



**Greene County  
Health Department**

# Greene County HD

Illinois Project for Local Assessment of Needs- IPLAN

# IPLAN 2027-2031

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***Stakeholders and Partners:***

Babies and Books  
Business owners  
Bright Futures  
Carrollton Early Childhood Center  
Carrollton Police Department  
Community members  
Crisis Center  
Christ United Church  
Department of Children and Family Services  
Jersey Community Hospital  
Greene County Board  
Greene County Board of Health  
Greene County School Districts  
Greene County Sheriff's Department  
Greene County Judge, Judicial Services & Probation  
Greene County Police Chiefs  
Locust St. Resource Center  
Pharmacy Plus  
St. John's Catholic School  
Thomas H. Boyd Hospital

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# Greene County Board of Health

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# Letter from Public Health Administrator

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Greene County Health Department values the Illinois Project for Local Assessment of Needs (IPLAN) as an opportunity to pause, listen, assess, and plan alongside the community we serve. Every community is different, and in a rural county like Greene, our health outcomes are shaped not only by access to health care, but also by transportation, employment, housing, food access, behavioral health resources, education, and the strength of our social connections. A meaningful community health plan must recognize these interconnected factors and identify strategies that are both responsive to current needs and realistic for our community.

As we begin the 2027–2031 IPLAN cycle, I am proud of how Greene County Health Department and our community partners have grown since the last assessment. The 2022–2026 IPLAN identified access to healthy food, mental health services, substance use prevention, and recreational activities as priority areas. While these needs have not disappeared, our community has become increasingly invested in addressing them, advocating for change, and directly shifting processes to improve the health and well-being of our residents. We have seen business owners step up to address challenges to maintain healthy food access; farm-to-school programs, farm stands, and farmers' markets provide additional opportunities for local food access; and community members invest in recreational opportunities. We have seen adults playing on recreational softball teams, pickleball courts being developed, residents walking in new parks, and children playing in newly developed basketball spaces. Inspired volunteers, community members, and organizations have advocated for the needs of rural communities and, when a need was identified, stepped up to help get things done. Greene County has demonstrated that our greatest strength is our willingness to come together and find solutions.

Over the past five years, Greene County Health Department has expanded its role in community health and strengthened partnerships across health care, schools, law enforcement, the judicial system, human services, behavioral health, and community organizations. We have developed greater capacity for community health programming, strengthened our work related to substance use prevention and recovery, expanded connections to behavioral health and social resources, and increased our ability to bring partners together around shared community concerns. Initiatives such as recovery support and peer navigation, overdose fatality review, community referral and resource coordination, and expanded prevention and education efforts reflect a continued commitment to addressing the underlying factors that influence health—not simply responding after a crisis occurs.

The progress made during this cycle has reinforced an important lesson: improving health in Greene County cannot be accomplished by the health department alone. It requires a team effort from community leaders working across all facets, including schools, health care providers, local government, law enforcement, community organizations, businesses, families, and residents working toward common goals. Our community has repeatedly demonstrated its ability to do this. The previous IPLAN described Greene County as a community where people are willing to come together and support one another. Five years later, that spirit remains one of our greatest public health assets, with a renewed focus on bringing leaders and community members together to champion solutions that make Greene County a healthier, stronger, and more prosperous place to live.

We extend our sincere appreciation to the Greene County Board of Health and Greene County elected officials for their continued support of public health and of the Greene County Health Department. We are equally grateful to our staff, community partners, volunteers, schools, health care organizations, public

safety agencies, civic leaders, businesses, and residents who contributed their time, experience, and perspective throughout this assessment process. Their participation reminds us that IPLAN is not simply a health department document—it is a community plan.

As we look toward 2027–2031, we are committed to building upon the progress of the past five years while remaining honest about the challenges that continue to affect Greene County. We will use reliable data, community voice, and the experience of our partners to identify priorities that are meaningful, measurable, and achievable. Most importantly, we will continue to approach community health with the belief that when Greene County works together, we can create healthier opportunities, strengthen our communities, support economic and social well-being, and improve the quality of life for the people who call Greene County home.

Sincerely,

A handwritten signature in cursive script, reading "Molly Peters". The signature is written in dark ink on a light background.

Molly Peters, B.S., L.E.H.P  
Public Health Administrator

# Executive Summary

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The Illinois Project for Local Assessment of Needs (IPLAN) is a community health assessment and planning process conducted every five years by local health departments throughout Illinois. Local health departments must complete the process to meet the requirements of the Illinois Administrative Code Section 600.400, which governs the certification of local health departments. Under the Administrative Code, health departments must use a systematic process to assess community needs. The assessment process must be grounded in the core functions of public health and include analysis of health indicators that reflect the health status of the community.

Greene County Health Department utilized an IPLAN assessment process grounded in the principles of Assessment Protocol for Excellence in Public Health APEX-PH while incorporating key elements of the MAPP 2.0 framework. This assessment protocol includes both an organizational capacity assessment and community health needs assessment process. SWOT analysis, a countywide community survey, stakeholder focus groups, and a review of quantitative health data. Community input and cross-sector collaboration were used to identify strengths, challenges, emerging trends, and priority health needs, consistent with MAPP 2.0's emphasis on community engagement and shared ownership of community health improvement efforts.

