%	6.0%	-0.3%	Illinois Dept. of Employment Security

Unemployment burdens families and communities and limits access to health care. Increasing unemployment increases demand for social services, and can contribute to psychological stress.

The unemployment rate in Champaign County is significantly lower than that of Peoria County and that of the state, but is increasing more rapidly here. Illinois' unemployment rate is currently ranked 43rd (lowest) in the nation.

Median Household Income

	1989	2003	% Change	Source
Champaign County	$27,986	$39,227	+28.6	US Census Bureau
Peoria County	$29,201	$41,169	+29.0	
Illinois	$31,846	$47,367	+32.7	

Median Household Income is rising here, but not as quickly as elsewhere. It still lags behind that of Peoria County and Illinois.

EDUCATION

Percent of Persons 25 Years of Age and Older Who Are High School Graduates

	1990	2000	Source
Champaign County	87.5	91.0	US Census Bureau
Peoria County	77.9	83.8	
Illinois	76.2	81.4	

Percent of Persons 25 Years of Age and Older Who Are College Graduates

	1990	2000	Source
Champaign County	34.1	38.0	US Census Bureau
Peoria County	19.5	23.3	
Illinois	21.0	26.1	

The educational status of the population of Champaign County is significantly higher than Peoria County and that of the state as a whole. Champaign County has a higher proportion of high school and college graduates than many other communities.

Educational status is a key ingredient in the public health equation. According to the Centers for Disease Control and Prevention, studies have shown that women with a high school diploma, GED or some college are much more likely to get potentially life-saving medical tests than women who are not high school graduates.

Health, happiness, employment, health insurance and quality of life measures always rise with educational attainment. Teenagers who stay in school are less likely to contract sexually transmitted diseases or to become teen parents.

POVERTY

Percent of Children Age 0-17 Below Poverty Level

	1989	2003	% Change	Source
Champaign County	12.3	14.6	+2.3%	US Census Bureau
Peoria County	18.6	19.5	+0.9%	
Illinois	18.4	15.6	-2.8%	

Child poverty in Champaign County is significantly lower than in Peoria County and in the state. It is increasing more rapidly here and is approaching the national rate (17.6%).

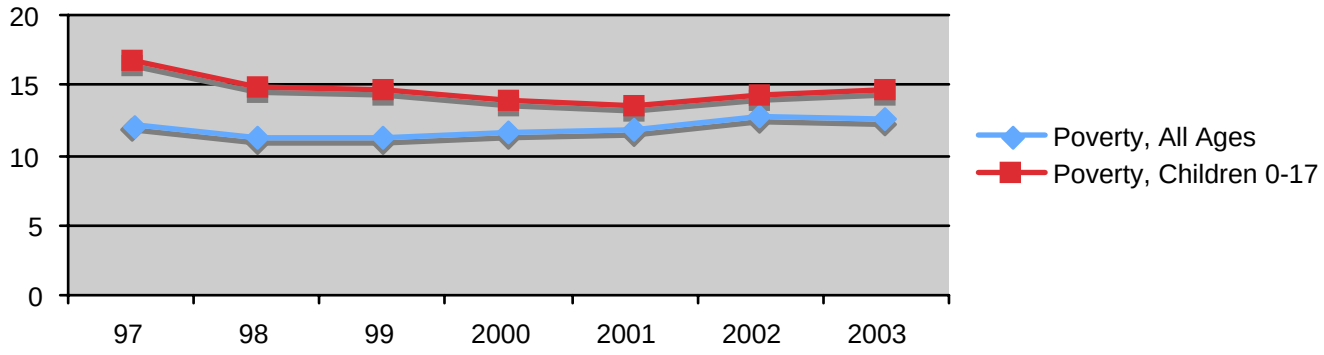
Percent All Ages Below Poverty Level

	1989	2003	% Change	Source
Champaign County	10.7	12.6	+1.9%	US Census Bureau
Peoria County	10.7	13.4	+2.7%	
Illinois	11.9	11.4	-0.5%	

Percent Families Below Poverty Level

	1989	2000	% Change	Source
Champaign County	8.0	6.9	-1.1%	US Census Bureau
Peoria County	11.3	10.0	-1.3%	
Illinois	8.97	7.8	-1.17%	

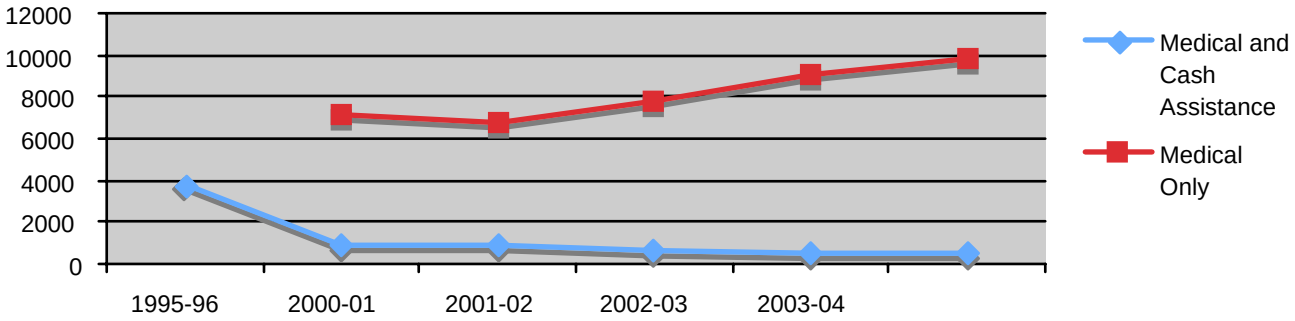
Percent Living Below the Poverty Level, 1997-2003 (U.S. Census Bureau)



Poverty rates in Champaign County decreased in 2000-2001, but are rising again. The number of children receiving Temporary Assistance to Needy Families (TANF) has decreased dramatically since 1994, but there has not been a similar decline in the number of children living below the poverty level.

As pointed out in the Project 18 Community Report Card, 2004, children whose families are leaving TANF often remain dependent on Medicaid – and many others are joining their ranks. While the number of those receiving cash assistance declines, the number of children on Medicaid continues to increase, a sign that poverty persists and may be worsening for those near the bottom of the economic ladder.

Children Receiving Temporary Assistance to Needy Families (1995-'96 and 2000-'01)

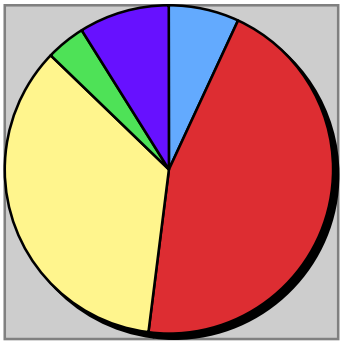


Project 18 also notes that poverty disproportionately burdens African American children. Nearly 47 percent of children living in poverty households in the county are African American. White children account for nearly 37% of those living in households with incomes below the poverty level.

Children under 12 Living in Poverty Households, 2000

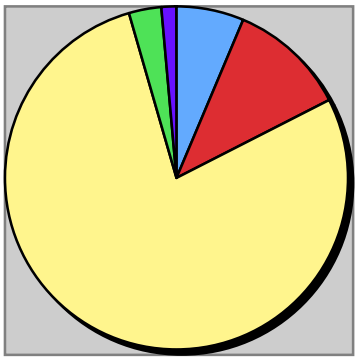
Race/Ethnicity	Number	% of Children in Poverty	TOTAL POPULATION Champaign County
African-American	1,553	(46.9%)	11.2 %
White	1,209	(36.6%)	78.8%
Asian	242	(7.3%)	6.5%
Hispanic	140	(4.2%)	2.9% (any race)
Other	303	(1.0%)	1.3%
American Indian or Alaska Native	NA	NA	0.2%
Two or More Races	NA	NA	2.0 %

Source: US Census



- Asian
- African American
- White
- Hispanic
- Other

Race/Ethnicity of Children Living in Poverty Households Champaign County 2000



- Asian
- African American
- White
- Hispanic
- Other

Race/Ethnicity of Champaign County 2000

HEALTH INSURANCE COVERAGE

According to the US Census Bureau, in 2000, in Champaign County 11.8 percent of residents (more than 19,000 individuals) were uninsured.

Estimated Health Insurance Coverage, 2000

	# Insured	# Uninsured	Percent Uninsured
Champaign County	147,944	19,833	11.8
Peoria County	155,954	21,375	12.1
Illinois	10,677,676	1,623,382	13.2
Source: US Census Bureau			

By 2003-2004 estimates, the proportion of uninsured residents increased in Illinois, to 14 percent. If Illinois state trends hold true for Champaign County, this translates to 25,153 uninsured people currently living here.

The two main providers of primary care in Champaign County have closed their doors to new Medicaid patients. They have also limited access to doctors who accept Medicaid. This presents obstacles to those who rely on this federal program for their health care. The health insurance picture is also grim for children. An estimated 11percent of kids up to age 18 (4,160 in Champaign County) are uninsured, and more than one-third (13,770 in Champaign County) are Medicaid enrollees. While health care is more available for children on Medicaid than for adults on Medicaid, their options are also limited. The Illinois KidCare program will make health insurance available to more children, but their health care status will not improve unless more providers agree to see these children.

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2004 and 2005 Current Population Survey (CPS: Annual Social and Economic Supplements). The number of adult and children Medicaid enrollees in Champaign County was provided by the Illinois Department of Healthcare and Family Services in a response to a Freedom Information Request dated March 1, 2006.

Medicaid Enrollees in Champaign County
(All Eligibility Data as of 12-31-2005)

Total Enrollees in Champaign County: 23,293

- By Race

Race	Number	Percent
Caucasian	12,100	51.9%
African American	8,950	38.4%
American Indian/Alaskan	59	0.25%
Hispanic	1,023	4.3%
Asian/Pacific Islander	597	2.5%
Other	98	0.42%
Not Available	463	1.98%
TOTAL	**23,293**	

- By Age

Age	Number	Percent
Less than 19yrs	13,770	59.1%
Between 19-64yrs	8,475	36.3%
Greater than 65yrs	1,048	4.4%
TOTAL	**23,293**	

- By Citizenship

Citizenship	Number	Percent
US Citizen	18,893	81.1%
Non Citizen	515	2.2%
Unknown	3,885	16.6%
TOTAL	**23,293**	

Source: Illinois Department of Healthcare and Family Services, response to Freedom of Information Request, received March 1, 2006.

MIGRATION

Percent of Residents Who Are Foreign Born

	1990	2000	% Change	Source
Champaign County	6.1	8.0	+1.9%	US Census Bureau
Peoria County	2.3	3.2	+0.9%	
Illinois	8.3	12.3	+4.0%	

Non-English Speaking Persons

	1990		2000		% Change
Champaign County	19,914	(11.8%)	14,562	(9%)	-2.8%
Peoria County	10,185	(6%)	7,984	(4.6%)	-1.4%
Illinois	2,220,719	(19.2%)	1,499,112	(14.1%)	-5.1%

Source: US Census Bureau

Population Changes Due to Migration: April 1, 2000 to July 1, 2004

Location	Net International Migration	Net Internal Migration	Change in Population Due to Migration	Overall Population Change	Source
Champaign County	+6.3	-6.0	+0.3	+6.1	US Census Bureau
Peoria County	+1.6	-7.3	-5.7	-1.3	

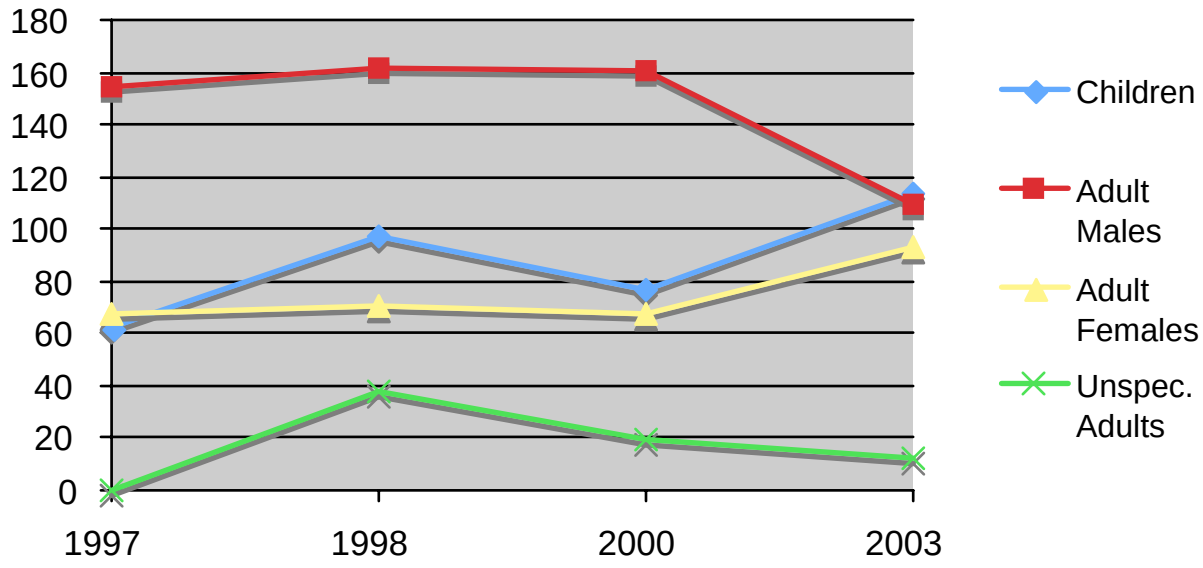
Champaign County has a relatively high population of foreign-born residents (8.0%) and a steady influx of international migrants more than compensates for those who leave the county. This migration has public health implications. The vast majority of infectious diseases that are diagnosed in Champaign County are among American citizens, but international migrants account for more than half of the cases of tuberculosis diagnosed and treated by Public Health nurses each year.

HOMELESSNESS

Homelessness in Champaign County 1997-2003

	1997	1998	2000	2003	SOURCE
Children	62	97	77	114	Continuum of
Adult Males	154	162	161	109	Care Home-
Adult Females	68	71	67	93	lessness
Unspecified Adults	0	38	19	12	Survey
TOTAL	**284**	**368**	**324**	**328**	**HUD**
* Data collected by Project 18 Community Report Card, 2004					

Homeless in Champaign County 1997-2003

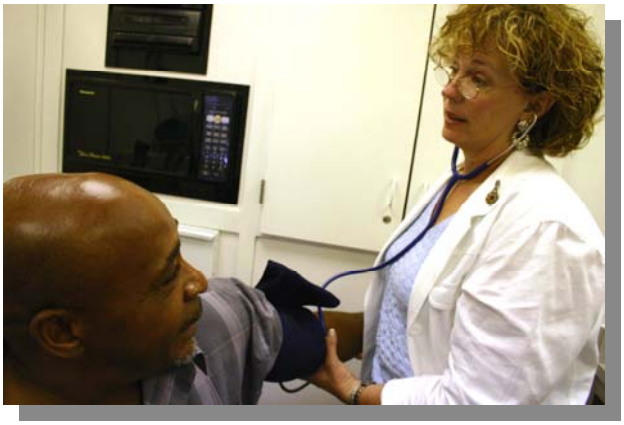


Overall, homelessness in Champaign County is down somewhat from its peak in 1998, but the number of homeless children is at its highest point in more than a decade. Between 1997 and 2003, the number of homeless adult males dropped 29 percent, while the population of homeless children nearly doubled. Homelessness among women and children has climbed significantly since 2000.

Health Resource Availability

"Access to health care" is the most-often cited public health problem in Champaign County. Participants in the Health Assessment process ranked this issue above other local health concerns and participants in a telephone survey listed this topic as a primary problem in the community. But what does "access to Health care" mean?

For some, the shortage of Medicaid providers is a top concern. The county's only Federally Qualified Health Center, Frances Nelson Community Health Center, suspended its waiting list in 2005 when its managers determined that the waiting list was an ineffective way to manage its huge patient load. Over 90 percent of Frances Nelson's patients are uninsured or on Medicaid. While many new patients (newborns and those with urgent medical needs) are seen immediately upon referral from a hospital, clinic or health department, others must wait weeks or months to be seen.



An estimated 43,000 people are uninsured or on Medicaid in Champaign County. Frances Nelson Community Health Center has a caseload of over 6,000 and Carle Clinic and Christie Clinic stopped enrolling new Medicaid patients in late 2003 and the number they currently serve is unknown. Champaign-Urbana Public Health District diagnoses and treats sexually transmitted diseases and tuberculosis, but it does not provide primary medical care to children or adults.

Estimates of health insurance coverage vary depending on the source and the methods used. Less than 13 percent of participants in a Behavioral Risk Factor Survey

conducted in 2004 reported that they lacked health insurance. Other estimates are closer to the 14 percent reported for the state of Illinois.

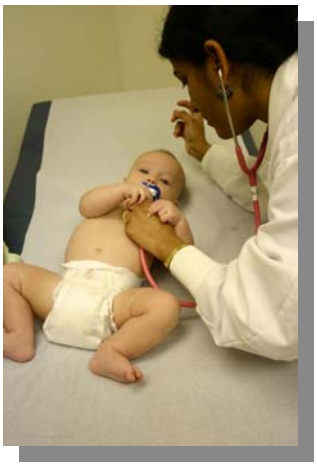
The local office of the Department of Human Services reported that 23,293 Medicaid enrollees resided in the county as of December 31, 2005. This puts the proportion of Medicaid recipients here at 12.9 percent.

Illinois Department of Public Health
Behavioral Risk Factor Survey for Champaign County, 2004

HEALTH CARE UTILIZATION	YES	NO
Do you have health coverage	128,339 (87.4%)	18,426 (12.6%)
Have usual person as health care provider	123,655 (84.3%)	23,110 (15.7%)
Could not see doctor due to cost past 12 months	19,514 (13.3%)	127,251 (86.7%)
Could not fill prescription due to cost past 12 months	20,836 (14.2%)	125,929 (85.8%)

In Champaign County the ratio of Medicaid "eligible persons" to participating physicians is 58.1 to 1. (Peoria's ratio is 51.4 to 1; in Illinois the ratio is 82.3 to 1.) These numbers are misleading because many "participating physicians" (i.e. those providing care to Medicaid recipients) are also serving other patients (i.e. those with other types of health insurance). As noted, the two main providers of primary care services in Champaign County (Carle Clinic and Christie Clinic) are currently not accepting new Medicaid patients.

Specialty care for the Medicaid population is also in dire needs due to limited resources. There are few cardiologists, neurologists and other specialists in Champaign County who accept Medicaid patients into their busy practice. Those that do accept, usually do it as referrals from colleagues.



Local physicians and other health providers report that they are reluctant to accept Medicaid clients because:

1) Reimbursement for services is much lower than for private health insurance;
2) Reimbursement for services is unpredictable and slow;
3) Medicaid does not adequately cover the variable costs of a visit; and
4) Medicaid patients have higher missed appointment rates than other patients.

The Medicaid reimbursement rate for some services to children improved on January 1, 2006, thanks to a successful legal effort to force the state of Illinois to offer children on Medicaid the same access to health care as kids who have private health insurance.

Federal Judge Joan Humphrey Lefkow ruled in August, 2004, that the Illinois Department of Public Aid and the Illinois Department of Human Services were violating the rights of Medicaid-eligible children in Cook County by not ensuring that they had access to medical care equal to that of children on private health insurance.

In a settlement agreement, the state of Illinois increased the statewide reimbursement rate for more than a dozen health services to children.

Access to care is of course an even greater problem for the 25,000-plus people in the smaller towns of Champaign County who are uninsured. The lack of affordable options for the uninsured is aggravating the problem of access for those who are Medicaid eligible.

For example, Frances Nelson Community Health Center is equipped to provide primary care and preventive health services to more than 6,000 Medicaid patients. Because it is a Federally Qualified Health Center (FQHC) it is reimbursed for these services at a higher rate than other providers receive. Unfortunately, Frances Nelson's caseload is dominated by the uninsured. Nearly 70 percent of those currently enrolled at Frances Nelson are uninsured and are not eligible for Medicaid. As a result the only FQHC in the county is losing out on hundreds of thousands of dollars in potential revenue, a resource that could enable it to better serve the Medicaid population.

With the help of local hospitals, clinics and other benefactors, Frances Nelson is building a bigger, newer facility that will be able to accommodate more patients. This facility will most likely become a primary health center for the uninsured. Finding a medical home for the uninsured is therefore the primary problem of access to care in Champaign County.

There are, of course, other limits to Champaign County residents' access to care. These include:

Language Barriers

More than 14,000 residents of Champaign County (9% of the population) speak no English. While many providers offer Spanish and some Chinese or other language translation services, the number and variety of translators and educational materials in other languages fails to meet the local need.

Transportation

A majority of low-income clients rely on mass transit or car services to meet their transportation needs. This adds to the expense and travel time required to make

appointments. Those who work have difficulty getting themselves or their children to medical or social service appointments on weekdays.

School Health

There are no school nurses in Champaign schools and a limited number of nurses in county schools outside Champaign-Urbana. On the positive side, Urbana schools have full time and some part time nurses available for the school district.

The Urbana School-based Health Center provides medical care, mental health services and dental services to hundreds of Urbana school children each year, but there is no such school health center in Champaign. The Champaign-Urbana Public Health District and Christie Clinic bring preventive health services to Central and Centennial High Schools for a few hours every month (via Christie's mobile health unit), but this program cannot by itself meet the needs of thousands of Champaign school children.

Champaign County Health Resource Availability

According to the Illinois Department of Public Health, the population to primary care physician ratio threshold for rural areas is 2,400 population per full-time equivalent primary care physician. In urban areas the threshold ratio is 3,000 population per full-time equivalent primary care physician. These thresholds are defined in *77 Ill. Adm. Code Part 594.*

In Champaign County:

- Number of physicians in the primary care specialties of pediatrics, family practice, internal medicine and OB/GYN: 122
- Ratio of population to primary care physician: ~1,472:1(This is a positive indicator of Health care providers in Champaign)
- Number of dentists: 81

- Ratio of population to dentists: ~2,228:1

Licensed hospital beds

Carle Foundation Hospital:	295		
Staffed beds:	256;	Occupancy:	84.4%
Provena Hospital:	299		
Staffed beds:	120;	Occupancy:	89%

Licensed psychiatric in-patient beds

Carle Pavilion:	53
Staffed:	30
Provena Covenant Medical Center	24

(Source: Research conducted by Dr. Curtis Krock, Interim Head, Dept. of Internal Medicine, University of Illinois College of Medicine at Urbana-Champaign, November – December, 2005 and Mark Driscoll, Mental Health Board)

Other Measures

- Medicaid eligible clients participating physicians: 58.1 : 1 (US Census, 2000)
- Per capita health care spending for Medicare beneficiaries: $6,478 per person served in Illinois and $5,884 per enrollee in Illinois. (Kaiser Family Foundation, 2004)
- Proportion of population without a regular source of primary care:
- Local health department full time equivalent employees: number per total population: (105 FTEs) 1 per 1,711 population
- Total Health Department operating budget: ($7.6 million) $42 per capita

By 2003-2004 estimates, the proportion of uninsured residents in Illinois is 14 percent. In Champaign County this translates to 25,153 uninsured people. Nearly 13 percent (23,293) are on Medicaid and 12 percent (21,560) rely on Medicare. A significant proportion of those on Medicaid have no access to regular primary care. By the most conservative estimates, more than 30,000 residents of the county lack the means to obtain regular primary care. This is more than 16 percent of the total population.

Although the above data suggests that the number of uninsured in Champaign is close to 13 percent, a study conducted by the Families USA in 2004 had differing results. According to the results of the study, the number of non-elderly (<65yrs) Illinoisans

without health insurance at some point over a two year period rose form 3,118,000 in 1999-2000 to 3,597,000 during 2003-2004. That is an increase of over 13 percent. The Illinois Campaign for Better Health Care extrapolated these trends for Champaign and estimated 54,990 uninsured in Champaign County. This amounts to 29% of the population without health insurance at any point in the 2003-2004 calendar year.

This contradictory finding warrants further systematic research in defining the accurate number of uninsured and or underinsured in Champaign to better plan and implement strategies in dealing with this critical issue.

Quality of Life

Child Care Options in Champaign, Urbana & Savoy (November 22, 2005)

Facility Type	Champ	Champ	Urbana	Urbana	Savoy	County	TOTAL	TOTAL
	# of Providers	Licensed Capacity	Count	Licensed Capacity	Count	Licensed Capacity	Count	Licensed Capacity
Before/After School	15	1,218	7	307	0	0	22	**1,525**
Head Start/Early Head Start Only	1	78	1	20	1	162	3	**260**
ISBE Pre-K Only	2	338	1	279	0	0	3	**617**
Park/Recreation Only	3	825	3	1,354	0	0	6	**2,179**
Special Needs Care Only	1	30	0	0	0	0	1	**30**
In-home Care	0	0	0	0	0	0	0	**0**
Child Care Center	17	1,383	11	980	2	223	30	**2,586**
Family Child Care	185	1,421	70	516	1	6	262	**1,943**
Preschool Program	4	275	5	176	1	49	10	**500**
School Age Program	0	0	0	0	0	0	0	**0**

(Source: Child Care Resource Service, November 22, 2005. Laura Herriott of the Child Care Resource Service: "There are lots of child care options in Champaign County, even in rural areas.")

BEHAVIORAL RISK FACTORS

The Behavioral Risk Factor Surveillance System (BRFSS) is a telephone survey that targets a representative sample of people in a community. State health departments regularly conduct the surveys using standardized questionnaires. The surveys are designed to reveal the health risks and health-related behaviors of adults living in a community or in particular groups within the community. This survey was conducted explicitly for residents of Champaign County.

The 2004 BRFSS interviewed 400 randomly selected adults aged 18 and older. In the surveys, interviewers ask participants about their behaviors related to chronic diseases ("Have you ever had a mammogram?"), injuries ("Do you wear a seatbelt?"), infectious diseases ("Have you had a tetanus shot in the past 10 years?") and other issues.

These surveys are very useful tools, but they are not perfect measures of health trends or outcomes. In some cases the sample sizes are quite small, which can affect the reliability of the data. Those hoping to use these indicators to support a particular project or intervention should probably go to the BRFSS website for a fuller description of individual indicators, the wording of the questions, the number of people responding and the confidence interval for each percentage.

According to the designers of the survey: "Participants are selected through a random digit dialing of telephone numbers. The data collected are weighted for the probability of selecting a telephone number, the number of adults and the number of telephones per household. A final post-stratification adjustment is made for non-response and non-coverage of households without telephones. The weights for each relevant factor are multiplied to get a final weight."

(For more details: http://www.cdc.gov/brfss/technical_infodata/surveydata.htm)

Behavioral Risk Factor Surveillance System Results, 2004

ALCOHOL	**YES**	**NO**
At risk for acute/binge drinking	18.1 % (26,084)	81.9 % (117,853)
Males	25.4% (17,998)	74.6% (52,826)
Females	11.1% (8,086)	88.9 % (65,027)

The risk for binge drinking is higher for males, those in the $15,000 to $50,000 income level, and high school graduates with no college education. More than 30 percent of those who never married are at risk, compared to 18.3 percent of those who are divorced/separated, and 11.2 percent of those who are married. There is no significant difference between whites and non-whites.

ASTHMA		
	YES	**NO**
Ever diagnosed with asthma	14.4% (21,179)	85.6% (125,586)
Children in households with asthma, aged 5-17	16.0% (6,810)	84.0% (35,665)

Significantly more females than males have been diagnosed with asthma (19.6% compared to 9.2% among males). More than 18 percent of those in the $15,000 to $35,000 income level have been diagnosed with asthma, compared to 12.7 percent of those making $35,000 to $50,000, and 7.5 percent of those earning over $50,000. Nearly 16 percent of non-whites have asthma, compared to 14 percent of white respondents.

CARDIOVASCULAR		
	YES	**NO**
Ever told high blood pressure	18.6% (27,265)	81.4% (119,265)
Ever told blood cholesterol level high	26.4% (33,530)	73.6% (93,358)

Nearly 31 percent of females (30.8%) have been diagnosed with high cholesterol, compared to 22.1 percent of males. Whites (29.0%) were much more likely than non-whites (17.4%) to be diagnosed with high cholesterol.

CARDIOVASCULAR (continued)		
Last time cholesterol checked		
1 year or less	63.8% (91,224)	
More than 1 year	22.3% (31,956)	
Never	13.9% (19,877)	
	YES	**NO**
12 months: doctor advice eat less fat/cholesterol	20.3% (29,815)	79.7% (116,950)
12 months: doctor advice to eat more fruit and vegetables	32.7% (48,015)	67.3% (98,750)
12 months: doctor advice to exercise	29.7% (43,581)	70.3% (103,071)

The three categories above describe the behavior of doctors (and their patients' memories of their advice). It appears that a majority of physicians are not suggesting better diets and exercise for their patients. Older patients are much more likely to be advised to eat fruits and vegetables (64%, compared to 31-36% for younger patients). Older patients are also more likely to be advised to be more physically active (51.3% compared to 27-36% of younger patients).

COLORECTAL CANCER SCREENING		
	YES	**NO**
Had sigmoidoscopy or colonoscopy exam (ages 50+)	73.0% (30,845)	27.0% (11,408)
Had blood stool test (ages 50+)	64.5% (27,060)	35.5% (14,899)
	YES	**NO**
DIABETES		
Diabetic	4.3% (6,269)	95.7% (139,823)

HEALTH CARE UTILIZATION	**YES**	**NO**
Do you have health coverage	87.4% (128,339)	12.6% (18,426)
Have usual person as health care provider	84.3% (123,655)	15.7% (23,110)
Could not see doctor due to cost past 12 months	13.3% (19,514)	86.7% (127,251)
Could not fill prescription due to cost past 12 months	14.2% (20,836)	85.8% (125,929)
Had no coverage at any time in past 12 months	9.7% (12,459)	90.3% (115,655)

Health care coverage disparities between whites and non-whites are striking. Over 90 percent (91.8%) of white respondents reported that they had some kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare. Only 72.5 percent of non-whites said they had such coverage. Close to 94 percent of those with some college education were covered, as compared to 78.1

percent of those with no more than a high school degree. Over 22 percent (22.1%) of non-whites reported that they were unable to see a doctor in the previous year due to cost, as compared to 10.7 percent of whites. Over 28 percent (28.7%) of non-whites and 10.0 percent of whites said they were unable to fill a prescription in the past 12 months due to cost.

HEALTH STATUS		
General Health		
Excellent / very good	61.5% (90,209)	
Good / fair	36.7% (53,853)	
Poor	1.8% (2,606)	
Days Mental Health Not Good		
none	58.8% (85,635)	
1-7	25.5% (37,118)	
8-30	15.7% (22,890)	

A larger portion of non-whites (23.4%) than whites (13.5%) reported that they had 8-30 days in the previous month when their mental health was "not good" (in terms of stress, depression and problems with emotions).Those who reported the most days when their mental health was not good include the employed (18.6%), those earning $15,000 to $35,000 (30.4%), those who are divorced / separated (25.4%), and families that include more than one adult with children (20.6%).

