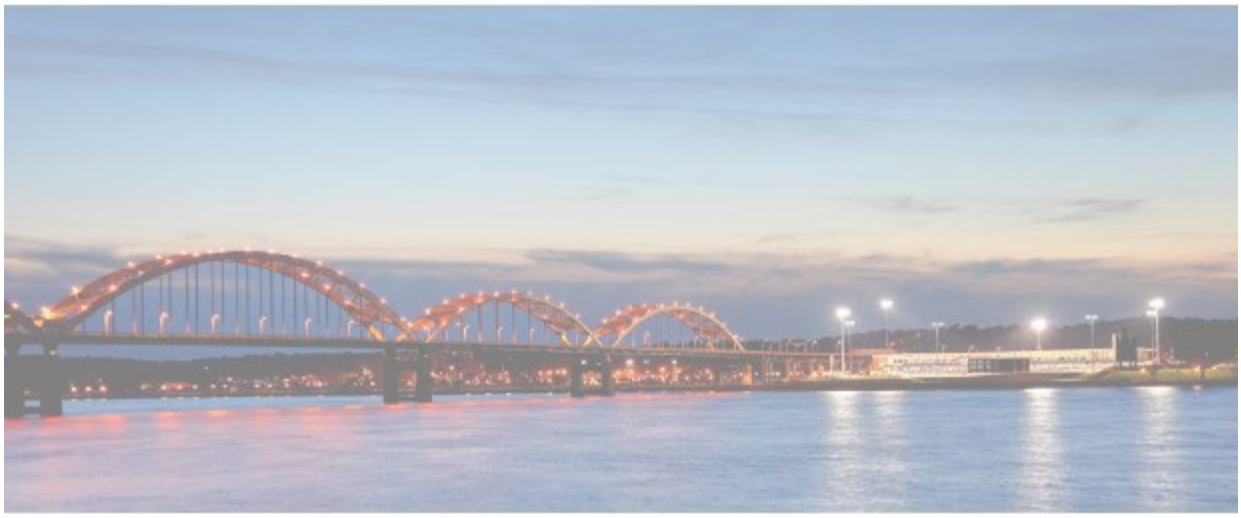
Community Health Improvement Plan

2023-2026

Scott County, Iowa

Rock Island County, Illinois



Scott County Health Department

Public Health
Prevent. Promote. Protect.
Rock Island County Health Department

Community Health Assessment (CHA) & Community Health Improvement Plan (CHIP) Steering Committee

Community Health Care, Inc.

Genesis Health System

Quad City Health Initiative

Rock Island County Health Department

Scott County Health Department

UnityPoint Health – Trinity

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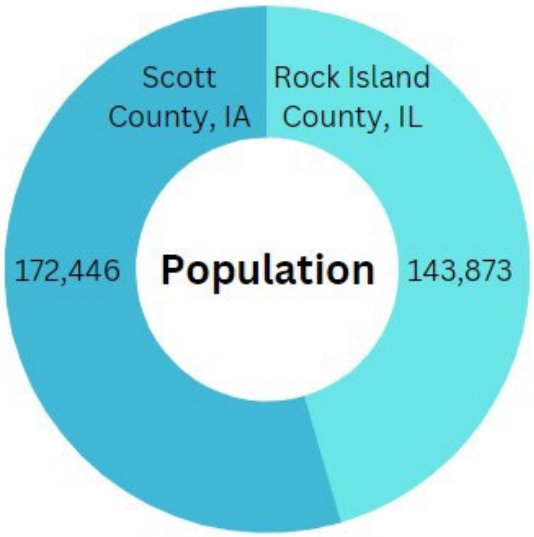
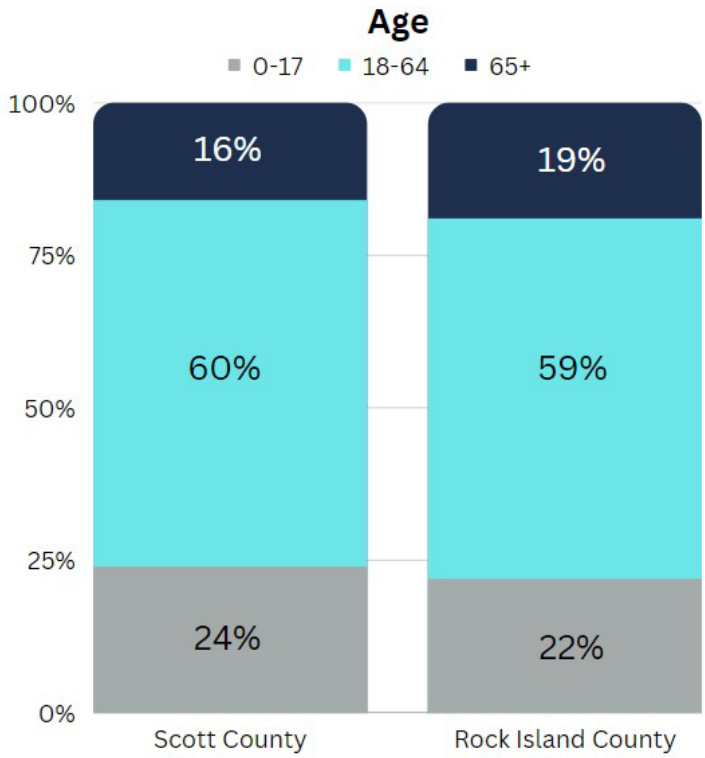
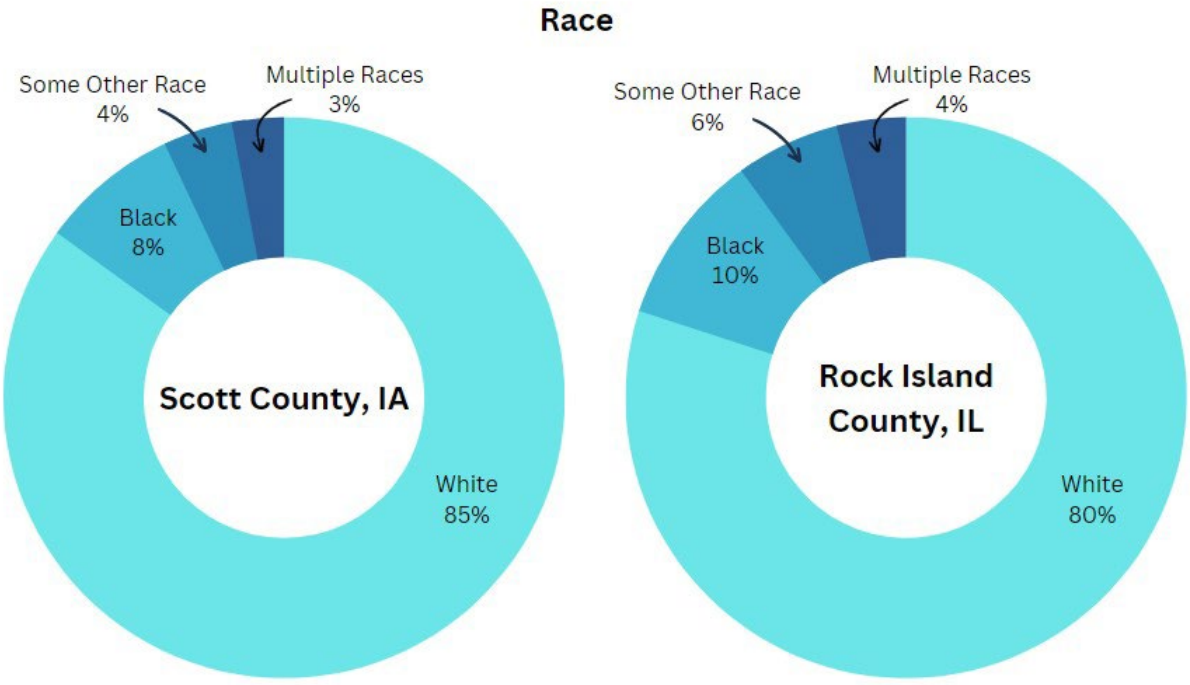
Introduction