Health data were collected using national, state, and county-level statistical information to capture the current status of seven specific health indicator groupings, reflecting a format to acquire input indirectly from both citizens of Greene County and community stakeholders. In the process of developing the Community Health Plan, Greene County Health Department stressed that the Plan is a *community* plan. The priorities were selected based on statistical significance and frequency of community concerns.

Based on the results of the organizational capacity and community health needs assessment, four core priorities were established, which will be used to develop a community health plan:

**PRIORITY 1:           Community Health Navigation**

**PRIORITY 2:           Behavioral Health Services**

**PRIORITY 3:           Substance Use Disorder Prevention**

**PRIORITY 4:           Rural Community Infrastructure & Sustainability**

These priorities deeply describe our current advancements in support and community access since our last IPLAN cycle and speak to our status on this work and development of community needs. Can people find and access what they need? Can people get the behavioral health care and support they need? Can we prevent substance use and strengthen the systems that support recovery? Will the community have the people, places, resources, and systems necessary to provide those services over time? These questions are rooted in the priority area and are all tied together in development of sustainability of our public health in rural Illinois.

This document provides priority objectives, impact objectives, and strategies to achieve progress over the next five years. In compliance with the Illinois Department of Public Health (IDPH) Project for Local Assessment of Needs (IPLAN) protocol, the following categories were assessed through countywide needs assessment: demographic and socioeconomic characteristics; general health and access to care; maternal and child health; chronic disease; infectious disease; environmental, occupational, and injury control; and sentinel events. Also, in compliance with IPLAN protocol, progress and achievements of the 2022-2026 Greene County Community Health Plan were received, reviewed, and considered during the data analysis phase. The Greene County Health Department also fulfilled the requirement of conducting an Organizational Capacity and Self-Assessment.

Greene County's priorities of Community Health Navigation, Behavioral Health Services, Substance Use Prevention, and Rural Community Infrastructure & Sustainability closely align with this statewide direction. Behavioral Health Services and Substance Use Prevention directly support the SHIP priority of Mental Health and Substance Use Disorder. Community Health Navigation supports improved access to health care and wrap-around services while addressing social and structural barriers that affect residents' ability to obtain needed resources. Rural Community Infrastructure & Sustainability supports the SHIP's crosscutting focus on public health infrastructure, workforce, funding, system coordination, physical and built environments, and the long-term capacity of communities to maintain essential services.

Through these locally identified priorities, Greene County will contribute to statewide health improvement goals while addressing the specific needs, assets, and challenges identified by residents and community partners. Alignment with the SHIP also provides opportunities to expand connections to support funding efforts, strengthen regional and statewide partnerships, and use local experience to champion rural community systems change.

This report will provide an assessment of Greene County, IL, and establish objectives to address identified public health needs. Further priorities and programs will be developed to enhance each priority group implementation strategy.

# IPLAN Purpose and Background

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Greene County Health Department's mission is to assure access to resources with a focus on prevention, health education, home health, and resource support to tirelessly serve Greene County, Illinois, residents. To accomplish this mission, we must balance three public health functions: assessment of community health status and resources, development of policies and programs, and assurance of quality and effective services.

The Illinois Project for Local Assessment of Needs (IPLAN) provides an opportunity to step back from the day-to-day work of public health and examine the broader conditions that influence the health and well-being of Greene County residents. Health is influenced by much more than access to medical care. Transportation, housing, employment, food access, education, behavioral health, substance use, social connection, environmental conditions, and the availability of essential community services all contribute to the health and stability of a community.

As a rural community, Greene County experiences unique challenges in maintaining these resources and services. Geographic distance, limited workforce availability, competition for employees and wages with larger communities, limited financial resources, aging infrastructure, and the sustainability of essential services can create barriers to health and quality of life. These challenges are interconnected and require solutions that extend beyond any single organization or sector.

Through the IPLAN process, we can assess current and emerging trends identified through community surveys, focus groups, leadership discussions, health data, and organizational assessments. By utilizing the voices and experiences of our community to help determine public health priorities, we can identify needs that are meaningful, actionable, and achievable. IPLAN is not simply a plan for the health department; it is an opportunity for Greene County to establish shared priorities and identify the collective actions needed to improve the health and well-being of our community.

Our goal is to use these priorities and objectives as a framework that can extend beyond the Greene County Health Department. We hope they will inform community initiatives, strengthen connections among organizations, support grant and funding opportunities, guide resource development, and provide a foundation for advocacy efforts that champion sustainable solutions and rural community systems change. By identifying shared needs and working together toward shared outcomes, Greene County can strengthen the systems, resources, and relationships necessary to remain a healthy, resilient, and prosperous rural community.

The IPLAN process also recognizes that community health improvement requires sustained collaboration. Greene County Health Department's role is not to address every identified need independently, but to help assess needs, connect resources, convene partners, identify opportunities, support evidence-informed strategies, and champion improvements that strengthen the community as a whole. Our greatest opportunity for meaningful and lasting change is through the collective knowledge, resources, and commitment of residents, community organizations, health care providers, schools, businesses, local government, public safety agencies, and other partners.

Results of the assessment will be shared with community members, policymakers, health care professionals, community organizations, and other stakeholders. Greene County Health Department's goal is to be a leader in uniting the community toward common goals, strengthening partnerships, and supporting strategies that improve health outcomes and the conditions in which Greene County residents live, work, learn, and participate in their communities.

