

PRIORITY AREA –IMPROVE ACCESS TO CARE: WITH FOCUS ON NON-EMERGENCY TRANSPORTATION; HEALTH CARE COVERAGE; AND THE NUMBER OF PROVIDERS IN SPECIFIC DISCIPLINES (IE PSYCHIATRIST, DENTIST, ETC.)

GOAL - Improve access to comprehensive, high-quality health care services.

RATIONALE

Access to quality care is important to eliminate health disparities and increase the quality and years of healthy life for all persons in the United States. Access to high-quality health care across each of the components in the continuum of care must be improved to realize the full potential of prevention. For example, success in reducing the burden of heart disease and narrowing the gap in heart disease outcomes between different groups will depend on several factors. These factors include ensuring access to clinical preventive services, such as blood pressure and cholesterol screening; effective primary care to educate people about modifiable risk factors, such as smoking, and to manage effectively chronic conditions like hypertension; high-quality emergency services to improve outcomes of acute cardiac events; and access to rehabilitative and long-term care for heart disease patients. The public health system is important in this area because it educates people about prevention and addresses the need to eliminate disparities by easing access to preventive services for people less able to use existing health services⁰¹. Adequate access to health care and related services can increase appropriate patient use of the health care system and, ultimately, improve health outcomes⁰².

Clinical preventive services have a substantial impact on many of the leading causes of disease and death. People must have access to clinical preventive services that are effective in preventing disease (primary prevention) or in detecting asymptomatic disease or risk factors at early, treatable stages (secondary prevention).

Results of the 1994 National Access to Care Survey suggest that some studies have missed substantial components of unmet needs by failing to include specific questions about supplementary health care services, such as prescription drugs, eyeglasses, dental care, and mental health care or counseling. When specific questions were added about these services, the findings showed that 16.1 percent of respondents (approximately 41 million) were unable to obtain at least one service they believed they needed. The highest reported unmet need was for dental care. This problem can be attributed partly to insufficient provider reimbursement, which discourages participation in plans even when the service is covered⁰³.

BARRIERS

Improving access to appropriate preventive care requires addressing many barriers, including those that involve the patient, provider, and system of care. *Patient* barriers include lack of knowledge, skepticism about the effectiveness of prevention, lack of a usual source of primary care, and lack of money to pay for preventive care⁰². Uninsured people are less than half as likely as people with health insurance to have a primary care provider; to have received appropriate preventive care, such as recent mammograms or Pap tests; or to have had any recent medical visits. Lack of insurance also affects access to care for relatively serious medical conditions⁰⁴. Quality rehabilitative care needs are evident across all populations, and access to rehabilitative care is a significant problem for people who lack health insurance or who are underinsured and are unable to pay for the type and quality of health care they need. Individuals also may lack a usual source of care or may face other barriers to receiving services, such as financial barriers (having no health insurance or being underinsured), structural barriers (no facilities or health care professionals nearby), and personal barriers (sexual orientation, cultural differences, language differences, not knowing what to do, or environmental challenges for people with disabilities). *Patients with disabilities* may face additional barriers arising from facilities that are not physically accessible or from the attitudes of clinicians⁰⁵. Certain people, such as those who are disabled,

elderly, chronically ill, or HIV-infected, require access to health care providers who have the knowledge and skills to address their special needs⁰⁶.

In addition to a lack of insurance or underinsurance, barriers include a lack of appropriate referrals, travel distance to the provider, lack of transportation, and unavailability of specialists. Families experience barriers to care for a variety of reasons: inability to afford health care (60 percent); insurance-related causes (20 percent), including (1) the insurance company not approving, covering, or paying for care, (2) preexisting conditions for which insurance coverage often is restricted, (3) lack of access to required referrals, and (4) clinicians refusing to accept the family's insurance plan; and other problems (21 percent), such as transportation, physical barriers, communication problems, child care limitations, lack of time or information, or refusal of services⁰⁷. Although the lack of health insurance is clearly a major factor impeding access to care, having health insurance does not guarantee that health care will be accessible or affordable. Gaps persist in coverage for effective preventive services, especially counseling⁰⁸.

Health provider barriers include limited time, lack of training in prevention, lack of perceived effectiveness of selected preventive services, and practice environments that fail to facilitate prevention. Although consensus is growing regarding the value of a range of preventive services, providers identify lack of time and reimbursement as specific barriers to more consistent delivery of counseling about behavioral risk factors such as diet and exercise.

System barriers can include lack of resources or attention devoted to prevention, lack of coverage or inadequate reimbursement for services, and lack of systems to track the quality of care⁰². Significant progress in the delivery of clinical preventive services (CPS) is unlikely without appropriate data systems to allow providers and administrators to identify those services and populations most in need of better delivery⁰⁹.

BEHAVIORAL RISK/PROTECTIVE FACTORS AND CONTRIBUTING FACTOR ANALYSIS

Having health insurance, a high income, and a primary care provider are strong predictors that a person will receive appropriate preventive care. Although reimbursement for common screening tests, such as mammograms and Pap tests, is provided by most health insurance plans reimbursement for effective counseling interventions, such as smoking cessation, is less common⁰². Evidence suggests that lack of insurance over an extended period significantly increases the risk of premature death and that death rates among hospitalized patients without health insurance are significantly higher than among patients with insurance. Among those without insurance, chronically ill persons are even less likely than those with acute conditions to get health care services they need⁰⁴. Having a primary care provider as the usual source of care is especially important because of the beneficial attributes of primary care⁰⁹.

Computerized or manual tracking systems, patient and clinician reminders, guidelines, and patient information materials can help providers improve delivery of necessary preventive care⁰². Systems interventions that can increase delivery of health care include offering clinical preventive services among standard covered benefits, providing feedback on performance to providers and practices, offering incentives for improved performance, and developing and implementing systems to identify and provide outreach to patients in need of services⁰⁹.

Increasing the number and proportion of members of underrepresented racial and ethnic groups who are primary care providers also is important because they are more likely to practice in areas where health services are in short supply and in areas with high percentages of underrepresented racial and ethnic populations⁰⁹.

Healthy People 2010 Objectives

1-3. Increase the proportion of persons appropriately counseled about health behaviors.

Target and baseline:

Objective	Increase in Counseling on Health Behaviors Among Persons at Risk With a Physician Visit in the Past Year	1995 Baseline	2010 Target
1-3a.	Physical activity or exercise (adults aged 18 years and older)		Developmental
1-3b.	Diet and nutrition (adults aged 18 years and older)		Developmental
1-3c.	Smoking cessation (adult smokers aged 18 years and older)		Developmental
1-3d.	Reduced alcohol consumption (adults aged 18 years and older with excessive alcohol consumption)		Developmental
1-3e.	Childhood injury prevention: vehicle restraints and bicycle helmets (children aged 17 years and under)		Developmental
1-3f.	Unintended pregnancy (females aged 15 to 44 years)	19%	50%
1-3g.	Prevention of sexually transmitted diseases (males aged 15 to 49 years; females aged 15 to 44 years)		Developmental
1-3h.	Management of menopause (females aged 46 to 56 years)		Developmental

Livingston County Impact Objectives

Increase the proportion of people having access to low-cost counseling regarding Metabolic Syndrome. (MS risk factors = blood pressure, waist measurement, HDLs, triglycerides and glucose. Protective factors = physical activity, diet/nutrition, limited alcohol consumption) through the LCPHD’s Hubert Wellness clinic by 5% annually.

Baseline: Two year average (FY08-FFY09) – 756 clients received Metabolic Syndrome counseling through LCPHD’s Hubert Wellness clinic.

Increase by 10% annually the number of people receiving free counseling and NRT for tobacco cessation through the health departments ITFC grant program.

Baseline: 53adults enrolled in Livingston County’s free telephone counseling and free NRT program ‘Break the Habit’ in FY10.

Increase the proportion of people receiving low/no cost counseling regarding alcohol consumption.

Baseline: IHR

Decrease the percent of teen pregnancies to 1.8% by 2015.

Baseline: 5 year average (2004-2008) for teen pregnancies is 2.4%, with a high of 3.3% in 2006 and a low of 2.1% in 2007 and 2008 (IDPH/Illinois Vital Statistics/teen birth rates 2004-2008).

Decrease the Sexually Transmitted Disease rate by 20% by 2015.

Baseline: 5 year (2004-2008) average number of cases of STDs were:35 for Gonorrhea and 143 for Chlamydia.

Healthy People 2010 Objective

1-6. Reduce the proportion of families that experience difficulties or delays in obtaining health care or do not receive needed care for one or more family members. Target: 7 percent.

Baseline: 12 percent of families experienced difficulties or delays in obtaining health care or did not receive needed care in 1996.

Livingston County Impact Objective

Annually, maximize use of funding provided by IDPH to provide women in Livingston County with mammograms and PAP test through the Illinois Breast and Cervical Cancer program.

Baseline: In FY10 LCPHD IBCCP provided screening for 149 Livingston County women.

Increase by 5% annually the number of men who receive low-cost PSA blood tests to screen for prostate cancer through the LCPHD Wellness Clinic.

Baseline: In FY09 237 men received low-cost PSA blood tests through the LCPHD Wellness Clinic.

Healthy People 2010 1-9. Reduce hospitalization rates for three ambulatory-care-sensitive conditions: pediatric asthma, uncontrolled diabetes, and immunization-preventable pneumonia and influenza.

Target and baseline:

Objective	Reduction in Hospitalizations for Ambulatory-Care-Sensitive Conditions	1996 Baseline	2010 Target
		<i>Admissions per 10,000 Population</i>	
1-9a.	Pediatric asthma—persons under age 18 years	23.0	17.3
1-9b.	Uncontrolled diabetes—persons aged 18 to 64 years	7.2	5.4
1-9c.	Immunization-preventable pneumonia or influenza—persons aged 65 years and older	10.6	8.0

Livingston County Impact Objective

Increase by 10% annually the number of identified diabetics who enroll in the LCPHD's grant program to prevent complications from diabetes.

Baseline: Eleven diabetics enrolled in the program in FY10.

Increase by 3% annually the number of persons who receive low/no-cost seasonal influenza vaccines from LCPHD.

Baseline: Two year average (2008 & 2009) for number of people receiving low/no-cost seasonal influenza vaccine from LCPHD was 2817 (3150 in 2008 and 2484 in 2009).

Healthy People 2010

1-15. (Developmental) Increase the proportion of persons with long-term care needs who have access to the continuum of long-term care services.

Livingston County impact objective

Increase by 20% annually the number of people receiving public health nursing services through the Livingston County Community Health Care Program (LCCHCP).

Baseline: In the first 24 months of LCCHCP, 33 people, received public health nursing services through the LCCHCP.

Increase by 20% annually the number of people receiving homemaker and/or home health aide services through the Livingston County Community Health Care Program (LCCHCP) .