Scott County, Iowa and Rock Island County, Illinois make up the unique bi-state community of the Quad Cities. Over 316,000 people reside within the two counties, which are predominantly urban (87.7%). Below are the population, age, and racial demographic breakdowns of residents in the Quad Cities (Professional Research Consultants, 2021).







Consistent with previous cycles, this community health assessment and health improvement planning process was completed with the following community partners that made up the Community Health Assessment (CHA) Steering Committee: Community Health Care, Inc., Genesis Health System, Quad City Health Initiative, Rock Island County Health Department, Scott County Health Department, and UnityPoint Health – Trinity.

This strong community partnership allows for a comprehensive assessment of community health that will enable organizations throughout the Quad Cities to work towards improving community health.

Organizing for Success and Partnership Development

MAPP Phase 1

The six CHA Steering Committee partners worked together to complete qualitative and quantitative assessments for the 2021 Quad Cities CHA.

This was the second community health assessment and health improvement planning process in the Quad Cities area that was guided by the National Association for County and City Health Officials' (NACCHO) Mobilizing for Action through Planning and Partnerships (MAPP) framework. This approach helps communities identify ways to address priority public health issues through a strategic planning process.

The CHA Steering Committee identified stakeholders from 17 sectors to be a part of the Stakeholder Committee for the assessment.

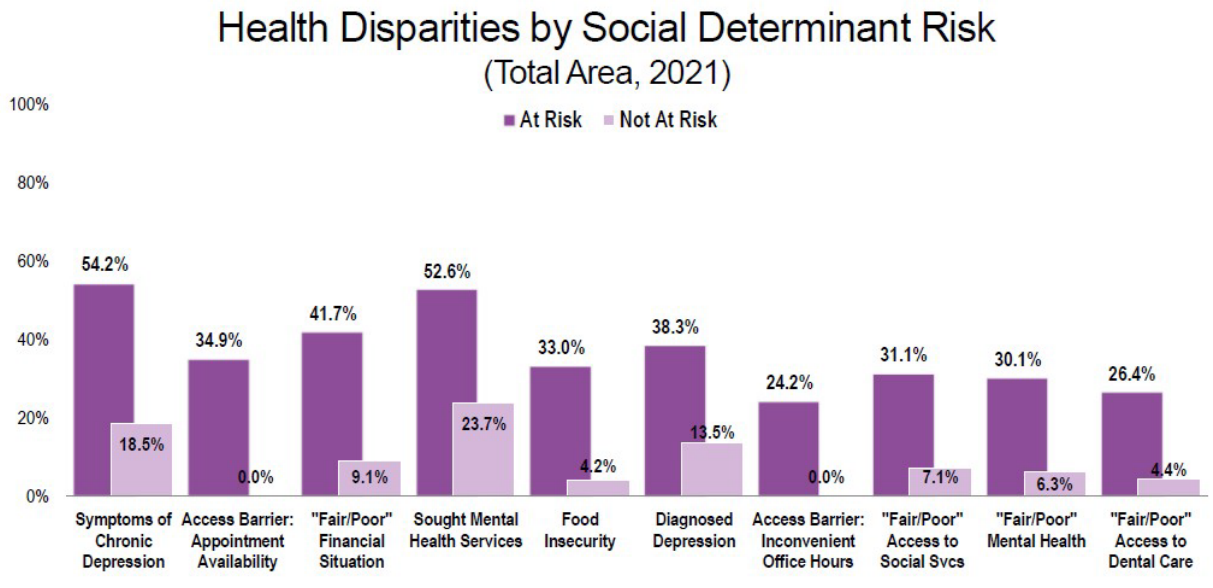
Sectors Represented by CHIP Community Partners

Social Determinants of Health

The social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. – Healthy People 2030

Both the quantitative and qualitative data collected during the CHA illustrated a common theme on the impact of the SDOH. Examples of SDOH include safe housing, transportation, and neighborhoods; racism, discrimination, and violence; education, job opportunities, and income; access to nutritious foods and physical activity opportunities; polluted air and water; language and literacy skills.

Research has shown that SDOH contribute to several health disparities and inequities. **The CHA survey conducted by PRC showed that adults who reported any number of adverse social experiences or conditions** (below 100% of the federal poverty level; living in unhealthy/unsafe housing conditions; experience of homelessness; mortgage/rent insecurity; lack of high school diploma; currently out of work; victim of a violent crime in the past three years; abused or neglected as a child; victim of domestic violence; low health literacy; and/or food insecure) **were determined to be an "at-risk" population.** These at-risk adults are more likely to report a number of health problems, as shown in the table below.