The Greene County Board of Health reviews the proposed health priorities and community health plan for approval of implementation. Upon approval, the IPLAN document is submitted to the Illinois Department of Public Health (IDPH) for review and approval as part of the local health department's recertification process. Following approval, implementation of the five-year community health plan begins in Greene County.

# Data Assessment

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The Greene County Health Department IPLAN core team included GCHD staff in collaboration with community partners and stakeholders. Collaboration and data assessment activities took place from November 2025 through July 2026. Data was collected through a variety of methods and reliable sources to develop an understanding of current health status, emerging trends, community strengths, barriers, and disparities affecting Greene County residents.

The Community Health Needs Assessment incorporated multiple sources of information, including quantitative health data, a community survey, three community focus groups, individual leadership discussions, and an organizational capacity assessment. The organizational capacity assessment utilized the Mobilizing for Action through Planning and Partnerships (MAPP 2.0) framework to assess organizational strengths, resources, partnerships, capabilities, and areas for continued development. The broader assessment process provided opportunities for community members, organizational leaders, and community partners to identify strengths, emerging concerns, barriers, and opportunities for improvement. Findings from these assessment activities were considered collectively to identify and prioritize the health issues that will guide the 2027–2031 Greene County IPLAN.

The assessment included the collection and analysis of community health data as well as the community’s perceptions and experiences related to health needs and access to resources. Discussions with community leaders, observed data trends, previous health assessments, and local knowledge were reviewed to provide additional context to the quantitative findings. By gathering both quantitative and qualitative data, Greene County Health Department developed a more comprehensive understanding of the depth and interconnected nature of community health needs.

## **Organizational Capacity Assessment**

Greene County Health Department assessed internal capabilities and organizational capacity utilizing the Mobilizing for Action through Planning and Partnerships (MAPP 2.0) framework. The assessment examined organizational strengths, resources, partnerships, capabilities, and areas for continued development. Results were reviewed by the Greene County Board of Health and used to inform capacity planning and development of the 2027–2031 IPLAN.

The previous 2022–2026 IPLAN was reviewed to assess progress, identify continuing needs, and determine opportunities to build upon work completed during the previous planning cycle. The 2022–2026 IPLAN established four priority areas: Access to Healthy Food, Mental Health Services, Substance Abuse Prevention, and Recreational Activities. These priorities remain relevant to the health and well-being of Greene County residents; however, the current assessment demonstrates that the needs identified during the previous cycle are interconnected and can be addressed through broader community systems and approaches.

The organizational capacity assessment, review of the previous IPLAN, community health data, and community input demonstrate that Greene County has developed significant strengths and partnerships while continuing to

experience challenges associated with rural workforce availability, resource limitations, service access, infrastructure, and long-term sustainability. The 2027–2031 priorities therefore build upon previous accomplishments while expanding the focus toward interconnected community systems and the conditions necessary to sustain health improvement.

### **Assessment Highlights**

The assessment was conducted from November 2025 through July 2026. The community survey was promoted through social media, email, newsletters, and direct engagement with clients and staff.

Over the past several years, Greene County Health Department has experienced significant growth in community partnerships, collaboration, advocacy, communication, and public health leadership. The department has received state and association recognition for collaborative work and partnership development. Relationships among community leaders and organizations have strengthened, creating a greater shared understanding of community needs, available resources, and resource gaps.

Community leadership discussions demonstrated strong collaboration among emergency response, health care, education, the judicial system, law enforcement, and other community organizations. Hospital leadership, school district superintendents, judicial system representatives, chiefs of police, emergency response leadership, and other community partners are increasingly connected through shared partnerships and community aspirations. Multiple agencies have experienced opportunities for direct connection to resources, shared advocacy, and alignment of community goals during the past five years.

Despite these advances, significant barriers remain. Lack of sustained funding and limited access to behavioral health services were identified as ongoing high-priority concerns. Substance use disorder continues to have generational impacts in Greene County, although access to resources has increased and community response systems have improved. The assessment also reinforced the need to strengthen connections between residents and available resources, sustain essential services, support the rural workforce, and address the infrastructure and systems necessary to maintain long-term community health.

Over the next five years, Greene County Health Department will continue to build upon the progress made during the previous IPLAN while responding to current and emerging needs. The 2027–2031 priorities reflect both the continued importance of previously identified concerns and the growth of the community’s capacity to address them. The next planning cycle represents an opportunity for continued growth, deeper connections, stronger systems, and improved health outcomes.

### **Previous IPLAN Priorities and 2027–2031 Expansion**

The 2027–2031 priorities build upon the foundation established during the previous IPLAN:

#### **Access to Healthy Food → Community Health Navigation**

The previous priority focused on improving access to healthy food through community initiatives, education, and advocacy. The current assessment expands this concept to recognize that residents experience barriers not only to food, but also to identifying, accessing, and navigating health and social resources throughout the community. Community Health Navigation provides an opportunity to strengthen connections between residents and the resources available to support health and well-being.

## **Mental Health Services → Behavioral Health Services**

The previous priority focused on increasing access to mental health services and strengthening community partnerships. The current priority expands this work to encompass a broader behavioral health continuum, including mental health, crisis response, prevention, treatment, recovery support, and connections to community resources.