Baseline: In the first 24 months of the LCCHCP 49 people, received homemaker and/or home health aide services through the LCCHCP.

INTERVENTION STRATEGIES/EVALUATION PLAN

LCPHD will increase and track number of wellness clinics/clients served at the health department clinic site and at community/work-place clinic sites.

SOC will refer people at risk for alcohol use/abuse to IHR for alcohol counseling. *Evidence demonstrates that brief clinician counseling is effective in getting patients to stop smoking and reduce problem drinking¹⁰.*

LCHPH will promote and coordinate the Break the Habit free telephone counseling program and provide four weeks of free NRT through the Illinois Tobacco Free Communities grant.

LCPHD will promote and coordinate the Break the Habit free telephone counseling program and advise Medicaid recipients on how to access free NRT through the Medicaid program.

LCPHD will provide free physical activity, nutrition, tobacco cessation, alcohol, and childhood injury prevention counseling to women participating in the Women, Infants and Children and Healthy Families grant programs. *More intensive dietary counseling can lead to reduced dietary fat and cholesterol intake and increased fruit and vegetable consumption. Some evidence shows that provider counseling can increase the use of seat belts, child safety seats, and bicycle helmets, especially when directed to parents of infants and young children¹⁰.*

LCPHD will promote teen pregnancy prevention through: programs provided free of charge to high school classes; the free Its Your Future Its Your Choice program for junior high schools; and low/no cost pregnancy prevention education and services to teens through the Family Planning Clinic grant.

LCPHD will provide free physical activity, nutrition, tobacco cessation, and alcohol counseling to women receiving services through the Family Planning Clinic grant. *Evidence demonstrates that brief clinician counseling is effective in getting patients to stop smoking and reduce problem drinking¹⁰.*

LCPHD will promote and track STD prevention through free prevention education programs to high schools and prevention education to people of all ages through the STD Clinic grant and the Family Planning Clinic grant. *Brief counseling interventions aimed at high-risk individuals can increase condom use and prevent the spread of sexually transmitted diseases¹⁰.*

LCPHD will promote and provide free STD counseling, testing and treatment through the STD Clinic grant. *Brief counseling interventions aimed at high-risk individuals can increase condom use and prevent the spread of sexually transmitted diseases¹⁰.*

LCPHD will work with Mennonite College of Nursing at Illinois State University student nurses to distribute information regarding the LCPHD STD clinic and services provided.

LCPHD will promote and coordinate the free services offered to women by the Illinois Breast and Cervical Cancer Program (IBCCP).

OSF Saint James John W. Albrecht and other medical centers in the Livingston County service area will contract with the Livingston County IBCCP to provide breast and cervical cancer screenings at the reduced rate provided by the IBCCP.

LCPHD will identify diabetics to be enrolled in the Prevention of Complications from Diabetes through Wellness and Family Planning Clinics.

LCPHD will offer low/no-cost seasonal influenza vaccine at various sites throughout the county. *Illness and death from preventable pneumonia and influenza among elderly persons can be avoided through the use of pneumococcal and influenza vaccines¹¹.*

LCPHD will coordinate with local medical providers and social service agencies to promote the LCCHCP and CCU services. *The long-term care population needs access to a range of services, including nursing home care, home health care, adult day care, assisted living, and hospice care. Persons with long-term care needs require the help of other persons to perform activities of daily living (personal care activities) and instrumental activities of daily living (routine needs). Access problems are viewed as a need for specified long-term care services that were not received in the past 12 months¹².*

PRIORITY AREA - INCREASE AVAILABILITY OF AND ACCESS TO MENTAL HEALTH SERVICES

GOAL: To improve mental health and ensure access to appropriate, quality mental health services.

RATIONALE:

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. Mental health is indispensable to personal well-being, family and interpersonal relationships, and contribution to community or society. *Mental disorders* are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof), which are associated with distress and/or impaired functioning and spawn a host of human problems that may include disability, pain, or death. *Mental illness* is the term that refers collectively to all diagnosable mental disorders.

Mental disorders generate an immense public health burden of disability. The World Health Organization, in collaboration with the World Bank and Harvard University, has determined the “burden of disability” associated with the whole range of diseases and health conditions suffered by peoples throughout the world. A striking finding of the landmark *Global Burden of Disease* study is that the impact of mental illness on overall health and productivity in the United States and throughout the world often is profoundly under-recognized. In established market economies such as the United States, mental illness is on a par with heart disease and cancer as a cause of disability. Suicide—a major public health problem in the United States—occurs most frequently as a consequence of a mental disorder.

Mental disorders occur across the lifespan, affecting persons of all racial and ethnic groups, both genders, and all educational and socioeconomic groups. At least one in five children and adolescents between age 9 and 17 years has a diagnosable mental disorder in a given year. Mental and behavioral disorders and serious emotional disturbances (SEDs) in children and adolescents can lead to school failure, alcohol or illicit drug use, violence, or suicide. About 5 percent of children and adolescents are extremely impaired by mental, behavioral, and emotional disorders. In later life, the majority of people aged 65 years and older cope constructively with the changes associated with aging and maintain mental health, yet an estimated 25 percent of older people experience specific mental disorders, such as depression, anxiety, substance abuse, and dementia, that are not part of normal aging. Alzheimer’s disease strikes 8 to 15 percent of people over age 65 years, with the number of cases in the population doubling every 5 years of age after age 60 years. Alzheimer’s disease is thought to be responsible for 60 to 70 percent of all cases of dementia and is one of the leading causes of nursing home placements.

Mental disorders vary in severity and in their impact on people’s lives. Mental disorders—such as schizophrenia, major depression and manic depressive or bipolar illness, and obsessive-compulsive disorder and panic disorder—can be enormously disabling.

Modern treatments for mental disorders are highly effective, with a variety of treatment options available for most disorders. Despite the effectiveness of treatment the majority of persons with mental disorders do not receive mental health services. Nationally, of those aged 18 years and older getting help, about 15 percent receive help from mental health specialists. Of young people aged 9 to 17 years who have a mental disorder, 27 percent receive treatment in the health sector. However, an additional 20 percent of children and adolescents with mental disorders use mental health services only in their schools.

Lost productivity and disability insurance payments, crime, criminal justice costs, and property loss all contributed to the total cost of mental illness. People with mental illnesses are overrepresented in jail populations. The majority—53 percent—of mental health treatment is paid for by public sector sources, including the States and local governments as well as Medicaid and Medicare and other Federal programs¹³.

BARRIERS

As noted in Healthy People 2010 and other literature:

There is no “one size fits all” treatment for mental disorders. Additionally, 40 percent of all people who have a severe mental illness do not seek treatment from either general medical or specialty mental health providers¹⁴. Stigma creates barriers to providing and receiving competent and effective mental health treatment and can lead to inappropriate treatment, unemployment, and homelessness¹⁵.

Barriers identified by the Livingston County Children’s Mental Health System of Care (SOC) community team, as they prepared a Children’s Mental Health Initiative (CMHI) grant proposal in April 2010, included: difficulty for parents in accessing mental health services for their children due to being uninsured or underinsured; lack of transportation to services; the burden of poverty making regular attendance for appointments, taking time off work, and managing childcare arrangements for siblings insurmountable obstacles; and the culture of the community stigmatizes mental health and psychiatric care. The nearest child psychiatrist and psychologist are located approximately 40 miles outside the county. Many mental health professionals do not accept Medicaid at all or not from another county. The wait to see a child therapist is several weeks to months. There are a limited number of specialty providers making it difficult to recruit to rural areas, in addition to the issue of low reimbursement rates to providers and the time it takes to build a patient base. Need for additional primary care physician training in identifying mental health disorders in children and adolescents. Mental health screening in educational settings remains controversial in the community¹⁶.

BEHAVIORAL RISK/PROTECTIVE FACTORS AND CONTRIBUTING FACTOR ANALYSIS

Among adults aged 18 years and older with a lifetime history of any mental disorder, 29 percent have a history of an addictive disorder; of those with an alcohol disorder, 37 percent have had a mental disorder; and among those with other drug disorders, 53 percent have had a mental disorder. Having both mental and addictive disorders within the same year is a particularly significant clinical treatment issue, complicating treatment for each disorder. About 3 percent of the population aged 18 years and older has been identified as having co-occurring mental and addictive disorders in 1 year. Of those with a serious mental illness, 15 percent have both types of disorder in 1 year, and of those with a severe and persistent mental illness, 27 percent have both mental and addictive disorders^{17&18}.

Co-occurring, or co-morbid, mental and addictive disorders are estimated to affect 50 to 60 percent of *homeless persons*. Co-morbid mental and addictive disorders also are evident in *children and adolescents*¹⁸. Especially at risk for alcohol use problems are boys diagnosed with so-called externalizing disorders such as conduct problems, oppositional-defiant disorder, and attention deficit/hyperactivity disorder (ADHD). From public health promotion and disease prevention perspectives, it is noteworthy that children and adolescents with mental illnesses often do not become substance abusers until after the mental illness becomes apparent. This time lag creates a window of opportunity when prevention of substance abuse in these children may be possible¹⁷. Some of these persons can be identified by their behavior problems at the time of their entry into *elementary school*. Such youth tend to use substances at a young age and exhibit sensation-seeking (or “novelty-seeking”) behaviors. These youth benefit from more intensive preventive interventions, including family therapy and parent training programs¹⁹.

Women who are poor, have little formal schooling, and are on welfare or are unemployed are more likely to experience depression than women in the general population. And, anxiety, panic, and phobic disorders affect two to three times as many *women* as men. A *history of physical or sexual abuse* appears to be a serious risk factor for suicide attempts in both women and men. Women attempt suicide more often than men, but *men’s* risk of completed suicide is on average four and one half times higher than women’s. Eating disorders, affecting up to 2 percent of the population, arise predominantly—but not exclusively—in *adolescent*

and young adult women (90 percent of all cases); the median age of onset is 17 years. Eating disorders often persist into adulthood and have among the highest death rates of any mental disorder²⁰.

Depression rates are much higher among *older people who experience a physical health problem*—12 percent for persons hospitalized for problems such as hip fractures or heart disease. Depression rates for *older persons in nursing homes* range from 15 to 25 percent. Although fewer old persons attempt suicide than do young persons, the rate of completed suicide is highest among *elderly men*, who account for about 80 percent of suicides among persons aged 65 years and older. Moreover, *elderly white men* have a suicide rate six times the national average²⁰. Depression and anxiety are seen more frequently among *people with disabilities* than those without disabilities²¹.

There is increasing awareness and concern in the public health sector regarding the impact of stress, its prevention and treatment, and the need for *enhanced coping skills*. Coping skills, acquired throughout the lifespan, are positive adaptations that affect the ability to manage stressful events²¹.