Sources: • 2021 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 368]
Note: • In this case, "at-risk" includes survey respondents who answered affirmatively to any of these indicators: below 100% of the federal poverty level; live in unhealthy/unsafe housing conditions (including lead hazards); incidence of homelessness; mortgage/rent insecure; lack of high school diploma; currently out of work; victim of a violent crime in the past three years; abused as a child; victim of domestic violence; low health literacy levels; food insecure.

Social Determinants of Health in the Quad Cities

Housing

14.8% reported **unhealthy** or **unsafe** housing conditions in the past year

31% reported being "always, usually, or sometimes" **worried** about paying rent or mortgage in the past year

Racism, Discrimination, & Violence

4.5% reported being a **victim** of violent crime in the past 3 years

25.1% reported ever being hit, slapped, pushed, kicked, or **hurt** in any way by an intimate partner

Transportation

8.6% reported that **lack** of transportation **hindered** ability to access health care in the past year

Food Access

15.2% reported **low** food access (do not live within 1/2 mile of supermarket or large grocery store)

25.2% were food **insecure** (ran out of food in the past year and/or had been worried about running out of food)

Neighborhoods

Focus groups expressed a need for **safer, more walkable neighborhoods** for play and other physical activities, as well as a desire to **address neighborhood violence** to make the community a better place to live

Language & Literacy

2.6% of the population in Rock Island County is **linguistically isolated**

1.3% of the population in Scott County is **linguistically isolated**

**no person aged 14+ in the household proficient in English*

Income

12.9% of the total population in the QC live **below** the poverty level

19.2% of **children** in the QC live **below** the poverty level

Education

9.1% aged 25+ **do not have** a high school diploma

18.2% report **low** health literacy

Visioning

MAPP Phase 2

In May 2021, the Stakeholder Committee met for the first time and was asked to reflect on the Vision Statement created during the 2018 assessment cycle. The Stakeholder Committee provided suggestions for revisions to produce the updated Vision Statement below:

> *"The Quad Cities region is united as one vibrant, diverse, collaborative community with engaged citizens, safe, thriving neighborhoods, and equitable and inclusive access and opportunities for overall health and social well-being."*

The Assessments

MAPP Phase 3

Phase three of MAPP consisted of conducting the quantitative and qualitative assessments to provide a comprehensive overview of health status in the community. PRC completed a quantitative Community Health Status survey via telephone of residents from Scott, Rock Island, and Muscatine counties.

- Results from the Community Health Assessment, including the community health status PRC survey can be found here.

The Quad Cities CHA Steering Committee also completed a series of focus groups with various subpopulations to complement the quantitative survey conducted by PRC. Focus group objectives included discussing the biggest health concerns for community members and exploring challenges, resources, and ideas for action. Subpopulations who participated in focus groups included:

- African American community, faith/nonprofit/social services sector, Hispanic community, immigrant and refugee community, individuals experiencing food insecurity, individuals experiencing homelessness/housing insecurity, individuals with lived experience managing a mental health condition, LGBTQ+ community, local law enforcement, public health/healthcare sector, school/childcare sector, and senior (65+) community
- Results from the Community Health Assessment, including the qualitative focus group data gathering can be found here.
- Assets and resources that could be used to improve the health of the community were identified in the CHA and can be found in Appendix A here.

Identifying Strategic Issues/COVID-19 Impact

MAPP Phase 4

PRC identified 13 areas of opportunity to represent significant health needs within the Quad Cities community. These areas were determined based on various criteria, including comparison with benchmark data, trends, the magnitude of the issue (number of persons affected), and the potential health impacts.

Areas of Opportunity

In the 2018 cycle, the community prioritized **mental health, nutrition, physical activity, and weight, and access to healthcare** as the three top areas to focus on in the Community Health Improvement Plan (CHIP). The ongoing COVID-19 pandemic hindered implementation of many health improvement strategies. The Scott and Rock Island County Health Departments, Genesis Health System, UnityPoint Health – Trinity, Community Health Care, Inc., and many other community partners had to transition resources to the pandemic response. Throughout 2022, representatives of the CHA Steering Committee hosted a series of focus groups with CHIP implementation partners to gather data and updates on the current status of strategy implementation. Implementation partners agreed to re-invigorate efforts towards these areas and transition several strategies into the 2023-2026 CHIP.

CHIP Community Partners				
Name	**Organization**	**Mental Health**	**Nutrition, Physical Activity, & Weight**	**Access to Healthcare**
Ameya Kotwal	Genesis Health	X	X	X
Amy Maxeiner	Black Hawk College	X	X	X
Ann Garton	Institute for Person Centered Care	X	X	X
Anne McNelis	Transitions Mental Health	X		
Bill Horrell	Alternatives for the Older Adult	X	X	X
Bob Gallagher	City of Bettendorf	X	X	X
Brian Strusz	Pleasant Valley School District	X	X	X
Brooke Barnes	Scott County Health Department	X	X	X
Caitlin Wells	The Project of the Quad Cities	X	X	X
Cecilia Bailey	Quad Cities Open Network	X		
Cheryl True	True Lifestyle Medicine Clinic	X	X	X
Dave Donovan	Scott County Emergency Management Agency	X	X	X
Denise Bulat	Bi-State Regional Commission	X	X	X
Ellen Gackle	Scott County Health Department	X	X	X
Gina Ekstrom	Davenport Community School District	X	X	X
Janessa Calderon	Greater Quad Cities Hispanic Chamber of Commerce	X	X	X
Janet Hill	Rock Island County Health Department	X	X	X
Kate Horberg	United Way Quad Cities	X	X	X
Kathleen Hanson	Scott County Board of Health	X	X	X
Kristin Humphries	East Moline School District	X	X	X
Linda Frederiksen	Medic EMS	X	X	X
Lindsey Mack	Iowa State University Extension	X		
Marie Ziegler	River Bend Foodbank	X	X	X
Michele Dane	Genesis Health	X	X	X
Nicole Carkner	Quad City Health Initiative	X	X	X
Nicole Mann	Scott County Kids	X		
Nita Ludwig	Rock Island County Health Department	X	X	X
Pam Samuelson	UnityPoint Health – Trinity	X	X	X

Name	Organization	Mental Health	Nutrition, Physical Activity, & Weight	Access to Healthcare
Richard Whitaker	Vera French Community Mental Health Center	X	X	X
Sherri DeVrieze	UnityPoint Health – Trinity	X	X	X
Terry Hanson	Scott County Kids	X		
Tiffany Peterson	Scott County Health Department	X	X	X
Tom Bowman	Community Health Care, Inc.	X	X	X

Formulate Goals and Strategies

MAPP Phase 5

In September 2022, the CHA Steering Committee partners brought the Stakeholder Committee together to discuss progress made on the three priority areas, as well as to brainstorm modifications and additions to the strategies and activities for the CHIP.