HEALTH STATUS (continued)		
Days Physical Health Not Good		
none	64.3% (93,591)	
1-7	23.7% (20,498)	
8-30	13.2% (19,270)	
Days Health Kept From Doing Usual Activities		
none	62.8% (54,283)	
1-7	23.7% (20,498)	
8-30	13.5% (11,702)	

HIV/AIDS and SEXUALLY TRANSMITTED DISEASES	**YES**	**NO**
Ever Had an HIV TEST	36.4% (46,579)	63.6% (81,471)
Treated for an STD in Last 5 Years	2.6% (3,411)	97.4% (125,518)
Number of Sexual Partners in Past 12 Months		
none	19.7% (24,505)	
1	70.4% (87,456)	
2	5.2% (6,476)	
3 or more	4.6% (5,824)	

Females are more likely to be tested for HIV than males (40.5% vs. 32.5%). More than 70 percent of residents have only one sexual partner, which is a positive indicator.

IMMUNIZATIONS	**YES**	**NO**
Had a Flu Shot in the past 12 months	30% (43,983)	70.0% (102,782)
Ever Had a Pneumonia Shot	22.6% (31,193)	77.4% (107,012)
Had a Tetanus Shot in past 10 years	77.1% (107,684)	22.9% (32,029)

INJURY CONTROL	**YES**	**NO**
Are Firearms Kept in or Near Home	17.5% (24,961)	82.5% (117,934)
Risk for Injury Due to Not Using Seatbelt	15.7% (22,976)	84.3% (123,677)
Working Smoke Detector on Each Floor	92.0% (134,085)	8.0% (11,620)

Males are much more likely than females to report keeping firearms in the home (21.1 % vs. 13.9%). Whites are much more likely than non-whites to have firearms in the home (20.0% vs. 8.6%). High school graduates without any college education are more likely than those with some college to keep firearms in the home (25.0% vs. 15.4%). And 28.7% of people aged 45-64 report having firearms in the home, as compared to 17.9% of those aged 25-44 and 17.9% of those aged 65+.

As for seatbelt use, non-whites are much more likely than whites to report being at risk of injury due to failure to use a seatbelt (31.3% vs. 11.1%), and 22.6% of males are at risk, versus 8.7% of females.

ORAL HEALTH		
Last Dental Visit		
< or = 1 year	69.4% (101,879)	
1-2 years	14.8% (21,739)	
>2 years/never	15.8% (23,147)	
	YES	**NO**
Do You Have Dental Health Insurance	57.2% (83,143)	42.8% (62,254)
Could Not Afford Dentist in Last 12 months	25.8% (37,929)	74.2% (108,836)
ORAL HEALTH (continued)		
Last Time Teeth Cleaned		
Within 1 year	63.9% (92,620)	
More than 1 year or never	36.1% (52,250)	

The oral health needs of respondents in general are worrisome, but the disparity in access to care between whites and non-whites is even more disturbing. Over twenty-five percent of non-white respondents reported that they had not seen a dentist in two years or ever, compared to 13.0 percent of whites.

Non-whites were more likely to report that they could not afford a dentist in the past year even when they needed to see one (36.6%, versus 22.7% of whites). They were less likely to have dental insurance (49.7% compared to 40.8% of whites). They were less likely to have read about cancers of the mouth (80.1% had not, versus 65.1% of whites). They were also less likely than whites to have had their teeth cleaned by a dentist or dental hygienist (47.6% of non-whites reported they had last had their teeth cleaned more than a year before or never, as compared to 32.7% among whites).

PHYSICAL ACTIVITY		
Regular & Sustained Physical Activity Guidelines		
Meets or exceeds standard	44.8% (65,682)	
Does not meet standard	47.1% (69,112)	
Inactive	8.1% (11,860)	
Work Activity		
Mostly sitting or standing	48.7% (71,493)	
Mostly walking	19.7% (28,950)	
Mostly heavy labor or physically demanding work	12.5% (18,303)	
Other	*	
Not employed	17.8% (26,049)	
PHYSICAL ACTIVITY (continued)		
Physical Activity Behavior		
Exercise regularly for 6 months or more	37.6% (54,733)	
Exercise regularly for < 6 months	10.6% (15,471)	
Don't exercise but intend to start	11.5% (16,772)	
Do not exercise and don't intend to start	5.8% (8,383)	

About 36-42 percent of all age groups reported that they have exercised regularly for six months or longer. Obviously a large majority of respondents are not getting the physical activity they need to remain healthy. Seniors were more likely than other groups to have given up on the idea of ever getting any exercise. Eleven percent of those aged 65 and over said that they do not exercise and do not intend to (6.6% of respondents aged 45-64 and 8.3% of respondents aged 25-44 said this).

Notable differences appear between whites and non-whites. More than 40 percent of whites and only 28.5 percent of non-whites report that they have exercised regularly for six months or longer.

PHYSICAL ACTIVITY (continued)	**YES**	**NO**
Do You Think You Get Enough Exercise	45.1% (65,977)	54.9% (80,229)
Meets Moderate Activity Standard 5 x Week x 20 Min	31.0% (44,828)	69.0% (99,638)
Meets Vigorous Activity Standard 3 x Week x 20 Min	29.9% (43,530)	70.1% (102,239)

	YES	**NO**
PROSTATE CANCER SCREENING		
Ever Had a PSA Test (Men > 40)	75.1% (22,466)	24.9% (7,446)
Had Digital Rectal Exam (Men > 40)	78.5% (23,491)	21.5% (6,420)

QUALITY OF LIFE	**YES**	**NO**
Activities Limited by Health Problems	13.9% (20,405)	86.1% (126,031)
Need Help Due to Health	18.6% (3,804)	81.4% (16,602)
Need Special Equipment Due to Health	3.7% (5,401)	96.3% (141,364)
Days Past Month Depressed, Sad or Blue		
none	51.0% (74,070)	
1 or 2 days	18.7% (27,098)	
More than 2 days	30.4% (44,128)	

Female respondents were more likely than their male counterparts to report that physical, mental or emotional problems limited their activities. Over nineteen percent (19.4%) of women answered yes to this question, and 8.5 percent of men. Over thirty percent (30.4%) of single adults without children answered yes to the same query, while 13.5 percent of families in households with more than one adult and 5.9 percent of families with more than one adult and children reported that their activities were limited by health problems.

It is notable that nearly a third of respondents reported that they felt depressed, sad or blue more than two days per month.

TOBACCO		
Smoking Status		
Smoker	20.1% (29,498)	
Former Smoker	21.5% (31,426)	
Non-smoker	58.4% (85,582)	

Significant differences appear in the smoking habits of different age groups. Adults age 65 and over are more likely to have never smoked (40.4%) or to have kicked the smoking habit (46.3%). Only 13.3 percent of people aged 65+ and 12.6 percent of those aged 45-64 said they were smokers, compared to 24 percent of people aged 25-44.

Should Restaurants Allow Smoking?		
All areas	1.7% (2,476)	
Some areas	39.3% (56,901)	
Not allowed at all	59.0% (85,591)	

It is notable that 59 percent of respondents favor a complete ban on smoking in restaurants.

WEIGHT CONTROL		
Obesity		
Underweight / normal	51.9% (73,923)	
Overweight	30.9% (43,979)	
Obese	17.1% (24,397)	

WEIGHT CONTROL (continued)	**YES**	**NO**
Are You Now Trying to Lose Weight	39.6% (58,103)	60.4% (88,514)
Are You Now Trying to Maintain Current Weight	67.2% (59,566)	32.8% (29,096)
Control Weight: Exercise	69.3% (81,466)	30.7% (36,089)

There are no significant differences in obesity rates among men (17.7%) and women (16.6%), or between whites (17.3%) and non-whites (16.5%).

WOMEN'S HEALTH	**YES**	**NO**
Ever Had a Mammogram	50.7% (36,984)	49.3% (35,981)
Had a Mammogram (Age 40+)	84.6% (29,840)	15.4% (5,428)
Last Mammogram		
<= 1 year	85.0% (31,452)	
> 1 year	15.0% (5,532)	
Ever Had a Pap Smear	92.7% (67,147)	7.3% (5,259)
Last Pap Smear		
<= 1 year	84.6% (56,455)	

> 1 year	15.4% (10,239)	
WOMEN'S HEALTH (continued)		
Ever Had a Clinical Breast Exam	88.2% (64,337)	11.8% (8,628)
Last Clinical Breast Exam		
<= 1 year	88.6% (56,911)	
> 1 year	11.4% (7,312)	

Environmental Health Indicators

Most of the Environmental Health Indicators are regulated by the Illinois Environmental Protection Agency (I-EPA) and Occupational Safety and Health Administration (OSHA). Public Health's Division of Environmental Health does not regulate or participate in this process.

According to Garry Bird, Champaign-Urbana Public Health District's Director of Environmental Health and a long-term resident of Champaign, the county is largely agricultural with little heavy industry and no landfill. The amount of toxic agents released into air, water and soil are minimal in comparison to counties with more industrial sites. The agricultural use of fertilizers, herbicide and pesticide may be of concern here, however, polluting the county's surface water, and negatively impacting local plant and animal life.

According to Mr. Bird, most of the population of Champaign County is served by EPA regulated water supplies. These water supplies are required to be fluoridated. Private water supplies are not required to be fluoridated. Less than 20 percent of the county population is served by private water supplies.

Social and Mental Health

Social and mental health needs have been documented through a number of reports that supplement the data presented here.

The United Way of Champaign County spearheaded the work of the Community Needs Consortium of Champaign County. The Consortium surveyed the public, conducted focus groups and interviewed community leaders to assess human and social service needs across ten broad based topics. The findings of the Consortium are described in this document under the heading Summary of United Way Assessment Survey.

Another locally focused assessment of children and youth is completed by Project 18. The Project 18 Community Report Card is a compilation of various indicators on children and youth using data from local sources. The longitudinal data on indicators such as economic security, family stability and juvenile crime is subjected to trend analysis.

The Champaign County Mental Health Board initiated an assessment of the system of care for children and youth in 2002 and revisited the subject in 2006. The attributes of a system of care include child centered care, family focused care, culturally competent, strength based service planning and community based delivery. Dr. Shallcross, a nationally recognized expert on the subject, completed the two assessments and reported his findings: "Categorical fee-for-service public funding and managed care practices are not easily aligned with System of Care functions and objectives, and provider business practices based on the requirements of these revenue streams have further compromised provider capacity to implement System of Care practices ….

Champaign County needs better organization and structure as a system of inter-related, community based services and resources ...." One of Dr. Shallcross' recommendations for strengthening the system of care acknowledges the role of Public Health – "CCMHB and

its strategic partners should conduct public forums (Study Sessions) focusing on Community Health issues, such as access to healthcare, youth in trouble, single parenting, and school failure.... Integrating these sessions with information from the MAPP process and Big/Small/All efforts is very timely."

Alcohol Abuse

ALCOHOL	YES	NO
At risk for acute/binge drinking	18.1 % (26,084)	81.9 % (117,853)
Males	25.4% (17,998)	74.6% (52,826)
Females	11.1% (8,086)	88.9 % (65,027)

Source: CDC Behavioral Risk Factor Surveillance System Survey Data, Atlanta, Georgia: US Dept. of Health and Human Services, Centers for Disease Control and Prevention, 2004

The risk for binge drinking is higher among males, those in the $15,000 to $50,000 income level, and high school graduates with no college education. More than 30 percent of those who never married are at risk, compared to 18.3 percent of those who are divorced/ separated, and 11.2 percent of those who are married. There is no significant difference between whites and non-whites.

Alcohol Dependence Syndrome Hospitalizations (Rates are per 100,000 population)

1999-2001	C-U	Champaign County	Peoria	Illinois
	# (Rate)	**# (Rate)**	**# (Rate)**	**# (Rate)**
Age 15-44	85 (43.6)	115 (39.0)	192 (82.8)	10,000 (60.2)
Age 45-64	47 (103.1)	61 (62.9)	53 (42.3)	5,954 (74.4)

Source: IPLAN

Assault Rates (per 100,000 population)

1996-1998	C-U	Champaign County	Peoria	Illinois
	# (Rate)	# (Rate)	# (Rate)	# (Rate)
Criminal Sexual Assault	NA	333 (66.1)	604 (110.3)	19,480 (54.4)
Robbery	NA	765 (151.9)	1,366 (249.5)	98,661 (275.7)
Aggravated Assault & Battery & Attempted Murder	NA	3,493 (693.5)	3,901 (712.6)	192,616 (538.2)

Source: *IPLAN*

Domestic Violence, Child Abuse, Sexual Assault and Elder Abuse

Violence in the home, sexual assault, substance abuse, homicide, suicide, depression and other social and mental health problems are often linked.

There is significant overlap between child abuse or neglect and domestic violence. If one form of violence exists in a family, there is a high likelihood that other forms of violence are also present. Children are often the invisible victims of domestic violence.[1]

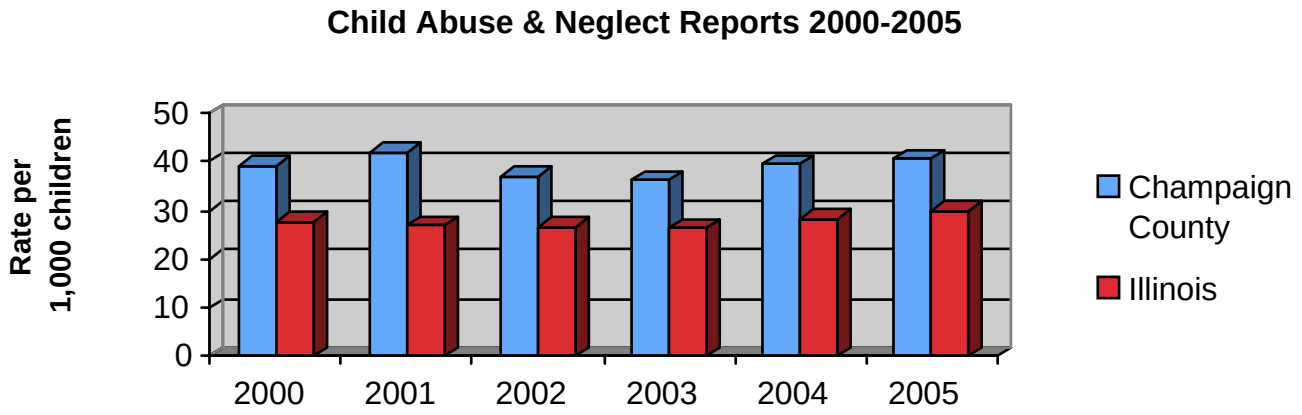
Abuse of pets or other animals is often an indicator of other types of violence in the home. According to the United States Humane Society, batterers use the threat of violence or actual violence against pets to control and isolate their human victims, to prevent them from reporting the violence or to stop them from leaving the relationship.

[1] Carter, L.S., Weithorn, L.A., & Behrman, R.E., (1999). Domestic violence and children: Analysis and Recommendations. The Future of Children, 9(3) 4.

Children in families where violence occurs face three risk factors: the risk of being abused themselves, the risk of being neglected, and the risk of being traumatized by observing the violence.[2] Exposure to violence in the home can have significant negative effects on children's physical, behavioral, emotional, social and cognitive development.[3]

There is also significant overlap between domestic violence and substance abuse. Administrators at Prairie Center Health Systems, a primary provider of substance abuse counseling to people in Champaign and Vermilion Counties, estimate that up to 75 percent of those in treatment have been perpetrators or victims of domestic violence. In 2004, 200 individuals in treatment at the Prairie Center were steered to its domestic violence counseling program.

What is the extent of these problems in Champaign County? For child abuse and neglect, the data are troubling. The report rate here is significantly higher than that of the state as a whole, a fact that has persisted for years.



[2] Carter, J, & Schechter, S, (1997). Child abuse and domestic violence: Creating community partnerships for safe families. Available on line at http://www.mincava.edu/link/fvpfl.htm

[3] Fantuzzo, J.W. & Mohr, W.K. (1999) Prevalence and effects of child exposure to domestic violence. The Future of Children, 9 (3) 5-15.

	No. of Abuse & Neglect Reports (Rate per 1,000 Children)	
Year	**Champaign County**	**Illinois**
2000	39.3 per 1,000 (1,434)	27.6 per 1,000 (87,834)
2001	42.1 (1,537)	26.9 (85,646)
2002	36.9 (1,346)	26.7 (87,834)
2003	36.2 (1,565)	26.4 9 (97,449)
2004	39.6 (1,710)	28.2 (91,338)
2005	40.5 (1,751)	30.0 (97,545)

Source: *Illinois Department of Children & Family Services* (http://www.state.il.us/dcfs/library/index.shtml)

Champaign County Child Abuse Cases, 2005, by Zip Code

Zip Code	Place Name	Indicated Victims (Rate per 1,000 children)	Indicated Sex Abuse Victims (Numbers too small to calculate rates)
61801	Urbana	101 (26.57)	6
61802	Urbana	43 (11.01)	8
61803	Urbana	0	0
61815	Bondville	1 (*.*)	0
61816	Broadlands	0	0
61820	Champaign	84 (23.30)	4
61821	Champaign	85 (12.14)	3
61822	Champaign	8 (1.95)	2
61824	Champaign	0 (*.*)	0
61826	Champaign	1 (*.*)	0
61840	Dewey	3 (*.*)	0
61844	Fisher	1	0
61845	Foosland	0	0
61847	Gifford	2	0
61849	Homer	2	0
61851	Ivesdale	2	0
61852	Longview	10	1
61853	Mahomet	18	2
61859	Ogden	1	0
61862	Pennfield	1	0
61863	Pesotum	0	0
61865	Philo	0	0
61866	Rantoul	90	12
61871	Royal	--	--
61872	Sadorus	2	0
61873	St. Joseph	9	1
61874	Savoy	4	0
61875	Seymour	--	--
61877	Sidney	6	0
61878	Thomasboro	1	0
61880	Tolono	12	0
TOTAL		**487**	**35**
Source: Illinois Department of Children & Family Services (http://www.state.il.us/dcfs/library/index.shtml)			

* “Indicated” means that the report of abuse or neglect was founded, that is, significant evidence of abuse or neglect was revealed in the investigation.

Domestic Violence

It is difficult to measure the extent of domestic violence in Champaign County or in any community because no agency or government body is responsible for collecting comprehensive data on domestic violence. We do know that in 2004 in Champaign County there were 2,075 domestic battery reports to police. Of these, 1,313 led to charges against offenders and 660 orders of protection were issued.

National data is also available:

- Nearly one-third of American women (31%) report being physically or sexually abused by a husband or boyfriend at some point in their lives, according to a 1998 Commonwealth Fund survey.[4]
- Nearly 25 percent of American women report being raped and/or physically assaulted by a current or former spouse, cohabiting partner, or date at some time in their lifetime, according to the National Violence against Women Survey, conducted from November 1995 to May 1996.[5]
- Thirty percent of Americans say they know a woman who has been physically abused by her husband or boyfriend in the past year.[6]
- In the year 2001, more than half a million American women (588,490 women) were victims of nonfatal violence committed by an intimate partner.[7]
- Intimate partner violence is primarily a crime against women. In 2001, women

[4] The Commonwealth Fund, Health Concerns Across a Woman's Lifespan: 1998 Survey of Women's Health, May 1999

[5] The Centers for Disease Control and Prevention and The National Institute of Justice, *Extent, Nature, and Consequences of Intimate Partner Violence*, July 2000.

[6] Lieberman Research Inc., Tracking Survey conducted for The Advertising Council and the Family Violence Prevention Fund, July – October 1996

[7] Bureau of Justice Statistics Crime Data Brief, *Intimate Partner Violence, 1993-2001*, February 2003

accounted for 85 percent of the victims of intimate partner violence (588,490 total) and men accounted for approximately 15 percent of the victims (103,220 total).[8]

- While women are less likely than men to be victims of violent crimes overall, women are five to eight times more likely than men to be victimized by an intimate partner.[9]

The reports of domestic violence, sexual assault, child abuse and neglect and elder abuse that appear in the media point to a significant and troubling trend.

[8] Bureau of Justice Statistics Crime Data Brief, *Intimate Partner Violence, 1993-2001*, February 2003

[9] U.S. Department of Justice, *Violence by Intimates: Analysis of Data on Crimes by Current or Former Spouses, Boyfriends, and Girlfriends*, March 1998

Other Measures of Social and Mental Health

Total Psychoses Hospitalization Rates (per 100,000 population)

1999-2001	C-U	Champaign County	Peoria	Illinois
	# (Rate)	# (Rate)	# (Rate)	# (Rate)
Age 15-44	740 (1137.8)	1,005 (1022.5)	1,041 (1347.5)	152,387 (2750.4)
Age 45-64	308 (2026.9)	393 (1215.0)	473 (1133.0)	64,506 (2418.3)

Source*: IPLAN*

Assault Rates (per 100,000 population)

1996-1998	C-U	Champaign County	Peoria	Illinois
	# (Rate)	# (Rate)	# (Rate)	# (Rate)
Criminal Sexual Assault	NA	333 (66.1)	604 (110.3)	19,480 (54.4)
Robbery	NA	765 (151.9)	1,366 (249.5)	98,661 (275.7)
Aggravated Assault & Battery & Attempted Murder	NA	3,493 (693.5)	3,901 (712.6)	192,616 (538.2)

Source: *IPLAN*

While assault rates in Champaign County are lower than in Peoria, rates of criminal sexual assault, aggravated assault and battery and attempted murder are significantly higher than those of the state as a whole.

Homicide Rates (per 100,000 population)

1999-2001	C-U	Champaign County	Peoria	Illinois
	# (Rate)	# (Rate)	# (Rate)	# (Rate)
Total Crude	10 (*.*)	15 (2.8)	42 (7.7)	3,063 (8.3)
Total Premature (<65 years of age)	9 (*.*)	14 (2.9)	40 (8.5)	2,943 (9.0)

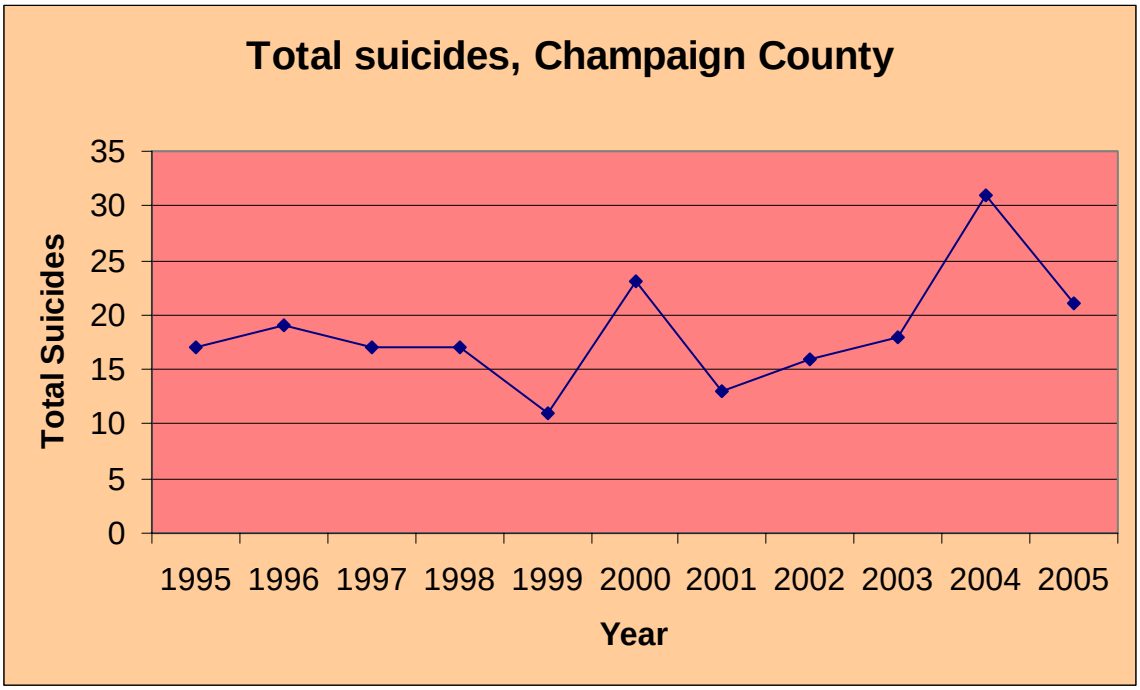
Source: *IPLAN*
(** : Rate too low to calculate to avoid identity)

Homicide rates in Champaign County are much lower than in Peoria or in the State of Illinois as a whole. Six of the 15 homicides (~40 percent) in Champaign County were among African Americans, who make up 11.2 percent of the population.

Total Suicides in Champaign County from 1995 through 2005

Year	Total Suicides
2005	21
2004	31
2003	18
2002	16
2001	13
2000	23
1999	11
1998	17
1997	17
1996	19
1995	17

Source*: Office of the Coroner, Champaign County, 2006*



As is evident in the chart above, suicide rates have been on a constant rise since 1995. This is a disturbing fact for Champaign and needs to be addressed.

Suicide Rates (per 100,000 population)

1999-2001	C-U	Champaign County	Peoria	Illinois
	# (Rate)	# (Rate)	# (Rate)	# (Rate)
Total Crude	10 (*.*)	39 (7.4)	46 (8.4)	3,143 (8.3)
Total Premature (<65 years of age)	9 (*.*)	31 (6.5)	37 (7.9)	2,587 (9.0)

Source: *IPLAN*

Suicide rates in Champaign County are lower than in Peoria or in the state as a whole, but by a lesser margin than homicide rates. Suicide disproportionately affects

whites. Thirty-five of the 39 suicides (~90%) in Champaign County were among whites, who make up approximately 79 percent of the population.

Data from the Behavioral Risk Factor Survey

Days Mental Health Not Good		
none	85,635 (58.8%)	
1-7	37,118 (25.5%)	
8-30	22,890 (15.7%)	

10

A larger portion of non-whites (23.4%) than whites (13.5%) reported that they had 8-30 days in the previous month when their mental health was "not good" (in terms of stress, depression and problems with emotions).

Those who reported the most days when their mental health was not good include the employed (18.6%), those earning $15,000 to $35,000 (30.4%), those who are divorced or separated (25.4%), and families that include more than one adult with children (20.6%).

CDC Behavioral Risk Factor Surveillance System Survey Data, Atlanta, Georgia: US Dept. of Health and Human Services, Centers for Disease Control and Prevention, 2004

QUALITY OF LIFE	**YES**	**NO**
Activities Limited by Health Problems	13.9% (20,405)	86.1% (126,031)
Need Help Due to Health	18.6% (3,804)	81.4% (16,602)
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Days Past Month Depressed, Sad or Blue		
none	51.0% (74,070)	
1 or 2 days	18.7% (27,098)	
More than 2 days	30.4% (44,128)	

Female respondents were more likely than their male counterparts to report that physical, mental or emotional problems limited their activities. Over nineteen percent (19.4%) of women answered yes to this question, and 8.5 percent of men. Over thirty percent (30.4%) of single adults without children answered yes to the same query, while 13.5 percent of families in households with more than one adult and 5.9 percent of families with more than one adult and children reported that their activities were limited by health problems.

It is notable that nearly one third of respondents reported that they felt depressed, sad or blue more than two days per month.

Maternal & Child Health

INDICATOR	Demog. Info.	Data Years	CC #	CC Rate	C-U #	C-U Rate	Peoria #	Peoria Rate	IL #	IL Rate	Source
Infant Mortality	**Race**	**99-01**									**IPLAN**
Total Infant Mortality	**TOTAL**		**61**	**9.0**	**50**	**12.1**	**70**	**8.9**	**4,411**	**8.0**	
highest in CC and CU	Asian/PI		5	*.*	4	*.*	1	*.*	117	5.0	
Black infant mortality	Black		26	**21.8**	255	**24.6**	39	19.0	1,647	16.2	
highest in CC and CU	White		30	6.0	21	**7.9**	30	5.4	2,635	6.2	
Neonatal Mortality	**Race**	**99-01**									**IPLAN**
Black rates > Others	**TOTAL**		**36**	**5.3**	**31**	**7.5**	**42**	**5.3**	**2,989**	**5.4**	
Black neonatal mortality	Asian/PI		2	*.*	2	*.*	1	*.*	82	3.5	
highest in CC and CU	Black		15	**12.6**	15	**14.7**	20	9.8	1,034	10.2	
	White		19	3.8	14	**5.3**	21	3.8	1,863	4.4	
Post-Neonatal Mortality	**Race**	**99-01**									**IPLAN**
Black rates > Others	**TOTAL**		**25**	**3.7**	**19**	**4.6**	**28**	**3.6**	**1,422**	**2.6**	
Black Post-Neonatal mortality	Asian/PI		3	*.*	2	*.*	0	*.*	35	1.5	
highest in CC and CU	**Black**		11	9.2	10	**9.8**	19	9.3	613	6.0	
	White		11	2.2	7	*.*	9	*.*	772	1.8	
Low Birth Weight	**Race**	**00-02**		**%**		**%**		**%**		**%**	**IPLAN**
Black rates > Others	**TOTAL**		**505**	**7.4**	**212**	**7.5**	**642**	**8.2**	**44,289**	**8.1**	
A majority of the low birth weight	Asian/PI		32	5.8	17	5.8	15	6.4	2,090	8.5	
babies are in the county	**Black**		153	12.4	85	12.2	258	12.6	13,956	14.1	
outside C-U	White		319	6.4	110	6.1	368	6.6	28,127	6.6	

Very Low Birth Weight	**Race**	**00-02**		**%**		**%**		**%**		**%**	**IPLAN**
Black rates > Others	**TOTAL**		**117**	**1.7**	**51**	**1.8**	**127**	**1.6**	**8,961**	**1.6**	
A majority of the low birth	Asian/PI		7	**1.3**	5	**1.7**	2	0.9	313	0.9	
wt babies are in the county	**Black**		37	3.0	21	3.0	61	3.0	3,350	3.4	
outside C-U	White		73	**1.5**	25	**1.4**	64	1.1	5,283	1.1	

Maternal & Child Health continued

INDICATOR	**Demog. Info.**	**Data Years**	**CC**	**CC**	**C-U**	**C-U**	**Peoria**	**Peoria**	**IL**	**IL**	**Source**
			#	**Rate**	**#**	**Rate**	**#**	**Rate**	**#**	**Rate**	
Mothers Beginning Prenatal Care in the First Trimester	**Race**	**00-02**		**%**		**%**		**%**		**%**	**IPLAN**
White rates > Black & Asian/PI	**TOTAL**		**5,619**	**82.7**	**2,252**	**80.1**	**6,773**	**86.0**	**449,422**	**81.8**	
	Asian/PI		449	**81.6**	238	**81.5**	212	91.0	20,060	81.8	
	Black		888	71.8	491	**70.5**	1,474	72.1	70,226	70.8	
	White		4,258	**85.6**	1,509	**83.7**	5,075	90.9	358,077	84.4	
	Other		24	**68.6**	14	**73.7**	12	85.7	1,059	78.7	

INDICATOR	**Demog. Info.**	**Data Years**	**CC**	**CC**	**C-U**	**C-U**	**Peoria**	**Peoria**	**IL**	**IL**	**Source**
			#	**Rate**	**#**	**Rate**	**#**	**Rate**	**#**	**Rate**	
Teen Birth Rate	**Ages**	**00-02**									**IPLAN**
	TOTAL		**209**	**25.6**	**86**	***.***	**372**	**37.5**	**20,935**	**29.9**	
Most teens giving birth in CC outside CU	**10-14**		13	**2.6**	5	*.*	25	4.0	1,054	2.4	
	15-17		196	64.0	81	*.*	347	93.8	19,881	76.9	
Mothers Who Drink During Pregancy	**Race**	**00-02**		**%**		**%**		**%**		**%**	**IPLAN**
	TOTAL		**18**	**0.3**	**NA**	**NA**	**13**	**0.2**	**2,541**	**0.5**	
Black rates >	Black		5	0.4	NA	NA	4	*.*	990	1.0	

Others											
	White		12	0.2	NA	NA	9	*.*	1,516	0.4	
	Other		1	*.*	NA	NA	0	*.*	35	0.1	
Mothers Who Smoke During Pregancy	**Race**	**00-02**									**IPLAN**
	TOTAL		**731**	**10.8**	**NA**	**NA**	**1,416**	**18.0**	**57,412**	**10.4**	
Black rates > Others	Black		167	**13.5**	NA	NA	360	17.6	13,030	13.1	
	White		554	**11.1**	NA	NA	1,047	18.8	43,963	10.4	
	Other		10	**1.7**	NA	NA	9	3.6	419	1.6	

Infant Mortality has been consistently higher in Champaign County when compared to neighboring Peoria county and the State of Illinois. Particularly disturbing is the infant mortality rate for African-Americans, which is highly disproportionate to whites and Hispanics. This gap in the rate can be attributed to multiple factors. One of the important factors is the low rate of black mothers receiving prenatal care in the first trimester as compared to white mothers. A significant factor is the higher rate of Black mothers who smoke and drink during pregnancy.