Research-based treatments afford an unprecedented opportunity to achieve a major reduction in the burden of disease associated with mental illness. With *enhancements of clinical services and service systems*, recovery is an achievable objective of mental health clinical interventions.

Evidence that mental disorders are legitimate and highly responsive to appropriate treatment promises to be a potent antidote to stigma. The *elimination of stigma* associated with mental disorders will in turn encourage more individuals to seek needed mental health care²¹.

Healthy People 2010 Objectives

18-6. (Developmental) Increase the number of persons seen in primary health care who receive mental health screening and assessment.

18-7. (Developmental) Increase the proportion of children with mental health problems who receive treatment.

Livingston County Impact Objectives

- 1.1 Increase the number of mental health practitioners serving the county by 4 dually-credentialed psychologists and 4 pre-doctoral interns, by 12/30/14. [*Baseline: LCSSU recruits and trains one intern per year.*]
- 1.2 Increase the number of primary care providers trained in conducting universal mental health screenings at office visits to 50% by 12/30/14. [*Baseline: Spring 2010 OSF pediatric provider survey indicated 25% of all office visits included discussion of psychological or mental health problems.*]
- 1.3 Increase use of technology for communication and coordination between systems providing services to children and adolescents by 12/30/14. [*Baseline: multiple entities providing services to the same families without knowledge of one another per December 2009 Process Map.*]
- 1.4 Expand and coordinate interventions to reduce risk factors and increase resilience of school children/adolescents to all schools districts in the county by 12/30/14 [*Baseline: As of 2010 several entities (including classroom teachers, IHR, ADV/SAS, and LCPHD)are providing limited/uncoordinated interventions to some school districts.*]

Livingston County Outcome Objectives

[*Baseline data for these objectives is not currently available. Establishment of baseline data and gathering data to assess outcomes are components of the SOC grant project which will unfold between 2010 and 2014.*]

- 1-1. Increase the number of children seen in primary health care who receive mental health screening and assessment.

- 1-2. Increase the number of children who receive mental health screening and assessment in the school setting.
- 1-1. Increase the number of parents of new born children who receive universal mental health screenings.
- 1-2. Increase the number of parents of school-aged children who receive universal mental health screenings.
- 1-3. Increase the number of students identified as at-risk of social-emotional-behavioral concerns.
- 1-4. Increase the number of students who receive mental health intervention services in the school setting.
- 1-5. Increase the number of children referred by primary care providers for mental health services.
- 1-6. Increase the number of parents of school-aged children who receive mental health intervention services.

INTERVENTION STRATEGIES

1. SOC will utilize ICHF funds to hire 4 dually-credentialed psychologist who will each supervise one pre doctoral intern. *With enhancements of clinical services and service systems, recovery is an achievable objective of mental health clinical interventions²¹.*
- 2.SOC will serve as a mental health screening training facilitator for the general medical and primary care sector. *The general medical sector has long been identified as the initial point of contact for many adults with mental disorders. This attention to mental state in primary care can promote early detection and intervention for mental health problems²².*
- 3.SOC will deliver a continuum of services in various non-clinic settings (ie schools, physicians' offices, Boys & Girls Clubs, Head Start) and by beginning to talk about services when children are infants, focusing on skill development and ecology, rather than diagnosis, to help reduce the stigma of mental health care. *Diverse groups share overlapping goals, including overcoming stigma and preventing discrimination toward person with mental illness, promoting self-help groups, and promoting recovery from mental illness¹⁷.*
- 4.SOC will assign a psychologist to work closely with: other SOC psychologist working in schools; probation/court services; DCFS-funded counseling program for runaways; IHR therapists providing services for wards of the court; SASS workers; IHR providers working with high-need families; and the sheriff's department, which responds to calls from parents of non-compliant teens. *Consumer and family organizations, which formed out of concern over frequent fragmentation of mental health services and lack of accessibility to such services, have assumed a substantial role in supporting development of mental health services¹⁷.*
- 5.SOC will identify technology to communicate access of various services, consent for services – including inter-agency alert, and develop lines of communication once formal releases are received. *Health care in the United States continues to undergo fundamental structural changes that require creative and flexible responses from service providers, administrators, researchers, and policymakers alike¹⁸.*
6. SOC will work with school psychologists and social workers and teachers to deliver a universal curriculum to develop social-emotional skills consistent with the Illinois State Board of Education's Social-Emotional Learning Standards. *Promising universal and targeted preventive interventions, implemented*

according to scientific recommendations, have great potential to reduce the risk for mental disorders and the burden of suffering in vulnerable populations²¹.

7. LCPHD Family Planning Clinic and IHR will continue collaboration for mental health services for FP clients. *Attention to mental state in primary care can promote early detection and intervention for mental health problems²².*

INTERVENTION STRATEGIES/EVALUATION PLAN

An evaluation team from Illinois State University Psychology Department will meet periodically with the SOC to assist in identifying target variables and gathering data to access program outcomes.

1. Relevant existing data from each SOC entity will be compiled during 210-2011 to serve as baseline.
2. Number of children/adolescents and parents/caregivers receiving services will be documented
3. Attendance and summaries of SOC partner meetings will be documented
4. Inter-agency consultations will be documented
5. Length of time clients wait between referral and services will be documented.
6. Number of mental health practitioners serving county will be documented.
7. Number of primary care providers conducting universal mental health screenings at office visits will be documented.
8. Interventions to reduce risk factors and increase resilience of children/adolescents will be documented.

COMMUNITY RESOURCES FOR IMPLEMENTATION

Livingston County System of Care grant
Livingston County Mental Health Board
Institute for Human Resources (IHR)
Livingston County Commission on Children and Youth
OSF Saint James John W. Albrecht Medical Center
Livingston County Public Health Department
A Domestic Violence & Sexual Assault Service (ADV/SAS)
Livingston County Probation/Court Services
Livingston County Special Services Unit
Regional Office of Education (ROE)

ESTIMATED FUNDING NEED FOR IMPLIMENTATION

Livingston County System of Care grant and funding from entities represented on the SOC board.

ANTICIPATED SOURCES OF FUNDING

Livingston County System of Care grant
IHR
ADV/SAS
DHS grants
ROE
Other grants
Fees for Service

PRIORITY AREA – DECREASE THE USE/ABUSE OF ALCOHOL AND OTHER DRUGS

GOAL: To protect the health, safety, and quality of life for all Livingston County residents by decreasing the use/abuse of alcohol and other drugs.

RATIONALE

Substance abuse and its related problems are among society's most pervasive health and social concerns. In 1995, the economic cost of alcohol and drug abuse in the United States was \$276 billion dollars. This represents more than \$1,000 for every man, woman, and child in the U.S. to cover the costs of health care, motor vehicle crashes, crime, lost productivity, and other adverse outcomes of alcohol and drug abuse²³.

Alcohol use has been linked with a substantial proportion of injuries and deaths from motor vehicle crashes, falls, fires, and drownings. Alcohol use is a factor in homicide, suicide, marital violence, and child abuse and has been associated with high-risk sexual behavior²⁴. Excessive drinking has consequences for virtually every part of the body²³. Long-term heavy drinking increases risk for high blood pressure, arrhythmias, and stroke. It also increases the risk of developing certain forms of cancer, and cirrhosis and other liver disorders. Drinking also may increase the risk for developing cancer of the colon and rectum. Women's risk of developing breast cancer increases slightly if they drink two or more drinks per day²⁴.

The majority of alcohol-related productivity losses were attributed to alcohol-related illness. Productivity losses were greatest *for males who started drinking before age 15 years*. For drug abuse, most of the estimated productivity losses were associated with crime, including lost earnings of victims, and incarcerated perpetrators of drug-related crime and foregone legitimate earnings because of participation in the drug trade. [As indicators of the adverse consequences of alcohol and drug misuse, estimates of lost productivity have important limitations, including concerns about statistical and methodological issues and data quality and completeness]²⁵.

Binge drinking is a national problem, especially among males and young adults²⁶. Alcohol continues to be the number one drug of youth. Alcohol use in the past month was reported by more than one in five 8th grade students and approximately one half of 12 grade students in Illinois. Comparison with national 8th, 10th, and 12th grade data show Illinois alcohol use percentages continue to be higher than national percentages²⁷. Males may be at risk for alcohol-related problems if they drink more than 14 drinks per week or more than 4 drinks per occasion. Females may be at risk if they drink more than seven drinks per week or more than 3 drinks per occasion²⁸.

The use of alcohol, tobacco, and illegal substances during pregnancy is a major risk factor for poor pregnancy outcomes. Alcohol use is linked to fetal death, low birth weight (lbw), growth abnormalities, mental retardation, and fetal alcohol syndrome²⁹. People who use or abuse drugs or alcohol sometimes reported being so high or intoxicated that they forgot use a condom³⁰. Smoking during pregnancy is linked to LBW, preterm delivery, SIDS, and respiratory problems in newborns. In addition to the human cost of these conditions, the economic cost of services to substance-exposed infants is great²⁹.

Drug dependence is a chronic, elapsing disorder. Addicted persons frequently engage in self-destructive and criminal behavior³¹.

Drug use among adolescents aged 12 to 17 years doubled between 1992 and 1997, from 5.3 percent to 11.4 percent. Youth marijuana use has been associated with a number of dangerous behaviors. Nearly 1 million youth aged 16 to 18 years (11 percent of the total) have reported driving in the past year at least once within 2 hours of using an illegal drug (most often marijuana.) Adolescents aged 12 to 17 years who smoke marijuana were more than twice as likely to cut class, steal, attack persons, and destroy property than those who did not smoke marijuana. Drug and alcohol use by youth also is associated with other forms of unhealthy and unproductive behavior, including delinquency and high-risk sexual activity³¹. Based on the 2008 survey results, 3.4% of Illinois 8th grade students and 8.2% of Illinois 12th grade students reported past year use of some illicit

drug (other than marijuana). Similarly, 4.5% of 8th grade students and 9.6% of 12th grade students reported past year use of a prescription drug for which they did not have a prescription²⁷.

Especially at risk for alcohol use problems are boys diagnosed with so-called externalizing disorders such as conduct problems, oppositional-defiant disorder, and attention deficit/hyperactivity disorder (ADHD). From public health promotion and disease prevention perspectives, it is noteworthy that children and adolescents with mental illnesses often do not become substance abusers until after the mental illness becomes apparent. This time lag creates a window of opportunity when prevention of substance abuse in these children may be possible¹⁷.

Illegal use of drugs, such as heroin, marijuana, cocaine, and methamphetamine, is associated with other serious consequences, including injury, illness, disability, and death as well as crime, domestic violence, and lost workplace productivity. Drug users and persons with whom they have sexual contact run high risks of contracting gonorrhea, syphilis, hepatitis, tuberculosis, and HIV. Injected drug use is associated with transmission of HIV and hepatitis B and C infections. The use of cocaine, nitrates, and other substances can produce cardiac irregularities and heart failure, convulsions, and seizures. Long term consequences, such as chronic depression, sexual dysfunction, and psychosis, may result from drug use³¹. An analysis of the epidemiologic evidence reveals that 72 conditions requiring hospitalization are wholly or partially attributable to substance abuse¹⁹.