## **Substance Abuse Prevention → Substance Use Disorder Prevention**

Substance use disorder prevention remains a significant community priority. The current assessment builds upon previous prevention efforts and partnerships while recognizing the importance of early intervention, education, recovery supports, peer services, overdose prevention, and coordinated community response. The previous IPLAN identified the need for stronger partnerships among health care, law enforcement, judicial systems, schools, and community organizations, and the current assessment demonstrates continued opportunity to strengthen these connections.

## **Recreational Activities → Rural Community Infrastructure & Sustainability**

The previous priority recognized the importance of recreational opportunities in supporting physical activity, social connection, and community well-being. The current assessment expands this concept to consider the broader infrastructure necessary to maintain healthy and active communities, including safe and accessible facilities, community spaces, workforce, essential services, environmental conditions, funding, and long-term sustainability.

## **Statistical Data**

Statistical data were reviewed using the Illinois Department of Public Health **IQuery** data system and other reliable data sources. Health indicators reviewed as part of the assessment included:

- Demographic and socioeconomic characteristics
- General health and access to care
- Maternal and child health
- Chronic disease
- Infectious disease
- Environmental, occupational, and injury control
- Sentinel events

IQuery data were supplemented with other reliable data sources and locally collected information. By utilizing statistical evidence alongside community perceptions and the perspectives of community partners, Greene County Health Department was able to identify current and emerging health needs and develop priorities that reflect both measurable health conditions and community experience.

The Thomas H. Boyd Memorial Hospital Community Health Needs Assessment completed in 2025, Birth to Five 2024 Mental & Behavioral Health Needs Assessment, and 2023 Early Childhood Needs Assessment were also reviewed as a supplemental source of information to provide additional context regarding regional and community health needs.

[boydhcs.org/\\_files/ugd/988460\\_a949a5aec8294ea9b7f0438f0ea196e4.pdf](https://boydhcs.org/_files/ugd/988460_a949a5aec8294ea9b7f0438f0ea196e4.pdf)

[https://www.birthtofiveil.com/s/R-MBH\\_Region40\\_English.pdf](https://www.birthtofiveil.com/s/R-MBH_Region40_English.pdf)

[https://www.birthtofiveil.com/s/Region\\_40\\_Needs\\_Assessment.pdf](https://www.birthtofiveil.com/s/Region_40_Needs_Assessment.pdf)

Greene & Scott County Recovery Oriented Systems of Care (ROSC) Survey results were also collected and reviewed as part of the survey response data and are attached in **Appendix B**.

## **Community Participation**

To establish the community's perception of health needs and concerns in Greene County, a community survey was developed and promoted through social media, email, newsletters, client and staff interactions, and other community connections.

Three community focus groups were conducted to contribute to the assessment, analysis, and prioritization of community health concerns. Focus groups were organized to represent different areas of Greene County and included a broad selection of community stakeholders. The Greene County Health Department Administrator facilitated the process, with staff assisting as observers, documenters, and notetakers.

Individual discussions with community leaders and stakeholders were also incorporated into the assessment. These discussions provided additional perspectives regarding community needs, available resources, barriers, partnerships, and opportunities for improvement.

Findings from the survey, focus groups, leadership discussions, quantitative data, previous assessments, and organizational capacity assessment were reviewed collectively by the IPLAN core team to establish the 2027–2031 Greene County public health priorities.

**Appendix A** provides supporting statistical information, community health indicators, posters, and quick facts shared with community stakeholders.

**Appendix B** includes community survey questions

**Appendix C** provides community survey analysis

**Appendix D** provides the focus group agenda and facilitator guide

**Appendix E** provides the current community resource guide

# Health Indicator- Demographic & Socioeconomic

## Population

|                         | 1980<br>Census | 1990<br>Census | 2000<br>Census | 2010<br>Census | 2020<br>Census | Percent<br>Change<br>1980-<br>1990 | Percent<br>Change<br>1990-<br>2000 | Percent<br>Change<br>2000-<br>2010 | Percent<br>Change<br>2010-<br>2020 |
|-------------------------|----------------|----------------|----------------|----------------|----------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| Greene<br>County,<br>IL | 16,661         | 15,317         | 14,761         | 13,886         | 11,985         | -8.1                               | -3.6                               | -5.9                               | -13.69                             |
| Illinois                | 11,426,518     | 11,430,602     | 12,419,293     | 12,830,632     | 12,812,508     | 0.0                                | 8.6                                | 3.3                                | -1.2                               |

IDPH HEALTH STATS AND SOURCE: U.S. CENSUS BUREAU QUICK FACTS

Based on 2025 estimates, population decline of 5.6% continues with an estimated population of 11,313 in Greene County. Illinois totals remain estimated at 12,719,141 residents only decreasing 0.73%. This continued population decline presents challenges for maintaining a sufficient workforce, sustaining essential services, supporting local infrastructure, and attracting economic development. In a rural community, a smaller and aging population can also affect the availability and sustainability of health care, behavioral health, public safety, transportation, and other essential community resources. These conditions reinforce the importance of long-term planning, resource coordination, workforce development, and sustainable investment in Greene County