CHA Steering Committee partners started with an overview of the CHA-CHIP process, including data from the CHA and a review of SDOH. Stakeholders were given several handouts, including a copy of the previous CHIP and a summary of indicators highlighting the scope of the problem, recent trends, and equity factors (race, age, income, and gender) for each priority area.

Several additional discussions were held throughout 2022 with other community coalitions and groups to gather feedback on strategy progress from the 2018 cycle. These implementation partners also provided feedback on which strategies and activities to continue working on or that needed modification. CHA Steering Committee partners provided a summary of these discussions to the Stakeholder Committee.

Stakeholder Committee members then worked in small groups through questions for each priority area. Members were asked to consider how previous or new strategies and activities could impact health equity disparities, be connected to the SDOH, or if there are other partners in the community who should be connected to this work. The small groups wrote their ideas on large posters and took turns sharing out highlights from their discussions with the large group. Following are some common themes for each priority area.

Mental Health	Nutrition, Physical Activity, & Weight	Access to Healthcare
Professional/career development support	Health equity	Health equity
Break professional silos & enhance communication	Education	Professional/career development support
Health equity	Food access & innovative solutions	Technology & service model innovation
Support youth mental health needs	Community health & safety	Transportation & communication

Using these themes and ideas, staff from Scott County Health Department and Rock Island County Health Department held several additional meetings with relevant community coalitions, groups, and individual stakeholders to refine the specific strategies and activities for each priority area.

For the **mental health** priority area, health department staff met with members of the Quad Cities Behavioral Health Coalition Steering Committee, Quad Cities Trauma Informed Consortium Steering Committee, Scott County Kids, and Community Health Care, Inc. All these organizations are implementing a variety of initiatives related to increasing access to mental health services for both youth and adults. For example, Community Health Care is providing mobile mental health services to vulnerable populations (including people without housing and people who use substances) and integrating mental health services into primary care and school-based settings. This reflects feedback from the Stakeholder Committee to support youth mental health needs and work towards health equity by increasing access to care. Another updated activity includes supporting and maintaining a comprehensive referral system for mental health services, which relates to another theme from the CHA Stakeholder meeting to break professional silos and enhance communication between agencies.

Health department staff asked members of the Be Healthy QC Coalition for feedback on progress of previous activities and any needed modifications within the **nutrition, physical activity, and weight** priority area. In September, the Stakeholder Committee discussed wanting to address more policy issues related to food access, community and school gardens, food costs, and safety of the built environment. Examples of updated activities related to this include educating policy makers on the importance of a Health in All Policies approach to decision making, identifying policy opportunities related to nutrition, physical activity, and weight, and building the capacity of Be Healthy QC members to advocate for policy changes.

For **access to healthcare**, health department staff met with other health system and human service partners to review the previous strategies and activities, which includes establishing a Healthcare Access Workgroup that will be the responsible party for implementation. The Stakeholder Committee voiced the need to educate the community on getting the right care at the right place at the right time. The health departments plan to help facilitate this workgroup

to assess gaps in consumers' knowledge of healthcare and develop and promote resources for finding healthcare. Enhancing partnerships and increasing intersystem communication between larger health systems, independent providers, and federally qualified health centers was another theme from the Stakeholder Committee, which relates to the second goal under this priority area on educating providers on available wraparound services and referral system options.

A final Stakeholder Committee meeting was held in February 2023 to share the updates and additions made to the CHIP. CHA Steering Committee partners gave an overview of the goals and strategies of each priority area, along with highlighting some of the changes made. Stakeholder Committee members were then given the opportunity to respond to a series of questions regarding updates made to the CHIP and how they might assist with implementation moving forward.

Mental Health

Over the past several CHA-CHIP cycles, mental health has continued to be a top priority area in the Quad Cities. Looking at trend data from the PRC survey, 23.1% of individuals in the QC report their mental health status as "fair" or "poor", compared to 17.6% in 2018.

> *"Why is mental health important for overall health? Mental and physical health are equally important components of overall health. For example, depression increases the risk for many types of physical health problems, particularly long-lasting conditions like diabetes, heart disease, and stroke. Similarly, the presence of chronic conditions can increase the risk for mental illness". – Centers for Disease Control and Prevention (CDC), 2021*

In the QC, 30.2% of individuals have been diagnosed with a depressive disorder and 42.7% report experiencing symptoms of chronic depression. Both figures are well above the national averages of 20.6% and 30.3% respectively. Of QC adults, 14.2% feel that most days for them are "very" or "extremely" stressful. This is a slight decrease from 15.8% in 2018. Symptoms of chronic depression and "very" or "extremely" stressful days were reported more often among women, young adults, and those at lower income levels.

Among parents of children under 18 in the QC, 16.5% consider their child's mental health to be "fair" or "poor", a significant increase from 8.7% in 2018.

The number of both adults and children currently receiving mental health treatment has increased significantly. One out of four (25%) adults report currently receiving mental health treatment, up from 17.6% in 2018. Similarly, 25.3% of children in the QC are receiving mental health treatment, up from 12.7% in 2018.

Almost 30% of respondents reported the ease of obtaining local mental health services as "fair/poor". This figure decreased from 35.1% in 2018, but still illustrates an overall worsening trend in the QC since 2002 (12.6%). This indicator was also reported more often among women, young adults, those at lower income levels, and Hispanics.