Tobacco use and addiction usually begin in adolescence. Furthermore, tobacco use may increase the probability that an adolescent will use other drugs³².

BARRIERS

As noted in Healthy People 2010 and other literature:

The perceived acceptance of problematic drug-using behavior among family, peers, and society influences an adolescent's decision to use or avoid alcohol, tobacco, and drugs²⁶. Widely spread societal expectations that young people will engage in binge drinking may encourage this highly dangerous form of alcohol consumption³³.

The stigma attached to substance abuse increases the severity of the problem. The hiding of a substance abuse can prevent persons from seeking and continuing treatment. Compounding the problem is the gap between the number of available treatment slots and the number of persons seeking treatment for illicit drug use or problem alcohol use¹⁹.

BEHAVIORAL RISK/PROTECTIVE FACTORS AND CONTRIBUTING FACTOR ANALYSIS

Age at onset of drinking strongly predicts development of alcohol dependence over the course of the lifespan. About 40 percent of those who start drinking at age 14 years or younger develop alcohol dependency at some point in their lives; for those who start drinking at age 21 years or older, about 10 percent develop alcohol dependence at some point in their lives²³.

Research confirms that a substantial number of frequent users of cocaine, heroin, and illicit drugs other than marijuana have *co-occurring chronic mental health disorders*¹⁹. Co-morbid mental and addictive disorders are evident in children and adolescents. Especially at risk for alcohol use problems are *boys diagnosed with so-called externalizing disorders* such as conduct problems, oppositional-defiant disorder, and attention deficit/hyperactivity disorder (ADHD)¹⁷.

Children and adolescents with mental illnesses often do not become substance abusers until after the mental illness becomes apparent. This time lag creates a window of opportunity when prevention of substance abuse in these children may be possible¹⁷. Some of these persons can be identified by their behavior problems at the time of their entry into elementary school. Such youth tend to use substances at a young age and exhibit *sensation-seeking (or "novelty-seeking") behaviors*. These youth benefit from more *intensive preventive interventions*, including family therapy and parent training programs¹⁹.

Whites and Hispanics are more likely than African Americans to use alcohol. Whites are more likely than African Americans and Hispanics to use tobacco¹⁹. Alcoholism and drug abuse affect *lesbians, gay men, and transgendered persons* at two to three times the rate of the general population³⁴.

Reducing the number of adolescents who ride in a motor vehicle with another adolescent driver who has been drinking is an important step to decrease motor-vehicle related deaths and injuries.

A combination of *community mobilization, media advocacy, and enhanced law enforcement* has been shown to reduce alcohol-related traffic crashes and sales of alcohol to minors. *Higher prices or taxes* for alcoholic beverages are associated with lower alcohol consumption and lower levels of a wide variety of adverse outcomes³⁵. *Disapproval of substance abuse* is inversely related to adolescents' reports of use. An increase in marijuana use among youth during the early 1990s coincided with an apparent decline in the percentage of parents and peers expressing strong disapproval³⁶.

Youth are put at increased risk of initiating tobacco use by socio-demographic, environmental, and personal factors. Socio-demographic risk factors include coming from a family with *low socioeconomic status*. Environmental risk factors include *accessibility and availability* of tobacco products, *cigarette advertising and promotion practices*, the *price* of tobacco products, *perceptions that tobacco use is normal, peers' and siblings' use and approval, and lack of parental involvement*. Personal risk factors include *low self-image and low self-esteem, the belief that tobacco use provides a benefit, and the lack of ability to refuse offers to use tobacco*³².

Persons with 9 to 11 years of education (38 percent) have *significantly higher levels of smoking* than individuals with 8 years or less of education or 12 years or more. *Individuals with 16 or more years of education have the lowest smoking rates* (11 percent). Individuals who are *poor are significantly more likely to smoke* than individuals of middle or high income (34 percent compared to 21 percent)³⁸.

The *ability of children and teenagers to reject using tobacco, illicit drugs, or alcohol* is an important and critical element in prevention activities because the required skills and attitudes can carry over into adulthood³⁹. The *attitude of influential adults* about alcohol and drugs is another critical predictor of attitudes in youth⁴⁰.

Healthy People 2010 Objectives

26-1. Reduce deaths and injuries caused by alcohol- and drug-related motor vehicle crashes.

26-1a. Reduce the death rate for Alcohol-related deaths to 4 per 100,000.

Baseline: 5.9 per 100,000 in 1998

Livingston County Outcome Objectives

Reduce the death rate for alcohol-related motor vehicle deaths to 5 per 100,000.

Baseline: 7.7 per 100,000 (IPLAN 1996)

Reduce the proportion of alcohol related MV deaths to 23.7% of all MV deaths.

Baseline: For the five-year period 2005-2009, 36.1% of all MV deaths were alcohol related. (Livingston County Coroner Report 07/13/10)

Healthy People 2010

26-1c. Reduce the death for drug-related motor vehicle deaths to (developmental)

Livingston County Outcome Objective

Reduce the proportion of drug-related MV deaths to 11% of all MV deaths.

Baseline: For the five-year period 2005-2009, 16.7% of all MV deaths were drug-related. (Livingston County Coroner Report 07/13/10)

Healthy People 2010

26-9. Increase the age and proportion of adolescents who remain alcohol and drug free.

Target and baseline:

Objective	Increase in Average Age of First Use in Adolescents Aged 12 to 17 Years	1998 Baseline	2010 Target
		Average Age in Years	
26-9a.	Alcohol	13.1	16.1
26-9b.	Marijuana	13.7	17.4

Healthy People 2010

27-4. Increase the average age of first use of tobacco products by adolescents and young adults.

Target and baseline:

Objective	Increase in Average Age of First Tobacco Use	1997 Baseline	2010 Target
		Average Age of First Cigarette Use, in Years	
27-4a.	Adolescents aged 12 to 17 years	12	14
27-4b.	Young adults aged 18 to 25 years	15	17

Livingston County Impact Objectives

Increase average age of first use of alcohol in adolescents in grades 8th thru 12th to age 17.7.

Baseline: Average age of first use 14.4 (Illinois Youth Survey 2008 – Livingston County, Note: Survey included 299 8th grade students from 4 schools and 44 12th grade students from 2 schools).

Increase average age of first use of marijuana in adolescents in grades 8th thru 12th to age 17.9.

Baseline: Average age of first use 14.1 (Illinois Youth Survey 2008 – Livingston County, Note: Survey included 299 8th grade students from 4 schools and 44 12th grade students from 2 schools).

Increase average age of first use of tobacco in adolescents in grades 8th thru 12th to age 15.7.

Baseline: Average age of first use was 13.1 (Illinois Youth Survey 2008 – Livingston County, Note: Survey included 299 8th grade students from 4 schools and 44 12th grade students from 2 schools).

Healthy People 2010

26-9. Increase the age and proportion of adolescents who remain alcohol and drug free.

Target and baseline:

Objective	Increase in High School Seniors Never Using Substances	1998 Baseline	2010 Target
		Percent	
26-9c.	Alcoholic beverages	19	29
26-9d.	Illicit drugs	46	56

Livingston County Impact Objectives

Increase the percent of high school seniors not having used alcohol in the past month to 67%.

Baseline: 44% have not used alcohol in past 30 days (Illinois Youth Survey 2008 – Livingston County, Note: 44 12th grade students from 2 schools).

Increase the percent of 10th grade students not having used marijuana in the past month to 95%.

Baseline: 86% have not used marijuana in past 30 days (Illinois Youth Survey 2008 – Livingston County, Note: 36 10th grade students from 2 schools).

Healthy People 2010

26-11c. Reduce to 6% the proportion of adults engaging in binge drinking of alcoholic beverages in the past month.

Baseline: 16.6% of adults engaged in binge drinking of alcoholic beverages in the past month. (1998)

Livingston County Impact Objective

Reduce to 8% the proportion of adults at risk for acute/binge drinking

Baseline: 22.7% of adults are at risk for acute/binge drinking. (BRFSS 2006)

Healthy People 2010

26-13. Reduce to 50% the proportion of adults who exceed guidelines for low-risk drinking.

Baseline: 72% of females and 74% of males exceeded the guidelines for low-risk drinking. (1992)

Livingston County Outcome Objectives

Reduce the rate of adults who are at risk for acute/binge drinking to 15.7% by 2015.

Baseline: 22.7% of adults are at risk for acute/binge drinking (2006 BRFSS)

Reduce the rate of hospitalization for alcohol-dependence syndrome to 34.5 per 100,000 for ages 15-44, and 8 per 100,000 for ages 45-64.

Baseline: ages 15-44 (3 year average 1999-2001) – 69.1 per 100,000 and ages 45-64 (3 year average 1999-2001) – 15.8 per 100,000(IPLAN 1999-2001)

Healthy People 2010

26-17. Increase the proportion of adolescents who perceive great risk associated with substance abuse.

Target and baseline:

Objective	Increase in Adolescents Aged 12 to 17 Years Perceiving Great Risk Associated With Substance Abuse	1998 Baseline	2010 Target
26-17a.	Consuming five or more alcoholic drinks at a single occasion once or twice a week	47%	80%
26-17b.	Smoking marijuana once per month	31%	80%

Livingston County Impact Objectives

Increase the percent of 6th, 8th, 10th, and 12th grade students who perceived risk of harm from regular alcohol use to 80%.

Baseline: 67% of 6th grade students, 66% of 8th grade students, 63% of 10th grade students, and 36% of 12th grade students perceived risk of harm from regular alcohol use (Illinois Youth Survey 2008 – Livingston County, Note: 296 6th grade students and 299 8th grade students from 4 schools and 36 10th grade students and 44 12th grade students from 2 schools participated in survey).

Increase the percent of 12th grade students who perceived risk of harm from regular marijuana use to 80%.

Baseline: 75% of 12th grade students perceived risk of harm from regular alcohol use (Illinois Youth Survey 2008 – Livingston County, Note: 44 12th grade students from 2 schools participated in survey).

Increase the number of percent of 12th grade students who perceive parental disapproval of alcohol use to 75%.

Baseline: 59% of 12th grade students perceived parental disapproval of alcohol use (Illinois Youth Survey 2008 – Livingston County, Note: 44 12th grade students from 2 schools participated in survey).

Healthy People 2010

27-1. Reduce tobacco use by adults.

Target and baseline:

Objective	Reduction in Tobacco Use by Adults Aged 18 Years and Older	1998 Baseline*	2010 Target
27-1a.	Cigarette smoking	24%	12%
27-1b.	Spit tobacco	2.6%	0.4%

Livingston County Outcome Objective

Reduce tobacco use by adults to 14.4%.