## Population by City, Village, and Township

| Population by City, Village | 2020 Census<br>Population | Population estimates<br>2025 |
|-----------------------------|---------------------------|------------------------------|
| Carrollton                  | 2,811                     | 2,479                        |
| Eldred                      | 182                       | 149                          |
| Greenfield                  | 972                       | 1,059                        |
| Hillview                    | 171                       | 99                           |
| Kane                        | 904                       | 509                          |
| Patterson                   | 578                       | 359                          |
| Rockbridge                  | 1,492                     | 1,571                        |
| Roodhouse                   | 2,043                     | 1,777                        |
| White Hall                  | 2,781                     | 2,257                        |
| Wrights                     | 285                       | 205                          |

SOURCE: Censusreporter.org

Age and Gender Distribution

|                         | Greene<br>County, IL | Greene<br>County, IL | Illinois | Greene<br>County,IL |
|-------------------------|----------------------|----------------------|----------|---------------------|
| Age<br>Group            | 2010<br>Census       | 2020<br>Census       | Percent  | Estimates<br>2025   |
| Person under 5          | 5.85%                | 5.4%                 | 5.9%     | 4.9%                |
| Persons under 18        | 17.18%               | 21.4%                | 22.2%    | 21.6%               |
| Persons 65 years & over | 17.20%               | 20%                  | 16.1%    | 23.3%               |
| Female persons          | 49.49%               | 49.4%                | 50.9%    | 50.1%               |

Source: U.S. CENSUS BUREAU QUICK FACTS

A slight increase of persons 65 years and older reflects the aging population. This may be attributed to the natural progression of the aging community and potentially the impact of reduced available resources.

Race and Ethnicity

| Race                                     | Percent<br>Population<br>2000 | Percent<br>Population<br>2010 | Percent<br>Population<br>2020 | Estimates<br>2025 |
|------------------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------|
| Total Population                         | 100%                          | 100%                          | 100%                          | 100%              |
| American Indian & Alaska Native alone    | 0.24%                         | 0.20%                         | 0.3%                          | 0.2%              |
| Asian alone                              | 0.11%                         | 0.10%                         | 0.2%                          | 0.3%              |
| Black or African American alone          | 0.75%                         | 0.90%                         | 1.3%                          | 0.5%              |
| Native Hawaiian & Other Pacific Islander | 0.02%                         | 0.00%                         | 0.0%                          | 0.0%              |
| Hispanic or Latino                       | 0.22%                         | 0.80%                         | 1.3%                          | 1.4%              |
| Two or More Races                        | 0.60%                         | 0.70%                         | 0.8%                          | 2.8%              |
| White alone                              | 98.06%                        | 97.30%                        | 97.3%                         | 96.2%             |

Source: Census Viewer & U.S. Census Bureau QuickFacts

Households

|                                                             |          |
|-------------------------------------------------------------|----------|
| HOUSING                                                     |          |
| HOUSING UNITS, JULY 1, 2025, (V2025)                        | 5,765    |
| OWNER-OCCUPIED HOUSING UNIT RATE, 2020-2024                 | 78.2%    |
| THE MEDIAN VALUE OF OWNER-OCCUPIED HOUSING UNITS, 2020-2024 | \$95,200 |

|                                                                                        |         |
|----------------------------------------------------------------------------------------|---------|
| MEDIAN SELECTED MONTHLY OWNER COSTS -WITH A MORTGAGE, 2020-2024                        | \$1,165 |
| MEDIAN SELECTED MONTHLY OWNER COSTS -WITHOUT A MORTGAGE, 2015-2019                     | \$506   |
| MEDIAN GROSS RENT, 2020-2024                                                           | \$754   |
| BUILDING PERMITS, 2025                                                                 | 2       |
| <b>FAMILIES &amp; LIVING ARRANGEMENTS</b>                                              |         |
| HOUSEHOLDS, 2020-2024                                                                  | 4,452   |
| PERSONS PER HOUSEHOLD, 2015-2019                                                       | 2.58    |
| LIVING IN THE SAME HOUSE 1 YEAR AGO, PERCENT OF PERSONS AGE 1 YEAR+, 2020-2024         | 92.0%   |
| LANGUAGE OTHER THAN ENGLISH SPOKEN AT HOME, PERCENT OF PERSONS AGE 5 YEARS+, 2020-2024 | 1.4%    |

Source: Census Viewer & U.S. Census Bureau QuickFacts

## Language

In Greene County, the population five years and older predominantly speaks only the English language at home.

## Unemployment

According to the *U.S. Bureau of Labor Statistics*, the unemployment rate in December 2025 for Greene County is 4.8%, compared to the State of Illinois at 4.6%; both rates are down 1- 2% from 2021.

## Income & Poverty

| Poverty & Income                                                  | Greene<br>County, IL | Illinois |
|-------------------------------------------------------------------|----------------------|----------|
| Median household income (2024 dollars) 2020-2024                  | \$62,192             | \$83,390 |
| Per capita income in past 12 months (2024 dollars), 2020-2024     | \$33,635             | \$46,406 |
| Persons in poverty, percent                                       | 14.0%                | 11.6%    |
| Poverty – Children Eligible for Free/Reduced Price Lunch, percent | 77.4%                | 68%      |

Source: U.S. Census Bureau, [2020 Census & https://2020.census.gov](https://2020.census.gov) Source: Census Viewer & U.S. Census Bureau QuickFacts

Median Household Income, Median Family Income, and Median Earnings for workers are substantially lower than both state and national income levels. Illinois estimated household income went up by almost \$20,000, while Greene County only shifted \$10,000. While housing, rent, and transportation costs also increased.