The issue of mental health was of major concern in the focus groups, and this topic appeared in relation to other themes as well. Issues raised included the shortage of local mental health care providers, long wait times for care, and difficulty navigating the complex health system and related services. The needs for better follow-up, care coordination, and case management were raised. There was an overall desire to see increased outreach and education on mental health. The issue of stigma towards those living with mental health issues was also raised.

The issue of stigma came up, not only in relation to mental health but also in relation to race, homelessness, sexual identity, weight, and age. There was a recurrent mention of the desire to see a reduction in stigma in these realms. This issue often came up in discussion of interactions with healthcare providers, and thus relates to the overarching theme of diversity, cultural competency/sensitivity, and trust. Focus group participants mentioned the need for a more diverse health workforce, including more bilingual providers. It was said that *providers should reflect the population they serve*. There was also a recommendation for more extensive training in cultural competency for healthcare providers and those in related professions.

Goal 1: To overcome physical, social, and financial barriers that limit timely and comprehensive access to mental health care.
Goal 2: Advocate for public policy that increases funding, resources, and coverage to allow flexibility and integrated care.
Goal 3: Improve and enhance mental health education with the Quad Cities region.

Nutrition, Physical Activity, & Weight

Eating a healthy diet – with foods like fruits, vegetables, and whole grains – can reduce the risk of developing chronic diseases and improve overall health. Unfortunately, most individuals in the QC do not get the recommended amounts of healthy foods. The number of adults consuming five or more servings of fruits/vegetables per day has decreased significantly since 2012, from 41.4% to 26.7%. A similar trend has occurred for children, from 61.1% in 2015 to 38.1% (PRC, 2021).

Access to healthy foods and the ability to afford enough food greatly impact an individual's nutrition status. Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. In the QC, 15.2% have low food access, which is lower than rates for Iowa, Illinois, and the US. Food insecure individuals include those who ran out of food at least once within the past year and/or were worried about running out of

food in the past year. One out of four (25.2%) adults are considered food insecure, but rates are unfavorably high in Rock Island County (28%) compared to Scott County (22.7%).

> *"Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health." – Healthy People 2030*

The Physical Activity Guidelines for Americans state that adults should complete at least 150 minutes a week of moderate-intensity, or 75 minutes a week of vigorous-intensity aerobic activity; children and adolescents should do 60 minutes or more of physical activity each day. In the QC, only 23.1% of adults and 44.4% of children are currently meeting physical activity recommendations.

> *"Regular physical activity is one of the most important things you can do for your health. Being physically active can improve your brain health, help manage weight, reduce the risk of disease, strengthen bones and muscles, and improve your ability to do everyday activities." – Centers for Disease Control and Prevention (CDC), 2022*

Weight status is linked to several health issues, including type 2 diabetes, heart disease, stroke, and some types of cancer. Unfortunately, the percentage of adults in the QC who are overweight and obese continues to increase. Nearly three out of four (74.2%) adults are overweight and four out of 10 (41.3%) are obese. Among children, 35.7% are considered overweight and 17.3% are obese.

> *"Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight." – Healthy People 2030*

Many focus group participants expressed the need for more community outreach and activities, particularly free opportunities to participate in group classes and exercise. Outreach and education were mentioned as ways to improve mental health, nutrition, physical fitness, and to reduce stigma around numerous issues. In fact, the idea of community came through strongly

across both focus groups and topics. The need to bring services to people in need came up frequently. This was expressed as a desire for more mobile and community-integrated services, such as food trucks, community centers, community gardens, and for healthcare and health resource providers to be made available in places like food banks.

Goal 1: Engage cross-sector community partners and individuals in developing and implementing a comprehensive strategy toward regional health.

Goal 2: Maximize awareness and connect individuals with nutrition and physical activity resources in the Quad Cities region.

Goal 3: Promote policy, systems, and environment changes to improve nutrition, physical activity, and weight in the Quad Cities region.

Access to Healthcare

"Many people in the United States don't get the health care services they need. …People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them." – Healthy People 2030

Among adults aged 18-64 in the QC, 7.1% report a lack of health insurance coverage. This is a significant improvement from 10.6% in 2002. Still, a disparity exists with lack of coverage reported more often among low-income and Hispanic respondents (PRC, 2021).

Several types of barriers can hinder an individual's access to needed healthcare, including inconvenient office hours, finding a doctor, lack of transportation, and cost of prescriptions or visits. In the QC, 42% of respondents experienced difficulties or delays of some kind in receiving needed healthcare in the past year, a worsening trend since 2012 (33.3%). This indicator is reported more often among women and communities of color.

Most respondents gave positive ratings of the ease with which they can obtain local healthcare services, but 13.3% considered it to be "fair" or "poor".

The need to grow the local healthcare workforce, including more specialists, emerged repeatedly. Long wait times, particularly for psychiatry and other mental healthcare, were brought up. The need for more local gerontologists and providers competent in LGBTQ+ issues was raised. There was also a desire to see a greater focus on preventive/holistic care for both

individuals and communities, particularly in the areas of mental health and weight. This was sometimes expressed as a desire for a greater focus on wellness, root causes, and self-care.

Finally, the related issues of access/barriers to care and services and navigating complex systems of care and services were recurrent themes among focus groups. Although focus group participants voiced a desire for more programs and services overall, along with increased funding for existing programs and services, there was a greater emphasis on raising awareness of existing resources. The complexity of the insurance and medical systems was mentioned, along with a need for centralizing referral systems, coordinating care, and providing follow-up (particularly for mental health). Barriers to access included high cost of services, limited financial resources, transportation needs, and limited hours of availability.

Goal 1: Improve and enhance education and outreach to healthcare consumers in the Quad Cities region.

Goal 2: Improve coordination of wraparound service and education for providers.

Action Cycle

MAPP Phase 6

Phase six of the MAPP process is the Action Cycle, which is similar to conducting continuous quality improvement to assess progress on goals and strategies formed in the previous phase. The strategies and activities for each priority area involve multiple community partners, therefore consistent communication will be essential. CHA Steering Committee partners will regularly monitor progress and work with implementation partners to make any necessary changes to improve implementation and evaluation.