Baseline: 28.7% of adults smoke (2006 BRFSS)

Healthy People 2010

27-5. Increase smoking cessation attempts by adult smokers to 75%.

Baseline: 41 percent of adult smokers aged 18 years and older stopped smoking for 1 day or longer because they were trying to quit in 1998 (age adjusted to the year 2000 standard population).

Livingston County Impact Objectives

Increase by 10% annually the number of adults who attempt to quit smoking.

Baseline: 53 adults enrolled in Livingston County’s Break the Habit program in FY10.

Healthy People 2010

27-2. Reduce tobacco use by adolescents.

Target and baseline:

Objective	Reduction in Tobacco Use by Students in Grades 9 Through 12	1999 Baseline	2010 Target
27-2a.	Tobacco products (past month)	40%	21%
27-2b.	Cigarettes (past month)	35%	16%
27-2c.	Spit tobacco (past month)	8%	1%
27-2d.	Cigars (past month)	18%	8%

Livingston County Outcome Objective

Reduce tobacco use by 10th grade students to 8.8%, and by 12th grade students to 13.5%.

Baseline: 17% of 10th grade students, and 27% of 12 grade students reported using tobacco in the past month (Illinois Youth Survey 2008 – Livingston County, Note: 36 10th grade students and 44 12th grade students from 2 schools participated in survey).

Livingston County Impact Objectives

Increase the percent of 6th, 8th, 10th and 12th grade students who perceived risk of harm from regular tobacco use to 95%.

Baseline: 87% of 6th, 94% of 8th, 88% of 10th and 86% of 12th grade students perceived risk of harm from regular tobacco use (Illinois Youth Survey 2008 – Livingston County, Note: 296 6th grade students and 299 8th grade students from 4 schools and 36 10th grade students and 44 12th grade students from 2 schools participated in survey).

Increase the percent of 10th grade students who perceive parental disapproval of tobacco use to 95% and the percent of 12th grade students who perceive parental disapproval of tobacco use to 88%.

Baseline: 90% of 10th grade students and 83% of 12th grade students perceived parental disapproval of tobacco use (Illinois Youth Survey 2008 – Livingston County, Note: 36 10th grade students and 44 12th grade students from 2 schools participated in survey).

INTERVENTION STRATEGIES

Livingston County Public Health Department (LCPHD) will continue to seek funding for implementation of the *Its Your Future-Its Your Choice* teen pregnancy/STD prevention program for 7th and 8th grade students. Informing youth about the connection between substance use and abuse and other problem behaviors, such as unsafe sex, dating violence, and suicide, is important³⁰.

LCPHD will continue to address alcohol and illicit drug use in WIC, Family Case Management, Healthy Families Illinois, Family Planning, and STD programs and clinics. Informing youth about the connection between substance use and abuse and other problem behaviors, such as unsafe sex, dating violence, and

suicide, is important³⁰.

LCPHD will continue to address tobacco use in WIC, Family Case Management, Healthy Families Illinois, Family Planning and STD programs and clinics. *Evidence is accumulating that shows maternal tobacco use is associated with mental retardation and birth defects such as oral clefts⁴¹.*

IHR will continue to offer school-based programs focusing on altering perceived peer-group norms about tobacco, alcohol and other drug use and developing skills in resisting peer pressures to use tobacco, drink alcohol and use other drugs. *Studies indicate that school-based programs focused on altering perceived peer-group norms about alcohol use and developing skills in resisting peer pressures to drink reduce alcohol use among participating students³⁵. Overwhelming evidence indicates that nicotine found in tobacco is addictive and that addiction occurs in most smokers during adolescence³⁷.*

Local law enforcement agencies will continue to conduct alcohol and drug impaired driver campaigns. *A combination of community mobilization, media advocacy, and enhanced law enforcement has been shown to reduce alcohol-related traffic crashes and sales of alcohol to minors³⁵.*

Local law enforcement agencies will continue to conduct checks of alcoholic beverage retailers to ensure compliance with the minimum purchase age. *A combination of community mobilization, media advocacy, and enhanced law enforcement has been shown to reduce alcohol-related traffic crashes and sales of alcohol to minors³⁵.*

IHR will continue to coordinate the activities of the, peer driven, “Snowball” teen drug/alcohol prevention program. *Communitywide programs involving school curricula, peer leadership, parental involvement and education, and community task forces also have reduced alcohol use among adolescents³⁵.*

IHR will continue to provide services, to clients who suffer chronic mental illness, that will keep these clients from needing to be admitted to state institutions. *Research confirms that a substantial number of frequent users of cocaine, heroin, and illicit drugs other than marijuana have co-occurring chronic mental health disorders¹⁹.*

IHR will continue to provide substance abuse evaluations, DUI evaluations, and remedial education for persons arrested for driving under the influence of alcohol or drugs. *Research has confirmed that treatment can help end dependence on addictive drugs and reduce the consequences of addictive drug use on society. While no single approach for substance abuse and addiction treatment exists, comprehensive and carefully tailored treatment works³¹.*

IHR will continue to offer programs to assist clients with special needs (ie, Parenting Classes.) *For substance abuse prevention to be effective, people need access to culturally, linguistically, and age-appropriate services; job training and employment; parenting training; general education; and programs for women, dually diagnosed patients, and persons with learning disabilities³⁴.*

LCPHD will continue to promote tobacco use cessation through IDPH funded toll-free QuitLine and will offer free Nicotine Replacement Therapy, as funds allow, for staff, clients, and the general public. *The prevention and treatment of substance abuse require that all abused substances be addressed-from tobacco and alcohol to marijuana and other illicit drugs³⁴.*

INTERVENTION STRATEGIES EVALUATION PLAN

1. Progress of teen pregnancy/STD prevention programming in Livingston County will be tracked.
2. LCPHD client counseling regarding alcohol will be documented in Corner Stone and case notes.
3. Number of school programs will be tracked
4. Alcohol and drug impaired driver campaigns will be tracked.
5. Alcohol sales compliance checks will be tracked.
6. “Snowball” activities will be tracked.
7. Services to clients with chronic mental illness will be tracked.
8. Number of clients served by the Substance Abuse Department will be tracked.
9. Programs to assist clients with special needs will be tracked.
10. Number of clients participating in QuitLine tobacco cessation program will be tracked.

COMMUNITY RESOURCES FOR IMPLEMENTATION

Institute for Human Resources (IHR)
OSF Saint James John W. Albrecht Medical Center
Livingston County Public Health Department
Livingston County Sheriff’s Department
Dwight Police Department
Fairbury Police Department
Pontiac Police Department

ESTIMATED FUNDING NEED FOR IMPLIMENTATION

LCPHD staff will continue to incorporate tobacco, alcohol and other drug prevention messages into existing programs. Additional funding will be sought to address this issue.

ANTICIPATED SOURCES OF FUNDING

IHR funding
Local Law Enforcement Funding
DHS grants
Other grants
Fees for Service

Priority Area-DECREASE THE INCIDENCE OF HEART DISEASE: WITH A FOCUS ON CORONARY HEART DISEASE

GOAL

To improve cardiovascular health and quality of life through the prevention, detection, and treatment of risk factors; early identification and treatment of heart attacks and stroke; and prevention of recurrent cardiovascular events.

RATIONALE

Heart disease is the leading cause of death for all people in the United States. Heart disease and stroke continue to be major causes of disability and significant contributors to increases in health care costs in the United States. Coronary heart disease (CHD) accounts for the largest proportion of heart disease. About 12 million people in the United States have CHD. Although the age-adjusted death rate for CHD continues to

decline each year, declines in the unadjusted death rate and in the number of deaths have slowed because of an increase in the number of older people in the United States, who have higher rates of CHD⁴².

About 4 million persons have cerebrovascular disease, a major form of which is stroke. About 600,000 strokes occur each year in the United States, resulting in about 158,000 deaths⁴³. By the end of the 1990s, one in every four persons was aged 50 years or older. By 2030, about one in three will be aged 50 years or older. Most significant has been the increase in the size of the population aged 65 years and older. In addition, the percentage of persons aged 85 years and older has increased significantly. In the 1980s and 1990s, heart failure emerged as a major chronic disease for older adults. Almost 75 percent of the nearly 5 million patients with heart failure in the United States are older than 65 years. Hospitalization rates for heart failure continue to increase significantly in those aged 65 years and older⁴³.

The lifetime risk for developing CHD is very high in the United States: one of every two males and one of every three females aged 40 years and under will develop CHD sometime in their life. Primary prevention, specifically through lifestyle interventions that promote heart-healthy behaviors, is a major strategy to reduce the development of heart disease or stroke. For high blood pressure, these interventions include increasing the level of aerobic physical activity, maintaining a healthy weight, limiting the consumption of alcohol to moderate levels for those who drink, reducing salt and sodium intake, and eating a reduced-fat diet high in fruits, vegetables, and low-fat dairy food. Moreover, studies show that a diet low in saturated fat, dietary cholesterol, and total fat—with physical activity and weight control—can lower blood cholesterol levels⁴⁵.

Tobacco use often begins in adolescence; therefore, primary prevention efforts should be expanded in elementary and secondary schools and at the college level. Screening for risk factors, particularly for high blood pressure and high blood cholesterol, is an important step in identifying individuals whose risk factors may be undiagnosed and referring them to ongoing care. A host of studies has shown that dietary and pharmacologic therapy can reduce CHD and stroke risk factors, especially high blood pressure and high blood cholesterol. These interventions, coupled with other lifestyle changes, such as stopping smoking, increasing physical activity, and maintaining a healthy weight, can be even more effective in lowering the risk of a heart attack or stroke⁴⁶.

Public outreach and community health intervention efforts, such as those that encourage persons to lower their high blood pressure or to get their cholesterol checked or to help people stop smoking, are important parts of health care in the United States. Culturally and linguistically appropriate counseling by health care providers is important to those efforts⁴⁷.

BARRIERS

As noted in Healthy People 2010 and other literature:

Increasing the level of (people's) physical activity remains a challenge. The percentage of people who say they engage in no leisure-time physical activity is higher among females than males, among African Americans and Hispanics than whites, among older adults than younger adults, and among the less affluent than the more affluent⁴⁵.

Although reimbursement for common screening tests, such as mammograms and Pap tests, is provided by most health insurance plans (and is required by law in some States), reimbursement for effective counseling interventions, such as smoking cessation, is less common⁰².

High blood pressure is known as the "silent killer" and remains a major risk factor for CHD, stroke, and heart failure. A large proportion of persons with high blood pressure are unaware that they have this disorder⁴³.

Experience with the long-term management of asymptomatic CHD risk factors such as hypertension indicates that a sizable number of patients do not successfully carry out their prescribed treatment regimen⁴⁷.