According to the Surgeon Generals Report, 2001,"The risk for perinatal mortality—both stillbirth and neonatal deaths—and the risk for sudden infant death syndrome (SIDS) are increased among the offspring of women who smoke during pregnancy. Infants born to women who smoke during pregnancy have a lower average birth weight and are more likely to be small for gestational age than are infants born to women who do not smoke"

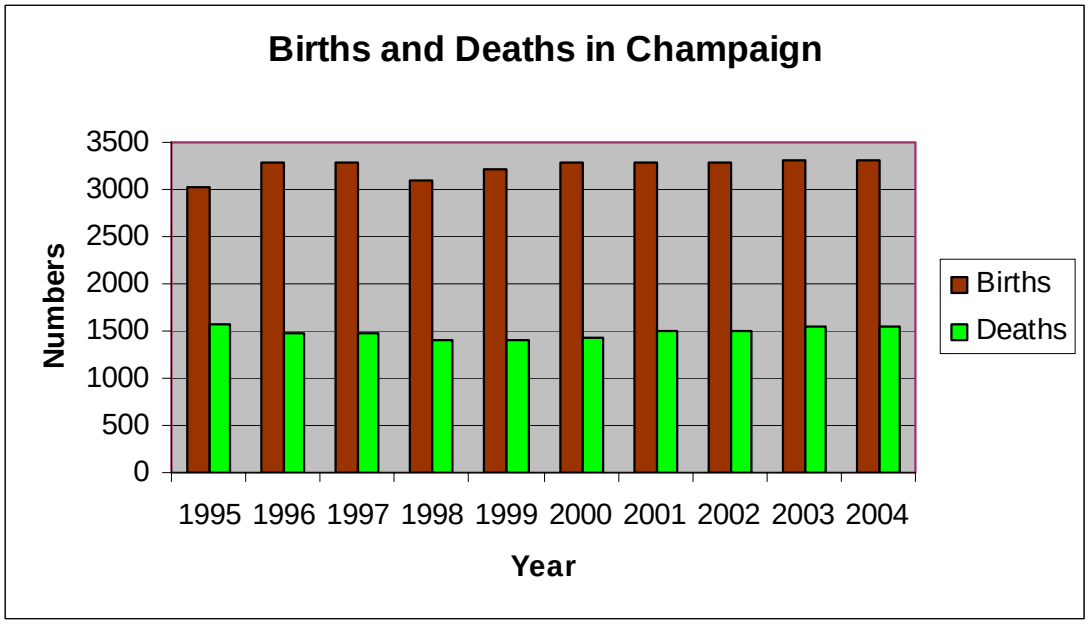
Death, Illness and Injury

INDICATOR	Demog. Info.	Data Years	CC	CC	C-U	C-U	Peoria	Peoria	IL	IL	Source
			#	Rate	#	Rate	#	Rate	#	Rate	
Breast Cancer: Crude	See page 62 for rates	**99-01**	68	*.*	47	*.*	92	*.*	5,880	31.1	**IPLAN**
Breast Cancer: Premature (<65)		**99-01**	27	*.*	20	*.*	27	*.*	2,306	14.2	
Prostate Cancer: Crude		**99-01**	54	*.*	33	*.*	82	*.*	4,226	23.3	**IPLAN**
Prostate Cancer: Premature (<65)		**99-01**	0		0	*.*	4		313	1.9	
Lung Cancer: Crude		**99-01**	226	42.8	130	*.*	370	67.6	20,280	54.8	**IPLAN**
Lung Cancer: Premature (<65)		**99-01**	63	13.2	38	*.*	111	23.6	5,787	17.8	
Cervical Cancer: Crude		**99-01**	6	*.*	3	*.*	5	*.*	615	3.3	**IPLAN**
Cervical Cancer: Premature (< 65)		**99-01**	5	*.*	2	*.*	2	*.*	403	2.5	
Colorectal Cancer: Crude		**99-01**	76	14.4	47	*.*	144	26.3	8,270	22.3	**PLAN**
Colorectal Cancer: Prem. (<65)		**99-01**	17	3.6	9	*.*	29	6.2	1,954	6.2	
Chronic Liver Disease & Cirrhosis: Age-Adjusted, Crude		**99-01**	38	7.2	23	*.*	50	9.1	3,250	8.8	**IPLAN**
Chronic Liver Disease & Cirrhosis: A-A, Prem. (<65)		**99-01**	27	5.7	17	*.*	24	5.1	1,940	6.0	
Motor Vehicle Crashes: Crude		**2001**	23		5		23		1,559	12.5	**IPLAN**
Premature			17		4		19		1,289	11.7	
Cerebrovascular Disease: Crude		**99-01**	226	42.8	136	*.*	506	92.4	22,307	60.2	**IPLAN**
Premature			35	7.4	23	*.*	52	11.1	2,530	7.8	

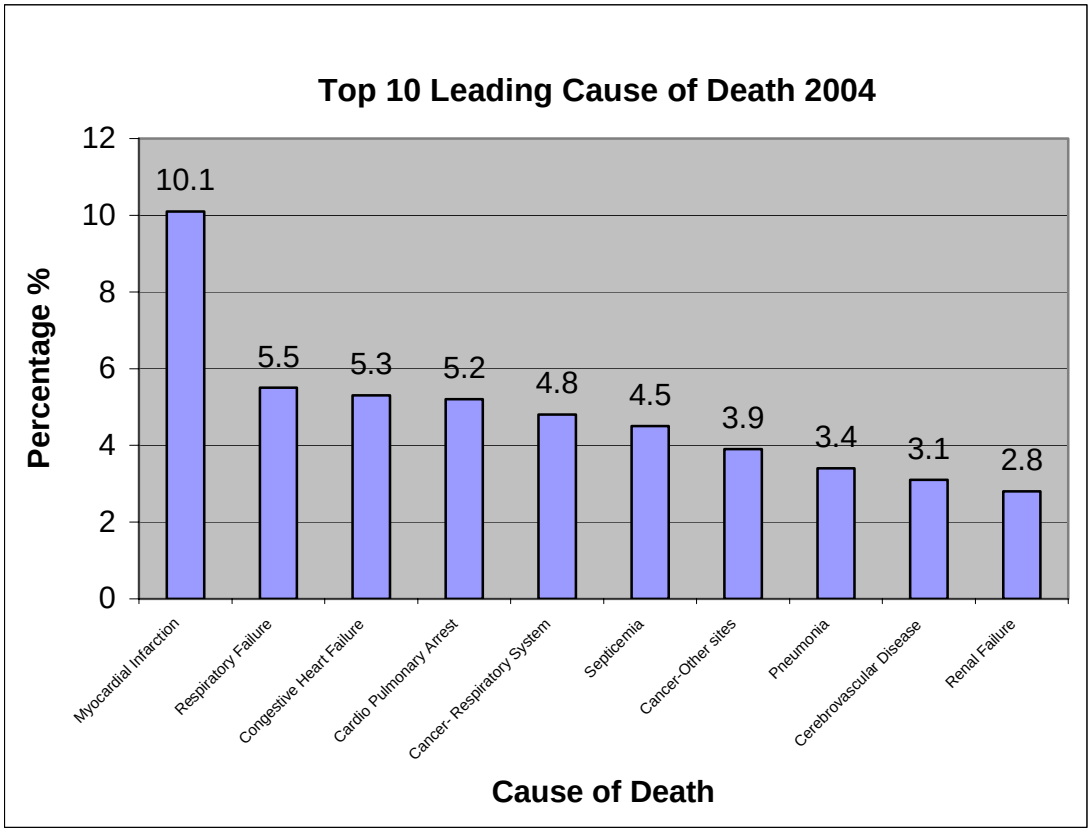
Coronary Heart Disease: Crude		**99-01**	530	100.3	309		954	174.2	72,921	196.9	**IPLAN**
Premature			114	23.9	57		133	28.3	12,454	38.3	
Childhood Cancer	**AGE**	**99-01**									**IPLAN**
	0-4		0	*.*	0	*.*	0	*.*	69	2.6	
	5-14		1	*.*	0	*.*	1	*.*	124	2.3	

Death, Illness & Injury

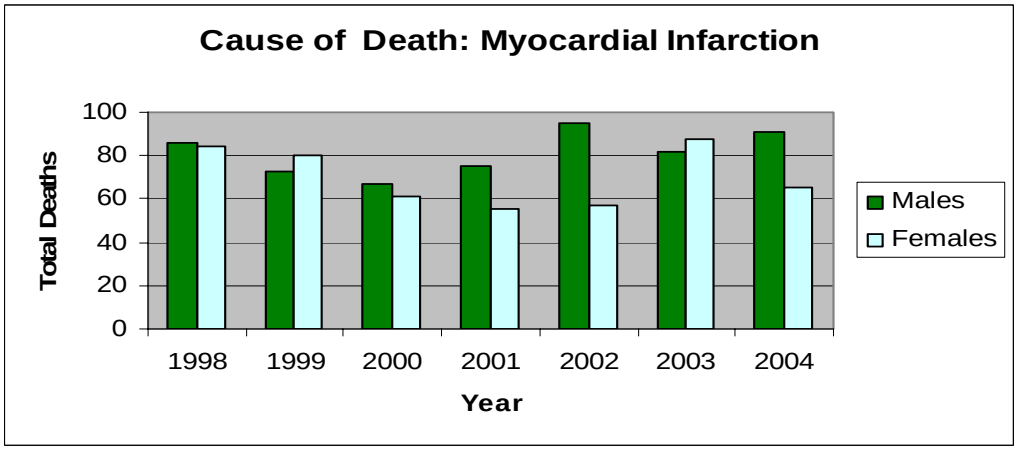
Birth and death trends for Champaign County have been consistent over the years. There are on average 3,000 births and 1,500 deaths in any given year. Of the total births, 99.7 percent are delivered at Carle Foundation Hospital and Provena Covenant Hospital. Less than ½ percent of mothers deliver at their own residences. An interesting fact is the number of back children born in the county. Approximately 28 percent of all Champaign County newborns are black. This is a much higher proportion than the percentage of backs in Champaign County which is close to 11 percent



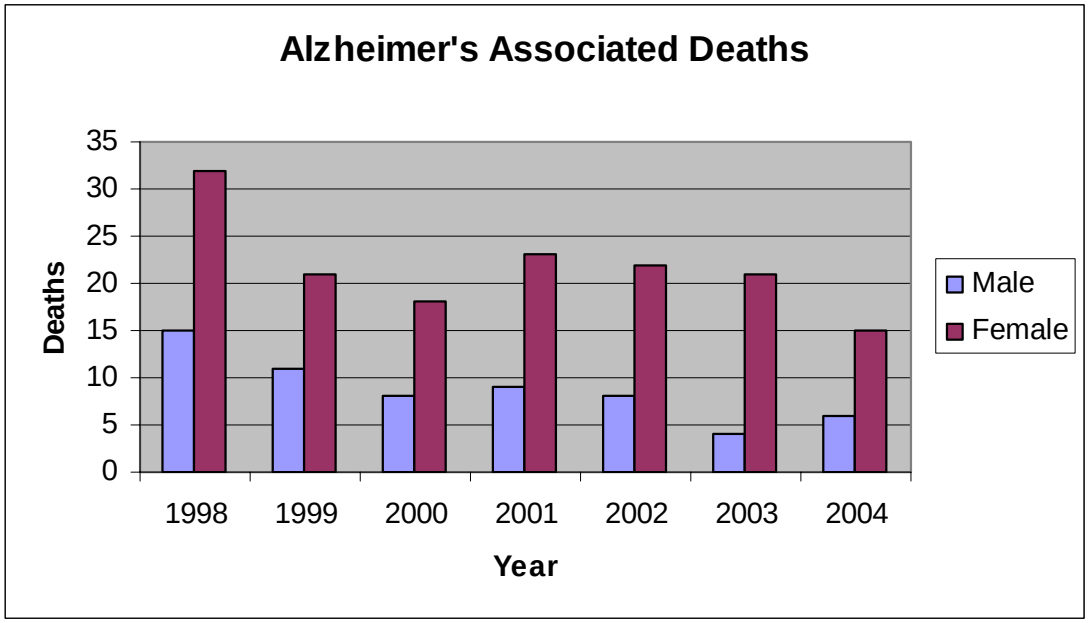
The top two leading cause of death for males and females are heart disease (including myocardial infarction, congestive heart failure and cardiopulmonary arrest) and cancer (of all types).



Myocardial Infarction is the leading cause of death in Champaign County. The distribution among males and females is very consistent. This is comparable to the state and national statistics.



Alzheimer's disease is among the leading causes of death in Champaign County. Females are twice as likely as males from this disease. This trend is consistent with state and national statistics. One of the most important reasons for this difference is the longer life expectancy for females. And since Alzheimer's disease has an increased in incidence proportional to the age, women who live longer are more at risk.

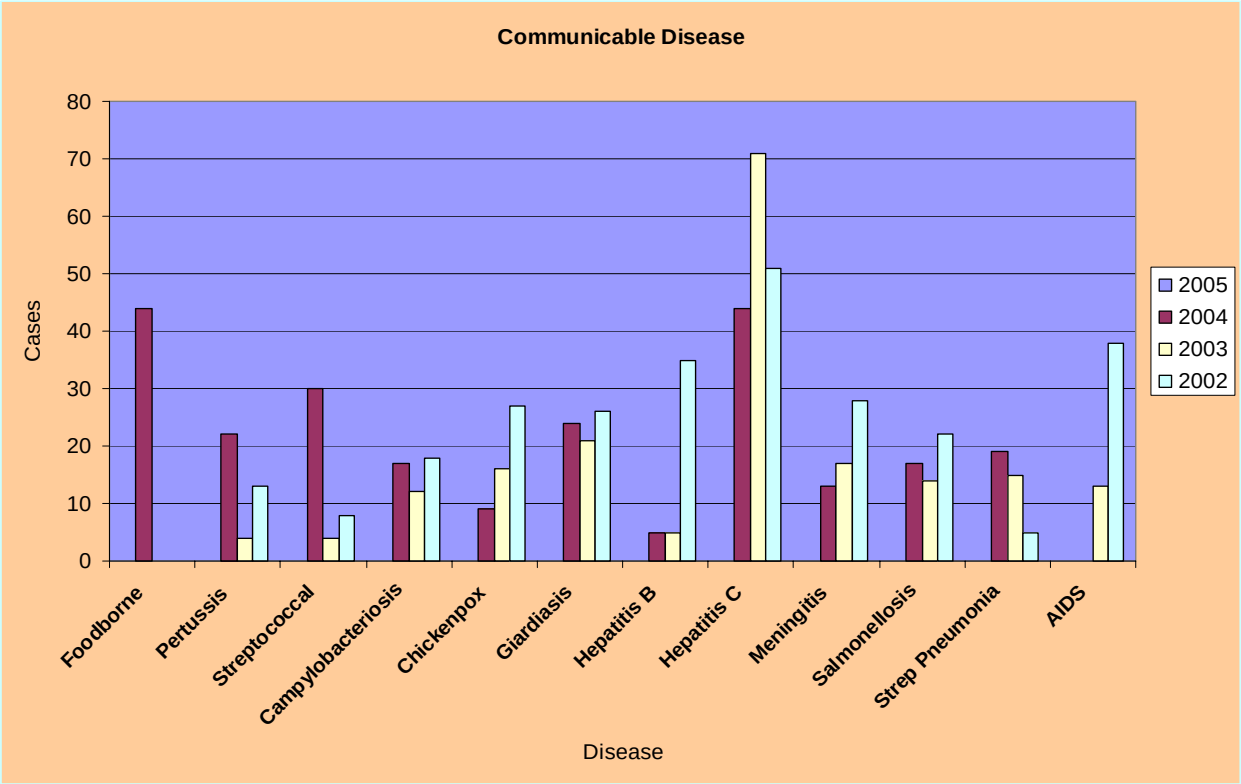


Communicable Diseases

A communicable / infectious disease is caused by microorganisms and spreads from one infected person or animal to another infected person or animal. The number of cases of communicable disease in Champaign County has seen some significant ups and downs. Vaccine preventable diseases have been on the decline and others such as sexually transmitted diseases and Pertussis (Whooping cough) have seen a significant rise.

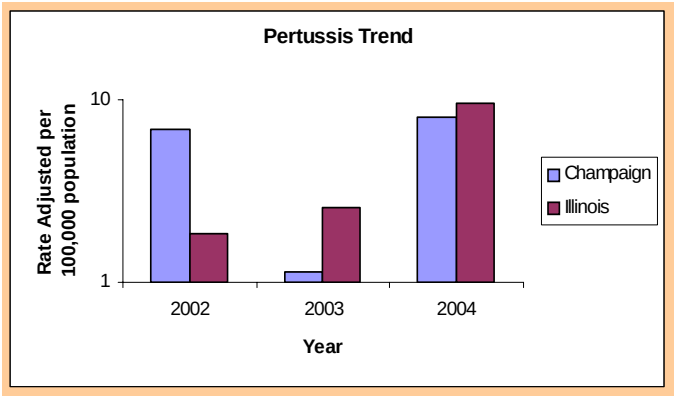
The downward trend in vaccine-preventable diseases may be the high proportion (nearly 90%) of Champaign county residents who receive the recommended

immunizations. This high vaccination rate also protects the remaining ten percent that are unvaccinated, as it reduces the incidence of communicable disease in the community.



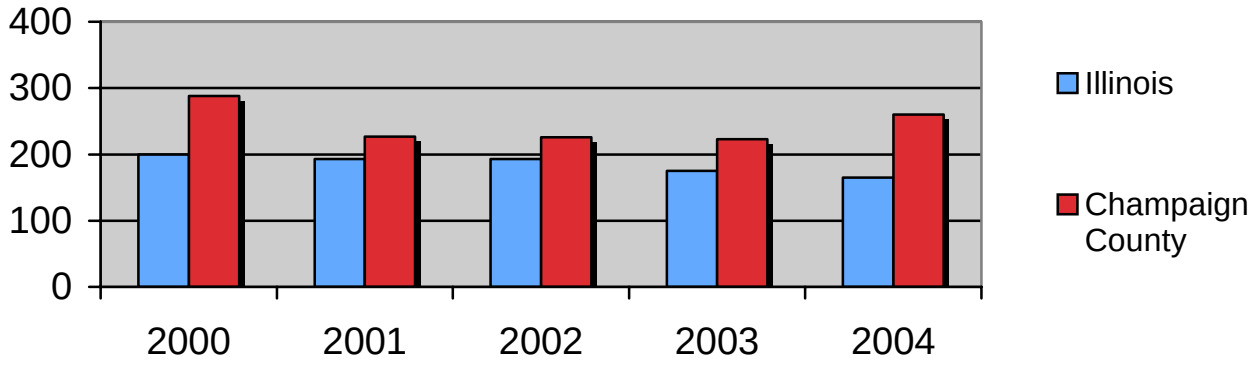
Another surprise is the number of cases of Pertussis (Whooping cough). Pertussis infections were at their lowest level from the mid 1980's until the early 1990's, when numbers started to rise not only in Champaign county but nationwide.

Although Pertussis is preventable, until recently there was no vaccination for those over ten years of age. Because immunity lasts only seven-to-ten years, there has been a significant rise in cases for adolescents and the elderly.

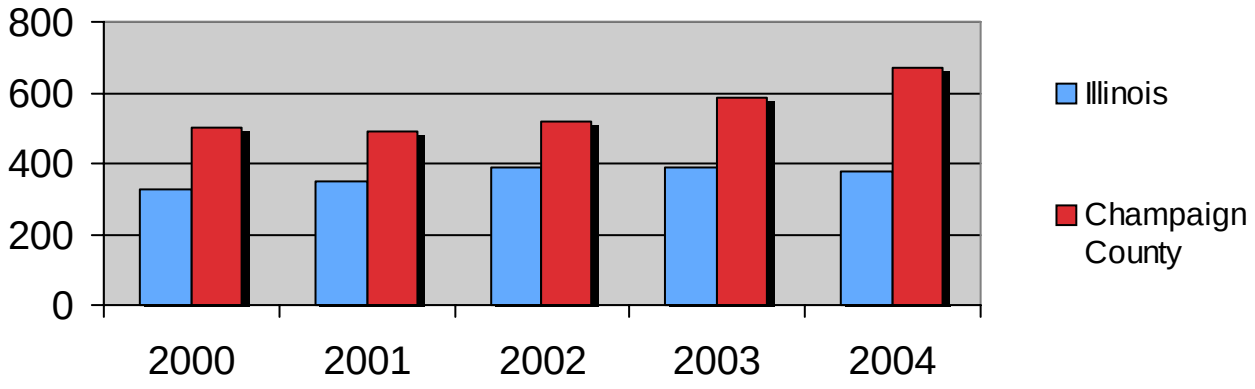


Sexually transmitted disease (STD) has been on the rise in the last decade. STDs like Chlamydia and Gonorrhea in Champaign County are significantly higher than state rates. A reason may be the high proportion of students in a small county. Also, better interventions and a more aggressive approach to detecting and treating cases have lead to increased case finding and reporting of these two common STDs.

Gonorrhea Rates, 2000-2004
per 100,000 population



Chlamydia Rates, 2000-2004
per 100,000 population



Chlamydia Rates Per 100,000 population	2000	2001	2002	2003	2004
Champaign County	501	488	520	588	669
Illinois	324	352	387	388	379
Gonorrhea Rates Per 100,000 population	**2000**	**2001**	**2002**	**2003**	**2004**
Champaign County	288	227	226	223	260
Illinois	200	193	193	175	165

Sentinel Events

Sentinel health events are those indicators that serve as a warning signal that the quality of care may need to be improved. They assume that unnecessary disease and disability and untimely death would have been prevented or better managed if the health care system had functioned satisfactorily. The occurrence of any of these diseases, disabilities and untimely deaths should indicate that something is wrong in the health care system and can be used to determine the level of health of the general population and the effects of economic, political and other environmental effects upon it (*Dever, G. E. Alan. (1984). Epidemiology in Health Services Management. Rockville, MD: Aspen Publication*

Sentinel Events: General

Condition YEAR: 1999-2001	Champaign Number	Illinois Number
Infants(0-1) Hospitalization for Dehydration	29	3,415
Children (1-17) Hospitalization for Rheumatic Fever	0	83
Children (1-14) Hospitalization for Asthma	187	21,984

Adults (>=18) Tuberculosis	28	2,660
Hosp. for Uncontrolled Hypertension	237	33,860

Source: IPLAN

Sentinel Events: Cancer (Note: Rates are per 100,000, age-adjusted to 2000 US standard.)

Cancer	Champaign Number	Champaign Rate	Illinois Number	Illinois Rate
In Situ				
Breast Cancer	107	**29.2**	8243	26.3
Black	8	*****	795	19.2
White	95	**29.1**	6,991	26.7
Late				
Cervical Cancer	12	*.*	1,432	4.5
Black	2	*.*	360	8.3
White	9	*.*	1,015	3.9

Source: IPLAN
(5-year average age-adjusted rate and 5-year number; If number < 15, no rates calculated.)
(In Situ breast cancer is cancer that has not spread to nearby tissues)

As it is seen that rate of in Situ Breast Cancer is greater in Champaign County than in the state of Illinois.

MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP)

PART 2: Assessment of Community Themes and Strengths

Purpose Statement

The Community Themes and Strengths assessment is a systematic approach to understanding issues of concern to the community, perceptions about quality of life and community assets. The assessment includes:

- Building a coalition of partners to design and conduct this assessment of a cross-section of the community.

- Use of telephone interviews, focus groups, individual discussions and surveys to gather information.
- Use of open-ended questions to raise issues of concern and to elicit thoughts and opinions.
- Holding meetings and discussions at accessible locations and times to facilitate broad participation.
- Ranking issues, potential solutions and assets in order of importance.
- Sustaining community involvement and empowerment throughout the MAPP process.

The Community Themes and Strengths assessment is a vital part of a community health improvement and planning process. Every participant is an integral part of the process. The information gathered through this process feeds into the other phases of the MAPP process to build stronger community collaboration in improving health.

The goal is to identify:

1) Which health issues are important to the community?
2) How is quality of life perceived in the community?
3) Which assets can be used to improve community health?

Approach

Most of the 10 members on the assessment team were community-based health providers, but the group also included elected officials, academicians and representatives of local non-profit organizations. Open ended, unstructured questions were used to gather information on community concerns, thoughts and suggestions.

Findings

What are the most important characteristics of a healthy community?

- Access to affordable health care
- Safe and affordable housing
- Employment leading to a living wage
- Safe and efficient transportation systems that serve all community members

What makes you most proud of your community?

- High level of civic involvement
- Progressive thinking
- Excellent educational resources
- Diversity
- Multiculturalism
- Varied employment opportunities
- Presence of more than a few Noble prize winners

Examples of people or groups working together to improve health and quality of life in our community.

- Habitat for Humanity
- Center for Women in Transition
- St Jude's Catholic Worker House
- Champaign County Christian Health Center
- HeRMES Student-run Free Medical Clinic
- Wellness on Wheels
- Urbana School-Based Health Center

What issues need to be addressed to improve health and quality of life?

- Access to affordable health care

- Quality of health care
- More diverse employment opportunities
- Improvements in quality of the public school system
- Diversity of educational opportunities

What obstacles hinder the community from improving health and quality of life?

- Poor quality of the public school system
- Inadequate relation of school system to community (Champaign Community School District 4)
- Apathy
- Lack of awareness of community members about school issues and needs
- Priorities elsewhere
- Lack of community interaction
- Lack of feeling of respect for one another
- Inaction

What actions, policy, or funding priorities would you support to build a healthier community?

- Community neighborhood services/ projects
- Integration of community leaders to make collaborative health care decisions
- Identifying and soliciting grants or gifts from donors
- Collaborations between big and small organizations to provide better services
- Improve communication
- Improve outreach

What projects would entice you to become involved in improving our community?

- Collaborative public education campaigns
- Better communication of local health needs

- Improved education of donors/funders

Recommendations

What works in the current public health system and what would you recommend to strengthen the system?

- Increase availability of affordable and accessible health care
- Broaden and enhance local employment opportunities;
- Build collaborative partnerships between providers to make informed improvements to the system;
- Work together to educate donors and philanthropists;
- Create collaborative public education campaigns;
- Set priorities based on need and work together to address regional or community issues;
- Improve communication between providers and to the public;
- Build trust, change attitudes between providers;
- Capitalize on the diversity, educational resources and progressive thinking of the community to build a healthy and safe Champaign County.

Telephone Survey

Purpose

The purpose of the telephone survey was to gather perceptions from a representative sample of the adult (18+) Champaign County population regarding the quality of life and the quality of health care in the local community.

A series of structured and open-ended questions sought comments on major quality-of-life issues as well as impressions of significant health problems and potentially risky behaviors. Respondents were asked to list:

- assets that help make Champaign County a healthy community; and
- perceived obstacles to improving overall health and quality of life in the county.

Methodology

The survey was conducted May 15-17, 2005. Initially a random sample was drawn from current telephone directories for Champaign County. The last digit of each listing was changed in a systematic way to insure the inclusion of all working telephone numbers, including unlisted numbers.

Because of the subject matter involved, it was decided that interviewers would ask for the "health care decision maker" at each household contacted. The health care decision maker was defined as "the person who makes most of the health care decisions or arrangements." Potential survey participants were told that the survey was being done "on behalf of the Champaign-Urbana Public Health District," that their answers would be "anonymous and confidential" and that they would help the District "better serve the residents of Champaign County."

Calls originated at the Research Survey Service telephone facility in Champaign. Standard procedure was for as many as four calls (an initial call and up to three call-backs) to be made, on different days and at different times, in efforts to reach as many of the originally selected sample as possible. Calling was done between 5:00 and 9:00 pm, except when the person contacted suggested a call-back be made at a different time in order to reach the health care decision maker.

Ten interviewers received detailed training on the questionnaire. On most occasions, two supervisors were on duty during the calling. Subsequent call-backs to respondents were used to verify that at least 10 percent of the assigned interviews were in fact conducted by each interviewer.

The target for this project was 200 interviews; in actuality, 207 were completed. That produced a maximum margin of sampling error of + or – 7 percentage points (at the 95% confidence level) for results based on the total sample.

Quota sampling was applied to insure that the completed sample matched the actual composition of the county population based on location. Of the completed interviews, 57 percent were with respondents in Champaign and Urbana, closely matching the 58 percent share of the county population represented by the twin cities in the 2000 census. No other quotas were used.

Results

The first section of the survey contained three open-ended questions. These sought participants' first responses regarding: 1) the overall quality of life in Champaign County; 2) health problems in the county; and 3) risky behaviors that might impact community health. On each question, respondents were asked to name the "three most important" issues or concerns.

Participants who said they didn't know or just couldn't think of anything were then read, for each question, a list of a dozen or more potential issues or problems, and asked to select the three they deemed most important. Responses from the unaided (open-ended) questions were then combined with those from these aided ones to give overall totals for the sample as a whole on each of the three major areas.

Quality of Life Issues in Champaign County

A total of 156 of the 207 participants, or just over 75 percent, were able to come up with responses on the first unaided question, which concerned the quality of life in Champaign County. This was the question:

"In your opinion, what things are most important for a strong community – things which most improve the quality of life [in Champaign county]. If you can, name three things that you think are most important to quality of life." (Question 1)

These survey participants produced a total of 403 responses – an average 2.6 responses per person. Each response was assigned to one of more than 30 comment categories.

Interviewers read 16 specific attributes to aid the 51 respondents who did not provide responses on the initial open-ended question. The participants in the aided question (Q. 2) chose a total of 149 responses, or an average of 2.9 per person.

A**ccess to health care** was deemed the most important quality of life issue in the total tabulation. More than half (58%) of respondents mentioned it, and the margin over **good schools**, the number two attribute (35%), is statistically significant.

The table shows the 11 attributes, which received mentions by at least ten respondents (5% of the sample). The attributes are shown in rank order, based on total mentions. Additional columns also show the number and percentage of responses to the separate unaided and aided questions.

While **access to health care** was the clear leader on the unaided question, and for the sample as a whole, it was ranked in a virtual tie with **good schools** and **low crime/safe neighborhoods** among those responding to the question in the aided format.