Conclusion

Scott and Rock Island County Health Departments envision this Community Health Improvement Plan will be implemented to a further extent this cycle to make progress in addressing the three priority areas that have carried over from the previous cycle. Community partners and members of the public made clear the need to utilize a health equity lens in writing the strategies and activities, as well as addressing SDOH that are impacting the community's ability to improve health status.

Thank you to all community stakeholders, partners, and members of the public for participating and contributing valuable input in this process. This plan is community-based thanks to the time, knowledge, and commitment of all participants.

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2023-2026 Scott & Rock Island County Community Health Improvement Plan (CHIP)

Priority Issue: Mental Health

Goal 1: To overcome physical, social, and financial barriers that limit timely and comprehensive access to mental health care.

Strategy 1: Increase innovative services available in the QC region.	**Measure:** 9.4% reported being unable to access mental health services in the QC region in the past year (CHA, 2021)	
Activities	**Timeline**	**Responsible Parties**
1. Provide crisis, wraparound, and transitional services outside of the clinic setting.	2023-2026	Eastern Iowa Mental Health/Disability Services Region
2. Using collaborative community portals and other resources, promote services available in the Quad Cities to the public and providers.	2023-2026	Quad Cities Behavioral Health Coalition
3. Support efforts of community partners to integrate mental health services in care teams and where community members are at, including primary care and school-based settings.	2023-2026	Quad Cities Behavioral Health Coalition Scott County Kids
4. Continue mobile mental health services to vulnerable populations, including people without housing and people who use substances.	2023-2026	Community Health Care, Inc.
5. Promote the integration of annual mental health screenings into primary care settings.	2023-2026	UnityPoint Health – Trinity Genesis Health System Community Health Care, Inc.

6. Promote Trauma Informed Care micro-credential program and implementation of trauma informed care in workplaces.	2023-2026	Quad Cities Trauma Informed Consortium

Strategy 2: Maintain a comprehensive referral system in the QC region.	**Measure:** 1 comprehensive referral system (QCON, The Hub)	
Activities	**Timeline**	**Responsible Parties**
1. Re-engage conversations regarding comprehensive referral system options for mental health services in the QC region.	2023-2026	Quad Cities Open Network (QCON) Quad Cities Behavioral Health Coalition Member Organizations
2. Promote information sharing on existing mental health services to facilitate access and referrals.	2023-2026	Quad Cities Open Network Quad Cities Behavioral Health Coalition Member Organizations
3. Maintain updated mental health resource information through The Hub or other identified referral system.	2023-2026	Quad Cities Open Network Quad Cities Behavioral Health Coalition Member Organizations

Goal 2: Advocate for public policy that increases funding, resources, and coverage to allow flexibility and integrated care.

Strategy 1: Support growth of the Quad Cities Behavioral Health Coalition's membership.	**Measure: 82 Quad Cities Behavioral Health Coalition Member Organizations (2022)**	
Activities	**Timeline**	**Responsible Parties**
1. Promote participation in the Coalition to employers, community groups, and organizations representing underserved populations.	2023-2026	Quad Cities Behavioral Health Coalition Steering Committee
2. Convene regular coalition meetings and updates of progress of Quad Cities Behavioral Health Coalition Teams (Innovation, Promotion, Outcomes, Funding & Resources).	2023-2026	Quad Cities Behavioral Health Coalition Steering Committee

Strategy 2: Promote community awareness of Quad Cities Behavioral Health Coalition.	**Measure: 577 QCBHC Facebook followers (2022)**	
Activities	**Timeline**	**Responsible Parties**
1. Implement a communication plan for educating the community on the activities of the Quad Cities Behavioral Health Coalition.	2023-2026	Quad Cities Behavioral Health Coalition Promotion Team
2. Track progress of Coalition promotion via website and Facebook page.	2023-2026	Quad Cities Behavioral Health Coalition Promotion Team

Strategy 3: Develop a community policy agenda to support mental health.	**Measure:** TBD by Quad Cities Behavioral Health Coalition Member Organizations	
Activities	**Timeline**	**Responsible Parties**
1. Explore the development of a coordinated, unified messages for advocacy on behavioral health issues (loan forgiveness, licensure requirements/restrictions).	2023-2026	Quad Cities Behavioral Health Coalition Member Organizations National Alliance on Mental Illness
2. Compile and develop behavioral health measures to support advocacy efforts.	2023-2026	Quad Cities Behavioral Health Coalition Member Organizations National Alliance on Mental Illness
3. Coordinate advocacy efforts among membership of the Quad Cities Behavioral Health Coalition.	2023-2026	Quad Cities Behavioral Health Coalition Member Organizations National Alliance on Mental Illness
4. Identify collaborative opportunities to expand the community's financial resources available to support behavioral health.	2023-2026	Quad Cities Behavioral Health Coalition Member Organizations National Alliance on Mental Illness

Goal 3: Improve and enhance mental health education within the Quad Cities region.

Strategy 1: Increase the number of mental health education opportunities in the QC region.	**Measure: # of mental health trainings provided by QCBHC, TIC, QCON, Scott County Kids**	
Activities	**Timeline**	**Responsible Parties**
1. Promote participation in the Quad Cities Trauma Informed Consortium by industry/business community, faith-based community, and community members to receive education on Adverse Childhood Experiences and resiliency.	2023-2026	Quad Cities Trauma Informed Consortium Quad Cities Behavioral Health Coalition
2. Promote participation in mental health trainings in the community [Mental Health First Aid; Question, Persuade, and Refer (QPR); Vera French training; Adverse Childhood Experiences (ACEs), Toxic Stress, and Trauma Informed Care (TIC)].	2023-2026	Quad Cities Behavioral Health Coalition Quad Cities Open Network Quad Cities Trauma Informed Consortium Scott County Kids Vera French
3. Support work of the Quad Cities Behavioral Health Coalition to provide education and training on evidence-based practices in behavioral health (health care providers, schools, colleges).	2023-2026	Quad Cities Behavioral Health Coalition
4. Support work of the Quad Cities Behavioral Health Coalition to facilitate community educational opportunities.	2023-2026	Quad Cities Behavioral Health Coalition
5. Demonstrate and promote the use of trauma-informed care pillars/principles for mental health and non-mental health professionals during Quad Cities Behavioral Health Coalition meetings.	2023-2026	Quad Cities Behavioral Health Coalition Quad Cities Trauma Informed Consortium