In general, factors such as age (older), gender (female), race or ethnicity, low socioeconomic status, and prior medical conditions (previous heart attack, history of angina or diabetes) have been associated with longer pre-hospital delays in seeking care for symptoms of a heart attack⁴⁸.

BEHAVIORAL RISK/PROTECTIVE FACTORS AND CONTRIBUTING FACTOR ANALYSIS

Heart disease and stroke deaths rise significantly after age 65 years, accounting for more than 40 percent of all deaths among persons *aged 65 to 74 years* and almost 60 percent of those *aged 85 years and older*. The number of existing cases of AF increases with age and is more common in *males* than in females. About 70 percent of persons with AF are between age *65 and 85 years*. Cases of AF may continue to rise as persons live longer and as more persons *survive a first heart attack*⁴³.

In general the heart disease death rate has been consistently higher in *males* than in females⁴⁴. *Females*, in general, have poorer outcomes following a heart attack than do males: 44 percent of females who have a heart attack die within a year, compared with 27 percent of males. *At older ages, females* who have a heart attack are twice as likely as males to die within a few weeks. These differences are explained, in part, by the presence of *coexisting conditions such as high blood pressure, diabetes, and congestive heart failure*. After controlling for such factors, however, studies indicate an association remains between *female gender* and death following a heart attack. Complications are more frequent in *females* than in males after coronary intervention procedures, such as angioplasty or bypass surgery, are performed⁴⁴.

Heart disease and stroke share several risk factors, *including high blood pressure, cigarette smoking, high blood cholesterol, and overweight*. *Physical inactivity and diabetes* are additional risk factors for heart disease⁴⁵. Overweight and obese persons are at increased risk of illness from high blood pressure, high blood cholesterol and other lipid disorders, type 2 diabetes, CHD, stroke, and other diseases. *Balancing calorie intake with physical activity* is critical to preventing overweight and obesity. Research in the 1990s showed that a wide range of *physical activities* are beneficial to health and that everyone can benefit from physical activity. Even when physical activity is less than vigorous, it can still produce health benefits, including a decreased risk of CHD⁴⁵.

Smoking cessation has major and immediate health benefits for men and women of all ages. *Risk factors for heart disease and stroke develop early in life*: atherosclerosis already is present in late adolescence, diabetes in overweight children is on the rise, and hypertension can begin in the early teens. A slowly changing issue has been the recognition of *systolic blood pressure* as a more important predictor of CHD than diastolic blood pressure, especially in older adults⁴⁶.

Lowering high blood cholesterol significantly reduces the risk for heart attacks and heart attack deaths. Clinical trials have proved that lowering cholesterol in persons with and without existing CHD reduces illness and death from CHD and even reduces overall death rates⁴⁹.

Males in the highest *obesity* category have more than twice the risk of high blood pressure, high blood cholesterol, or both, compared to males of normal weight. Females in the highest obesity category have four times the risk of either or both of these risk factors, compared to normal weight females⁵⁰.

Healthy People 2010

Reduce coronary heart disease deaths to 166 deaths per 100,000 population.

Baseline: 208 coronary heart disease deaths per 100,000 population in 1998 (age adjusted to the year 2000 standard population).

Livingston County- Outcome Objective

Reduce coronary heart disease deaths to 140 deaths per 100,000 by 2015.

Baseline: 175.3 coronary heart disease deaths per 100,000 in 2006 (2006 IPLAN)

Healthy People 2010

27-1a. Reduce the proportion of adults who smoke Cigarettes to 12%.

Baseline: 24% of adults smoke cigarettes (1998)

27-1c. Reduce the proportion of adults who smoke cigars to 1.2%.

Baseline: 2.5% of adults smoke cigars (1998)

Livingston County – Impact Objective

Reduce to 17% the proportion of adults who smoke, by 2015.

(Baseline: 28.7% of adults smoke. (BRFS 2010)

Healthy People 2010

27-5. Increase to 75% smoking cessation attempts by adult smokers.

Baseline: 41% of adult smokers stopped smoking for 1 day or longer because they were trying to quit in 1998 (age adjusted to the year 2000 standard population).

Livingston County – Impact Objective

Increase by 10% annually the number of adults who attempt to quit smoking.

Baseline: 53 adults enrolled in Livingston County’s Break- the- Habit program in FY10.

Healthy People 2010

27-21. Increase to \$2.00 the average Federal and State tax on cigarettes.

Baseline: \$0.63 (1998)

Livingston County Impact Objective

Increase the Illinois tax on cigarettes to \$1.48 per pack, by 2015.

Baseline: Illinois tax on cigarettes is \$0.98 per pack (Campaign for Tobacco Free Kids, State Cigarette Excise Tax Rates and Rankings, 2010)

Healthy People 2010

Reduce the proportion of adults with high blood pressure to 16%.

Baseline: 28 percent of adults aged 20 years and older had high blood pressure in 1988–94 (age adjusted to the year 2000 standard population).

Livingston County- Impact Objective

Reduce the proportion of adults with high blood pressure to 16.4%.

Baseline: 29.8% of adults had been told by a health care provider that their blood pressure was high in 2006 (2006 BRFSS).

Healthy People 2010

12-10. Increase the proportion of adults with high blood pressure whose blood pressure is under control to 50 percent.

Baseline: 18 percent of adults aged 18 years and older with high blood pressure had it under control in 1988–94 (age adjusted to the year 2000 standard population).

Livingston County- Impact Objective

Increase the proportion of adults who are taking medication to control blood pressure to match then proportion of adults who have been prescribed medication to control blood pressure.

Baseline: 83.1% of adults with high blood pressure had been prescribed medication to control blood pressure and 81.4% of them were taking medication to control blood pressure in 2006 (2006 BRFSS).

Healthy People 2010

12-15. Increase the proportion of adults who have had their blood cholesterol checked within the preceding 5 years to 80 percent.

Baseline: 67 percent of adults aged 18 years and older had their blood cholesterol checked within the preceding 5 years in 1998 (age adjusted to the year 2000 standard population).

Livingston County- Impact Objective

Increase to 81% the proportion of adults who have had their blood cholesterol checked in the past year.

Baseline: 67.7% of adults had had their cholesterol level checked in the past year in 2006 (2006 BRFSS)

Healthy People 2010

19-1. Increase the proportion of adults who are at a healthy weight to 60 percent.

Baseline: 42 percent of adults aged 20 years and older were at a healthy weight (defined as a body mass index [BMI] equal to or greater than 18.5 and less than 25) in 1988–94 (age adjusted to the year 2000 standard population).

Livingston County- Impact Objective

Increase to 54.8% the proportion of adults who are at a healthy weight by 2015

Baseline: 37.8% of adults were at a healthy weight in 2006 (2006 BRFSS).

Healthy People 2010

19-2. Reduce the proportion of adults who are obese to 15 percent.

Baseline: 23 percent of adults aged 20 years and older were identified as obese (defined as a BMI of 30 or more) in 1988–94 (age adjusted to the year 2000 standard population).

Livingston County- Impact Objectives

Reduce the proportion of adults who are obese to 14 percent.

Baseline 22% of adults were identified as obese in 2006 (2006 BRFSS).

Increase to 20% the proportion of adults who are advised to lose weight by a health professional.

Baseline: 14.7% of adults were advised to lose weight by a health professional (2006 BRFSS).

Healthy People 2010

19-5. Increase to 75% the proportion of persons aged 2 years and older who consume at least two daily servings of fruit.

Baseline: 28 percent of persons aged 2 years and older consumed at least two daily servings of fruit in 1994–96 (age adjusted to the year 2000 standard population).

19.6 Increase to 50% the proportion of persons aged 2 years and older who consume at least three daily servings of vegetables, with at least one-third being dark green or orange vegetables.

Baseline: 3 percent of persons aged 2 years and older consumed at least three daily servings of vegetables, with at least one-third of these servings being dark green or orange vegetables in 1994–96 (age adjusted to the year 2000 standard population).

Livingston County- Impact Objectives

Increase to 50% the proportion of adults who eat 3-4 servings of fruits/vegetables per day.

Baseline: 49.5% of adults eat less than 3 servings of fruits/vegetables per day; 34.7% of adults ate 3-4 servings of fruits/vegetables per day; (2006 BRFSS)

Increase to 20% the proportion of adults who eat 5 or more servings of fruits/vegetables per day.

Baseline: 15.8% of adults eat 5 or more servings of fruits/vegetables per day, (2006 BRFSS)

Healthy People 2010

22-1. Reduce to 20% the proportion of adults who engage in no leisure-time physical activity.

Baseline: 40 percent of adults aged 18 years and older engaged in no leisure-time physical activity in 1997 (age adjusted to the year 2000 standard population).

Livingston County Impact Objectives

Reduce to 15% the proportion of adults who engage in no leisure-time physical activity.

Baseline: 23.4% of adults do no physical activity (BRFS 2006)

Healthy People 2010

22-2. Increase to 30% the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day.

Baseline: 15 percent of adults aged 18 years and older engaged in moderate physical activity for at least 30 minutes 5 or more days per week in 1997 (age adjusted to the year 2000 standard population).

Livingston County Impact Objectives

Increase to 80% the proportion of adults who engage in moderate physical activity for at least 30 minutes per day, at least 5 days per week.

Baseline: 41.4% of adults engage in moderate physical activity for at least 30 minutes per day, at least 5 days per week (BRFSS 2006)

INTERVENTION STRATEGIES

LCHPH will offer CVD screenings through the Hubert Wellness Clinic both at the health department and at community/work-sites. *Public outreach and community health intervention efforts, such as those that encourage persons to lower their high blood pressure or to get their cholesterol checked or to help people stop smoking, are important parts of health care in the United State⁵¹.*

Adults who are identified with risk factors for coronary heart disease through the Hubert Wellness Clinic Will be provided with information regarding health risks associated with elevated blood pressure, lipid levels, glucose level, out of range waist measurement and smoking. *Public outreach and community health intervention efforts, such as those that encourage persons to lower their high blood pressure or to get their cholesterol checked or to help people stop smoking, are important parts of health care in the United States⁵¹.*

Local medical providers will advise adults who are obese/ overweight about losing weight. *Counseling by primary care providers about the need to participate in physical activity is an important way to change behavior⁵². Registered dietitians and other qualified health care practitioners can improve health outcomes through efforts focused on nutrition screening, assessment, and primary and secondary prevention⁵³.*

Women enrolled in the WIC program will be encouraged to breastfeed for at least 6 months, preferable 12 months. *Breastfeeding for at least 6 months was associated with a healthier weight after age 4 among non Hispanic white children. And those who nursed for at least a year were less than half as likely to become obese later in childhood*⁵⁴.