**Supplemental Nutrition Assistance Program (SNAP)**

**Let me know if there is anything else I can help you with.**

SNAP helps low-income people and families buy the food they need for good health. Households are eligible for SNAP based on monthly gross income limits. Greene County had a 3% increase in use since 2020.

| Population with Food Stamp/SNAP benefits in the past 12 months estimates |                   |          |                   |
|--------------------------------------------------------------------------|-------------------|----------|-------------------|
| Greene County, IL                                                        |                   | Illinois |                   |
| Percent                                                                  | Number Recipients | Percent  | Number Recipients |
| 17%                                                                      | 895               | 13.3%    | 637,000           |

Source: U.S. Census Bureau, 202 American Community Survey 5-Year Estimates

**Women, Infants, and Children (WIC) Program**

The Health and Human Services (HHS) poverty guidelines are used by Federal programs such as WIC as the basis for determining and updating program income eligibility limits. To be eligible based on income, applicants’ gross income (before taxes are withheld) must fall at or below 185% of the U.S. Poverty Income Guidelines. In 2025, the Greene County Health Department had 1,744 active WIC clients. Source: Greene County Health Department Annual Report

**Worker Class and Industry:**

DP03 | American Community Survey | 2024: ACS 1-Year Estimates Data Profiles

| Class of Worker                                                                  | Percent |
|----------------------------------------------------------------------------------|---------|
| Private wages and salary workers                                                 | 79.3%   |
| Government workers                                                               | 14.6%   |
| Self-employed in own not incorporated business workers                           | 5.9%    |
| Unpaid family workers                                                            | 0.2%    |
| Industry                                                                         | Percent |
| Agriculture, forestry, fishing and hunting, and mining                           | 1.5%    |
| Construction                                                                     | 6.9%    |
| Manufacturing                                                                    | 9.6%    |
| Wholesale trade                                                                  | 1.9%    |
| Retail trade                                                                     | 10.6%   |
| Transportation and warehousing, and utilities                                    | 5.9%    |
| Information                                                                      | 1.8%    |
| Finance and insurance, and real estate and rental and leasing                    | 6.5%    |
| Professional, scientific, management, administrative & waste management services | 12.9%   |
| Educational services, health care and social assistance                          | 23.8%   |
| Arts, entertainment, recreation, accommodation and food services                 | 8.9%    |
| Other services, except public administration                                     | 4.8%    |
| Public Administration                                                            | 4.7%    |

Source: U.S. Census Bureau | 2024 American Community Survey 1-Year Estimates Data Profiles | DP03 | United States National Data

Website Link | <https://data.census.gov/table/ACSDP1Y2024.DP03>

| Class of Worker                                                                  | Percent |
|----------------------------------------------------------------------------------|---------|
| Private wages and salary workers                                                 | 79.3%   |
| Government workers                                                               | 14.5%   |
| Self-employed in own not incorporated business workers                           | 6.0%    |
| Unpaid family workers                                                            | 0.2%    |
| Industry                                                                         | Percent |
| Agriculture, forestry, fishing and hunting, and mining                           | 1.6%    |
| Construction                                                                     | 6.9%    |
| Manufacturing                                                                    | 9.9%    |
| Wholesale trade                                                                  | 2.2%    |
| Retail trade                                                                     | 10.8%   |
| Transportation and warehousing, and utilities                                    | 5.9%    |
| Information                                                                      | 1.9%    |
| Finance and insurance, and real estate and rental and leasing                    | 6.7%    |
| Professional, scientific, management, administrative & waste management services | 12.6%   |
| Educational services, health care and social assistance                          | 23.5%   |
| Arts, entertainment, recreation, accommodation and food services                 | 8.7%    |
| Other services, except public administration                                     | 4.7%    |
| Public Administration                                                            | 4.7%    |

Source: U.S. Census Bureau | 2024 American Community Survey 5-Year Estimates Data Profiles | DP03 | United States National Data

Website Link | <https://data.census.gov/table/ACSDP5Y2024.DP03>

**Educational Facilities & Attainment**

Facilities: There are three school districts with a total of six public schools and one parochial school.

| Category                          | Facility Name                  | City       |
|-----------------------------------|--------------------------------|------------|
| Nonpublic Schools                 |                                |            |
|                                   | St. John the Evangelist School | Carrollton |
| Public Districts & Public Schools |                                |            |
|                                   | Carrollton CUSD 1              | Carrollton |
|                                   | Carrollton High School         | Carrollton |
|                                   | Carrollton Grade School        | Carrollton |
|                                   | North Greene CUSD 3            | White Hall |
|                                   | North Greene Jr/Sr High School | White Hall |

North Greene  
Elementary

Roodhouse

**Greenfield CUSD 10**

**Greenfield**

Greenfield High School

Greenfield

Greenfield Elementary School

Greenfield

*Source: Illinois State Board of Education*

| <b>Educational Attainment</b>                                               | <b>2020-2024</b> | <b>Greene<br/>County, IL</b> | <b>Illinois</b> |
|-----------------------------------------------------------------------------|------------------|------------------------------|-----------------|
| High school graduate or higher, percent of persons age 25 years+, 2020-2024 |                  | 91.2%                        | 90.5%           |
| Bachelor's degree or higher, percent of people aged 25 years+, 2015-2019    |                  | 19.0%                        | 37.9%           |