Most Important Quality of Life Issues

Demographics – There were few substantial differences across demographic sub-groups in the selection of items important to quality of life. Two related to respondents' ages. Sixty-three percent of those 35 and older mentioned "access to health care," compared to only 38 percent of participants under age 35. Another issue, "good jobs and a healthy economy" was noted three times as often by those under 50 (28%) as by older respondents (8%). Women (41%) were more likely than men (24%), and upper-income respondents (52%) were more likely than others (28%), to mention "good schools."

Health Problems in Champaign County

Response rates were somewhat lower here. Just over two-thirds (69%) of survey participants volunteered what they felt were major health problems in Champaign County, in response to the open-ended question (Q. 4). The 142 respondents noted a total 316 health issues. That's an average of 2.2 per person – short of the three requested and the 2.6 achieved in response to Q. 1 about "quality of life" issues. This was the question:

"…What are the three most important health problems in our community, referring to all of Champaign County?" (Q. 4)

The 65 participants who responded with "none" or said they "didn't know" were then read a list of 17 potential health problems, and asked to select three as "most important." These respondents averaged 2.7 per person, although six still answered "don't know."

Unlike in the previous section, no response dominated here. **Cancer** and **heart disease/stroke** were the top two issues identified in both the unaided and aided questions.

In responses to the unaided question, two health topics – affordable health care and available/affordable health insurance – finished among the top four issues. Neither

was included in the list of 17 potential health problems that were read to respondents in the aided question, and no one in that group volunteered them.

Risky Behaviors Affecting Community Health

Questions on this topic followed the same format as described above. First, all participants were asked:

"What are the three most important risky behaviors, those that have the greatest impact on overall community health?" (Q. 7)

The response rate on this question was slightly lower, with 68 percent naming at least one risky behavior. The average was 2.6 per person. It rose to 2.8 among the one-third of the group which was read a list of 12 potentially risky behaviors on the aided question (Q. 8) after failing to come up with any on the open-ended one.

Alcohol abuse (57%) and **drug abuse** (54%) were both mentioned by just over half of those surveyed and clearly topped the list of risky behaviors. Their margins over all other risky behaviors are statistically significant.

For the most part, answers from the two groups of respondents (on the unaided versus aided questions) were similar. Major differences occurred on the issue of **being overweight**, which was volunteered by only 2 percent on the unaided question, but ranked third with 11 percent among those given this issue as one of 12 potential risky behaviors in the aided version. **Careless/unsafe driving**, by contrast, was mentioned by 6 percent in the open-ended (unaided) question, but was not on the list used in the aided question.

Most Important Risky Behaviors

- Alcohol Abuse
- Drug Abuse

- Unsafe Sex
- Tobacco Use
- Obesity

Demographics – Gender differences were most notable here. Women (60%) were more likely than men (44%) to list "drug abuse." There was a similar pattern on mentions of "alcohol abuse" – women 61%, men 49% – although the difference was smaller. On the other hand, men more often mentioned "obesity, being overweight" (19%, to 9% for women) and "lack of exercise" (men 14%, women 2%). And 31 percent of Champaign-Urbana residents suggested smoking/tobacco use is a risky behavior, compared to 19 percent of participants from the rest of the county.

Perceptions of Community Health/Personal Health

The vast majority – 90 percent – of survey participants generally categorized themselves as "healthy." However, only two-thirds (66%) said the Champaign County community is healthy. These results came from two of questions asking respondents to rate community health and their own personal health on the same five-point scale. These were the questions:

> "How would you rate our community as a 'healthy community' – 'very healthy,' 'somewhat healthy,' 'neither unhealthy nor healthy,' 'somewhat unhealthy' or 'very unhealthy'? (Q. 10)
>
> "How would you rate your own personal health [on the same scale]?" (Q. 11)
>
> The following table summarizes the responses:

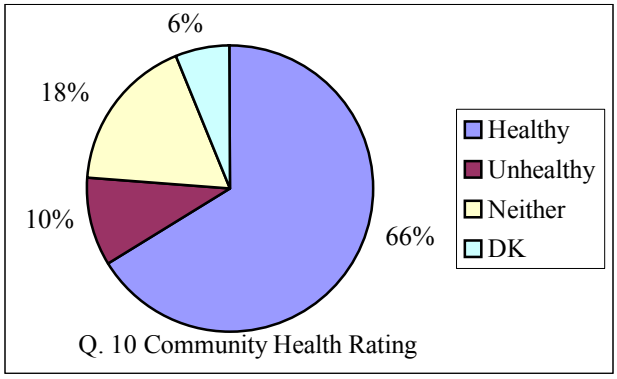
Perceptions of Community/Personal Health

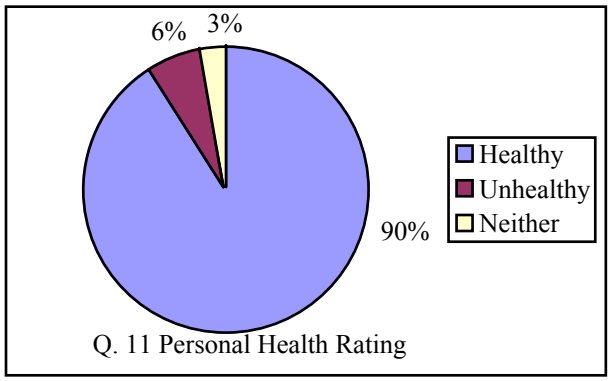
Scale	Community Health (Q. 10)	Personal Health (Q. 11)
Very healthy	11%	51%
Somewhat healthy	56	39
Neither unhealthy nor healthy	18	3
Somewhat unhealthy	8	5
Very unhealthy	2	1
Don't know	6	--

The difference remains when the five categories are collapsed to three by combining "very" and "somewhat healthy" to an overall "healthy" category, and doing the same on the "unhealthy" side:

Perceptions of Community/Personal Health

Scale	Community Health (Q. 10)	Personal Health (Q. 11)
Healthy ("very" or "somewhat")	66%	90%
Neither unhealthy nor healthy	18	3
Unhealthy ("very" or "somewhat")	10	6
Don't know	6	--





Demographics – Almost three-fourths (72%) of participants reporting no children in the household said they believed Champaign County was a "healthy" community, while just over half (53%) of those *with* children agreed. However, 90 percent of both groups said they considered themselves to be personally healthy.

What Keeps Our Community From Improving Health?

A lack of financial resources is the main thing that respondents believe keeps the Champaign County community from improving overall health.

This was one of a number of responses, which survey participants gave in answer to this open-ended question:

"In your opinion, what is keeping our community from doing what needs to be done to improve health and quality of life?" (Q. 12)

A total of 35 (17%) responded with "don't know" or "nothing" on this question. The remaining 172 participants came up with a total of 257 reasons, or just under 1.5 per person. Each response was coded and assigned to one of more than 30 categories.

As noted above, an overall **lack of money** received the most mentions, coming from just over one-fourth (26%) of respondents. And the difference between this category and all others is statistically significant. The following table includes the nine comment categories noted by at least 10 respondents (5%). These categories represent more than 60% of all comments received.

Demographics – Again, there were few substantial differences across the demographic sub-groups here. However, responses noting a "lack of money" increased with the age of the participant. Only 10 percent of those under 35 gave this response. The incidence rose to 27 percent among those 35-65, and was 37 percent in the 65+ group. And as might be expected, respondents who said they paid cash for their healthcare were more than three times as likely (14% vs. 4%) as those with some form of insurance to mention the "high cost of healthcare."

Assets That Make Champaign County a Healthier Community

Specific local institutions – including the **University of Illinois**, **Carle**, and the **Champaign-Urbana Public Health District** – were among those receiving the most mentions as community assets in response to this question:

"What assets does Champaign County have that make it a healthier community?" Again here, a small minority of respondents (16%) said they didn't know. The remaining 174 came up with a total of 320 assets, averaging 1.8 per participant. The comments were coded and assigned to one of more than 40 separate categories.

As noted in the next table, a category of comments praising local doctors, clinics and hospitals in general led the list. One-third (33%) of all participants offered such remarks. Next came comments highlighting local parks and recreation facilities, followed by specific mentions of the U. of I. (20%), Carle (9%) and the Public Health District (8%). (Provena was mentioned specifically by 4% and Christie Clinic by 2%, but these are not shown on the table because the they fell below the 5% cutoff).

The six categories receiving at least 10 mentions (5%) covered more than 60% of all remarks.

Community Assets	**#**	**%**
Positive comments re: local doctors, clinics, hospitals, etc	69	33%
Local parks, recreation, exercise facilities	44	21
The University of Illinois	41	20
Carle (clinic, hospital, foundation)	19	9
Public Health District	16	8
The local environment, air and water quality	16	8

Demographics – Responses mentioning "local parks, recreation, exercise facilities" decreased as respondent age increased. One-third (33%) of participants under 35 mentioned parks and recreation, compared to only 12% of those 65 and older. The "parks and recreation" category also got more mentions from respondents with children (31%) than from those with no children in the household (17%).

Mention of the "University of Illinois" was twice as frequent among those with education beyond a bachelor's degree (31%) as among those with a bachelor's or less (15%). And respondents with incomes of $75,000+ were almost twice as likely (32% vs. 17%) as those with lower incomes to specifically single out the U. of I. as a community asset.

Survey participants living outside the cities of Champaign and Urbana were three times as likely (22% vs. 6%) as those living in the twin-cities to mention Carle or Provena hospital by name.

Satisfaction with Community's Quality of Life, Healthcare System

Questions near the end of the survey sought to measure respondents' overall satisfaction with the Champaign County community's 1) quality of life and 2) health care system. Satisfaction was measured on a five-point scale: "very satisfied," "somewhat satisfied," "neither satisfied nor dissatisfied," "not very satisfied" and "not satisfied at all." These were the questions:

"Overall, how satisfied are you with the quality of life in our community, considering safety, well-being, participation in community life and associations?" (Q. 24)

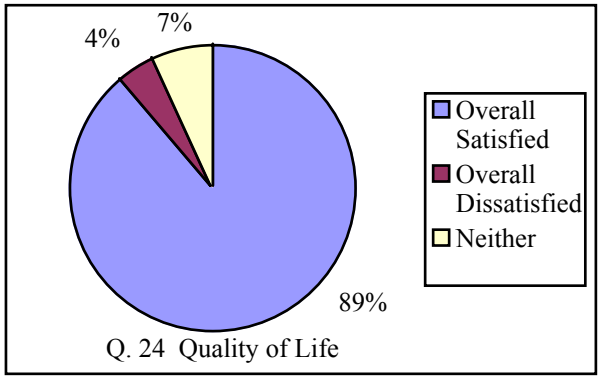
"How satisfied are you with the health care system in the community – access, cost, availability, quality, options or choice?" (Q. 25)

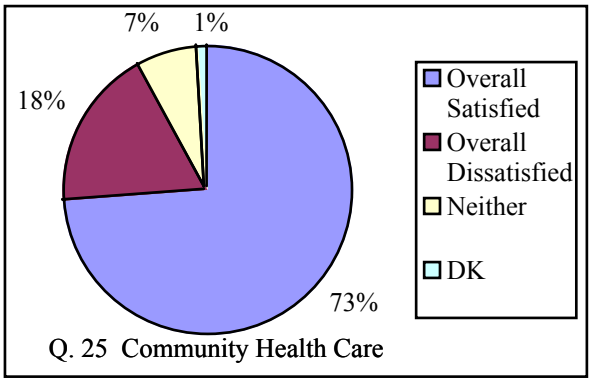
As the following table shows, survey participants indicated general satisfaction in both areas. However, when the five categories are collapsed to three, there is clearly more dissatisfaction overall with the health care system (18%) than with the quality of life (4%), and the difference is statistically significant. And when the 7 percent who are neither satisfied nor dissatisfied is added in, fully 25 percent indicated they are less than satisfied with the Champaign County health care system.

Overall Satisfaction with Champaign County Community's…

	Quality of Life (% of Sample)	Health Care System (% of Sample)
Very satisfied	38%	35%
Somewhat satisfied	51	38
Overall "satisfied"	89	73

Neither satisfied nor dissatisfied	7	7
Not very satisfied	3	13
Not satisfied at all	<1	5
Overall "dissatisfied"	4	18





Demographics – Some sub-groups were more likely than others to indicate satisfaction with the quality of life in Champaign County. These included the oldest respondents (65+ = 97%) more than the youngest (<35 = 83%); whites (91%) more than minorities (77%); households without children (92%) more than those with children (82%); and residents outside the twin-cities (93%) more than those living in Champaign-Urbana (86%).

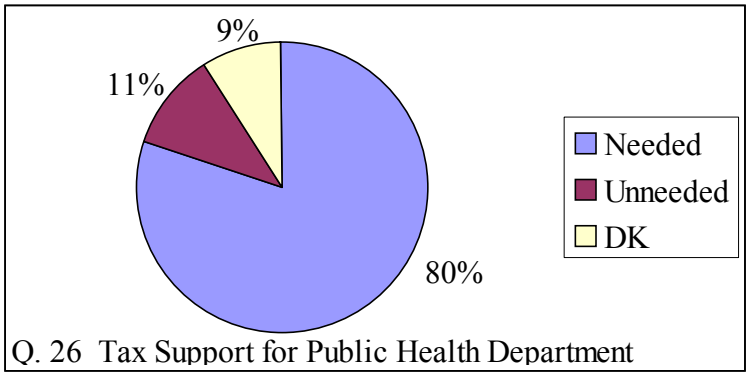
Regarding the county's healthcare system, whites (75%) were more likely to be satisfied than minorities (59%) and those with incomes above $30,000 (75%) were more satisfied than were households with incomes under $30,000 (65%).

Tax Support for Public Health Department

There was broad backing for a tax-supported public health department. The final question asked:

"Do you think that tax support for a public health department is a needed expense or an unneeded expense?" (Q. 26)

Fully four-out-of-five (80%) said tax support for a public health department is a "needed expense." Only 11 percent responded that it's an "unneeded expense," and 9% said they didn't know.



Q. 26 Tax Support for Public Health Department

Demographics – Support for a tax-supported public health department was greater among women (85%) than men (72%), among minorities (100%) more than whites (79%), and among households with incomes of $75,000+ (88%) more than those in the lowest income brackets (<$30,000 = 78%). Also, 85% of Champaign-Urbana residents said tax support for a public health department is a "needed expense;" the comparable figure among residents of the rest of the county was 75%.

Summary of the United Way Assessment Survey

Telephone survey: A total of 326 county residents, randomly selected, were interviewed during January 19-26, 2004. The interviews averaged 5 to 10 minutes and included more than 50 questions.

Focus group: Ten two-hour focus groups were conducted during February 2004. The subjects and participants centered on ten general issues identified by the group. A total of 105 experts in various subject areas participated in one or more groups, which varied in size from 5-17. They also completed as brief written questionnaire, which included 22 questions identical to those used in the telephone survey.

Personal interview: In-depth personal interviews, in person or by telephone, were completed from March 17 through April 19, 2004, with 35 Champaign County community leaders. The interviews ranged from 20-90 minutes and included the same 22 questions used in the focus group and phone survey questionnaire.

The ten pre-selected issue areas determined are as follows:

1) Basic needs- the ability to pay for food, clothing and other necessities
2) Housing and homelessness
3) Jobs and employment
4) Support for families. Such as childcare, youth activities and senior services
5) Education
6) Health care
7) Behavioral health care, including care for mental health, alcohol or substance abuse, or developmental disabilities
8) Family violence, abuse, or delinquency
9) Transportation
10) Ability to get help from social service agencies when needed.

Results:

All three groups – the general public (telephone survey), experts (focus groups) and community leaders (personal interviews) – were asked identical questions.

Education and Jobs/employment were the top concerns of all three groups averaged together. These were followed by health care issues, support for families and availability of basic needs, among the top five concerns across the group. On the scale of seriousness, health care ranked as the most important concern when averaged across the group's response. This was followed by delinquency prevention and behavioral health care issues.

Education

Nearly one-fifth (20%) of all respondents said poor education was the biggest problem facing Champaign County residents. Focus group participants blamed lack of funding as the major cause of concern. They also complained about policies and mandates imposed by federal and state government agencies without adequate support to implement them. The importance of early childhood education was also emphasized during several focus groups.

Educational Attainment in Champaign County

According to the 2004 Champaign County Statistical Abstract, Champaign County has a greater proportion of population enrolled in school — 42.3 percent as compared to the state of Illinois – 29 percent. A greater percentage of the county's population has had some secondary education than Illinois or the nation as a whole. 19.4 percent of Champaign County residents 25 years or older had some college beyond a bachelor's degree, versus 9.5 percent for the state and 8.9 percent for the nation. Thirty-eight percent of the residents had at least a bachelor's degree as compared to 26 percent for the state and 24.4 percent for the nation. Only 9 percent of county residents lacked a high school diploma, compared to 18.6 percent for Illinois and 19.6 percent for the U.S.

These comparisons suggest that, contrary to the community's perception, Champaign county fares significantly better than the average U.S. County in terms of educational attainment. This is a primary community asset.

Employment Opportunities

Employment opportunity was among the top ten issues raised by the general public. It was ranked as the second biggest problem or need. Participants complained about jobs that do not provide a living wage, health insurance or other family benefits. The participants described a need for better training and education for minorities and the poor.

Local Jobs Data

According to the 2004 Champaign County Statistical Abstract, Champaign County's average unemployment rate for 2003 was 3.3 percent – less than half the state rate (6.7%) and well below the national rate of six percent. Non-farm employment had a marginal positive growth of 0.2 percent from 2000 to 2003 as compared to a decline of 3.8 percent for the state.

However Champaign County's average manufacturing wage ($13.95 per hour in 2003) was 8.2 percent below the state average of $15.20 per hour. The 2001 Champaign County per capita personal income ($26,808) is 19 percent below the state's average of $32,990. The high university student population may contribute to the low local average. Lower rates of unemployment are very encouraging for the County.

Health Care

On average, health care ranked third among the ten pre-selected general issues. It ranked fourth among issues considered the biggest problems facing Champaign county residents. It was ranked the most serious local issue by all groups.

Declining financial support for health services by the government was noted as a cause of concern. Respondents noted that a reduction in Medicare and Medicaid reimbursement rates limited access of many patients to care. Rising costs of prescription drugs and malpractice insurance were common concerns of the focus group.

Recommendations included increasing funding for prevention activities and expansion of services by Frances Nelson Community Health Center or other facilities to meet the local need.

Local Healthcare Data

Ninety percent of the respondents in the general public had a regular doctor and 84 percent had a regular dentist. Forty-eight percent of the people were aware of some low cost health care services available in the County, including the Frances Nelson Community Health Center and the Champaign-Urbana Public Health District.

Support for Families

This category ranked fourth among the ten general issues. The three components of this category were child care, youth activities and senior services. Community leaders stressed the need for reaching children early so as to prepare them for school. Participants were also concerned about the growing number of youth gangs, the adverse effects they have on members and on the quality of life in areas of gang activity. The need to expand transportation services for senior citizens was mentioned in several focus groups. Inadequate Medicare reimbursement was mentioned in several discussions.

Local Family/Youth Data

In 2001, 9.3 percent of all births in Champaign County were to teenage mothers. Single mothers represented 31.7 percent of all births. A total of 511 child care facilities were available in 2003, including 92 Child Care Centers and 419 Child Care Providers.

Between 1996 and 2002, the average total crime rate index has reduced by 11.6 percent.

Between 1980 and 2000, the County's total population increased by 6.7 percent. During the same period, the percentage of seniors (65+) increased by 44.9 percent and those 85+ increased by 75 percent.

Basic Needs

Basic needs were ranked fifth on average by all three groups. Ten percent of participants picked this as the biggest problem facing county residents. The group suggested the need for more coordination and cooperation among governmental and private agencies to improve basic needs services.

Local Economic Data

Champaign County's cost of living index is below that national average. The per capita income in 1999 was 14.7 percent below the State of Illinois average. Median family income in 1999 was $52,591, which was also below the State average of $55,545.

Behavioral Healthcare and Housing/ Homelessness

These two categories tied in sixth place when averaged over the three groups of respondents. A shortage of psychiatrists, especially those dealing with problems of children, and a lack of funding were the most significant concerns of the focus group.

Seventy-one percent of those interviewed own their own homes while 28% rent and 1% live with their parents. Thirty percent of the respondents found affordable housing a serious problem. Thirty-seven percent cited financial concerns as potential barriers to purchasing a home. A majority (63%) were not aware of programs to help low income residents with home repairs.

Local Housing Data

In 2000, homeowners accounted for 65.3 percent of housing units in Champaign County, below the state (69.8%) and the national (68.8%) average. This could be due to the high population of university students, most of who rent rather than own. Housing is generally more affordable in the County than in much of the U.S.

Family Violence, Abuse and Delinquency

Participants ranked this category eighth on average. They felt very strongly that violence is an increasing problem in the county and the nation as a whole. Particular concern was expressed about hostility and violence among young people. Community leaders expressed general concern about problems facing families. Some of the suggestions were to get kids to school early to teach core values such as ethics. Participants also cited a need for more resources for law enforcement agencies to deal with problems that produce juvenile delinquency.

Local Violence, Abuse and Delinquency Data

From 1996 to 2002, the Total Crime Index in Champaign County declined by 36.8 percent compared to that of Illinois which dropped 22.6 percent. In 2002, the rates of violent crimes for the county were below the state's rate for murder and robbery, and above the state's average for criminal sexual assault and aggravated assault. Domestic crimes in Champaign County rose 13.9 percent from 1999 to 2002 and crimes against children were up by 35.2 percent.

Getting Help from Social Service Agencies and Transportation

These two categories were tied at ninth place among the ten general issues. "Not being able to get help;" "lack of awareness," "lack of money" and "lack of transportation" were cited as major reasons. Approximately one-in-six respondents' households had received help from an agency in the previous six months. About 89

percent were satisfied with the help they received. The concerns were that there were too many agencies working independently without cooperation and there should be better coordination of services. Lack of funding was also a concern. As far as transportation, problems related to transportation for seniors and for the disabled.

Local Transportation and Social Service Data

Over fourteen percent (14.2%) of workers commuted to Champaign County from outside and only 5.4 percent commuted outside for work in 2004. Nearly fourteen percent (13.7%) car-pooled to work compared to 12.9% for Illinois. Ridership of Champaign Urbana Mass Transit District increased by 66.7 percent from 1990 but declined 10.1 percent between 2001 and 2004.

Review of Telephone Survey Data

MAPP participants reviewed the methodology and the findings of the survey and offered the following comments:

* The demographics of the survey do not match the demographics of the community. The white population of the county is about 78%, whereas the survey included 87% whites.

* There is confusion over the idea of "access to health care." What does this mean? This phrase could have different meanings for different people.

* An assessment should include input from low-income and Medicaid eligible participants. Other concerns, such as food, shelter, heat, etc., may be more prevalent among these community members.

* Need to differentiate the term "issues" from "problems" or "things that are important." "Desires" are not the same as "issues."

*Perceptions of community and personal health are very interesting. It would be interesting to look at the demographics of the respondents. How is it that 90 percent of the respondents believe they are healthy? Are people honest with themselves about their own health?

* While some people believe money is the problem, there are ample resources available to meet the local challenges. It's more a matter of will to address the problems. There is a lack of public awareness of the value of public health.

*** Need to educate policy makers and others about public health issues.**

MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP)

PART 3: Public Health System Assessment

Local Public Health System Assessment (LPHSA)

Ten Essential Services of Public Health

1. Monitor Health Status
2. Diagnose and investigate health problems
3. Inform, educate, and empower people
4. Mobilize Community Partnerships
5. Develop policies & plans to support health
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed health services
8. Assure a competent workforce
9. Evaluate health services
10. Research health problems

A. Purpose

The purpose of the system assessment was to:

1. Identify how organizations, agencies, and institutions contribute to the delivery of public health services in Champaign County.

2. Understand the existing infrastructure of organizations, agencies and institutions.
3. Identify potential gaps, barriers, or challenges to delivering public health services in Champaign County.

B. Approach

Champaign-Urbana Public Health District (CUPHD) convened a committee from the community to assess the local public health system. Representatives from the following agencies were invited to participate: Pro Ambulance, Greater Community AIDS Project, Christie Clinic, American Heart Association, CUPHD's Division of Infectious Disease Prevention and Management, CUPHD's Division of Family Health, Planned Parenthood, Champaign County Board of Health, CUPHD's Board, Cunningham Township Supervisor's Office, Head Start, Champaign County Mental Health Board, Community Services Center of Northern Champaign County, Mahomet Schools, A Woman's Place (domestic violence shelter and programming), Champaign County Christian Health Center (free medical care), American Lung Association, Frances Nelson Community Health Center (Federally-qualified health center), Health Alliance (HMO), The Urban League and two physicians in private practice. Representation varied throughout the process. The only consistent input was from CUPHD, Frances Nelson Health Center, Cunningham Township Supervisor's Office, Champaign County Mental Health Board, Champaign County Board of Health, and Champaign-Urbana Public Health District's Board.

Committee members met for two hours, once a month, for five months (total of 10 hours). Staff from Champaign-Urbana Public Health District facilitated the meetings. The first meeting of the LPHSA oriented participants to the process and described the

ten essential public health services. The rest of the meetings were used to discuss and complete the performance measurement instrument.

The following is an analysis of the performance scores by essential public health service and indicators.

C. Contributions and Challenges to the Ten Essential Public Health Services in Champaign County

Essential Public Health Service 1: Monitor Health Status to identify community health problems

The average score for the population based community health profile was 62.23 out of 100. It was recognized that Champaign-Urbana Public Health District regularly keeps health-related statistics, and CUPHD and Champaign County Mental Health Board do periodic community assessments related to their programming. While that data is available to their individual agencies, the data has not been widely available to the community.

Committee members felt that the local public health system was best at accessing community demographic (age, race, ethnicity) and socioeconomic characteristics (income, education, and employment), health resource availability (access, utilization, cost, quality of health care and prevention resources), maternal and child health data (birth data and outcomes, infant and child mortality, utilization of care) death, illness and injury data, and communicable disease (diseases passed primarily through person-to-person contact) data.

What appears to be lacking is the availability of data on sentinel events (unnecessary disease, disability, or untimely death that was avoidable) from the local primary care agencies such as Frances Nelson Health Center, Carle Clinic, Christie

Clinic, Carle Foundation Hospital, and Provena Hospital. Access to social and mental health data was also reported as lacking.

An overall collection, analysis, and reporting mechanism for community-wide data such as quality of life data (determinants of overall satisfaction with neighborhoods and the community) and health assessment data seemed to be what participants felt was most lacking.

CUPHD plans to make strides in alleviating this concern. Data collected and analyzed, starting with this report, will be made available as a searchable and printable document on the CUPHD website. The existence of the document with key findings will be distributed widely to the local health system partners. Every effort will be made to systematically gather supplementary data to better inform members of the local health system.

Access to and utilization of current technology such as state-of-the-art databases, geo-coded health data (addresses matched and assigned to a corresponding latitude and longitude), and the availability of the Community Health Profile in an electronic version were all areas of concern.

The committee was more confident that geographic information systems (GIS) and computer-generated graphics to identify trends and compare data will be widely used in the future. CUPHD purchased a GIS system in 2005. While its use has been limited to date, there are plans to make the data and computer-generated graphics available on the CUPHD website as early as mid-2006. The committee also felt that the local public health system does a good job maintaining and/or contributing to population health registries

(Information system maintains current, unduplicated counts of individual health-related events for a defined population). This is done where it is mandated. There has been no effort to create other local health registries.

Essential Public Health Service 2: Diagnose and Investigate Health Problems

The committee assessed that the local public health system does a good job diagnosing and investigating health problems (Average score of 83.4 out of 100). Specifically it was noted that the LPH does a good job submitting timely reportable disease information, using information technology (IT) for surveillance, and having a procedure in place to alert communities about health threats and disease outbreaks. CUPHD has access to a Masters level epidemiologist to interpret and report data.

The committee did indicate that there is room for improvements in monitoring changes in occurrence of health problems and health hazards (problems associated with exposure to air pollution, nuclear radiation, lead, and other toxicants, as well as hazards resulting from natural and technological disasters). In order for this to be monitored more effectively it would require additional cooperation and collaboration between CUPHD, the Environmental Protection Agency, and local health care providers and emergency rooms.

Emergency planning and preparedness, while better than in previous years, can still use improvement. The LPH does have a plan that was revised recently. It also has practiced the plan through a series of "mock events" during the past year. This additional preparation was facilitated through an influx of money and mandates related to bioterrorism. The committee felt that there has not been enough effort put into identifying public health disasters and emergencies and having an emergency preparedness and response plan.

The committee had much confidence that the local public health system has adequate laboratory support for investigation of health threats (100 out of 100). This is most likely due to CUPHD's access to the Illinois Department of Public Health laboratories and the fact that all laboratories are highly regulated. The Centers for Medicare & Medicaid Services (CMS) regulates all laboratory testing (except research) performed on humans in the U.S. through the Clinical Laboratory Improvement Amendments (CLIA). The committee felt that the local public health system had access to laboratory support, access to laboratories capable of meeting routine diagnostic and surveillance needs, documentation that laboratories are licensed and/or credentialed, and current guidelines or protocols for handling laboratory samples.

Essential Public Health Service 3: Inform, Educate, and Empower People

The committee had a high degree of confidence in the ability of the LPHS to provide health education (100 out of 100) and health promotion activities (94.69 out of 100). Health education includes providing information on community health to public and policy leaders, using the media to communicate health information, sponsoring health education programs, and assessing the public health education activities that were provided. Health promotion activities include any combination of education and organizational, economic, and environmental supports aimed at the stimulation of healthy behavior in individuals, groups, or communities. The LPHS collaborates within networks to develop, implement, and assess health promotion activities. Examples include the HIV Prevention-Care Alliance (to enhance HIV prevention and services), IL Health Cares Coalition (to prevent domestic violence); Local Area Network for Mental Health Services, Human Services Council, and Emergency Services and Disaster Agency.

Essential Public Health Service 4: Mobilize Community Partnerships

While the committee acknowledged that many community partnerships exists there was an obvious concern that there is no attempt made to assess the effectiveness of or improve existing community partnerships. There is room for improvement in areas of identifying key constituents, encouraging them to improve community health, creating a directory of organizations that comprise the LPHS, and using communications to strengthen linkages.

While the committee indicated that CUPHD should take a lead in the above-mentioned activities, lack of funding was mentioned as a barrier to CUPHD's expanded role. It was acknowledged that most of the strong community partnerships are related to either mandate or funding streams (such as grants). Often when the funding ends, so too does the partnership. Including constituents often includes costs for such things as childcare, transportation, food, and often stipends.

Essential Public Health Service 5: Develop Policies and Plans

The LPHS has a presence at the local government level. The committee reported that CUPHD is highly involved locally and works closely with the Illinois Department of Public Health. While CUPHD conducts its requisite assignments for the Illinois Project for Local Assessment of Needs (IPLAN), it does not have a good record of getting enough participation from the myriad stakeholders in the implementation of the community plan. There are several barriers that prevent this: lack of funding, time constraints, and no requirement or incentives for other agencies or organizations to participate in the process. Many of the stakeholders have their own assessments to conduct related to grants or mandates.