6. Support Scott County school districts and non-public schools in assessing social emotional health via evidence-based screenings.	2023-2026	Scott County Kids
7. Support work of the Quad Cities Behavioral Health Coalition to develop and promote evidence-based practices and collaborative opportunities to implement system innovations (telepsych, etc.).	2023-2026	Quad Cities Behavioral Health Coalition

Strategy 2: Invest in outreach efforts.	**Measure:** 577 QCBHC Facebook followers (2022)	
Activities	**Timeline**	**Responsible Parties**
1. Collaborate with the Quad Cities Behavioral Health Coalition to provide information to the broader community on organizations and services existing within the community's behavioral health system.	2023-2026	Quad Cities Health Improvement Plan Partners and other Mental Health Stakeholders
2. Support work of the Quad Cities Behavioral Health Coalition to connect community members with mental health resources (via food banks, public health, schools, provider offices, churches, and other agencies).	2023-2026	Quad Cities Health Improvement Plan Partners and other Mental Health Stakeholders
3. Gather data according to progress tracking measures developed by the Quad Cities Behavioral Health Coalition's Outcomes Team.	2023-2026	Quad Cities Behavioral Health Coalition Outcomes Team
4. Support promotion of the Zero Suicide Initiative of the Quad Cities Behavioral Health Coalition.	2023-2026	Quad Cities Behavioral Health Coalition
5. Promote community awareness of 988 as a mental health resource.	2023-2026	Quad Cities Behavioral Health Coalition Member Organizations

Alignment with National/State Health Improvement Plans & Best/Promising Practices

Healthy Illinois 2021

- **Goal 1:** Improve the collection, utilization, and sharing of behavioral health-related data in Illinois.
  - *Goal 1, Strategy 1:* Determine which data currently exist on critical behavioral health problems, resources, and assets.
  - *Goal 1, Strategy 2:* Draw on the resources of other state agencies and private associations.
  - *Goal 1, Strategy 4:* Establish a process for annual review of surveillance/asset data and adjustment of plans and programs to reduce problem prevalence.
- **Goal 2:** Build upon and improve local system integration
  - *Goal 2, Strategy 1:* Encourage the creation of local behavioral health planning councils that include, at a minimum, local health departments, local law enforcement, community health systems including hospitals and physician practices, and local behavioral health providers to develop collaborative action plans.
  - *Goal 2, Strategy 2:* Expand evidence-based community education/capacity-building efforts such as those previously identified so that community members have increased capacity to respond to others who may be experiencing emotional distress with the goal of increasing community social and emotional intelligence and response.
- **Goal 3:** Increase access to behavioral health services across the continuum.

Healthy Iowans 2017-2021

- **Goal 3:** Increase access to behavioral health services across the continuum.
  - *Goal 3, Strategy 3-1.1:* Advocate for the following: increase crisis stabilization services in local communities, increase utilization of "transitional level of care units," increase sub-acute services, decrease days waiting placement.

Healthy People 2030

- **Goal:** Improve mental health.
  - *MHMD-03:* Increase the proportion of children with mental health problems who receive treatment.
  - *MHMD-04:* Increase the proportion of adults with serious mental health illness who get treatment.
  - *EMC-D06:* Increase the proportion of children and adolescents who get preventive mental health care in school.
  - *MHMD-R01:* Increase the proportion of homeless adults with mental health problems who get mental health services.
  - *MHMD-01:* Reduce the suicide rate.
  - *AH-R09:* Increase the proportion of public schools with a counselor, social worker, and psychologist.

Priority Issue: Nutrition, Physical Activity, & Weight

Goal 1: Engage cross-sector community partners and individuals in developing and implementing a comprehensive strategy toward regional health.

Strategy 1: Align cross-sector strategies and resources.	**Measure:** 28 Be Healthy QC Coalition member organizations (2022)	
Activities	**Timeline**	**Responsible Parties**
1. Convene regular meetings of the Be Healthy QC Coalition.	2023-2026	Be Healthy QC Coalition
2. Promote participation in the Coalition to employers, community groups, and organizations representing underserved populations.	2023-2026	Be Healthy QC Coalition
3. Maintain and update a dashboard of community data to measure progress in improving nutrition, physical activity, and weight outcomes.	2023-2026	Be Healthy QC Coalition
4. Explore financial resources to support implementation of the Be Healthy QC Coalition goals.	2023-2026	Be Healthy QC Coalition

Strategy 2: Maintain consistent communication and collaboration of available community resources addressing nutrition, physical activity, and weight.	**Measure:** 4 Be Healthy QC Coalition meetings (2022)	
Activities	**Timeline**	**Responsible Parties**
1. Support current work in the community to increase coordination of services amongst providers.	2023-2026	Be Healthy QC Coalition
2. Promote community conversations around available resources.	2023-2026	Be Healthy QC Coalition
3. Identify opportunities to collaborate on community conversations around social determinants of health that impact nutrition, physical activity, and weight (built environment, community safety, equitable access).	2023-2026	Be Healthy QC Coalition Scott County and Rock Island County Health Departments

Goal 2: Maximize awareness and connect individuals with nutrition and physical activity resources in the Quad Cities region.

Strategy 1: Support and promote Quad Citians to eat well and move more.	**Measure:** # of Be Healthy QC Coalition Facebook posts	
Activities	**Timeline**	**Responsible Parties**
1. Implement the Be Healthy QC Coalition workplan to promote healthy eating and physical activity.	2023-2026	Be Healthy QC Coalition
2. Continue to engage partners in implementation of the workplan through Be Healthy QC Coalition meetings.	2023-2026	Be Healthy QC Coalition

3. Share and celebrate success stories broadly across all sectors and communication channels.	2023-2026	Be Healthy QC Coalition

Goal 3: Promote policy, systems, and environment changes to improve nutrition, physical activity, and weight in the Quad Cities region.