Parents, of children enrolled in the WIC program who are identified as obese/ overweight, will be provided with information regarding: a) the health risks associated with being obese/overweight b) improving dietary habits; and c) opportunities for increasing physical activity. *Establishing healthful dietary and physical activity behaviors needs to begin in childhood*⁵⁵.

The School Based Health Center, at Pontiac Township High School, will continue to assess and counsel students regarding the importance of proper diet in avoiding/reducing the health risks related to obesity. *The impact of nutrition education on health may be more effective if targeted directly at school-aged children*⁵⁶.

LCPHD and OSF will provide persons with diabetes information regarding managing their condition through proper nutrition and exercise. *(Regular physical activity helps to maintain the functional independence of older adults and enhances the quality of life for people of all ages*⁵⁷.

LCHPD will promote heart disease prevention through diet and physical activity through local media opportunities. *Public education about the long-term health consequences and risks associated with overweight and how to achieve and maintain a healthy weight is necessary*⁵⁶. *As research continues to illustrate the links between physical activity and selected health outcomes, people will be able to choose physical activity patterns optimally suited to individual preferences, health risks, and physiologic benefits*⁵⁸.

LCHPD will promote Break the Habit NRT program for adults and track number of clients enrolling and remaining smoke-free at 3, 6 & 12 months. *Smoking cessation has major and immediate health benefits for men and women of all age*⁴⁶.

LCPHD and OSF will promote the Illinois toll-free Quit-line and LCPHS will track number of calls. *Smoking cessation has major and immediate health benefits for men and women of all ages*⁴⁶.

COMMUNITY RESOURCES FOR IMPLEMENTATION

OSF Saint James John W. Albrecht Medical Center

Livingston County Public Health Department

ESTIMATED FUNDING NEEDED FOR IMPLEMENTATION

Current programs will be enhanced to address heart disease as resources allow.

ANTICIPATED SOURCES OF FUNDING

IDPH grants

Hubert Foundation

Fees for service

PRIORITY AREA - REDUCE THE INCIDENCE/SEVERITY OF CANCER: WITH THE FOCUS ON LUNG AND COLORECTAL CANCERS

GOAL

Reduce the number of new cancer cases as well as the illness, disability, and death caused by cancer, with particular focus on lung and colorectal cancer.

RATIONALE

Cancer is the second leading cause of mortality in Livingston County, causing approximately 25% of all deaths⁵⁹. Lung, colon, breast, and prostate cancer account for approximately 56% of all cancer cases diagnosed in Illinois⁶⁰. Among males, lung cancer death rates have declined since 1990. In contrast, lung cancer death rates have continued to increase among females. Since 1987, more females have died from lung cancer than breast cancer⁶¹.

Evidence suggests that several types of cancer can be prevented and that the prospects for surviving cancer continue to improve. The ability to reduce cancer death rates depends, in part, on the existence and application of various types of resources. First, the means to provide culturally and linguistically appropriate information on prevention, early detection, and treatment to the public and to health care professionals are essential. Second, mechanisms or systems must exist for providing people with access to state-of-the-art preventive services and treatment⁶¹.

Regular screening examinations by health care professionals can result in the detection and removal of precancerous growths, as well as the diagnosis of cancers at an early stage. Cancers that can be diagnosed early through screening include cancers of the breast, colon, rectum, cervix, prostate, oral cavity, and skin⁶². For all cancers, treatments designed to increase survival are needed along with improved access to state-of-the-art care⁶³.

Laws that prohibit smoking in public places and create smoke-free environments are the most effective approach to prevent exposure to – and harm from – secondhand smoke⁶².

BARRIERS

As noted in Healthy People 2010 and other literature:

Numerous factors related to diversity contribute to the risk of developing cancer and having access to appropriate care to detect and treat. These factors include education, income, employment, insurance coverage, cultural and religious beliefs, language and literacy level. Social inequalities, such as racial discrimination, unequal education and access to information, also can affect the interactions between patients and physicians and contribute to reduced access to high quality care. Persons with lower socioeconomic status have disproportionately higher cancer death rates⁶².

Physical and mental disabilities create barriers, to recommended cancer screenings, such as transportation or access to specialists who can treat the disability and provide cancer treatment or screenings. Some disabilities limit individuals' abilities to communicate their concerns to health care providers or to understand the recommendations from health care providers⁵⁹.

Although patient awareness and acceptance of some interventions are high (such as screening for breast cancer) other interventions (for example, colorectal cancer screening and sexually transmitted disease [STD] screening) are less uniformly accepted⁶².

While many Americans would like to adopt a healthy lifestyle, many encounter substantial barriers that make it difficult to make healthy food and physical activity choices. Increased portion size, especially of restaurant meals; marketing and advertising of foods and beverages high in calories, fat, and added sugar, particularly to kids; schools and worksites that are not conducive to good health; community design that hinders

physical activity; economic and time constraints, as well as other influences, have collectively contributed to increasing trends in obesity⁶².

BEHAVIORAL RISK/PROTECTIVE FACTORS AND CONTRIBUTING FACTOR ANALYSIS

About 76% of all cancers are diagnosed in persons 55 and older⁶⁰. Poverty is another critical factor because it influences the prevalence of underlying risk factors (such as tobacco use and obesity), as well as access to services. According to the National Cancer Institute, research has shown that the underserved are more likely than the general population to: be diagnosed with and die from preventable cancers; be diagnosed with late-stage disease for cancers that are detectable at an early stage through screening; receive either no treatment or treatment that does not meet currently accepted standards of care; die of cancers that are generally curable; and suffer from terminal cancers in the absence of pain control and other palliative care⁶⁰.

Individuals who do not smoke or who maintain a vegetarian diet will experience a lower risk for many cancers⁶⁰. Cigarette smoking is by far the most important risk factor for lung cancer. The risk of developing lung cancer is about 23 times higher in male smokers and 13 times higher in female smokers, compared to lifelong nonsmokers. Recent studies suggest that smoking may also be associated with cancers of the colon-rectum, ovary, and female breast. Smokers who use smokeless products as a supplemental source of nicotine to postpone or avoid quitting will increase rather than decrease their risk of lung cancer. Regular cigar smoking is associated with an increased risk of cancers of the lung, oral cavity, larynx, esophagus, and probably pancreas. All cancers caused by cigarette smoking and heavy alcohol use could be prevented completely. Scientific evidence suggests that one-third of cancer deaths in the U.S.A. are related to nutrition, physical activity, excess weight or obesity, and thus could be prevented⁶². It is estimated that as much as 50 percent or more of cancer can be prevented through smoking cessation and improved dietary habits, such as reducing fat consumption and increasing fruit and vegetable consumption. Physical activity and weight control also can contribute to cancer prevention treatment⁶⁴.

The risk factor of colorectal cancer increases with age: 91% of cases are diagnosed in individuals age 50 and older. Several modifiable risk factors are associated with increased risk of colorectal cancer. Among these are obesity, physical inactivity, a diet high in red or processed meat, heavy alcohol consumption, long-term smoking, and possibly inadequate intake of fruits and vegetables. Consumption of milk and calcium appears to decrease risk. Studies suggest that regular use of nonsteroidal anti-inflammatory drugs, such as aspirin, and menopausal hormone therapy may also reduce colorectal cancer risk. Colorectal cancer risk is also increased by certain inherited genetic mutations and hereditary non-polyposis colorectal cancer (Lynch syndrome), a personal or family history of colorectal cancer and/or polyps, or a personal history of chronic inflammatory bowel disease. Studies have also found an association between diabetes and colorectal cancer.

Scientific data from randomized trials of cancer screening together with expert opinions indicate that adherence to screening recommendations for cancers of the breast, cervix, and colon/rectum reduces deaths from these cancers⁶⁴. Evidence shows that a reduction in CRC deaths can be achieved through detection and removal of precancerous polyps and treatment of CRC in its earliest stages. The findings from three randomized controlled trials indicate that biennial screening with fecal occult blood tests (FOBT) can reduce deaths from CRC by 15 to 21 percent in people aged 45 to 80 years. One trial reported a 33 percent reduction in deaths with annual screening in the same age groups, and a simulation model showed a 56 percent reduction. The efficacy of sigmoidoscopy has been supported by three case-control studies that showed 59 to 79 percent reductions in CRC deaths from cancers within reach of the sigmoidoscope in age groups 45 years and older⁶³.

Other risk factors for lung cancer include occupational or environmental exposure to secondhand smoke, radon, asbestos, certain metals, some organic chemicals, radiation, air pollution, and a history of tuberculosis. Genetic susceptibility plays a contributing role in the development of lung cancer, especially in those who develop the disease at a younger age⁶².

Smokers who quit before age 50 cut their risk of dying in the next 15 years in half, compared to those who continue to smoke. Quitting smoking substantially decreases the risk of lung, laryngeal, esophageal, oral, pancreatic, bladder, and cervical cancers⁶².

OBJECTIVES

Healthy People 2010

3-1. Reduce the overall cancer death rate to 159.9 deaths per 100,000 population.

Baseline: 202.4 cancer deaths per 100,000 population occurred in 1998, age adjusted to the year 2000 standard population.

Livingston County- Outcome Objective

Reduce to 20% the number of deaths in Livingston County due to malignant neoplasms, by 2015.

Baseline: 25% of deaths in Livingston County in 2006 were due to malignant neoplasms (2006 IPLAN)

Healthy People 2010

3-2. Reduce the lung cancer death rate to 44.9 deaths per 100,000 population.

Baseline: 57.6 lung cancer deaths per 100,000 population occurred in 1998, age adjusted to the year 2000 standard population.

Livingston County - Impact Objective

Reduce the lung cancer death rate to 54 deaths per 100,000, by 2015.

Baseline: 69.6 lung cancer deaths per 100,000 in 2006. (IPLAN)

Healthy People 2010

3-5. Reduce the colorectal cancer death rate to 13.9 deaths per 100,000.

Baseline: 21.2 colorectal cancer deaths per 100,000 population occurred in 1998 (age adjusted to the year 2000 standard population.

Livingston County - Impact Objectives

Reduce the colorectal cancer death rate to 18.7 deaths per 100,000, by 2015.

Baseline: 28.4 colorectal cancer deaths per 100,000 in 2006. (IPLAN)

Reduce the average age-adjusted colorectal cancer incidence rate to 40.1 for females and to 47.9 for males, by 2015.

Baseline: The average age-adjusted colorectal cancer incidence rate for 2002-2006, for females was 61.3 and for males was 72.5 (Illinois Cancer Registry Nov. 2008)

Increase the average percent of colorectal cancer diagnosed at local (early) stage to 45%, by 2015.

Baseline: The average percent of colorectal cancer diagnosed at local (early) stage for the five year period 2000-2004 was 39.7%. (IPLAN 2004)

Healthy People 2010

3-12a. Increase to 50% the proportion of adults age 50 and older who have received a colorectal cancer screening examination through fecal occult blood test (FOBT) within the preceding 2 years.