There is also no incentive to get stakeholders other than CUPHD to contribute to the development of public health policies, review the policies at least every two years,

and advocate for the development of prevention and protection policies. While there is some collaboration on specific polices, such as the "Smoke-free Restaurant" initiative, it is neither systematic nor necessarily tied to data. It is usually tied to a grant requirement or community initiative.

The same can be said for tasks related to strategic planning and alignment (a continuous process of determining the mission, goals, resources, and objectives of individual entities in the LPHS and aligning them with the community health improvement process and resulting action plan). This was an area where the committee agreed that more effort is needed. CUPHD has difficulty getting other organizations involved in a strategic planning process. This is likely true because most of the other entities involved in the LPHS, such as hospitals, clinics, mental health, community-based organizations, social service agencies, and others, must do their own strategic plans related to their services.

Many of the stakeholders in the LPHS do not view themselves as such. While CUPHD may view them as essential components, they may see the issue as one of "Public Health" and not the larger system. The process of strategic planning and systematic review and revision of the strategic plans, while crucial, takes a great deal of time. Often this is time away from providing actual services, or from each organization working on their own strategic plan. This makes it difficult for CUPHD to get participation from all of the community stakeholders in the LPHS.

Essential Public Health Service 6: Enforce Laws and Regulations

The local public health system does a good job of reviewing and evaluating laws, regulations, and ordinances. It does a poor job of identifying issues not already addressed by laws. All community stakeholders have access to laws, regulations, and ordinances

affecting public health issues. The internet provides access to such materials at all levels—national, state, and local.

Additionally stakeholders within the LPHS are required to keep current on regulations that may impact their programs or services. Participation in advocacy groups and professional organizations related to particular service areas will keep the stakeholders current by providing information updates, often in the form of newsletters, faxes, e-mails, or listserv. Such agencies as the Illinois Public Health Association, National Association of City and County Health Officials, National Association of Social Workers, American & IL Medical Associations, and American Nurses Association keep members updated on a wide variety of laws and regulations affecting the professions and venues (such as public health departments or hospitals). Issue-specific organizations such as AIDS Foundation of Chicago, IL Maternal and Child Health Coalition, IL Diabetes Association, and the IL Cancer Society can provide in-depth analysis of new and potential laws, opportunities for providing input, and advocacy.

Essential Public Health Service 7: Link People to Needed Personal Health Services

The committee reported that the LPHS does a respectable job of identifying populations who encounter barriers to accessing services, defining personal health needs for the County, and identifying personal health services (individual prevention, individual health promotion, primary care, specialty care, hospital care, emergency care, and rehabilitative care). The individual members of the LPHS also do a good job providing outreach and linkage to their services, and coordinating delivery of personal health services. Where the system breaks down is in assessing the extent that personal health services are being provided to the entire community. While each individual organization collects its own data, the data is not accessible to other members of the LPHS.

There is less confidence that the LPHS is assuring the provision of needed personal health services and providing initiatives to enroll eligible beneficiaries in state Medicaid or medical assistance programs. It is very difficult to get a good view of the "big picture" of how clients are working with and through the various members of the LPHS. Without a mechanism for consistent communication and regular data sharing among the members of the LPHS, it will be difficult to get an idea of the needs of the community and how best to address them.

Essential Public Health Service 8: Assure a Competent Workforce

Of all of the measures of the LPHS, "workforce assessment" received the lowest scores by the committee. Workforce assessment refers to the process of determining the personnel, training, skills, and competencies needed to achieve community-wide public and personal health goals. There was little confidence that any systematic workforce assessment has been completed during the past three years (2003-2005). Due to a lack of assessment no gaps within the public and personal workforce have been identified and disseminated.

The committee did have the confidence in the "public health workforce standards". There was a high level of belief that the public health workforce was aware of and in compliance with guidelines and/or licensure/certification requirements for personnel. There was also a high degree of certainty that the organizations developed written job standards and position descriptions, and conducted performance evaluations.

There was room for improvement in the areas of continuing education, training and mentoring of the LPHS workforce. While the committee believed that the LPHS did a good job identifying education and training needs, and interacting with the faculty and staff from academic and research institutions, there was much less confidence that

CUPHD provided opportunities or incentives to develop core public health competencies and participate in educational and training experiences. The lack of opportunities and incentives is likely due to time constraints and lack of funding for such activities.

During the past few years, most of the funding and opportunities for training has been part of the bioterrorism preparedness. Additional training emphasis is usually program-driven and limited to the staff working directly in the program area (STDs, maternal and child health, communicable disease, environmental health, etc.) There is very little emphasis in training staff on the ten essential service of public health.

Public health leadership development is an area that the committee felt could use some improvement as well. While there was acknowledgement that the Mid-America Public Health Leadership Institute (MARPHLI) does provide opportunities to develop leadership skills in members of the LPHS, there was also recognition that there need to be more opportunities to promote collaborative leadership and develop community leadership through mentoring.

Essential Public Health Service 9: Evaluate Effectiveness, Accessibility, and Quality

The committee reported that CUPHD and some of the individual members of the LPHS did evaluation of population-based health services (promote health; prevent disease, injury, disability and premature death as well as exposure to environmental hazards). This evaluation is used to identify gaps in services, access community satisfaction with population-based health services, and develop strategic and operational plans.

There was slightly less certainty that personal health services (services delivered to individuals through primary care, hospital care, emergency care, and rehabilitative care) were evaluated against established criteria, that information technology was used to

assure the quality of these services, and that the evaluation was used in strategic and operational plans. A low score indicated that the committee believed that LPHS members who provided personal care services did not assess client satisfaction with their services.

The committee reported that CUPHD did an excellent job of identifying community organizations or entities that contribute to the delivery of the LPHS, and that they did update their evaluation every three years, as required. The problem that was identified involved on-going linkages and relationships among the identified organizations of the LPHS and in utilizing the results from the evaluation process to guide community health improvements.

In past years, IPLAN needs assessments conducted by CUPHD were rarely utilized by any of the LPHS. The needs assessment was conducted, the report was written, and the results sat on a shelf. The information was not shared within CUPHD, let alone with other members of the LPHS. The IPLAN became an exercise in futility.

It is the intent of the 2005 IPLAN committee that the document created by this process will be a widely distributed, searchable, and useable document. The needs assessment process and the results will be used to guide CUPHD's strategic planning and operational efforts. It is apparent that CUPHD must take the lead on convening and facilitating the local public health system if it is to work together collaboratively in the future.

Essential Public Health Service 10: Research for New Insights and Innovative Solutions

Members of the LPHS typically do not have much encouragement to develop new solutions to community health problems. Often clinics are so busy, problems so

immediate, and staff too overwhelmed to focus on much but the problem at hand. Innovation comes from the ability to step back and look at a situation from several perspectives. It requires the ability to attend meetings and conferences and network with colleagues from many disciplines. This takes time and resources. Both are often in short supply in the LPHS, especially for the public entities who often are working on deficit budgets.

The members of the LPHS all have strong relationships with institutions of higher learning. This is made easier by the close proximity of the University of Illinois, McKinley Health Center, Parkland College, and the VA Medical Center. There is an understanding that the LPHS is available to provide interesting opportunities for research, practicum, field placements, and clinical rotations for students. This relationship is often one-sided. What's lacking is members of the LPHS identifying research needs within their settings and approaching the researchers for assistance. The resources are certainly available in Champaign County. It is up to LPHS members to make use of them.

There are many more barriers placed upon the LPHS members by the colleges and universities than the other way around. An example: The University of Illinois will not allow members of the LPHS to utilize their Institutional Review Boards to get feedback for proposed research activities unless they are affiliated with a University faculty member. Faculty members often do not want to get involved in a research project without funding. Much of the practical and applied research that members of the LPHS need to do is not funded.

One possible solution to this dilemma may be to have written agreements with the colleges and Universities who send students to gain experience in the organizations that make up the LPHS. In order to receive this benefit, the University would have to provide

access to some of its resources like the Institutional Review Board or researchers who would provide technical assistance on developing or implementing simple research within the LPHS.

Another problem with research and evaluation conducted by the Universities within the LPHS is that the results are often not communicated back to the members. This problem too could be alleviated with written agreements with potential researchers that their results or findings must be communicated back to the members of the LPHS either in a written report or through a presentation.

MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP)

PART 4: Forces of Change Assessment

Purpose Statement

This assessment is meant to identify local trends that affect community health or the local public health system. It also examines the threats or opportunities generated by these trends.

Approach

Members of the three assessment teams were given worksheets on which they listed forces and trends in public health and then for each of these, any related threats posed or opportunities created. More than 35 forces and trends were identified. These were consolidated onto a single worksheet and categorized into common groups.

Findings

Six categories of forces and trends that currently impact or could potentially impact Champaign County were identified. They are:

- An aging population
- Shifting funding streams and focus
- Changing demographics
- Disparities in health status
- Lack of collaborative body for public health planning
- Changing governmental policies

An Aging Population

With the aging of the baby boomers and longer life expectancies, an aging population is a major trend that will have important implications for long range planning.

The elderly population has special housing, recreation, health care, social service and transportation needs. 9.7% of the population in Champaign County is over 65 years of age. While overall population in the county increased only 3.8 percent from 1990 to 2000, the population of those 65 and over rose 15.5 percent in that same time period.

Chronic medical conditions account for the majority of health-related costs. Increasing numbers of older adults mean increasing numbers of people who are at greatest risk for chronic conditions. The increased need for health services may overburden already strained health care resources.

In general, most medical care delivery systems focus on acute case management and are not well organized to treat chronic diseases characteristic of the aging population. There is a shortage of home-based and community-based services, a fact that forces many elderly to enter nursing homes or hospitals before they otherwise would.

Although the number of elderly is increasing rapidly, resources to meet the needs have not kept up with the demand. More collaborative efforts need to be in place and more resources need to be devoted to this issue.

Threats

- The elderly have special needs; current strategies may be ineffective
- Increasing numbers of people with chronic medical conditions add to the existing burden on health and social services
- Some older adults are moving to other states with better services

Opportunities

- Developing strategies to meet the needs of the elderly can benefit other neglected segments of the population
- The elderly may themselves offer special insight into health problems that affect them and others with chronic conditions or special needs
- Seniors are often more politically active and so can become a strong voice for reform
- Community collaborations can help educate and empower the elderly
- Advocacy for this section of the population can improve overall health services

Shifting Funding Streams and Focus

Funding for public health services has remained relatively flat over the past decade. Increasing costs have forced providers to cut or scale back some services.

Along with the relative inadequacy in funding, we have also seen disproportionate allocation of public health funds relative to specific public health needs. After the September 11, 2001 terrorist attacks, a lot of funding was directed to emergency management, with reduced funding for other needs.

Many public health services are funded via grants that are targeted to specific programs. These narrow funding streams do not permit comprehensive and holistic approaches to public health delivery, and instead force the delivery of independently

focused programs that are not integrated with one another. This approach also discourages true partnerships and collaboration among providers and stakeholders by causing unhealthy competition for limited funds and delivery of services. Limited resources have also hindered community-driven priorities.

"An ounce of prevention is worth a pound of cure." This age-old proverb has lost its power in an era dominated by spending to manage or cure diseases that might have been prevented. Those providing treatment services are concerned that in the search for additional prevention dollars the system might draw from the existing pool of treatment resources, which could be a major setback to their effort.

Bioterrorism Funding and Pandemic Influenza Preparedness Funding: These funds represent significant potential resources for public health. A lot of these funds have been utilized to strengthen the existing infrastructure and focus on prevention rather than treatment. Although, these funds have many strings attached, the money has added to the spending power for some providers in conducting strategic planning and forming collaborative partnerships for better community interventions.

Threats

- Less funds for Public Health activities and programs
- Dependence on unstable funding stream can undermine health care agencies.
- Bioterrorism emphasis may take away from other vital health issues. When bioterrorism funds are reduced it also undermines stability.

Opportunities

- Public health can become an innovative, cost effective provider
- New funds can allow investment in much-needed infrastructure and staff

- Enhanced cooperation between providers/responders creates opportunities for better streamlining of services.
- Opportunity to incorporate a multidisciplinary model of health
- Potential for new partnerships

Changing Demographics

One of the many uncertainties facing health care planners these days is the impact of rapidly changing demographics. Aging baby boomers, migration in and out of the county and ethnic and racial changes directly and indirectly affect all aspects of health delivery. Health care strategic planners must take into account the changing demographics in their community.

Health care professionals will need new talents and skills to meet the needs of an increasingly diverse community. They must have sophisticated interpersonal and management skills, the capacity to apply principles of disease prevention and behavioral change appropriate for specific populations, and they must be willing and able to negotiate and communicate with a wide range of constituents and their family members.

The other significant demographic change is increased longevity, which is to a considerable degree a consequence of advances in medical science, technology and health care delivery (as well as the aging of the baby boomer generation). Currently about 15 percent of Champaign County residents are over 65 and this is expected to rise in coming years. As a result there will be more patients with chronic conditions.

Changes needed include:

- Improved mechanisms for ongoing communication and coordination of services across providers and settings, and

- Education programs and communication mechanisms directed at patients, their families and other informal caregivers

Threats

- Non-targeted services and untested interventions
- Arrival of new immigrants with low literacy and low income can overburden the local health care system

Opportunities

- New opportunities to partner with community based organizations
- Opportunities for staff growth and diversity
- Introduction of new energy and resources into the community planning process
- Flexibility in service provision can help reach those most in need

Disparities in Health Status

"Healthy People 2010 is designed to achieve two overarching goals: Increase quality and years of healthy life and to Eliminate health disparities. Health disparities include differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation."

As demonstrated in the Health Status section of this plan, Champaign experiences significant racial, ethnic, gender and socioeconomic disparities in health status. African Americans have the highest infant mortality rates of all races and are disproportionately affected by child poverty. Women are more likely than men to be diagnosed with asthma, and homelessness among women and children is increasing at an alarming rate. Communities with low income, higher unemployment and lower levels of educational attainment tend to have the poorest status on every health indicator.

Eliminating health disparities will require greater knowledge of the determinants of disease, causes of health disparities and effective interventions for prevention and

treatment. It will also require improving access to the benefits of society, including quality preventive and treatment services, as well as innovative ways of working in partnership with community health care providers and caretakers.

The demographic changes that are anticipated over the next decade increase the importance of addressing disparities in health status. The proportion of residents who currently experience poorer health status is expected to increase, so the future health of the community as a whole will be greatly influenced by our success in improving the health of those most in need. A specific focus on disparities in health status is particularly important as major changes unfold in the way in which health care is delivered and financed.

Threats

- Perception that Public Health is ineffective at meeting the need
- Increasing disparities in access threaten the availability of health care to all
- Unaffordable and unavailable health care affects overall community health

Opportunities

- Those working to address the disparities may discover new means of providing care
- The health care "crisis" may motivate community leaders to find innovative ways to expand primary health care access
- Opportunity to expand outreach and form new partnerships to meet the need

Lack of Collaborative Body for Public Health

Many public health agencies, practitioners and organizations have promoted collaborative partnerships to increase community health. Collaborations have generally been recognized as beneficial in public health. For many public health officials,

responding to the rising threat of Bioterrorism and recent attacks has necessitated a steep learning curve. The lack of effective collaboration between groups has left the community ill prepared for emergent health care issues. The arrival of Hurricane Katrina evacuees in Champaign County showed both the strengths and weaknesses of the community's ability to respond. Thanks to the brave efforts of some organizations working as a team, most of the evacuees received the health and social services they needed.

This experience and others have shown that the delivery of health care is a complex and difficult task that must be improved so that it works not only for disaster victims but also for community residents who are sometimes left without services in spite of the abundance of available resources. A strong, dynamic partnership that brings residents, community groups, and health providers together to improve community health is urgently needed.

Threats

- Emergent healthcare issues can result in an uncoordinated, inefficient response
- Planning and preparedness are undermined by lack of cooperation
- Community educational opportunities are sometimes missed because providers have poor access to information about local health trends

Opportunities

- Cooperation, not competition leads to a more efficient health care system
- Individual providers may reach those missed by other services
- Collaboration can create a more holistic, multidisciplinary model of health care

Changing Governmental Policies

The ever-changing and unpredictable nature of governmental policies has been a constant barrier to the effective delivery of health care. The policies of the federal, state and local governments all influence the manner in which care is provided to community residents. Medicare or Medicaid eligibility is no longer a guarantee of access to health care. Physicians are turning away these patients due to low – and late – reimbursement from the government.

Threats

- Worsening health status of those not served
- Access to care more limited than ever

Opportunities

- Local collaborators are pushing for increase in Medicaid rates and access to care for all
- Creative partnerships are taking root.
- The public is beginning to see the value of effective public health measures

Strategic Issues for Champaign County

How to?

- **Improve access to care**
- **Improve communication**
- **Create better data sharing tools**
- **Eliminate disparities in health care**
- **Build sustainable community health leadership**
- **Create an integrated approach to deal with important issues collectively**
- **Use information technology to improve collaboration and communication**
- **Collectively use the media, billboards and other public venues to educate and empower community residents**

Strategies for Public Health System Improvement

Pearl Criteria for Establishing Strategies:

Propriety — is a strategy consistent with the essential services and public health principles?

Economics — is the strategy financially feasible? Does it make economic sense?

Acceptability - Will the stakeholders and the community accept the strategy?

Resources — are funding likely to be available to apply this strategy? Are organizations able to offer personnel time and expertise or space needed to implement this strategy?

Legality — do current laws allow the strategy to be implemented?

C-U Public Health's Organizational Strategy:

- **Take leadership role**
- **Create sustainable partnerships**
- **Improve external communications**
- **Strengthen the organization's personnel resource management, budgeting process, organizational learning and internal communication.**

Public Health System's Community Strategy:

- **Build Public Health System partnerships**
- **Market the Public Health message**
- **Improve communication among partners**
- **Initiate Public Health research to identify and resolve issues**
- **Advocate for improved Public Health infrastructure**

IPLAN PRIORITIES

- **Access to Health Care**
- **Cancer**
- **Cardiovascular Disease**
- **Domestic Violence, Sexual Abuse, Elder Abuse and Child Abuse and Neglect**
- **Infant Mortality**
- **Mental Health**
- **Obesity**
- **Oral Health**
- **Sexually Transmitted Diseases**
- **Substance Abuse**

Access to Health Care

"Access to health care" came up on several occasions in the Health Assessment process and participants in a telephone survey listed this topic as a primary problem in the community.

The shortage of Medicaid providers, the ratio of the uninsured to Medicaid patients at the county's only Federally Qualified Health Center, the low and slow reimbursements for services provided to Medicaid recipients, the undersupply of specialists even for the insured population, the lack of affordable health care for the uninsured, language and transportation barriers to care and the lack of health providers in schools were all identified as major public health concerns in this assessment.

IPLAN Objective: To build collaborations among partners in the local public health system to assess the barriers to health care and to increase the availability of primary and specialty health care to all members of the community.

Cancer

Deaths related to cancer are second only to death by cardiovascular diseases. It is one of the leading causes of death in Champaign County. In 2004 cancer accounted for 15.6% of all deaths in Champaign County. Of all cancers, lung and colon cancer are the top causes of cancer mortality in the county.

IPLAN Objective: To reduce the number of cancer deaths across all categories.

Impact Objective: Since smoking is the leading cause of many cancer deaths, the objective will be to reduce the proportion of smokers in the population from the current 20% to 12% or less by the year 2010 (Healthy People 2010 Objective).

Impact Objective: To increase screening for breast, cervical and prostate cancer and improve community awareness for early screening through education and active intervention.

Cardiovascular Disease

For decades cardiovascular disease has been the leading cause of death in the United States and in Champaign County. Males and females are equally affected. 25% of all deaths are directly attributed to this condition. It is also the leading cause of disability.

For these reasons Cardiovascular Disease is among the top priorities for the Champaign County Health Plan.

IPLAN Objective: To reduce mortality and morbidity related to Cardiovascular Diseases like Myocardial Infarction, Stroke and Cardio-Pulmonary Arrest.

Impact Objectives:

- To reduce the percentage of smokers in the county from 20.1% to 12% or less by year 2010 (Healthy People 2010 Objective).
- To help individuals maintain their blood pressure and cholesterol level within the prescribed guidelines by education and active intervention
- To make individuals aware of early signs and symptoms of heart attacks and stroke through active educational programs.
- To increase community awareness of and access to active recreational opportunities (see Obesity, below).

Domestic Violence, Sexual Assault, Elder Abuse and Child Abuse and Neglect

Violence in the home or elsewhere, whether it is directed at adults or children, is aggravated by and contributes to a host of other social and psychological problems. Abusers have often been abused themselves, and one form of abuse often affects a larger circle than the apparent target of the abuse.

A primary problem in addressing domestic violence is that it is currently impossible to get good data on its prevalence in the community. Law enforcement does keep track of the number of domestic violence reports and orders of protection, but no agency or government body collects comprehensive data (hospital reports, calls to hotlines, police reports, etc.) on violence in the home.

We do know that the number of substantiated child abuse and neglect reports in Champaign County is significantly higher than in the state as a whole, a troubling trend that has persisted for many years.

IPLAN Objective: To reduce the incidence of domestic violence, sexual assault, elder abuse and child abuse and neglect in Champaign County.

Impact Objectives: To enhance partnerships with – and education and training of – personnel at local agencies and in the local public health system to increase screening for, and reporting of, cases of abuse and neglect in children and adults. To enhance community education on the interrelatedness of these problems and on resources available to victims and abusers.

Infant Mortality

Infant Mortality has been identified as a health priority for Champaign. The rate of infant mortality is higher in Champaign than for the state. The rate is disproportionately higher in the African American population than other groups. This difference could be attributed to lower prenatal care for the black population and a higher percentage of pregnant African American women who smoke, which increases the risk of fetal and neonatal mortality.

Plan Objective: To reduce the incidence of infant mortality in the total population to 4.5 per 1000 births (Healthy People 2010 Objective). African American infant mortality is currently 25 per 1000 births.

Impact Objective: To educate mothers who smoke and drink during pregnancy about the strong association of smoking and drinking with adverse pregnancy outcomes. To provide smoking cessation support to pregnant women. To improve access to prenatal care for all pregnant women, especially targeting the high-risk African American population. To alert and educate women of child-bearing age about the benefits of prenatal care, especially targeting African Americans. To promote screening for birth defects for all expectant mothers to detect congenital anomalies.

Mental Health

Nearly a third (30.4%) of respondents to the Behavioral Risk Factor Surveillance System survey reported that they felt depressed, sad or blue more than two days per month. In a separate question, a larger portion of non-whites (23.4%) than whites (13.5%) reported that they had 8-30 days in the previous month when their mental health was “not good” (in terms of stress, depression and problems with emotions).

Female respondents were more likely than their male counterparts to report that physical, mental or emotional problems limited their activities. 19.4% of women answered yes to this question, and 8.5% of men. 30.4% of single adults without children answered yes to the same query, as compared to 13.5% of families in households with more than one adult and 5.9% of families with more than one adult and children.

In a community with significant gaps in access to primary health care, it must be assumed that access to mental health services is also in short supply. No comprehensive data are available to help assess local demand for, and availability of, mental health services. The responses to the BRFSS questions, above, the high number of child abuse and neglect cases and domestic abuse reports to police all indicate a significant need for mental health services here.

IPLAN Objective: To foster collaborations with mental health providers to better assess the mental health needs of the community and create a strategic plan to address these needs. To target women and minority groups for interventions designed to increase their access to – and utilization of – local mental health services.

Obesity

There is a direct relationship between obesity and a host of diseases including diabetes, hypertension, myocardial infarction and stroke. Childhood obesity is one of the fastest growing concerns for public health authorities worldwide. According to the Behavioral Risk Factor Surveillance System report, 50% of the adults surveyed were in the overweight category and of that number 17% were obese. Diet, lack of exercise and isolated living were the main attributing factors. 55% of all adults surveyed indicated that they do not get the recommended amount of exercise.

Plan Objective: To reduce the proportion of adults who are obese to 15 percent or below and to reduce the proportion of children who are obese to 5 percent or below (Healthy People 2010 Objective).

Impact Objective: To create and deliver programs that promotes sound nutrition education in schools, agencies and community centers

To educate adults and children on the benefits of physical activity

To build partnerships with parks and recreation centers to enhance community awareness of, and access to, active recreational opportunities

To promote programs in schools and neighborhoods that broadens children's opportunities to be physically active

Oral Health

Often neglected, oral health is included as a priority problem in Champaign. The Surgeon General's report in 2000 emphasized the need for improvements in oral health via prevention and promotion. 42% of respondents in the 2004 Behavioral Risk Factor Surveillance Survey reported that they do not have any dental insurance and 25% said they could not afford to visit a dentist in 2004. There is also a great disparity in care between whites and non-whites.

Plan Objective: To reduce the proportion of oral health problems in all age groups, with a special emphasis on the non-white population.

Impact Objectives: To reduce the proportion of children and adolescents with dental caries. To increase the proportion of the population that makes yearly visits to the dentist. To increase the availability of affordable dental care. To increase the general knowledge of proper dental hygiene and means of promoting dental health in the population.

Sexually Transmitted Diseases

Sexually Transmitted Disease (STD) prevention was included in the priority list for Champaign County because of the higher than average rates of Gonorrhea and Chlamydia here. The rates for Gonorrhea (379 per 100,000 in 2004) and Chlamydia (669 per 100,000 in 2004) have been on the rise in previous years and are higher than state rates (175 and 388 per 100,000, respectively, in 2004) and national rates (in 2003, the Centers for Disease Control and Prevention reports a national Gonorrhea rate of 116.2 per 100,000 and for Chlamydia a rate of 304.3 per 100,000). STD's are of particular concern due to the direct association of increased risk of HIV.

Plan Objectives: To reduce the incidence of Chlamydia below state and national rates. To reduce the incidence of Gonorrhea to 19 cases per 100,000 (Healthy People 2010 Objective).

Impact Objective: Aggressive intervention to identify and treat cases coupled with education for high-risk populations.

Substance Abuse

Substance abuse takes an enormous toll on health, society and the economy. Not only did the Health Plan committee rank it as a high priority, but informal surveys conducted of the community also indicated high importance. According to the BRFSS, 18% of all adults in Champaign are at risk for acute/binge drinking. Smokers account for 20% of the adult population. There is increasing concern over the rise in use of marijuana and cocaine in adolescents.

Plan Objective: To reduce alcohol and drug abuse and substance abuse-related deaths occurring in Champaign County.

Impact Objective: To enhance community utilization of and access to alcohol and substance abuse treatment. To partner with schools to build and promote effective drug and alcohol abuse prevention programs for students (and to end ineffective programs). To build partnerships with Parks, other agencies and social service providers to increase the recreational and educational opportunities available to young adults. To partner with universities and other agencies to prevent alcohol and substance abuse in college students through targeted social marketing.

Appendix A

Domestic Violence, Child Abuse, Sexual Assault and Elder Abuse

Champaign, Illinois

Domestic Violence, Child Abuse, Child Sexual Assault and Elder Abuse in Central Illinois

Below are only *some* of the cases of domestic violence, sexual assault, child sexual abuse and child abuse reported in South and Central Illinois in late 2005. These reports were culled from the pages of the *News Gazette* between August 2005 and January 2006. Many more assaults have gone unreported in the media.

DOMESTIC VIOLENCE

RANTOUL – December, 2005: A 38-year-old Rantoul woman, **Veun Vin**, was beaten to death, allegedly by her husband.

GIBSON CITY – November, 2005: A 26-year-old Gibson City woman, **Danyelle Osborne**, was bludgeoned to death, sexually assaulted, burned and her body left under a bridge outside of town. Her husband, Robert T. Osborne, was charged in the murder.

URBANA – November, 2005: a Mahomet man, Nicholas Yeagle, shot himself after vandalizing an ex-girlfriend's home in Urbana.

DANVILLE – September, 2005: **Kimberly Gray**, 34, was fatally shot in her Newton home. A preliminary autopsy report found that she had been shot multiple times. She had recently moved herself and her young children away from her husband, Kenneth A. Gray, 34. Mr. Gray was charged with four counts of first-degree murder in connection with her death.

DANVILLE, September, 2005: A 21-year old Danville man was convicted of fatally stabbing his former girlfriend, **Wyneva Johnson**, 19, a high school senior and track star at Danville High School. In November he was sentenced to 35 years in prison.

URBANA – July 2005: Byron A. Ward, 35, pleaded innocent to charges of intimidation, unlawful restraint and domestic battery with great bodily harm. Ward was accused of

punching, pushing and threatening his ex-girlfriend, dragging her into an apartment and – after his arrest – threatening to "put a bullet in her head."

PEORIA – July 2005: An alleged serial killer, Larry Bright, 38, confessed to killing eight Peoria area women. All of the victims were African American women.

BELLEVILLE – May 2005: **Nicole Jacobs** and **Wayne Dunnavant** were found stabbed multiple times in Jacobs' apartment. Nicole Jacobs' husband, Leron Wilborn, later confessed to the killings.

PIPER CITY – November 2004: Jesus Alva, 39, stabbed his fiancé, **Michealina Helm**, to death with a butcher knife. She had just moved out of their shared home. Alva had been convicted of misdemeanor domestic battery against Ms. Helm one month prior.

SEXUAL ASSAULTS

URBANA – December, 2005: William H. Bouton was sentenced to 25 years in prison for raping and stalking an Urbana woman.

CHAMPAIGN – December, 2005: A Champaign man, Jesus Cervantes-Martinez, 25, was accused of sexually assaulting a Champaign woman in her apartment. (She fought him off and an acquaintance helped her capture him and hold him until the police arrived and made the arrest (according to the News Gazette).

URBANA – June 2005: A Champaign dentist, Scot E. Brewer, 48, was arraigned on charges he sexually assaulted a female employee in his office.

CHILD SEXUAL ABUSE

MONTICELLO – December, 2005: A former Monticello High School teacher, Larry Albaugh, 53, was tried for the indecent solicitation of sex from a child via the Internet.

CHAMPAIGN – December, 2005: A Champaign man, Cleo Ross, 19, was sentenced to 5½ years in prison for violating his probation by fondling a young girl. He also admitted to having had sex with two teenage girls.

PESOTUM – November, 2005: A Pesotum man, David Burger, pleaded guilty to sexually molesting a four year old girl and was sentenced to seven years in prison.

URBANA – August 31, 2005: Brian Dyson, a former substitute teacher's assistant in an Urbana after-school program was sentenced to five years after he admitted molesting a 14-year-old student.

PAXTON – August 2005: A Ford County jury found a Gibson City minister guilty of repeated sexual assaults on a woman over a six-year period that began when she was 14 years old.

(News Gazette, 8/20/2005: Minister's name: Danny O. Hill, 54)

CHAMPAIGN – June, 2005: William Lickly, 35, and Joseph Marchetti, 28, of Champaign, pleaded guilty to aggravated sexual abuse of a boy under the age of 13. They were each sentenced to four years of probation, ordered to get mental health evaluations and to have no contact with the boy.

URBANA – June, 2005: Urbana resident, Eager Dunn, 23, was convicted of sexually abusing a girl seven to 13 years of age.

CHILD ABUSE

CHAMPAIGN – February, 2006: The trial is scheduled to begin of Maurice LaGrone Jr. for the alleged drownings of his ex-girlfriend's three children: **Christopher Hamm**, age 6, **Austin Brown**, age 3 and **Kyleigh Hamm**, 23-months old.