Strategy 1: Educate policy makers on importance of a Health in All Policies approach to decision making.	**Measure: # of workgroup meetings and # of policy maker contacts**	
Activities	**Timeline**	**Responsible Parties**
1. Establish a workgroup to explore Health in All Policies framework.	2023-2026	Scott County and Rock Island County Health Departments
2. Create process to integrate Health in All Policies approach in communities.	2023-2026	Scott County and Rock Island County Health Departments
3. Promote consideration of health in policymaking to local decision makers.	2023-2026	Be Healthy QC Coalition
4. Share evidence-based and best practices with policy makers.	2023-2026	Bi-State Regional Commission Scott County and Rock Island County Health Departments
5. Monitor the implementation and provide technical assistance.	2023-2026	Bi-State Regional Commission Scott County and Rock Island County Health Departments

Strategy 2: Promote healthy policies for nutrition, physical activity, and weight.	**Measure:** # of educational opportunities implemented	
Activities	**Timeline**	**Responsible Parties**
1. Identify policy opportunities for nutrition, physical activity, and weight in the community, with special focus on policies that reduce barriers to accessing healthy foods and physical activity opportunities for populations disproportionately impacted by the social determinants of health.	2023-2026	Be Healthy QC Coalition
2. Monitor policy change opportunities and legislation at local, state, and national level.	2023-2026	Scott County and Rock Island County Health Departments
3. Build capacity of Coalition members to advocate for policy changes.	2023-2026	Be Healthy QC Coalition

Alignment with National/State Health Improvement Plans & Best/Promising Practices

Healthy Illinois 2021

- **Goal 3:**Increase opportunities for active living.
  - *Focus Area 1:* Adopt policy, systems, and environmental approaches to increasing physical activity opportunities in the built environment.
- **Goal 4:** Increase community-clinical linkages to reduce chronic disease.

Healthy Iowans 2017-2021

- **Healthy Living, Goal 9:** Improve the healthy weight status of all Iowans by creating supportive policy, systems, or environments for healthy eating and physical activity.

Healthy People 2030

- **Goal:** Reduce overweight and obesity by helping people eat healthy and get physical activity.
  - *NWS-03:* Reduce the proportion of adults with obesity.
  - *NWS*-04: Reduce the proportion of children and adolescents with obesity.

- **Goal:** Improve health by promoting healthy eating and making nutritious foods available.
  - *NWS-03:* Reduce the proportion of adults with obesity.
  - *NWS-06:* Increase fruit consumption by people aged 2 years and over.
  - *NWS-07:* Increase vegetable consumption by people aged 2 years and over.

Priority Issue: Access to Healthcare

Goal 1: Improve and enhance education and outreach to healthcare consumers in the Quad Cities region.

Strategy 1: Convene community partners to address health access.	**Measure:** # of workgroup meetings	
Activities	**Timeline**	**Responsible Parties**
1. Convene Community Health Assessment (CHA) Steering Committee to discuss healthcare access.	2023-2026	Community Health Assessment Steering Committee
2. Establish a CHA Steering Committee workgroup to facilitate community conversations around healthcare access.	2023-2026	Community Health Assessment Steering Committee
3. Invite members of community organizations and the public to participate in the workgroup.	2023-2026	Healthcare Access Workgroup
4. Convene regular workgroup meetings and communication.	2023-2026	Healthcare Access Workgroup
5. Establish a work plan of the healthcare access workgroup.	2023-2026	Healthcare Access Workgroup

Strategy 2: Identify existing gaps in consumers' knowledge of healthcare.	**Measure:** TBD by Healthcare Access Workgroup	
Activities	**Timeline**	**Responsible Parties**
1. Survey community partners who serve targeted populations to identify gaps in knowledge of healthcare.	2023-2026	Healthcare Access Workgroup
2. Analyze results of community partners' survey.	2023-2026	Healthcare Access Workgroup
3. Determine strategies to eliminate gaps in knowledge of healthcare.	2023-2026	Healthcare Access Workgroup
4. Implement identified strategies in the community.	2023-2026	Healthcare Access Workgroup

Strategy 3: Develop and promote a healthcare guide to support consumers in accessing the healthcare system.	**Measure:** # of consumer healthcare guides distributed	
Activities	**Timeline**	**Responsible Parties**
1. Explore existing resources for educating healthcare consumers on accessing and utilizing the healthcare system.	2023-2026	Healthcare Access Workgroup
2. Establish content for guide based on what information is most beneficial for the consumer.	2023-2026	Healthcare Access Workgroup

3. Develop draft consumer healthcare guide that addresses accessing the right care at the right time at the right place.	2023-2026	Healthcare Access Workgroup
4. Test the guide with a targeted group of healthcare consumers.	2023-2026	Healthcare Access Workgroup
5. Promote the finalized consumer healthcare guide to consumers, healthcare providers, and community partners.	2023-2026	Healthcare Access Workgroup

Goal 2: Improve coordination of wraparound service and education for providers.

Strategy 1: Maintain a coordinated resource system to connect providers and services in the community.	**Measure: # of community platforms connecting providers and services**	
Activities	**Timeline**	**Responsible Parties**
1. Re-engage conversations regarding comprehensive referral system options for healthcare services in the QC region.	2023-2026	Healthcare Access Workgroup Quad Cities Open Network
2. Promote information sharing on existing healthcare services to facilitate access and referrals.	2023-2026	Healthcare Access Workgroup Quad Cities Open Network
3. Maintain updated healthcare resource information through The Hub or other identified referral system.	2023-2026	Healthcare Access Workgroup Quad Cities Open Network

Alignment with National/State Health Improvement Plans & Best/Promising Practices

Healthy Illinois 2021

- **Goal 1, Maternal and Child Health:** Assure accessibility, availability, and quality of preventive and primary care for all women, adolescents, and children, including children with special health care needs, with a focus on integration, linkage, and continuity of services through patient-centered medical homes.
  - *Focus Area 2*: Engage providers in understanding how to provide a medical home.
  - *Focus Area 3*: Promote understanding of the benefits of medical homes among consumers and families.

Healthy Iowans 2017-2021

- **Health System Improvement, Transportation, Goal 1:** Provide transportation to health care services by making available State Transit Assistance Special Project funds to Iowa's 35 public transit agencies.
- **Health System Improvement, Lack of Primary Care Services, Goal 1:** Coordinate care for children and youth with special health care needs through a medical home.

Healthy People 2030

- **Goal:** Improve access to comprehensive, high-quality health care services.
  - *AHS-04:* Reduce the proportion of people who can't get medical care when they need it.
  - *AHS-07:* Increase the proportion of people with a usual primary care provider.