Baseline: 35% of adults age 50 and older received a colorectal cancer screening examination through fecal occult blood test (FOBT) within the preceding 2 years (1998).

3-12b. Increase to 50% the proportion of adults age 50 and older who have ever received a sigmoidoscopy.

Baseline: 37% of adults age 50 and older have ever received a sigmoidoscopy (1998).

Livingston County- Impact Objectives

Increase to 57% the proportion of adults age 50 and older who have ever received a colorectal cancer screening examination through fecal occult blood test (FOBT), by 2015.

Baseline: 39.1% of adults age 50 and older have ever received a colorectal cancer screening examination through fecal occult blood test (FOBT) (BRFSS 2006).

Increase to 67% the proportion of adults age 50 and older who have ever received a sigmoidoscopy, by 2015.

Baseline: 49.7% of adults age 50 and older have ever received a sigmoidoscopy (BRFSS 2006).

Healthy People 2010

27-1a. Reduce the proportion of adults who smoke Cigarettes to 12%.

Baseline: 24% of adults smoke cigarettes (1998)

27-1c. Reduce the proportion of adults who smoke cigars to 1.2%.

Baseline: 2.5% of adults smoke cigars (1998)

Livingston County – Impact Objective

Reduce to 17% the proportion of adults who smoke, by 2015.

(Baseline: 28.7% of adults smoke. (BRFS 2010)

Healthy People 2010

16-17 Increase to 99% the proportion of women who abstain from smoking during pregnancy.

Baseline: 13 percent of women smoked during pregnancy in 1998.

Livingston County Impact Objective

Reduce to 10% the proportion of women who smoke during pregnancy, by 2015.

Baseline: 25.3% of women smoke during pregnancy. (IPLAN 2006)

Healthy People 2010

27-5. Increase to 75% smoking cessation attempts by adult smokers.

Baseline: 41% of adult smokers stopped smoking for 1 day or longer because they were trying to quit in 1998 (age adjusted to the year 2000 standard population).

Livingston County – Impact Objective

Increase by 10% annually the number of adults who attempt to quit smoking.

Baseline: 53adults enrolled in Livingston County’s Break- the- Habit program in FY10.

Healthy People 2010

27-21. Increase to \$2.00 the average Federal and State tax on cigarettes.

Baseline: \$0.63 (1998).

Livingston County Impact Objective

Increase the Illinois tax on cigarettes to \$1.48 per pack, by 2015.

Baseline: Illinois tax on cigarettes is \$0.98 per pack (Campaign for Tobacco Free Kids, State Cigarette Excise Tax Rates and Rankings, 2010)

Healthy People 2010

27-13. Establish laws on smoke-free indoor air that prohibit smoking/limit it to separately ventilated areas in public places and worksites in all 50 states and the D. of C

Baseline: See HP2010 (page 27-27) chart listing objectives 27-13a.-13h for detailed list.

Livingston County-Outcome Objective

Increase public reporting of violations of the Smoke-Free Illinois Act by 10% annually.

Baseline: In FY10 10 violations in Livingston County were reported through the Smoke-Free Illinois complaints surveillance system.

Livingston County Impact Objective

Increase SFI compliance checks by 10% annually.

Baseline: In FY10 17 compliance checks were conducted.

INTERVENTION/EVALUATION STRATEGIES

Promote Break the Habit NRT program for adults and track number of clients enrolling and remaining smoke-free at 3,6 & 12 months. *Eighty-seven percent of lung cancer deaths could be prevented by eliminating tobacco use⁶⁵.*

Promote the Illinois toll-free Quit-line and track number of calls. *Eighty-seven percent of lung cancer deaths could be prevented by eliminating tobacco use⁶⁵.*

Conduct second-hand smoke education through health department clinics and track information distributed. *Each year, because of exposure to second-hand smoke, an estimated 3,000 nonsmokers die of lung cancer⁶⁵.*

Conduct “Its Your Future – Its Your Choice” for Junior High School students and track number attending and pre/post test results. *The younger you begin to smoke the more likely you are to be an adult smoker⁶⁵.*

In conjunction with the American Cancer Society, conduct a colorectal cancer prevention/screening awareness campaign and track campaign initiatives. *Nationally, colorectal cancer incidence rates have declined in recent years. Research suggests that the decline may be due to increased screening and polyp removal⁶⁵.*

Investigate opportunities to provide no/low cost fecal occult blood test kits to people who do not have insurance coverage for this screening and track results of investigation. *Most colorectal cancer can be prevented through removing precancerous polyps⁶⁵.*

Work with local medical providers to increase proportion of adults who receive a sigmoidoscopy and log contacts made with providers. *Detecting and removing precancerous colorectal polyps and detecting and treating the disease in its earliest stages will reduce deaths*⁶⁶.

Work with local health professionals to increase proportion of adults who have been advised, by a health professional, to quit smoking and track materials sent to health professionals. *Experts recommend that providers...counsel patients to prevent or reduce tobacco use...*⁶⁷.

Provide women enrolled in the health department's WIC program with information regarding the importance of quitting smoking before, during, and after pregnancy, including while breastfeeding, and track number of women attempting to quit, through cornerstone reporting system. *Evidence is accumulating that shows maternal tobacco use is associated with mental retardation and birth defects such as oral clefts*³⁷.

Facilitate efforts of the Livingston County Coalition Against Tobacco and other interested agencies/citizens in assisting in changing laws/regulations/taxation (including 2010) legislative efforts to raising the Illinois taxes on cigarettes to \$1.00 a pack) that would enhance efforts to reduce tobacco use and eliminate exposure to second-hand smoke and track success of legislative efforts. *An essential element in programs for reducing tobacco's appeal to youth is to change the current social environment that reinforces the acceptability of tobacco use*⁶⁸. *An increase in the excise tax on tobacco products would reduce rates of use among youth and adults. Data also indicate that earmarking funds from an excise tax increase for tobacco prevention and control programs increases both public support for the proposed tax and public health impact of the price increase*⁶⁹.

Respond to complaints made to the ITFC surveillance system with education letters to 1st time offending establishments and immediate compliance checks with repeat offenders. *An essential element in programs for reducing tobacco's appeal to youth is to change the current social environment that reinforces the acceptability of tobacco use*⁶⁸.

COMMUNITY RESOURCES FOR IMPLEMENTATION

Livingston County Public Health Department

IDPH

American Cancer Society

ESTIMATED FUNDING NEED FOR IMPLEMENTATION

Continuation and increased funding will be sought to implement interventions.

ANTICIPATED SOURCES OF FUNDING

IDPH and DHS grants

Other grants

American Cancer Society

Fees for service

References

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- 02 Healthy People 2010 page 1-4
- 03 Healthy People 2010 pages 1-23&24
- 04 Healthy People 2010 page 1-14
- 05 Healthy People 2010 page 1-7
- 06 Healthy People 2010 page 1-8
- 07 Healthy People 2010 page 1-13
- 08 Healthy People 2010 page 1-6
- 09 Healthy People 2010 page 1-5
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- 13 Healthy People 2010 page 18-3 to 18-6
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- 16 SOC 2010 grant application
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- 18 Healthy People 2010 page 18-7
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- 22 Healthy People 2010 page 18-16
- 23 Healthy People 2010 page 26-3
- 24 Healthy People 2010 page 26-4
- 25 Healthy People 2010 page 26-21
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- 27 Illinois Youth Survey 2008
- 28 Healthy People 2010 page 26-34
- 29 Healthy People 2010 page 16-5
- 30 Healthy People 2010 page 26-42
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- 32 Healthy People 2010 page 27-4
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- 49 Healthy People 2010 page 12-9
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- 58 Healthy People 2010 page 22-4
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- 60 ACS IL Cancer Facts & Figures 2006
- 61 Healthy People 2010 page 3-4
- 62 ACS IL Cancer Facts & Figures 2010
- 63 Healthy People 2010 page 3-7
- 64 Healthy People 2010 page 3-6
- 65 ACS IL Cancer Facts & Figures 2004
- 66 Healthy People 2010 page 3-15
- 67 Healthy People 2010 page 3-22
- 68 Healthy People 2010 page 27-32
- 69 Healthy People 2010 page 27-34

EXECUTIVE SUMMARY

The Livingston County 2010 - 2015 Community Needs Assessment and Community Health Plan is a public health approach to improving the quality of life for the citizens of Livingston County. This is the fourth needs assessment and health plan written for the county. Each of the plans share some similar characteristics but allow for growth, expansion, evaluation and improvement on the selected health priorities. Livingston County has made an impact on earlier priorities, such as increasing the immunization compliance rate for children, decreasing the teen pregnancy rate, and decreasing the severity/incidence of breast cancer. Some of the priorities continue to be addressed such as decreasing the incidence of cardiovascular disease and cancers. The focus will be on coronary heart disease, lung and colorectal cancer for chronic disease prevention. Risk factors often impact priorities and will be addressed. These risk factors that have been priorities in the past are obesity, drug/alcohol abuse and family violence.

The following health problems have been identified as the top priorities (in no particular order) and have been addressed by the plan.

1. Improve access to care: with a focus on non-emergency transportation; health care coverage; and the number of providers in specific disciplines (ie psychiatrist, dentist, etc).
2. Increase the availability of and access to mental health services.
3. Decrease the use/abuse of alcohol and other drugs.
4. Decrease the incidence of heart disease, with a focus on coronary heart disease.
5. Reduce the incidence/severity of cancer; with the focus on lung and colorectal cancers.

Linda Rhodes, Health Educator Coordinator at the Livingston County Health Department coordinated the health plan. The plan extensively utilizes *Healthy People 2010 Volume 1 & 2, U.S. Department of Health and Human Services, November 2000* as a resource. The health plan includes a goal, rationale, barriers, risk factor analysis, outcome/impact objectives, intervention strategies, evaluation plans, community resources for implementation, and funding issues for each priority. The definition of a health problem, the PEARL (propriety, economics, acceptability, resources, legality) test, statistics, and the needs assessment were utilized in the plan's development. Baseline statistics for Livingston County for each objective was furnished. The health plan was presented and discussed at the August 11, 2010 Community Coalition meeting with their input incorporated into the plan.

The Livingston County Community Coalition represents a group of dedicated individuals/agencies that desire to improve the quality of life for the citizens of the county. Implementation of the health plan will be conducted, facilitated and collaborated with other interested agencies. The Community Coalition serves as the Advisory Board for the development, implementation and evaluation of the needs assessment and health plan.

The health plan will provide the county with a valuable strategy for meeting the health needs of the county citizens. It will avoid duplication of services and foster collaboration among the various agencies. This provides a positive benefit to county citizens when everyone forms partnerships to promote a common goal. Together we will strive to make Livingston County a better place to live by promoting healthy lifestyles to prevent premature death, disability, and illness.