CHAMPAIGN – December, 2005: Cedric Weatherspoon, 25, was charged with aggravated battery to a child that caused great bodily harm.

DANVILLE – December, 2005: Andrew Drollinger was sentenced to more than eight years in prison for the February, 2004, involuntary manslaughter of his girlfriend's baby, **Macy Duewer**.

ELDER ABUSE

From January 1 to December 31, 2004, the Senior Resource Center received reports of elder abuse affecting 36 individuals. Physical abuse was alleged 16 times, emotional abuse was alleged 26 times. There was one report of sexual abuse and four reports of confinement.

"The above information refers to what was alleged at the time a report was received and does not reflect what was substantiated."

-- Pat Babich-Smith, C&A Manager, Senior Resource Center, Family Service.

Appendix B

General Public Telephone Survey

Champaign, Illinois

May, 2005

Champaign County Healthcare Needs Assessment

General Public Telephone Survey

Conducted for
Champaign – Urbana Public Health District

May 15 – 17, 2005

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Purpose

This telephone survey was planned as one segment of the Champaign-Urbana Public Health District's community needs assessment process – part of the Illinois Project for Local Assessment of Need (IPLAN). The purpose was to gather perceptions from a representative sampling of the adult (18+) Champaign County population regarding both the overall quality of life as well as the quality of healthcare in the local community.

A series of structured and open-ended questions sought comments on major quality-of-life issues as well as impressions of significant health problems and potential risky behaviors among the public at large. Respondents were also asked to list 1) assets which help make Champaign County a healthy community and 2) perceived roadblocks to improving overall health and quality of life in the county.

Methodology

The survey was conducted May 15-17, 2005. Initially, a random sample was drawn from current telephone directories covering Champaign County. Then the last digit of each listing was changed in a systematic way to insure the inclusion of all working telephone numbers, including unlisted numbers.

Because of the subject matter involved, it was decided that interviewers would ask for the "healthcare decision-maker" at each household contacted. The healthcare decision-maker was defined as "the person who makes most of the healthcare decisions or arrangements." Potential survey participants were told that the survey was being done "on behalf of the Champaign-Urbana Public Health District," that their answers would be "anonymous and confidential" and that they would help the District "better serve the residents of Champaign County."

Calling was done from the Research Survey Service telephone facility in Champaign. Standard procedure was for as many as four calls (an initial call and up to three callbacks) to be made, on different days and at different times, in efforts to reach as many as possible of the originally selected sample. Calling was done between 5 and 9 pm, except when the person contacted suggested a callback be made at a different time in order to reach the healthcare decision-maker.

Ten interviewers were assigned to the project and received detailed training on the questionnaire. On most occasions, two supervisors were on duty during the calling. Subsequent callbacks to respondents were used to verify at least 10% of the interviews conducted by each interviewer.

The target for this project was 200 interviews; in actuality, 207 were completed. That produced a maximum margin of sampling error of + or – 7 percentage points (at the 95% confidence level) for results based on the total sample.

Quota sampling was applied to insure that the completed sample matched the actual composition of the county population based on location. Of the completed interviews, 57% were with respondents in Champaign and Urbana, closely matching the 58% share of the county population represented by the twin cities in the 2000 census. No other quotas were used.

The following tables show the demographic composition of the completed sample on a number of other characteristics. Note that the requirement to interview the "healthcare decision-maker" in the household resulted in a preponderance (62%) of interviews with women.

Throughout this report, some totals may not add to exactly 100% due to rounding or multiple responses. For example, the table on this page titled "how is healthcare paid?" reflects multiple responses from roughly one-third of the sample.

Gender

Male	38%
Female	62

Income

Under $15,000	6%
$15,000-$30,000	17
$30,000-$50,000	27
$50,000-$75,000	16
$75,000+	24
Don't know	1
Refused	8

Marital Status

Married/living together	65%
Single/never married	11
Divorced	11
Widowed	13
Refused	<1

How is Healthcare Paid?

Cash	17%
Insurance	86
Medicare	25
Medicaid	4
Some other way	2

Education

Some high school	3%
High school grad	20
Some college	24
College grad	18
Graduate work/degree	35

Age

18-34	20%
35-49	25
50-64	25
65+	29
Refused	<1

Children (<18) in Household?

Yes	30%
No	70

Race/Ethnicity

White	87%
Black/African American	7
Asian	3
Mixed	<1
Hispanic/Latino	1
Refused	2

Results

The first section of the survey contained three open-ended questions. These sought participants' top-of-mind responses regarding: 1) the overall quality of life in Champaign County, 2) health problems in the county and 3) risky behaviors that may impact community health. On each question, respondents were asked to name the "three most important" issues or concerns.

Participants who said they didn't know or just couldn't think of anything were then read, for each question, a list of a dozen or more potential issues or problems, and asked to select the three they deemed most important. Responses from the unaided (open-ended) questions were then combined with those from these aided ones to give overall totals for the sample as a whole on each of the three major areas.

Quality of Life Issues in Champaign County

A total of 156 of the 207 participants, or just over 75%, were able to come up with responses on the first unaided question, which concerned the quality of life in Champaign County. This was the question:

> "In your opinion, what things are most important for a strong community – things which most improve the quality of life [in Champaign county]. If you can, name three things that you think are most important to quality of life." (Question 1)

These survey participants produced a total of 403 responses; that's an average of 2.6 responses per person. Each response was assigned to one of more than 30 comment categories.

Interviewers read 16 specific attributes to aid the 51 respondents who did not provide responses on the initial open-ended question. The participants in the aided question (Q. 2) chose a total of 149 responses, or an average of 2.9 per person.

As the following table shows, **access to health care** was deemed the most important quality of life issue in the total tabulation. More than half (58%) of respondents mentioned it, and the margin over **good schools**, the number two attribute with 35%, is statistically significant.

The table shows the 11 attributes which received mentions by at least 10 respondents (5% of the sample). The attributes are shown in rank order, based on total mentions. Additional columns also show the number and percentage of responses to the separate unaided and aided questions.

An asterisk (*) indicates the only attribute (senior issues) which was *not* included in the list of 16 used in the aided question (Q. 2). All the "senior issue" comments came from those responding to the unaided question (Q. 1). The opposite situation occurred with regard to the issue "good place to raise children." No one volunteered that comment on the unaided question; the only respondents selecting it did so from the list provided on the aided question.

While **access to health care** was the clear leader on the open-ended (unaided) question, and for the sample as a whole, it was ranked in a virtual tie with **good schools** and **low crime/safe neighborhoods** among those responding to the question in the aided format.

Most Important Quality of Life Issues
(# and % of sample)

	Total		Unaided (Q. 1)		Aided (Q. 2)	
Issue	**#**	**%**	**#**	**%**	**#**	**%**
Access to health care	120	58%	98	47%	22	11%
Good schools	72	35	47	23	25	12
Low crime/safe neighborhood	59	29	36	17	23	11
Good jobs/healthy economy	35	17	24	12	11	5
Religious or spiritual values	26	13	18	9	8	4
Parks and recreation	24	12	19	9	5	2
Affordable housing	24	12	14	7	10	5
Clean environment	22	11	18	9	4	2
Strong family life	20	10	14	7	6	3
Good place to raise children	16	8	--	--	16	8
Seniors issues*	11	5	11	5	--	--
Number of respondents	*207*		*156*		*51*	

Demographics – There were few substantial differences across demographic sub-groups in the selection of items important to quality of life. Two related to respondents' ages. 63% of those 35 and older mentioned "access to health care," compared to only 38% of participants under age 35. Another issue, "good jobs and a healthy economy" was noted three times as often by those under 50 (28%) as by older respondents (8%). Women (41%) were more likely than men (24%), and upper-income respondents (52%) were more likely than others (28%), to mention "good schools."

Health Problems in Champaign County

Response rates were somewhat lower here. Just over two-thirds (69%) of survey participants volunteered what they felt were major health problems in Champaign County, in response to the open-ended question (Q. 4). The 142 respondents noted a total 316 health issues. That's an average of 2.2 per person – short of the three requested and the 2.6 achieved in response to Q. 1 about "quality of life" issues. This was the question:

> "…What are the three most important health problems in our community, referring to all of Champaign County?" (Q. 4)

The 65 participants who responded with "none" or said they "didn't know" were then read a list of 17 potential health problems, and asked to select three as "most important." These respondents averaged 2.7 per person, although six still answered "don't know."

Unlike in the previous section, no response dominated here. **Cancer** and **heart disease/stroke** were the top two issues identified in both the unaided and aided questions. In responses to the unaided question, two health topics – affordable health care and available/affordable health insurance – finished among the top four issues. Neither was included in the list of 17 potential health problems that were read to respondents in the aided question, and no one in that group volunteered them.

The following table shows, in rank order, the 16 health problems or issues identified by at least 10 respondents – 5% of the sample. An asterisk (*) again denotes those problem categories that were *not* included in the list read to participants in the aided question.

Most Important Health Problems
(# and % of sample)

	Total		**Unaided (Q. 4)**		**Aided (Q. 5)**	
Problem	**#**	**%**	**#**	**%**	**#**	**%**
Cancer	61	29	29	14%	32	15%
Heart disease & stroke	56	27	32	15	24	12
Diabetes	35	17	14	7	21	10
Affordable health care*	29	14	29	14	--	--
Mental health problems	23	11	12	6	11	5
Accessible/affordable insurance *	23	11	23	11	--	--
Child abuse and neglect	19	9	--	--	19	9
Aging problems	18	9	5	2	13	6
Domestic violence	16	8	--	--	16	8
Drugs*	16	8	15	7	1	0
Obesity*	14	7	14	7	--	--
Sexually transmitted disease	13	6	10	5	3	1
High blood pressure	12	6	7	3	5	2
Teenage pregnancy	10	5	1	<1	9	4
Seniors issues*	10	5	10	5	--	--
Smoking*	10	5	10	5	--	--
Number of respondents	*207*		*142*		*65*	

Demographics – There were no major differences on this question across the demographic subgroups.

Risky Behaviors Impacting Community Health

Questions on this topic followed the same format as the two earlier sections. First, all participants were asked the open-ended question:

> "What are the three most important risky behaviors, those that have the greatest impact on overall community health? (Q. 7)

The response rate on this question was slightly lower than on the earlier two, with 68% naming at least one risky behavior. The average was 2.6 per person. It rose to 2.8 among the one-third of the group which was read a list of 12 potentially risky behaviors on the aided question (Q. 8) after failing to come up with any on the open-ended one.

As shown in the next table, **Alcohol abuse** (57%) and **drug abuse** (54%) were both mentioned by just over half of those surveyed and clearly topped the list of risky behaviors. Their margins over all other risky behaviors are statistically significant.

For the most part, answers from the two groups of respondents (on the unaided versus aided questions) were similar. Major differences occurred on **being overweight**, which was volunteered by only 2% on the unaided question, but ranked third with 11% among those given this issue as one of 12 potential risky behaviors in the aided version. **Careless/unsafe driving**, by contrast, was mentioned by 6% in the open-ended (unaided) question, but was not on the list used in the aided question. It is identified in the table with an asterisk (*).

As in earlier sections, this table includes those risky behaviors mentioned by at least 10 respondents (5%) of the total sample.

Most Important Risky Behaviors
(# and % of sample)

	Total		Unaided (Q. 7)		Aided (Q. 8)	
Risky Behavior	**#**	**%**	**#**	**%**	**#**	**%**
Alcohol abuse	117	57%	77	37%	40	19%
Drug abuse	112	54	72	35	40	19
Unsafe sex	69	33	54	26	15	7
Tobacco use	53	26	46	22	7	3
Obesity, being overweight	27	13	4	2	23	11
Poor eating habits	23	11	15	7	8	4
Lack of exercise	14	7	7	3	7	3
Not using seat belts/ child safety seats	13	6	4	2	9	4
Careless/unsafe driving*	13	6	13	6	--	--
Dropping out of school	11	5	--	--	11	5
Number of respondents	*207*		*140*		*67*	

Demographics – Gender differences were most notable here. Women (60%) were more likely than men (44%) to list "drug abuse." There was a similar pattern on mentions of "alcohol abuse" – women 61%, men 49% – although the difference was smaller. On the other hand, men more often mentioned "obesity, being overweight" (19%, to 9% for women) and "lack of exercise" (men 14%, women 2%). And 31% of Champaign-Urbana residents suggested smoking/tobacco use is a risky behavior, compared to 19% of participants from the rest of the county.

Perceptions of Community Health/Personal Health

The vast majority – 90% – of survey participants generally categorized themselves as "healthy." However, only two-thirds (66%) said the Champaign County community is healthy.

These results came from a pair of questions, which asked respondents to rate community health and their own personal health on the same five-point scale. These were the questions:

> "How would you rate our community as a 'healthy community' – 'very healthy,' 'somewhat healthy,' 'neither unhealthy nor healthy,' 'somewhat unhealthy' or 'very unhealthy'? (Q. 10)
>
> "How would you rate your own personal health [on the same scale]?" (Q. 11)

The following table summarizes the responses:

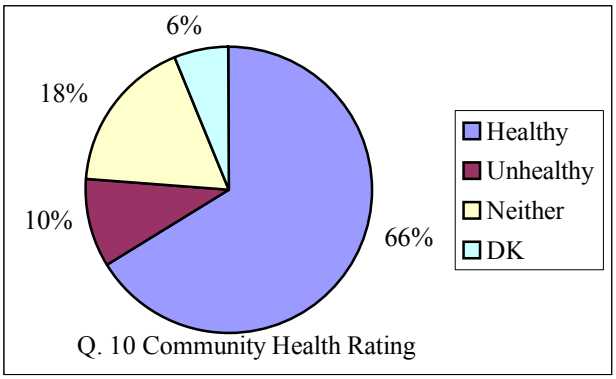
Perceptions of Community/Personal Health
(% of sample)

Scale	Community Health (Q. 10)	Personal Health (Q. 11)
Very healthy	11%	51%
Somewhat healthy	56	39
Neither unhealthy nor healthy	18	3
Somewhat unhealthy	8	5
Very unhealthy	2	1
Don't know	6	--

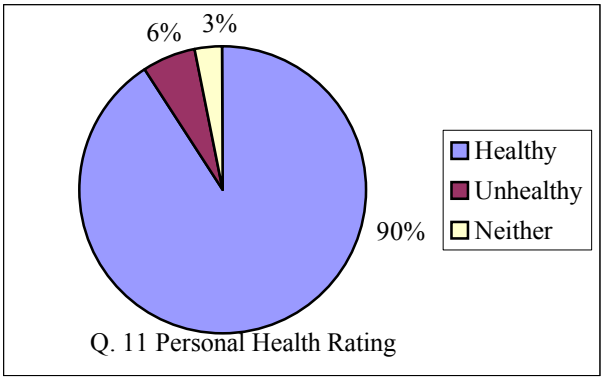
The difference remains when the five categories are collapsed to three by combining "very" and "somewhat healthy" to an overall "healthy" category, and doing the same on the "unhealthy" side:

Perceptions of Community/Personal Health
(% of sample)

Scale	Community Health (Q. 10)	Personal Health (Q. 11)
Healthy ("very" or "somewhat")	66%	90%
Neither unhealthy nor healthy	18	3
Unhealthy ("very" or "somewhat")	10	6
Don't know	6	--



Q. 10 Community Health Rating



Q. 11 Personal Health Rating

Demographics – Almost three-fourths (72%) of participants reporting no children in the household said they believed Champaign County was a "healthy" community, while just over half (53%) of those *with* children agreed. However, 90% of both groups said they considered themselves to be personally healthy.

What Keeps Our Community From Improving Health?

A lack of financial resources is the main thing that respondents believe keeps the Champaign County community from improving overall health.

This was one of a number of responses which survey participants gave in answer to this open-ended question:

> "In your opinion, what is keeping our community from doing what needs to be done to improve health and quality of life?" (Q. 12)

A total of 35 (17%) responded with "don't know" or "nothing" on this question. The remaining 172 participants came up with a total of 257 reasons, or just under 1.5 per person. Each response was coded and assigned to one of more than 30 categories.

As noted above, an overall **lack of money** received the most mentions, coming from just over one-fourth (26%) of respondents. And the difference between this category and all others is statistically significant.

The following table includes the nine comment categories noted by at least 10 respondents (5%). These categories represent more than 60% of all comments received.

What Keeps Community From Improving Health?
(# and % of sample)

Comment Category	#	%
Lack of money	54	26%
Low income, no health insurance	16	8
Lack of awareness of health issues, problems	15	7
Negative comments about politicians, "politics"	14	7
Lack of access to healthcare	13	6
Individual apathy, laziness	11	5
High cost of healthcare	11	5
Miscellaneous negative comments re: healthcare	11	5
Lack of cooperation among gov't, organizations	10	5

Demographics – Again, there were few substantial differences across the demographic sub-groups here. However, responses noting a "lack of money" increased with the age of the participant. Only 10% of those under 35 gave this response. The incidence rose to 27% among those 35-65, and was 37% in the 65+ group. And as might be expected, respondents who said they paid cash for their healthcare were more than three times as likely (14% vs. 4%) as those with some form of insurance to mention the "high cost of healthcare."

Assets That Make Champaign County a Healthier Community

Specific local institutions – including the **University of Illinois**, **Carle**, and the **Public Health District** – were among those receiving the most mentions as community assets in response to this question:

> "What assets does Champaign County have that make it a healthier community?" (Q. 13)

Again here, a small minority of respondents (33, or 16%) said they didn't know. The remaining 174 came up with a total of 320 assets, averaging 1.8 per participant. The comments were coded and assigned to one of more than 40 separate categories.

As noted in the next table, a category of comments praising local doctors, clinics and hospitals in general led the list. One-third (33%) of all participants offered such remarks. Next came comments highlighting local parks and recreation facilities, followed by specific mentions of the U. of I. (20%), Carle (9%) and the Public Health District (8%). (Provena was mentioned specifically by 4% and Christie Clinic by 2%, but these are not shown on the table because the they fell below the 5% cutoff).

The six categories receiving at least 10 mentions (5%) covered more than 60% of all remarks.

Community Assets
(# and % of sample)

Assets	#	%
Positive comments re: local doctors, clinics, hospitals, etc	69	33%
Local parks, recreation, exercise facilities	44	21
The University of Illinois	41	20
Carle (clinic, hospital, foundation)	19	9
Public Health District, etc.	16	8
The local environment, air and water quality	16	8

Demographics – Responses mentioning "local parks, recreation, exercise facilities" decreased as respondent age increased. One-third (33%) of participants under 35 mentioned parks and recreation, compared to only 12% of those 65 and older. The "parks and recreation" category also got more mentions from respondents with children (31%) than from those with no children in the household (17%).

Mention of the "University of Illinois" was twice as frequent among those with education beyond a bachelors degree (31%) as among those with a bachelors or less (15%). And respondents with incomes of $75,000+ were almost twice as likely (32% vs. 17%) as those with lower incomes to specifically single out the U. of I. as a community asset.

Survey participants living outside the cities of Champaign and Urbana were three times as likely (22% vs. 6%) as those living in the twin-cities to mention Carle or Provena hospital by name.

Agree/Disagree with Statements About the Community

In this section of the survey interview, respondents were read a series of ten statements about the Champaign County community and asked to indicate their agreement or disagreement with each. A five point scale was used: "strongly agree," "somewhat agree," "neither agree nor disagree," "somewhat disagree" or "strongly disagree."

These were the statements:

"This is a good community to raise children." (Q. 14)

"This is a good community [in which] to grow old." (Q. 15)

"There is economic opportunity in this community." (Q. 16)

"The community is a safe place to live." (Q. 17)

"The community has networks or organizations for support to individuals and families during times of stress and need." (Q. 18)

"Individuals and groups have the opportunity to contribute to and participate in the community's quality of life." (Q. 19)

"Residents believe that they as individuals or in groups can make the community a better place to live." (Q. 20)

"The assets of the community are available to everyone, regardless of sex, age, race, or religion." (Q. 21)

"Trust and respect for others is increasing in our community because of working together for common community goals." (Q. 22)

"Our community has a strong sense of civic pride." (Q. 23)

The results are contained in the following table, with the statements listed in rank order based on the percentage saying they "strongly agree."

Respondents reacted most favorably to the statements **"this is a good community to raise children"** (60% strongly agree) and **"individuals and groups have the opportunity to contribute to and participate in the community's quality of life"** (59% strongly agree).

On the other end of the scale, only 15% strongly agreed that "trust and respect for others is increasing in our community because of working together for common community goals." The difference between that and all the other statements is statistically significant.

Some statements have been abbreviated. "Don't know" responses, which ranged from 1% to 8%, have been omitted from this table.

Agree/Disagree Regarding Statements About Community
(% of sample)

Statement	Agree Strong	Agree Some	Neither	Disagree Some	Disagree Strong.
This is a good community to raise children (Q14)	60%	33%	2%	3%	2%
Individuals and groups can contribute to and participate in community's quality of life (Q19)	59	30	4	2	1
This is a good community to grow old (Q15)	47	34	8	6	4
Residents believe they can make the community a better place to live (Q20)	42	42	7	6	<1
The community has networks for support during times of stress and need (Q18)	41	35	7	6	3
Community has strong sense of civic pride (Q23)	40	40	10	6	1
The community is a safe place to live (Q17)	37	48	5	7	2
There's economic opportunity in community (Q16)	33	46	6	10	4
Assets of the community are available to all, regardless of sex, age, race or religion (Q21)	30	29	8	15	9
Trust & respect for others increasing because working together for common comm.. goals (Q.22)	15	39	17	17	7

Another way of analyzing these results is to reduce the five response categories to three. This combines the two statements on the "agree" side ("strongly" and "somewhat agree") and does the same on the "disagree" side.

The rank order of the statements did not change dramatically with this display. The top two categories remained unchanged, and the same was true for the two at the bottom of the list. Both of the latter statements showed nearly one-fourth (24%) in disagreement.

The statements have been somewhat abbreviated again here, and the "don't know" responses are included as the far right column in this table.

Combined Agree/Disagree Regarding Statements About Community
(% of sample)

Statement	Agree	Neither	Dis-agree	Don't Know
This is a good community to raise children (Q14)	93%	2%	5%	-
Individuals and groups can contribute to and participate in the community's quality of life (Q19)	89	4	4	3%
The community is a safe place to live (Q17)	85	5	9	1
Residents believe they can make the community a better place to live (Q20)	84	7	6	3
This is a good community to grow old (Q15)	81	8	10	1
Our community has strong sense of civic pride (Q23)	80	10	7	3
There is economic opportunity in this community (Q16)	79	6	14	1
The community has networks for support to individuals and families during times of stress and need (Q18)	76	7	9	8
The assets of the community are available to everyone, regardless of sex, age, race or religion (Q21)	60	8	25	8
Trust and respect for others is increasing because of working together for common community goals (Q22)	55	17	24	5

Demographics – The following are some of the more interesting differences in levels of agreement with these statements across the various demographic sub-groups.

Q.14 – This is a good community to raise children – Agreement with this statement was similar among both those with children in the household (94%) and those without (93%). Whites (94%) were more likely than minorities (82%) to express agreement.

Q.19 – Individuals and groups can… participate in community's quality of life – There were no notable differences among demographic groups.

Q.17 – The community is a safe place to live – Again, there were no major differences across demographic sub-groups.

Q.20 – Residents believe they can make the community a better place to live – Those with advanced degrees or college work beyond a bachelors were less likely (74% to 89%) than others with less education to agree with this statement.

Q.15 – This is a good community to grow old – More seniors (93%) agreed with this statement than did those under age 65 (76%). And more households with under $50,000 in income (90%) were in agreement than were those with incomes of $50,000+ (77%).

Q.23 – Our community has a strong sense of civic pride – Agreement with this statement was greater among whites (82%) than among minorities (68%). And by a margin of 88% to 74%, more survey participants living outside of Champaign and Urbana agreed with this statement than did residents of the twin-cities proper.

Q.16 – There is economic opportunity in this community – Agreement here was higher among whites (81%) than minorities (64%), among those with incomes of $30,000 and greater (83%) than among those with less income (67%), and a bit higher among respondents living outside the cities of Champaign and Urbana (82%) than among residents of the two cities (77%).

Q.18 – The community has networks for support… during times of stress and need – Once again, more whites (79%) agreed with this statement than did members of minority groups (55%). Also, agreement with this statement declined as the education of the respondent rose – 85% of those with a high school diploma or less agreed, compared to 63% of respondents with education beyond a bachelors degree. And agreement was higher (81% to 72%) among residents outside Champaign-Urbana than with those living in the two cities.

Q.21 – The assets of the community are available… regardless of age, sex, race or religion – This question produced quite a few differences across demographic groups. More men (65%) than women (57%) agreed with this statement, and households with children (69%) were more likely than those without (56%) to agree. Respondents from upper-income households ($50,000+) agreed more often (69% vs. 53%) than did participants from lower income categories. Two-thirds (66%) of those younger than age 50 agreed, compared to just over half (54%) of older respondents. Agreement was higher in areas outside of Champaign-Urbana (69%) than in the twin-cities themselves (53%). And whites (60%) were just slightly more likely than minorities (55%) to say they agreed with this statement.

Q.22 – Trust and respect for others is increasing because of working together for common community goals – There were no notable differences across demographic sub-groups on this question.

Satisfaction with Community's Quality of Life, Healthcare System

Questions near the end of the survey sought to measure respondents' overall satisfaction with the Champaign County community's 1) quality of life and 2) healthcare system. Satisfaction was measured on a five-point scale: "very satisfied," "somewhat satisfied," "neither satisfied nor dissatisfied," "not very satisfied" and "not satisfied at all." These were the questions:

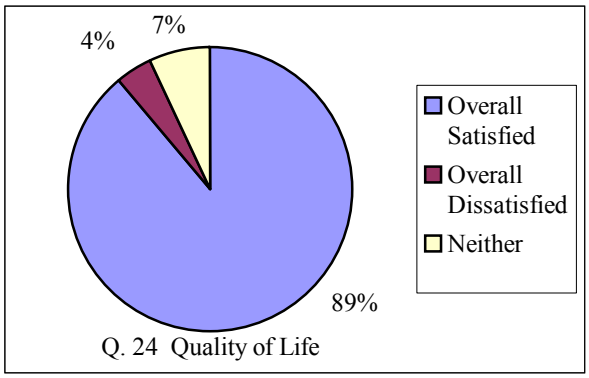
> "Overall, how satisfied are you with the quality of life in our community, considering safety, well-being, participation in community life and associations?" (Q. 24)

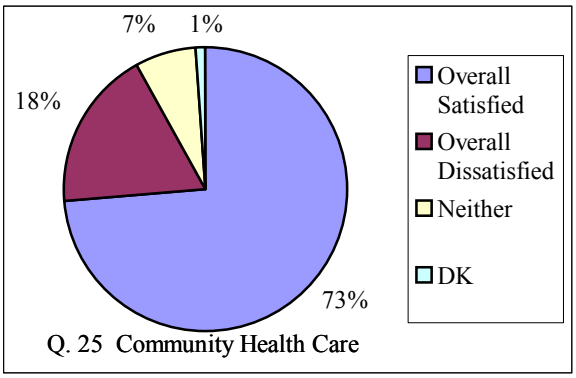
"How satisfied are you with the healthcare system in the community – access, cost, availability, quality, options or choice?" (Q. 25)

As the following table shows, survey participants indicated general satisfaction in both areas. However, when the five categories are collapsed to three, there is clearly more dissatisfaction overall with the healthcare system (18%) than with the quality of life (4%), and the difference is statistically significant. And when the 7% who are neither satisfied or dissatisfied is added in, fully 25% indicated they are less than satisfied with the Champaign County healthcare system.

Overall Satisfaction with Champaign County Community's…
(% of sample)

Satisfaction Level	Quality Of Life (Q.24)	Health-care System (Q. 25)
Very satisfied	38%	35%
Somewhat satisfied	51	38
Overall "satisfied"	89	73
Neither satisfied nor dissatisfied	7	7
Not very satisfied	3	13
Not satisfied at all	<1	5
Overall "dissatisfied"	4	18





Demographics – Some sub-groups were more likely than others to indicate satisfaction with the quality of life in Champaign County. These included the oldest respondents (65+ = 97%) more than the youngest (<35 = 83%); whites (91%) more than minorities (77%); households without children (92%) more than those with children (82%); and residents outside the twin-cities (93%) more than those living in Champaign-Urbana (86%).

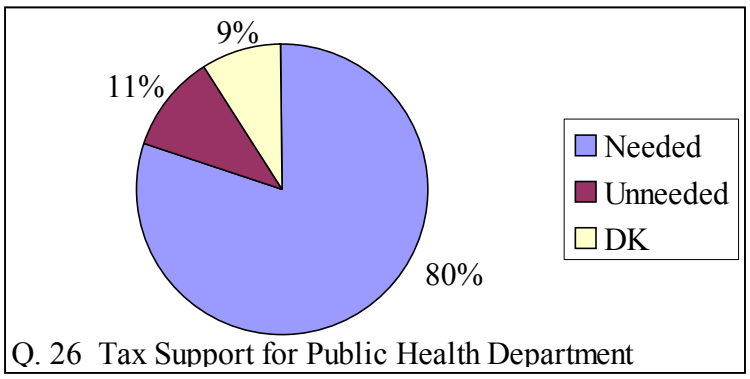
Regarding the county's healthcare system, whites (75%) were more likely to be satisfied than minorities (59%) and those with incomes above $30,000 (75%) were more satisfied than were households with incomes under $30,000 (65%).

Tax Support for Public Health Department

There was broad backing for a tax-supported public health department. The final question asked:

> "Do you think that tax support for a public health department is a needed expense or an unneeded expense?" (Q. 26)

Fully four-out-of-five (80%) said tax support for a public health department is a "needed expense." Only 11% responded that it's an "unneeded expense," and 9% said they didn't know.



Q. 26 Tax Support for Public Health Department

Demographics – Support for a tax-supported public health department was greater among women (85%) than men (72%), among minorities (100%) more than whites (79%), and among households with incomes of $75,000+ (88%) more than those in the lowest income brackets (<$30,000 = 78%). Also, 85% of Champaign-Urbana residents said tax support for a public health department is a "needed expense;" the comparable figure among residents of the rest of the county was 75%.

#589 Champaign-Urbana Public Health Telephone Survey
May 15 – 18, 2005

Interviewer_____ Date_____

Telephone number called_____ Time_____

Hello. I'm calling from Research Survey Service in Champaign. We're conducting a survey in Champaign County on behalf of the **Champaign-Urbana Public Health District.** We **are not selling** anything; we simply need your opinions. I need to talk to the person who makes most of the health care decisions or arrangements in this household. Is that you? Or May I speak to that person please?

Your answers will be completely anonymous and confidential and will help the Public Health District to better serve the residents of Champaign County.

1. In your opinion, what things are most important for a **strong community—things which most improve the quality of life.** When we say community, we are talking about Champaign County overall. **If you can, name three things that you think are most important to quality of life.**

See Table 1, p. 7

(If "don't know" say,)

2. Here is a list of things some people say are important **for a strong community—things which most improve the quality of life in a community**. After I read the list, and I will do it quickly, tell me which three are the most important to you. Remember we want the three most important ones **to you**. **(Circle 3)**

1. Good place to raise children
2. Low crime/safe neighborhoods
3. Low level of child abuse
4. Good schools
5. Access to health care
6. Parks and recreation
7. Clean environment
8. Affordable housing
9. Arts & cultural events
10. Good race relations
11. Good jobs & healthy economy
12. Strong family life
13. Healthy behaviors & lifestyles
14. Low adult death & disease rates
15. Low infant deaths
16. Religious or spiritual values
17. Or some other factor_____
18. Not asked
19. Don't Know

See Table 2, p. 8

3. _____ **(Office use only)**

See Table 3, p. 9

4. Now we want to talk specifically about **health problems.** What are the three most important health problems in our community, referring to all of Champaign County.