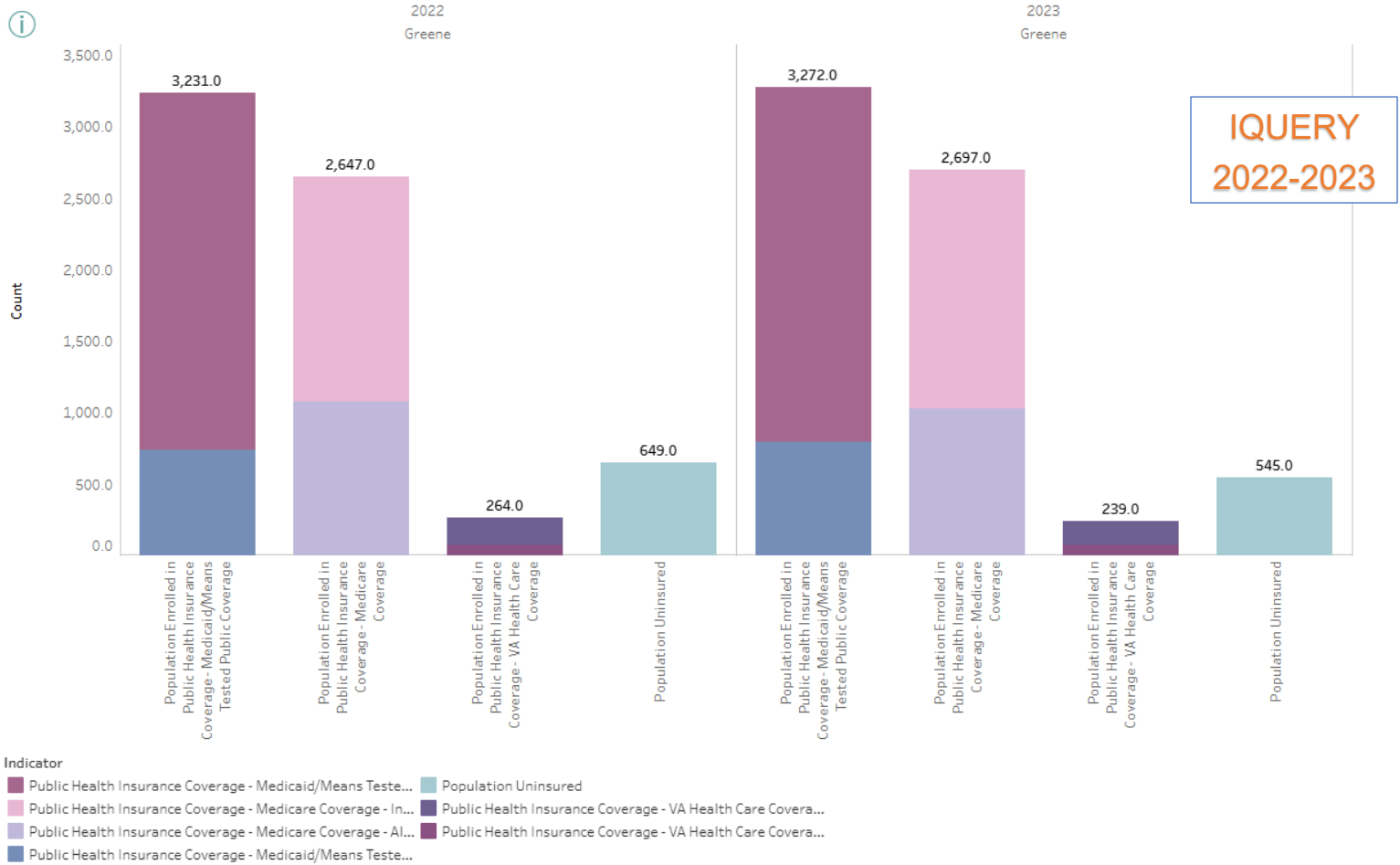
*Source: U.S. Census Bureau Quick Facts*

| <b>Education Level Attained 2020-2024</b> | <b>Greene County</b> | <b>Illinois</b> |
|-------------------------------------------|----------------------|-----------------|
| Less Than 9th Grade                       | 4.6%                 | 4.6%            |
| 9th to 12th Grade                         | 5.7%                 | 5.0%            |
| High School Graduate                      | 40%                  | 25.1%           |
| Some College                              | 20.4%                | 19.2%           |
| Associate's degree                        | 11.8%                | 8.3%            |
| Bachelor's degree                         | 15.7%                | 22.6%           |
| Graduate Degree                           | 3.3%                 | 15.3%           |

*SOURCE: US CENSUS 2019 ACS 5-YEAR SURVEY*

Lower educational attainment may indicate resistance to change and a reduction of health education priorities.