See Table 4, p. 10

(If "don't know" say,)

5. Here is a list of **health problems.** After I read the list, tell me which three are the most important to you. Remember we want the three most important ones **to you**. **(Circle 3)**

1. Aging problems
2. Cancers
3. Child abuse/neglect
4. Dental problems
5. Diabetes
6. Domestic violence
7. Heart disease & stroke
8. High blood pressure
9. HIV/AIDS
10. Infant Death
11. Infectious Diseases (hepatitis, TB)
12. Mental health problems
13. Rape & sexual assault
14. Respiratory/lung diseases
15. Sexually transmitted diseases
16. Suicide
17. Teenage pregnancy
18. Or some other problem_____

_____

19. Not asked
20. Don't Know

See Table 5, p. 11

6. _____ **(Office use only)**

See Table 6, p. 12

7. What are the three most important **risky behaviors**, those that have the greatest impact on overall community health?

See Table 7, p. 13

If "don't know," say,

8. Here is a list of **risky behaviors** that may have an impact on overall community health. Which are the three most important to you? **(Circle 3)**

1. Alcohol abuse
2. Being overweight
3. Dropping out of school
4. Drug abuse
5. Lack of exercise
6. Poor eating habits
7. Not getting "shots" to prevent disease
8. Racism
9. Tobacco use
10. Not using birth control
11. Not using seat belts/child safety seats
12. Unsafe sex
13. Or some other factor_____

_____

14. Not asked
15. Don't Know

See Table 8, p. 14

9. _____ **(Office use only)**

See Table 9, p. 15

Codes for Q. 10 & 11

1. Very healthy
2. Somewhat healthy
3. Neither unhealthy nor healthy
4. Somewhat unhealthy
5. Very unhealthy

DO NOT READ 6. Don't know

10. _____How would you rate our community as a 'healthy community'? (**Read 1 – 5**)

Very healthy	**22**	**11%**	**Somewhat unhealthy**	**16**	**8%**
Somewhat healthy	**115**	**56%**	**Very unhealthy**	**4**	**2%**
Neither unhealthy or healthy	**38**	**18%**	**Don't know**	**12**	**6%**

11. _____How would you rate your own personal health?

Very healthy	**106**	**51%**	**Somewhat unhealthy**	**10**	**5%**
Somewhat healthy	**81**	**39%**	**Very unhealthy**	**3**	**1%**
Neither unhealthy or healthy	**7**	**3%**	**Don't know**	**0**	**0%**

12. In your opinion, what is keeping our community from doing what needs to be done to improve health and quality of life?

See Table 10, p. 16

13. What assets does Champaign County have that make it a healthier community?

See Table 11, p. 17

We are just about finished. Here I will read you some statements. For each one tell me whether you agree or disagree with it—strongly agree, somewhat agree, neither agree nor disagree, somewhat disagree, or strongly disagree.

1. Strongly agree
2. Somewhat agree
3. Neither agree or disagree
4. Somewhat disagree
5. Strongly disagree

DO NOT READ 6. Don't Know

14. _____ This is a good community to raise children. (School quality, day care, after school programs, recreation)

Strongly agree	**124**	**60%**	**Disagree**	**6**	**3%**
Agree	**69**	**33%**	**Strongly disagree**	**4**	**2%**
Neither agree nor disagree	**4**	**2%**	**Don't know**	**0**	**0%**

15. _____ This is a good community to grow old. (Senior housing, transportation to medical services, churches, shopping, elder day care, social support for the elderly living alone, meals on wheels.)

Strongly agree	**97**	**47%**	**Disagree**	**13**	**6%**
Agree	**70**	**34%**	**Strongly disagree**	**8**	**4%**
Neither agree nor disagree	**16**	**8%**	**Don't know**	**3**	**1%**

16. _____ There is economic opportunity in this community. (Locally owned and operated businesses, jobs with career growth, job training/higher education opportunities, affordable housing, reasonable commute)

Strongly agree	**68**	**33%**	**Disagree**	**20**	**10%**
Agree	**96**	**46%**	**Strongly disagree**	**8**	**4%**
Neither agree nor disagree	**13**	**6%**	**Don't know**	**2**	**1%**

17. _____ The community is a safe place to live. (Safety in the home, workplace, schools, playgrounds, parks, the mall)

Strongly agree	**76**	**37%**	**Disagree**	**15**	**7%**
Agree	**100**	**48%**	**Strongly disagree**	**4**	**2%**
Neither agree nor disagree	**10**	**5%**	**Don't know**	**2**	**1%**

18. _____ The community has networks or organizations for support to individuals and families during times of stress and need. (Neighbors, support groups, faith, community outreach, agencies & organizations)

Strongly agree	**85**	**41%**	**Disagree**	**12**	**6%**
Agree	**72**	**35%**	**Strongly disagree**	**6**	**3%**
Neither agree nor disagree	**15**	**7%**	**Don't know**	**17**	**8%**

19. _____ Individuals and groups have the opportunity to contribute to and participate in the community's quality of life.

Strongly agree	**122**	**59%**	**Disagree**	**5**	**2%**
Agree	**62**	**30%**	**Strongly disagree**	**3**	**1%**
Neither agree nor disagree	**8**	**4%**	**Don't know**	**7**	**3%**

20. _____ Residents believe that they as individuals or in groups can make the community a better place to live.

Strongly agree	**87**	**42%**	**Disagree**	**12**	**6%**
Agree	**86**	**42%**	**Strongly disagree**	**1**	**0%**
Neither agree nor disagree	**15**	**7%**	**Don't know**	**6**	**3%**

21. _____ The assets of the community are available to everyone, regardless of sex, age, race, or religion.

Strongly agree	**63**	**30%**	**Disagree**	**32**	**15%**
Agree	**61**	**29%**	**Strongly disagree**	**19**	**9%**
Neither agree nor disagree	**16**	**8%**	**Don't know**	**16**	**8%**

22. _____ Trust and respect for others is increasing in our community because of working together for common community goals.

Strongly agree	**32**	**15%**	**Disagree**	**35**	**17%**
Agree	**81**	**39%**	**Strongly disagree**	**14**	**7%**
Neither agree nor disagree	**35**	**17%**	**Don't know**	**10**	**5%**

23. _____ Our community has a strong sense of civic pride.

Strongly agree	**83**	**40%**	**Disagree**	**12**	**6%**
Agree	**82**	**40%**	**Strongly disagree**	**3**	**1%**
Neither agree nor disagree	**21**	**10%**	**Don't know**	**6**	**3%**

Codes for Q. 24 & 25

1. Very satisfied
2. Somewhat satisfied
3. Neither satisfied nor dissatisfied
4. Not very satisfied
5. Not satisfied at all

DO NOT READ 6. Don't know

24. _____ Overall how satisfied are you with the quality of life in our community, considering safety, well-being, participation in community life and associations. (**Read 1-5**)

Very satified	**79**	**38%**	**Not very satisfied**	**7**	**3%**
Somewhat satisfied	**106**	**51%**	**Not satisfied at all**	**1**	**0%**
Neither satisfied nor dissatisfied	**14**	**7%**	**Don't know**	**0**	**0%**

25. _____ How satisfied are you with the health care system in the community—access, cost, availability, quality, options or choice? (**Read 1-5**)

Very satified	**72**	**35%**	**Not very satisfied**	**27**	**13%**
Somewhat satisfied	**79**	**38%**	**Not satisfied at all**	**11**	**5%**
Neither satisfied nor dissatisfied	**15**	**7%**	**Don't know**	**3**	**1%**

26. Do you think that tax support for a public health department is a needed expense or an unneeded expense?

1. Needed **166 80%** 2. Unneeded **23 11%** 3. Don't Know **18 9%**

Before finishing, I have some questions about you.

27. Which of the following groups describes your age—18-34, 35-49, 50-64 or 65 and over?

42 20%	**52 25%**	**52 25%**	**60 29%**	**1 0%**
1. 18-34	2. 35-49	3. 50-64	4. 65 and over	Refused

28. Are there **children**, under the age of 18, who live in this household?

62 30%	**145 70%**	**0 0%**
1. Yes	2. No	3. Refused

29. Which of the following describes your race? (read 1-4)

181 87%	1. white	**0 0%**	4. American Indian
14 7%	2. black or African American	**1 0%**	5. other (specify): **Mixed**_____
7 3%	3. Asian	**4 2%**	6. refused

30. Are you of Hispanic or Latino background or ethnicity?

3 1%	**200 97%**	**4 2%**
1. Yes	2. No	3. Refused

31. Are you (Read 1-4)

134 65%	1. Married (includes living together)	**27 13%**	4. Widowed
22 11%	2. Divorced	**1 0%**	5. Refused
23 11%	3. Single, never married		

32. What is the last grade in school you finished? (Read responses 1-5)

7 3%	1. Some high school or less	**37 18%**	4. College graduate
41 20%	2. Completed H.S./trade school	**72 35%**	5. Some grad. work or grad. degree
50 24%	3. Some college	**0 0%**	6. Don't know

33. We do not want to know your exact income, but please tell me from these following **broad** income groups which one fits your household. This is for total income from all sources before taxes last year in 2004. (Read 1-5)

13	**6%**	1. Less than $15,000	**50**	**24%**	5.$75,000 and over
36	**17%**	2. $15-30,000	**2**	**1%**	6. Don't know
56	**27%**	3. $30-50,000	**17**	**8%**	7. Refused
33	**16%**	4. $50-75,000			

34. Where do you live –within the city limits of Champaign, Urbana, or another community in Champaign County or an unincorporated area? If you live in the country, tell me that too.

66	**32%**	1. Champaign	**25**	**12%**	4. Unincorporated area/in the country
52	**25%**	2. Urbana	**0**	**0%**	5. Refused
64	**31%**	3. Another community (specify) _____			

35. How do you pay for health care? (Read 1-5)

35	**17%**	1. Cash	**4**	**2%**	5. Or some other way (specify)____
177	**86%**	2. Insurance	**0**	**0%**	6. Don't know
52	**25%**	3. Medicare	**0**	**0%**	7. Refused
8	**4%**	4. Medicaid			

In case we missed something and need to call back, what is your first name?_____

This concludes the interview. We appreciate your time, thank you very much.

Record these responses without asking.

	78 38%	**129 62%**
36. Sex	1. Male	2. Female
	118 57%	**89 43%**
37. Market	1. Primary—CU	2. Rest of the County/including Savoy

Questions: Call Research Survey Service for Jan Kiley or Dick Adams at 239-7880 during regular business hours—8 AM to 5 PM, Monday thru Friday.

Table 1. In your opinion, what things are most important for a strong economy – things which most improve the quality of life. When we say community, we are talking about Champaign County overall. If you can, name three things that you think are most important to quality of life.

Access to health care	98	47%	Community resources/misc.	6	3%
Don't know	51	25%	Business/stores	5	2%
Good schools	47	23%	Community activities/working together	5	2%
Low crime/safe neighborhoods	36	17%	Health insurance	4	2%
Good jobs & healthy economy	24	12%	City/county services	4	2%
Parks and recreation	19	9%	Social services	4	2%
Clean environment	18	9%	Library	3	1%
Religious or spiritual values	18	9%	Help for low income families	3	1%
Misc.	16	8%	Fire dept.	2	1%
Affordable housing	14	7%	Children's issues	2	1%
Strong family life	14	7%	Good water	2	1%
Seniors issues	11	5%	Infrastructure	2	1%
Public transportation	8	4%	Healthy behavior & lifestyles	1	0%
Taxes	7	3%	University – U of I	1	0%
Good government (honest politicians)	7	3%	Climate	1	0%
Arts & culture events	6	3%	Safety	1	0%
Friends, neighbors	6	3%	Condition of buildings	1	0%
Roads, streets, sidewalks	6	3%	Location/geography	1	0%

Table 2. Here is a list of things some people say are important for a strong community – things which most improve the quality of life in a community. After I read the list, and I will do it quickly, tell me which three are the most important to you. Remember, we want the three most important ones to you.

Not asked	156	75%	Strong Family life	6	3%
Good schools	25	12%	Parks and recreation	5	2%
Low crime/safe neighborhoods	23	11%	Clean environment	4	2%
Access to health care	22	11%	Healthy behaviors & lifestyles	4	2%
Good place to raise children	16	8%	Good race relations	2	1%
Good jobs & healthy economy	11	5%	Misc.	2	1%
Affordable housing	10	5%	Children's issues	2	1%
Religious or spiritual values	8	4%	Arts and cultural events	1	0%
Low level of child abuse	7	3%	Safety	1	0%

Table 3: Q. 3 Office use only

Access to health care	120	58%	Community resources/misc.	6	3%
Good schools	72	35%	Healthy behaviors & lifestyles	5	2%
Low crime/safe neighborhoods	59	29%	Businesses/stores	5	2%
Good jobs & healthy economy	35	17%	Community activities/working together	5	2%
Religious or spiritual values	26	13%	Health insurance	4	2%
Parks and recreations	24	12%	City/county services	4	2%
Affordable housing	24	12%	Children's issues	4	2%
Clean environment	22	11%	Social services	4	2%
Strong family life	20	10%	Library	3	1%
Misc.	18	9%	Help for low income families	3	1%
Good place to raise children	16	8%	Good race relations	2	1%
Seniors issues	11	5%	Fire dept.	2	1%
Public transportation	8	4%	Safety	2	1%
Low level of child abuse	7	3%	Good water	2	1%
Arts & cultural events	7	3%	Infrastructure	2	1%
Taxes	7	3%	University - U of I	1	0%
Good government (honest politicians)	7	3%	Climate	1	0%
Friends, neighbors	6	3%	Condition of buildings	1	0%
Roads, streets, sidewalks	6	3%	Location/geography	1	0%

Table 4: Q. 4 Now we want to talk specifically about health problems. What are the three most important health problems in our community, referring to all of Champaign County.

Don't know	65	31%	Dental problems	3	1%
Heart disease & stroke	32	15%	Infectious diseases (hepatitis, TB)	3	1%
Cancers	29	14%	RX costs and other issues	3	1%
Affordable health care	29	14%	Transportation to medical services	3	1%
Health insurance - low income, accessible/affordable	23	11%	Colds	3	1%
Drugs	15	7%	Doctor shortage/leaving	3	1%
Diabetes	14	7%	Preventive education	3	1%
Obesity	14	7%	Dental care	3	1%
Mental health problems	12	6%	Flu	2	1%
Sexually transmitted diseases	10	5%	Alzheimer's	2	1%
Seniors issues	10	5%	Allergies	2	1%
Smoking	10	5%	Nutrition/poor eating habits	2	1%
Neg. health care/misc.	10	5%	Pregnancy services	2	1%
Misc.	9	4%	Housing issues	2	1%
Environmental	8	4%	Teen issues	2	1%
High blood pressure	7	3%	Social services	2	1%
Shots/immunizations	7	3%	HIV/AIDS	1	0%
Alcohol	7	3%	Teenage pregnancy	1	0%
Respiratory/lung diseases	6	3%	Arthritis	1	0%
Aging problems	5	2%	County health	1	0%
Children's issues	5	2%	Support groups	1	0%
Lack of exercise	4	2%	Crime	1	0%
Medicaid, green card	4	2%			

Table 5: Q. 5 Here is a list of health problems. After I read the list, tell me which three are the most important to you. Remember we want the three most important ones to you.

Not asked	142	69%	Don't know	6	3%
Cancers	32	15%	High blood pressure	5	2%
Heart disease & stroke	24	12%	HIV/AIDS	4	2%
Diabetes	21	10%	Sexually transmitted diseases	3	1%
Child abuse/neglect	19	9%	Respiratory/lung diseases	2	1%
Domestic violence	16	8%	Suicide	2	1%
Aging problems	13	6%	Dental problems	1	0%
Mental health problems	11	5%	Infectious diseases (hepatitis, TB)	1	0%
Teenage pregnancy	9	4%	Drugs	1	0%
Rape & sexual assault	8	4%	RX costs and other issues	1	0%

Table 6: Q. 6

Cancers	61	29%	Children's issues	5	2%
Heart disease & stroke	56	27%	Dental problems	4	2%
Diabetes	35	17%	Infectious diseases (hepatitis, TB)	4	2%
Affordable health care	29	14%	RX costs and other issues	4	2%
Mental health problems	23	11%	Lack of exercise	4	2%
Health insurance - low income, accessible/affordable	23	11%	Medicaid, green card	4	2%
Child abuse/neglect	19	9%	Transportation to medical services	3	1%
Aging problems	18	9%	Colds	3	1%
Domestic violence	16	8%	Doctor shortage/leaving	3	1%
Drugs	16	8%	Preventive education	3	1%
Obesity	14	7%	Dental care	3	1%
Sexually transmitted diseases	13	6%	Suicide	2	1%
High blood pressure	12	6%	Flu	2	1%
Teenage pregnancy	10	5%	Alzheimer's	2	1%
Seniors issues	10	5%	Allergies	2	1%
Smoking	10	5%	Nutrition/poor eating habits	2	1%
Neg. health care/misc.	10	5%	Pregnancy services	2	1%
Misc.	9	4%	Housing issues	2	1%
Rape & sexual assault	8	4%	Teen issues	2	1%
Respiratory/lung diseases	8	4%	Social services	2	1%
Environmental	8	4%	Arthritis	1	0%
Shots/immunizations	7	3%	County health	1	0%
Alcohol	7	3%	Support groups	1	0%
Don't know	6	3%	Crime	1	0%
HIV/AIDS	5	2%			

Table 7: Q. 7 What are the three most important risky behaviors, those that have the greatest impact on overall community health?

Alcohol abuse	77	37%	Teen issues	3	1%
Drug abuse	72	35%	Not taking med./following med advice, going to doctor	3	1%
Don't know	67	32%	Affordable health care	2	1%
Unsafe sex	54	26%	Child abuse	2	1%
Smoking/Tobacco use	46	22%	Poor hygiene	2	1%
Poor eating habits	15	7%	Children's issues	2	1%
Careless/unsafe driving	13	6%	Teen pregnancy	2	1%
Misc.	11	5%	Rape	2	1%
Domestic violence	8	4%	Mental health	2	1%
Lack of exercise	7	3%	Health insurance - low income, accessible/affordable	1	0%
Pollution/environment	5	2%	Seniors issues	1	0%
Being overweight/obesity	4	2%	Pregnancy services	1	0%
Not using seat belts/ child safety seats	4	2%	Cost of medical care	1	0%
Guns	4	2%	Neg. health care/misc.	1	0%
Crime	4	2%	Accidents in home	1	0%
Not getting "shots" to prevent disease	3	1%	Housing	1	0%
Suicide	3	1%	Special diseases/ailments	1	0%
Cell phones & driving	3	1%			

Table 8: Q. 8 Here is a list of risky behaviors that may have an impact on overall community health. Which are the three most important to you?

Not asked	140	68%	Not using birth control	4	2%
Alcohol abuse	40	19%	Child abuse	3	1%
Drug abuse	40	19%	Not getting "shots" to prevent disease	2	1%
Being overweight/obesity	23	11%	Or some other factor	2	1%
Unsafe sex	15	7%	Don't know	2	1%
Dropping out of school	11	5%	Children's issues	2	1%
Not using seat belts/ child safety seats	9	4%	Misc.	2	1%
Poor eating habits	8	4%	Not taking med./following med. advice, going to doctor	2	1%
Lack of exercise	7	3%	Crime	1	0%
Smoking/Tobacco use	7	3%	Stress	1	0%
Racism	5	2%			

Table 9: Q. 9

Alcohol abuse	117	57%	Guns	4	2%
Drug abuse	112	54%	Suicide	3	1%
Unsafe sex	69	33%	Cell phones & driving	3	1%
Smoking/Tobacco use	53	26%	Teen issues	3	1%
Being overweight/obesity	27	13%	Don't know	2	1%
Poor eating habits	23	11%	Affordable health care	2	1%
Lack of exercise	14	7%	Poor hygiene	2	1%
Not using seat belts/ child safety seats	13	6%	Teen pregnancy	2	1%
Careless/unsafe driving	13	6%	Rape	2	1%
Misc.	13	6%	Mental health	2	1%
Dropping out of school	11	5%	Health insurance - low income, accessible/affordable	1	0%
Domestic violence	8	4%	Seniors issues	1	0%
Not getting "shots" to prevent disease	5	2%	Pregnancy services	1	0%
Racism	5	2%	Cost of medical care	1	0%
Child abuse	5	2%	Neg. health care/misc.	1	0%
Crime	5	2%	Accidents in home	1	0%
Pollution/environment	5	2%	Stress	1	0%
Not taking med./following med advice, going to doctor	5	2%	Housing	1	0%
Not using birth control	4	2%	Specific diseases/ailments	1	0%
Children's issues	4	2%			

Table 10: Q. 12 In your opinion, what is keeping our community from doing what needs to be done to improve health and quality of life?

Money - lack of, need more	54	26%	Nutrition/health info/Ed	5	2%
Don't know	35	17%	Mismanag. - funds, programs	4	2%
Health insurance/none, low income	16	8%	Drugs	4	2%
Awareness of issues/problems	15	7%	Smoking	4	2%
Misc.	15	7%	Lack of business/industry	3	1%
Neg. politics/politicians	14	7%	Jobs - need	3	1%
Access to health care	13	6%	Social services	3	1%
Apathy/laziness	11	5%	Environment/pollution	3	1%
High cost of health care	11	5%	Prevention/self help prog.	3	1%
Neg. health care/misc.	11	5%	Cost of living	3	1%
Lack of cooperation - people, gov., organizations	10	5%	Willingness to spend more money	2	1%
Neg. government	9	4%	Taxes	2	1%
Need better schools	6	3%	Senior issues	2	1%
Individual responsibility for self/ health care	5	2%	Youth issues	2	1%
High cost of malpractice insurance/in gen.	5	2%	Neg. develop & implement plan	1	0%
Need education/specific problems	5	2%	Doctor shortage	1	0%
Exercise	5	2%	Drug companies	1	0%
Parks/recreation	5	2%	Parents	1	0%

Table 11: Q. 13 What assets does Champaign County have that make it a healthier community?

Pos./misc. health care, docs, hospitals	69	33%	Parkland	3	1%
Parks/recreation/exercise	44	21%	Misc. organizations	3	1%
U of I	41	20%	People, authorities, professionals	3	1%
Don't know	33	16%	Businesses/stores	3	1%
Carle	19	9%	Pos. government	3	1%
Environment/air, water quality	16	8%	Philanthropy/volunteerism	3	1%
Public Health Dist./ Dept. of Public	16	8%	Dental	2	1%
Provena	8	4%	YMCA	2	1%
Good economy/jobs	8	4%	Social service programs	2	1%
Education	8	4%	Appearance/upkeep	2	1%
Misc.	8	4%	Children's activities/issues	2	1%
Christie	5	2%	Farmer's Market	2	1%
Sports/athletics	5	2%	Planned Parenthood	1	0%
Higher education/colleges	5	2%	Mental Health Center	1	0%
Senior issues	5	2%	Flu clinics	1	0%
Culture (libraries, museums)	5	2%	Housing	1	0%
Health care for the poor	4	2%	Streets, roads, sidewalks/lighting	1	0%
Francis Nelson	4	2%	Blood bank	1	0%
Prevention/wellness, self help	4	2%	Location/geography	1	0%
Good/clean water	4	2%	Transportation	1	0%
Agriculture	3	1%	Awareness of services, programs	1	0%

Appendix C

Local Public Health System Performance Assessment

Summary of Performance Scores

Champaign, Illinois

December 20005

NPHPSP Local Public Health System Performance Assessment Instrument

Summary of Performance Scores by EPHS and Indicators

Illinois State : IL008

Date Submitted: 16DEC2005

Description	Score
EPHS 1: Monitor Health Status	**62.23**
1.1 Population Based Community Health Profile	**72.80**
1_1_1 Conducted community health assessment?	**60.49**
1_1_2 Compile data into community health profile?	**87.59**
1_1_3 Access to community demographic characteristics?	**100.00**
1_1_4 Access to community socioeconomic characteristics?	**100.00**
1_1_5 Access to health resource availability data?	**100.00**
1_1_6 Access to quality of life data for the community?	**33.33**
1_1_7 Access to behavioral risk factors for the community?	**76.67**
1_1_8 Access to community environmental health indicators?	**76.67**
1_1_9 Access to social and mental health data?	**33.33**
1_1_10 Access to maternal and child health data?	**100.00**
1_1_11 Access to death, illness, injury data?	**100.00**
1_1_12 Access to communicable disease data?	**100.00**
1_1_13 Access to sentinel events data?	**33.33**
1_1_14 Community-wide use of health assessment or CHP data promoted?	**17.78**
1.2 Access to and Utilization of Current Technology	**43.67**
1_2_1 State-of-the-art technology to support databases?	**27.50**
1_2_2 Access to geocoded health data?	**33.33**

Centers for Disease Control and Prevention

Public Health Practice Program Office

Division of Public Health Systems Development and Research

National Public Health Performance Standards Program

1-800-PHPPO-49 or 1-800-747-7649

NPHPSP Local Public Health System Performance Assessment Instrument

Summary of Performance Scores by EPHS and Indicators

Illinois State : IL008

Date Submitted: 16DEC2005

Description	Score
1_2_3 Use geographic information systems (GIS)?	53.33
1_2_4 Use computer-generated graphics to identify trends and/or compare data?	66.67
1_2_5 CHP available in electronic version?	37.50
1.3 Maintenance of Population Health Registries	70.23
1_3_1 Maintain and/or contribute to one or more population health registries?	71.58
1_3_2 Used information from population health registries?	68.89
EPHS 2: Diagnose and Investigate Health Problems	83.40
2.1 Identification and Surveillance of Health Threats	75.62
2_1_1 Submit timely reportable disease information to state or LPHS?	66.67
2_1_2 Monitor changes in occurrence of health problems and hazards?	55.00
2_1_3 Have a comprehensive surveillance system?	80.00
2_1_4 Use IT for surveillance?	85.38
2_1_5 Access to Masters or Doctoral level epidemiologists and/or statisticians?	100.00
2_1_6 Procedure to alert communities about health threats/disease outbreaks?	66.67
2.2 Plan for Public Health Emergencies	66.67
2_2_1 Identified public health disasters and emergencies?	33.33
2_2_2 Have an emergency preparedness and response plan?	33.33

Centers for Disease Control and Prevention

Public Health Practice Program Office

Division of Public Health Systems Development and Research

National Public Health Performance Standards Program

1-800-PHPPO-49 or 1-800-747-7649

NPHPSP Local Public Health System Performance Assessment Instrument

Summary of Performance Scores by EPHS and Indicators

Illinois State : IL008

Date Submitted: 16DEC2005

Description	Score
2_2_3 Plan been tested through one or more “mock events” in the past year?	100.00
2_2_4 Plan been reviewed or revised within the past two years?	100.00
2.3 Investigate and Respond to Public Health Emergencies	91.33
2_3_1 Designated an Emergency Response Coordinator?	100.00
2_3_2 Have current epidemiological case investigation protocols?	100.00
2_3_3 Written protocols for implementing program of source and contact tracing?	100.00
2_3_4 Roster of response personnel with technical expertise?	56.67
2_3_5 Evaluate public health emergency response incidents?	100.00
2.4 Laboratory Support for Investigation of Health Threats	100.00
2_4_1 Access to laboratory services to support investigations?	100.00
2_4_2 Access to laboratories capable of meeting routine diagnostic and surveillance needs?	100.00
2_4_3 Documentation that laboratories are licensed and/or credentialed?	100.00
2_4_4 Current guidelines or protocols for handling laboratory samples?	100.00
EPHS 3: Inform, Educate, and Empower People	97.34
3.1 Health Education	100.00
3_1_1 Information on community health to public and policy leaders?	100.00
3_1_2 Use media to communicate health information?	100.00

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Summary of Performance Scores by EPHS and Indicators

Illinois State : IL008

Date Submitted: 16DEC2005

Description	Score
3_1_3 Sponsor health education programs?	100.00
3_1_4 Assessed public health education activities?	100.00
3.2 Health Promotion Activities	94.69
3_2_1 Implemented health promotion activities?	91.83
3_2_2 Collaborative networks for health promotion established?	100.00
3_2_3 Assessed health promotion activities?	92.22
EPHS 4: Mobilize Community Partnerships	45.60
4.1 Constituency Development	61.56
4_1_1 Process for identifying key constituents?	50.83
4_1_2 Encourage participation of constituents in improving community health?	62.58
4_1_3 Current directory of organizations that comprise the LPHS?	59.17
4_1_4 Use communications strategies to strengthen linkages?	73.67
4.2 Community Partnerships	29.63
4_2_1 Partnerships exist in the community?	68.89
4_2_2 Assure establishment of a broad-based community health improvement committee?	10.00
4_2_3 Assess the effectiveness of community partnerships?	10.00

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Description	Score
EPHS 5: Develop Policies and Plans	**50.53**
5.1 Governmental Presence at Local Level	**77.78**
5_1_1 Includes a local governmental public health entity?	**100.00**
5_1_2 Assures participation of stakeholders in implementation of community health plan?	**33.33**
5_1_3 Local governing entity (e.g., local board of health) conducts oversight?	
5_1_4 Local governmental public health entity work with the state public health system?	**100.00**
5.2 Public Health Policy Development	**37.06**
5_2_1 Contribute to the development of public health policies?	**34.50**
5_2_2 Review public health policies at least every two years?	**10.00**
5_2_3 Advocate for the development of prevention and protection policies?	**66.67**
5.3 Community Health Improvement Process	**65.06**
5_3_1 Established a community health improvement process?	**96.79**
5_3_2 Developed strategies to address community health objectives?	**33.33**
5.4 Strategic Planning and Alignment	**22.22**
5_4_1 Each organization in the LPHS conduct a strategic planning process?	**33.33**
5_4_2 Each organization in the LPHS review its organizational strategic plan?	**33.33**
5_4_3 Local governmental public health entity conduct strategic planning activities?	**0.00**

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Description	Score
EPHS 6: Enforce Laws and Regulations	**82.31**
6.1 Review and Evaluate Laws, Regulations, and Ordinances	**83.33**
6_1_1 Identify public health issues addressed through laws, regulations, or ordinances?	**100.00**
6_1_2 Access to current compilation of laws, regulations, and ordinances?	**100.00**
6_1_3 Review the public health laws and regulations every 5 years?	**33.33**
6_1_4 Access to legal counsel?	**100.00**
6.2 Involvement in Improvement of Laws, Regs and Ordinances	**77.78**
6_2_1 Identify local public health issues not adequately addressed through existing laws, regulations, and ordinan	**33.33**
6_2_2 Participated in the development or modification of laws, regulations or ordinances?	**100.00**
6_2_3 Provide technical assistance to legislative, regulatory or advocacy groups?	**100.00**
6.3 Enforce laws, Regulations and Ordinances	**85.83**
6_3_1 Authority to enforce public health laws, regulations, or ordinances?	**92.22**
6_3_2 Assure enforcement activities are conducted in a timely manner?	**66.67**
6_3_3 Provide information to individuals and organizations about public health laws, regulations, and ordinances?	**100.00**
6_3_4 Reviewed the activities of institutions and businesses in the community?	**84.44**
EPHS 7: Link People to Needed Personal Health Services	**61.89**

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Summary of Performance Scores by EPHS and Indicators

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Description	Score
7.1 Identification of Populations with Barriers to System	68.33
7_1_1 Identify any populations who may encounter barriers?	68.33
7.2 Identifying Personal Health Service Needs of Population	57.67
7_2_1 Defined personal health service needs for all of its catchment areas?	66.67
7_2_2 Assessed the extent personal health services are being provided?	33.33
7_2_3 Identify the personal health services of populations who encounter barriers to personal health services?	73.00
7.3 Assuring Linkage of People to Personal Health Services	59.67
7_3_1 Assure the provision of needed personal health services?	33.33
7_3_2 Provide outreach and linkage services for the community?	60.83
7_3_3 Initiatives to enroll eligible beneficiaries in state Medicaid or medical assistance programs?	33.33
7_3_4 Assure the coordinated delivery of personal health services?	70.83
7_3_5 Conducted an analysis of age-specific participation in preventive services?	100.00
EPHS 8: Assure a Competent Workforce	54.25
8.1 Workforce Assessment	13.89
8_1_1 Conduct a workforce assessment within past three years?	21.67
8_1_2 Gaps within the public and personal health workforce been identified?	10.00

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Description	Score
8_1_3 Results of the workforce assessment disseminated?	10.00
8.2 Public Health Workforce Standards	89.85
8_2_1 Aware of and in compliance with guidelines and/or licensure/certification requirements for personnel?	100.00
8_2_2 Organizations developed written job standards and/or position descriptions?	100.00
8_2_3 Agency developed job standards and/or position descriptions?	72.58
8_2_4 Organizations conduct performance evaluations?	100.00
8_2_5 Agency conduct performance evaluations?	76.67
8.3 Continuing Education, Training and Mentoring	60.76
8_3_1 Identify education and training needs?	90.00
8_3_2 Local governmental public health entity provide opportunities for personnel to develop core public health co	25.56
8_3_3 Incentives provided to the workforce to participate in educational and training experiences?	27.50
8_3_4 Opportunities for interaction between LPHS organization staff and faculty from academic and research institu	100.00
8.4 Public Health Leadership Development	52.50
8_4_1 Promote the development of leadership skills?	66.67
8_4_2 Promote collaborative leadership?	33.33
8_4_3 Opportunities to provide leadership in areas of expertise or experience?	66.67
8_4_4 Opportunities to develop community leadership through and mentoring?	43.33

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Summary of Performance Scores by EPHS and Indicators

Illinois State : IL008

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Description	Score
EPHS 9: Evaluate Effectiveness, Accessibility and Quality	**69.20**
9.1 Evaluation of Population-Based Services	**68.49**
9_1_1 Evaluated population-based health services?	**52.28**
9_1_2 Assess community satisfaction with population-based health services?	**55.00**
9_1_3 Identify gaps in the provision of population-based health services?	**66.67**
9_1_4 Use the results of the evaluation in the development of their strategic and operational plans?	**100.00**
9.2 Evaluation of Personal Health Care Services	**66.44**
9_2_1 Evaluated personal health services for the community?	**92.22**
9_2_2 Specific personal health care services in the community evaluated against established criteria?	**66.67**
9_2_3 Assess client satisfaction with personal health services?	**40.00**
9_2_4 Use information technology to assure quality of personal health services?	**66.67**
9_2_5 Use the results of the evaluation in the development of their strategic and operational plans?	**66.67**
9.3 Evaluation of Local Public Health System	**72.66**
9_3_1 Identified community organizations or entities that contribute to the delivery of the EPHS?	**100.00**
9_3_2 Evaluation of the LPHS conducted every three to five years?	**86.49**
9_3_3 Linkages and relationships among organizations that comprise the LPHS assessed?	**53.33**
9_3_4 Use results from the evaluation process to guide community health improvements?	**50.83**

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Description	Score
EPHS 10: Research for New Insights and Innovative Solutions	**70.19**
10.1 Fostering Innovation	**58.33**
10_1_1 Encourage staff to develop new solutions to health problems in the community?	**66.67**
10_1_2 Proposed to research organizations one or more public health issues for inclusion in their research agenda?	**33.33**
10_1_3 Identify and/or monitor “best practices” developed by other public health agencies or organizations?	**66.67**
10_1_4 Encourage community participation in the development or implementation of research?	**66.67**
10.2 Linkage with Institutions of Higher Learning and Research	**85.56**
10_2_1 Partner with at least one institution of higher learning and/or research organization?	**66.67**
10_2_2 Develop relationships with institutions of higher learning and/or research organizations?	**100.00**
10_2_3 Encourage proactive interaction between the academic and practice communities?	**90.00**
10.3 Capacity for Epidemiological, Policy and Service Research	**66.67**
10_3_1 Access to researchers?	**100.00**
10_3_2 Resources to facilitate research within the LPHS?	**100.00**
10_3_3 Plan for the dissemination of research findings to public health colleagues?	**33.33**
10_3_4 Evaluate research activities?	**33.33**
Average Total Performance Score	**67.69**

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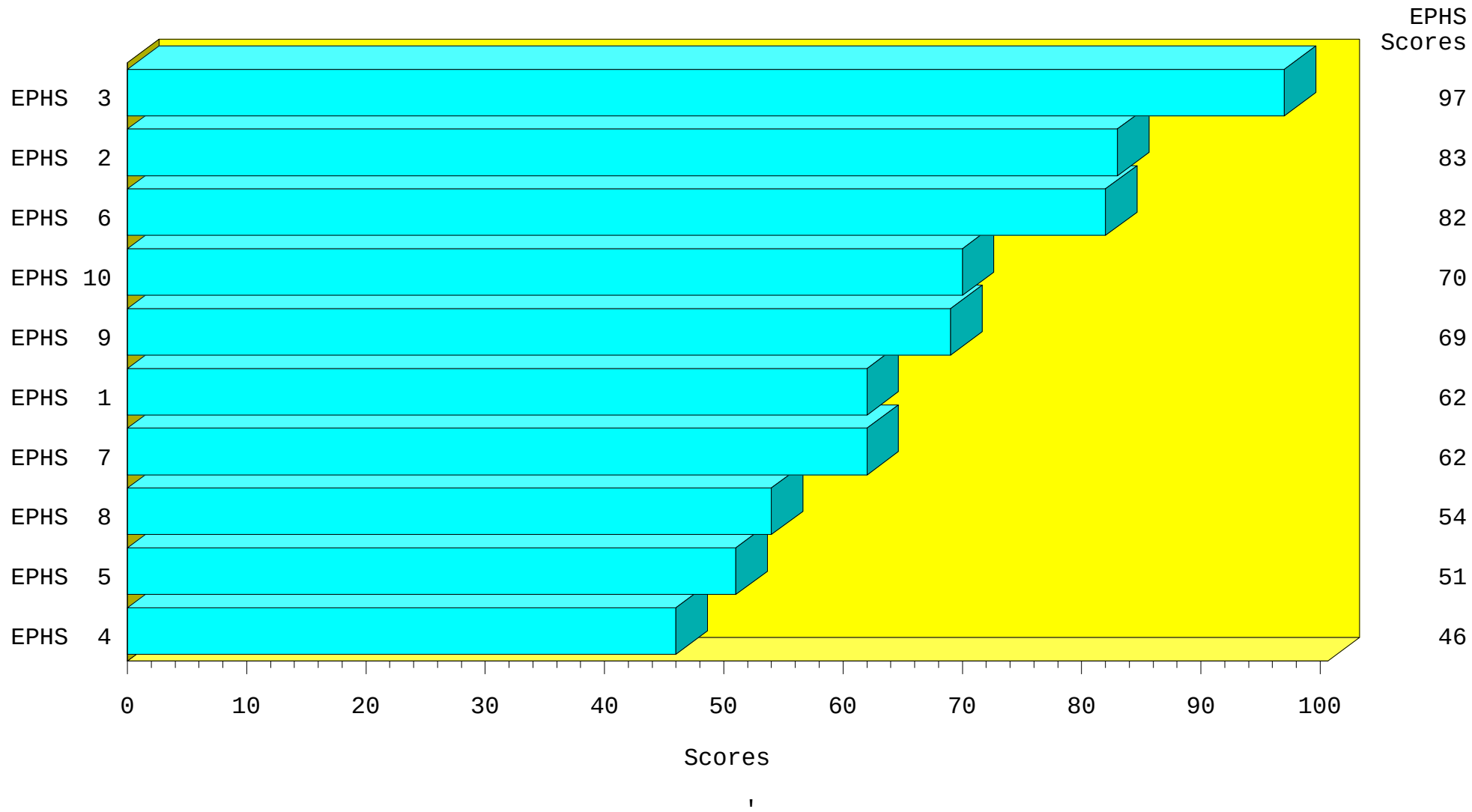
Essential Public Health Service (EPHS) Summary Scores (arranged in descending order)
Illinois State : IL008
Date Submitted: 16DEC2005



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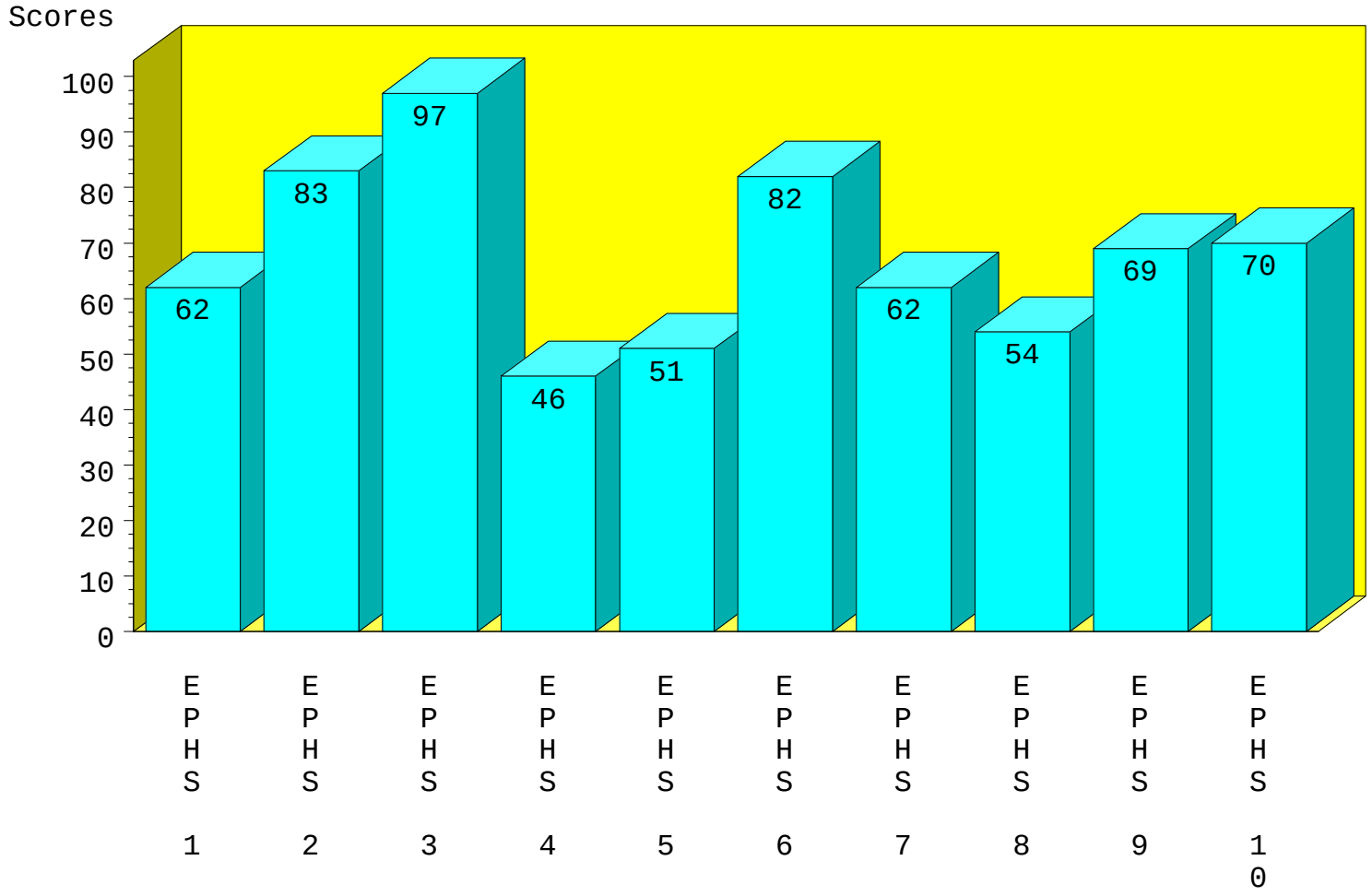
Summary Scores at the Essential Service Level

Illinois State : IL008

Date Submitted: 16DEC2005



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Summary of Performance on Model Standards

Illinois State : IL008

Date Submitted: 16DEC2005

Essential Public Health Service	Indicator/Model Standard Met	Indicator/Model Standard Substantially Met	Indicator/Model Standard Partially Met	Indicator/Model Standard Not Met
1: Monitor Health Status		1.1 Population Based Community Health Profile		
		1.3 Maintenance of Population Health Registries	1.2 Access to and Utilization of Current Technology	
2: Diagnose and Investigate Health Problems	2.3 Investigate and Respond to Public Health Emergencies			
	2.4 Laboratory Support for Investigation of Health Threats	2.1 Identification and Surveillance of Health Threats		
		2.2 Plan for Public Health Emergencies		
3: Inform, Educate, and Empower People	3.1 Health Education			
	3.2 Health Promotion Activities			
4: Mobilize Community Partnerships		4.1 Constituency Development	4.2 Community Partnerships	
5: Develop Policies and Plans		5.1 Governmental Presence at Local Level		
		5.3 Community Health Improvement Process	5.2 Public Health Policy Development	5.4 Strategic Planning and Alignment
6: Enforce Laws and Regulations	6.1 Review and Evaluate Laws, Regulations, and Ordinances			

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	6.3 Enforce laws, Regulations and Ordinances	6.2 Involvement in Improvement of Laws, Regs and Ordinances		
7: Link People to Needed Personal Health Services		7.1 Identification of Populations with Barriers to System	7.2 Identifying Personal Health Service Needs of Population	
			7.3 Assuring Linkage of People to Personal Health Services	
8: Assure a Competent Workforce	8.2 Public Health Workforce Standards	8.3 Continuing Education, Training and Mentoring	8.4 Public Health Leadership Development	8.1 Workforce Assessment
9: Evaluate Effectiveness, Accessibility and Quali		9.1 Evaluation of Population-Based Services		
		9.2 Evaluation of Personal Health Care Services		
		9.3 Evaluation of Local Public Health System		
10: Research for New Insights and Innovative Soluti	10.2 Linkage with Institutions of Higher Learning and Research	10.3 Capacity for Epidemiological, Policy and Service Research	10.1 Fostering Innovation	

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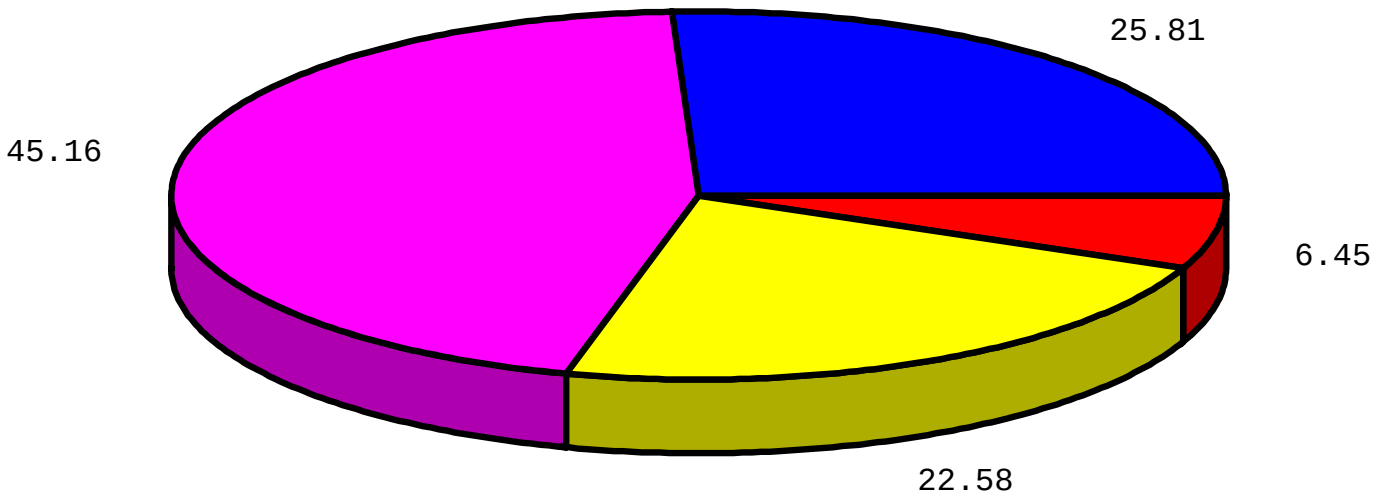

Fully Met:	Score of 80-100%
Substantially Met:	Score of 60-79%
Partially Met:	Score of 26-59%
Not Met:	Score of 0-25%

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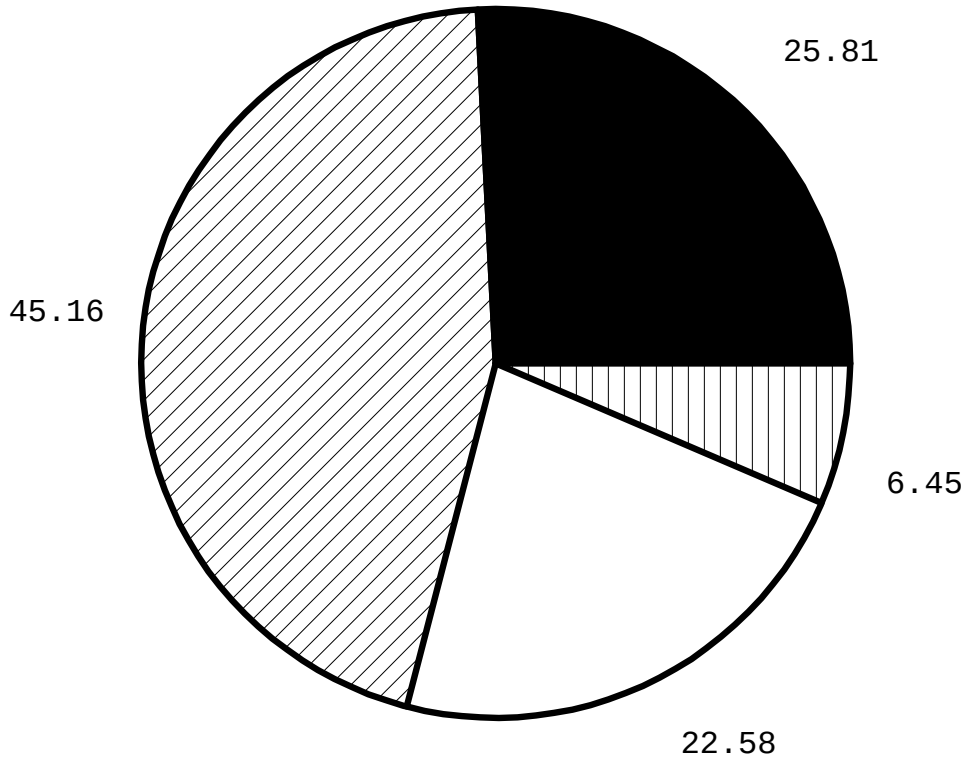

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	Not Met:	Score of 0-25%

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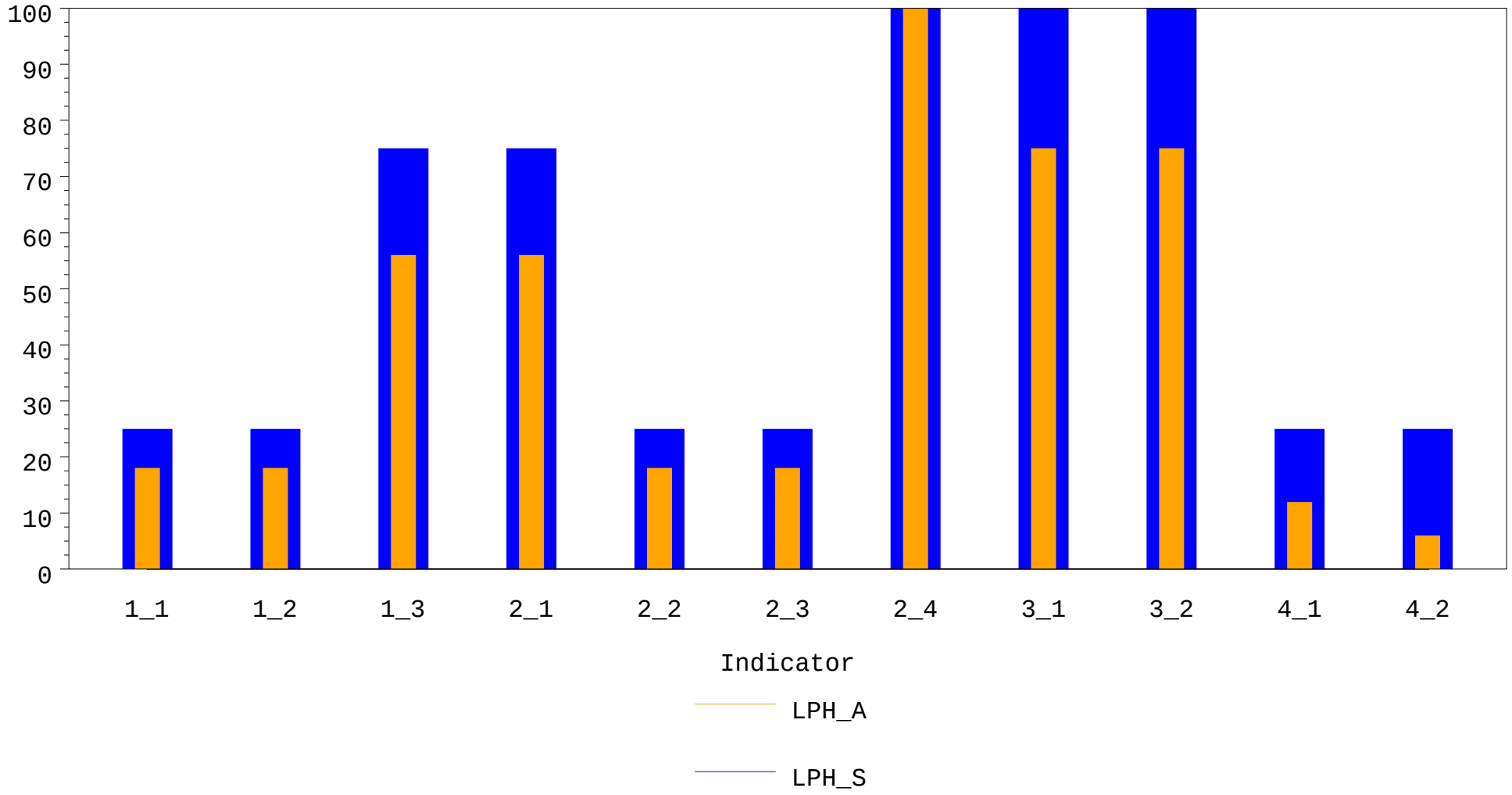
System Performance and Agency Contribution - Summary Question Responses
Illinois State : IL008
Date Submitted: 16DEC2005



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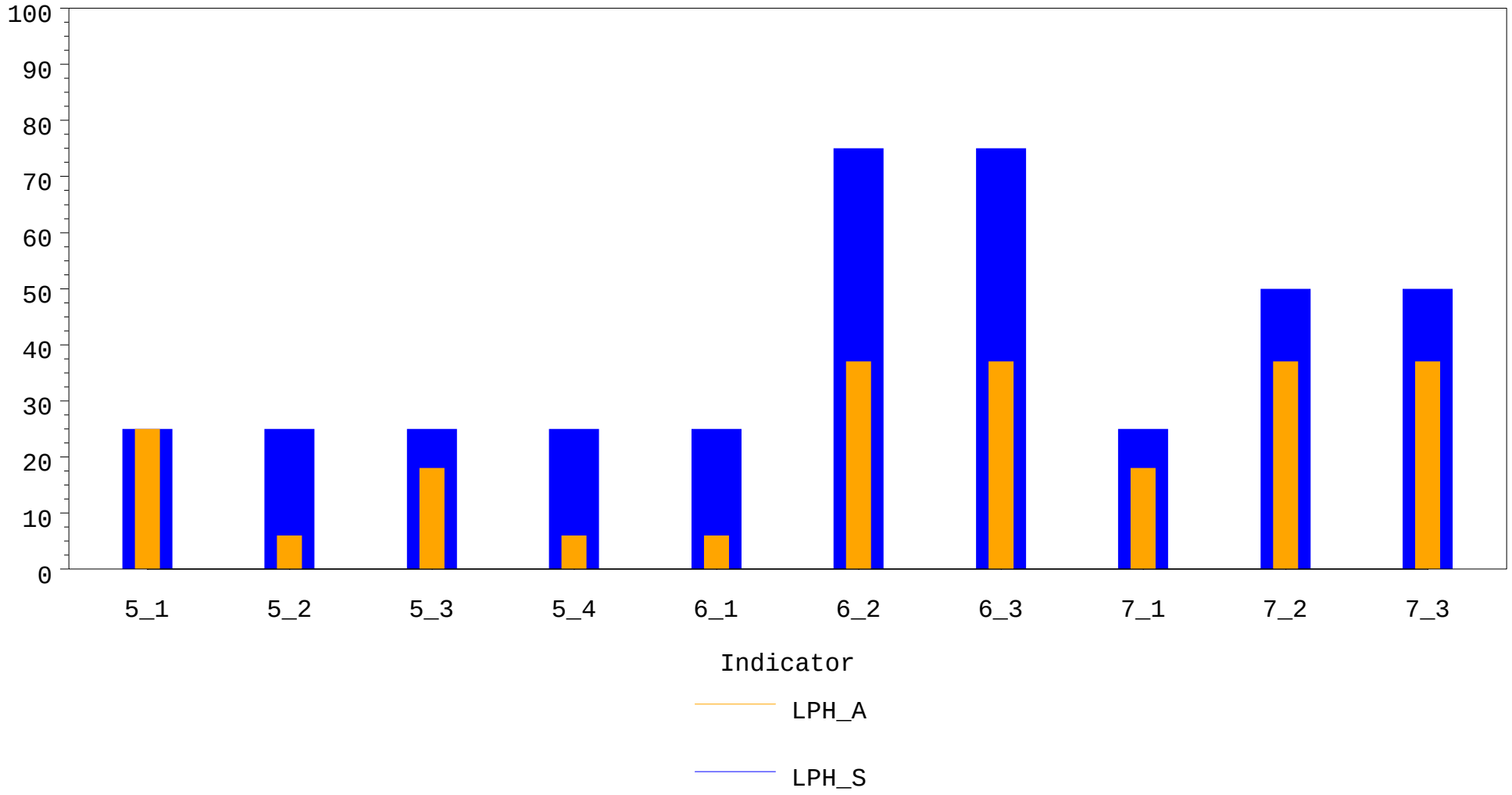

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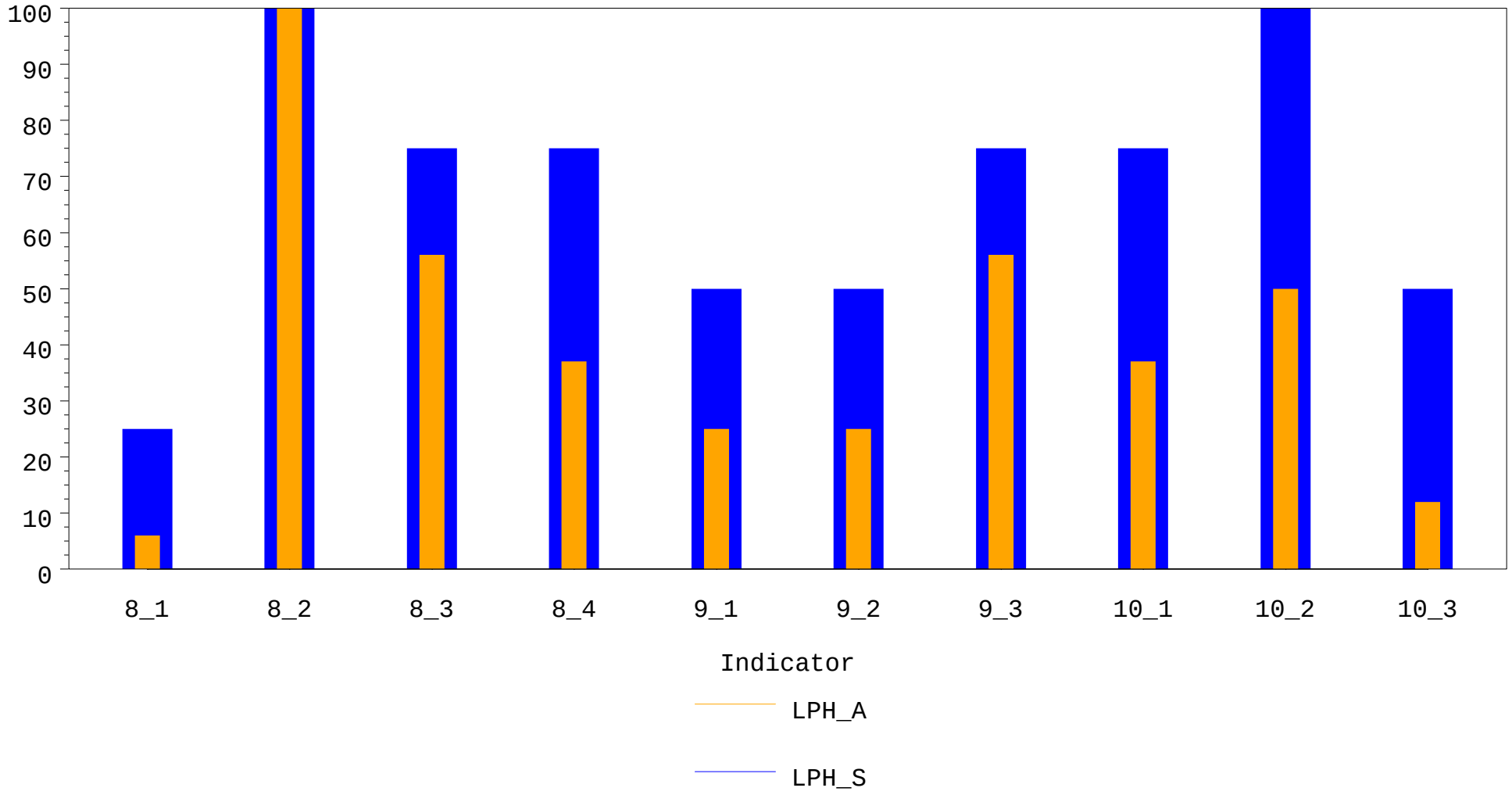

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