## Subcategory Comparison



# Health Indicator- General Health

## Mortality Demographics:

|               | 2022         | Sex    |        | Race   |        |       |
|---------------|--------------|--------|--------|--------|--------|-------|
|               | Total Deaths | Male   | Female | White  | Black  | Other |
| Illinois      | 122,924      | 63,735 | 59,189 | 90,343 | 21,213 | 3,318 |
| Greene County | 198          | 105    | 93     | 196    | 2      | 0     |

|               | 2022 | Age Group (Years) |       |       |        |        |        |
|---------------|------|-------------------|-------|-------|--------|--------|--------|
|               | <1   | 1-17              | 18-24 | 25-44 | 45-64  | 65-84  | 85+    |
| Illinois      | 713  | 599               | 1,099 | 6,475 | 22,214 | 55,247 | 36,577 |
| Greene County | 1    | 0                 | 3     | 3     | 43     | 100    | 48     |

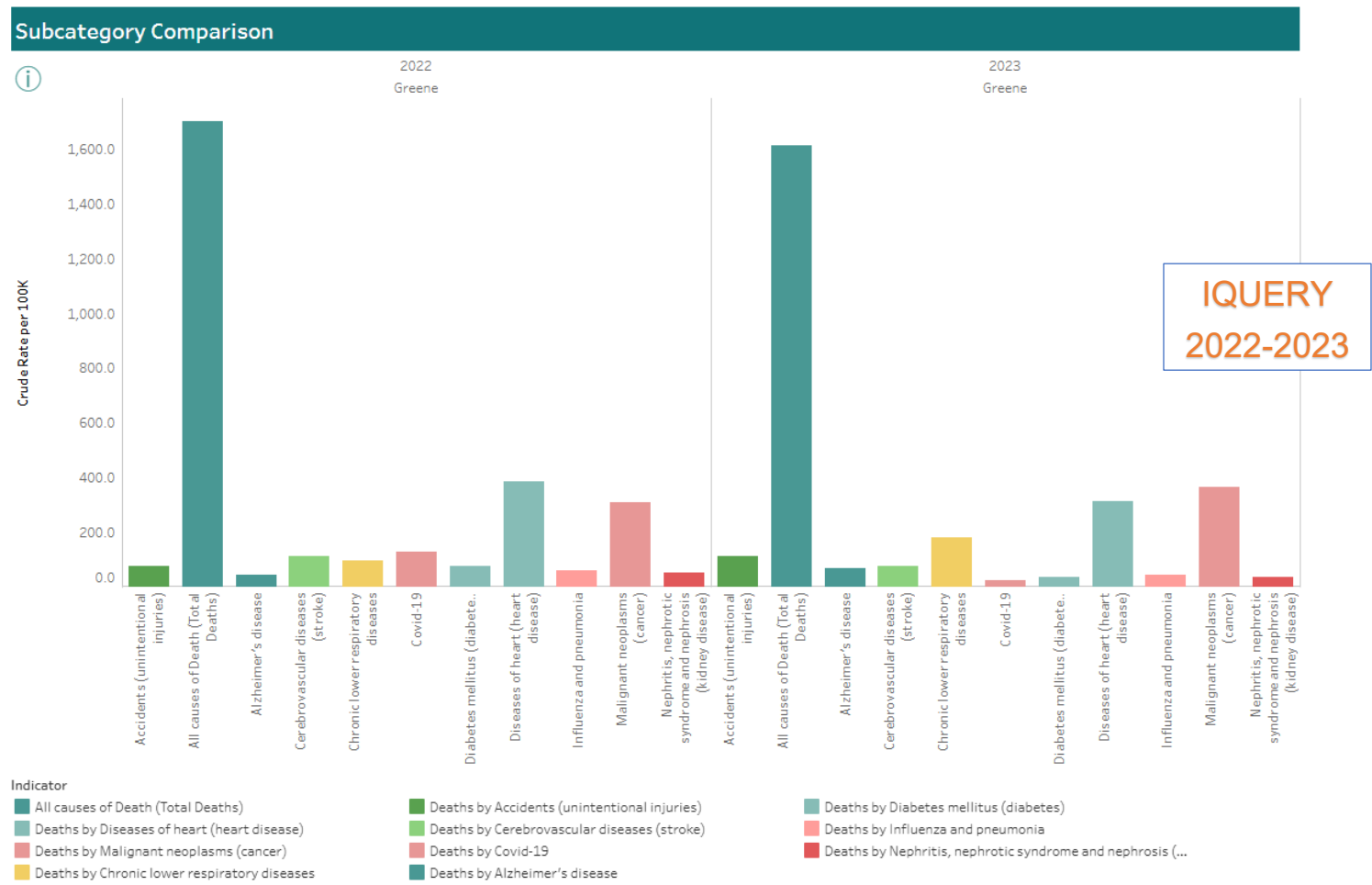
## Leading Causes of Mortality:

| 2023                                      | Illinois | Greene County, IL |
|-------------------------------------------|----------|-------------------|
| Total Deaths                              | 113,776  | 186               |
| Diseases of the heart                     | 25,630   | 36                |
| Malignant neoplasms                       | 23,479   | 42                |
| Accidents                                 | 7,227    | 13                |
| Cerebrovascular diseases stroke           | 6,954    | 9                 |
| Chronic lower respiratory diseases        | 4,893    | 21                |
| Alzheimer's disease                       | 3,854    | 8                 |
| Diabetes Mellitus                         | 2,913    | 4                 |
| Nephritis, nephrotic syndrome & nephrosis | 2,776    | 4                 |
| Septicemia                                | 1,934    | 7                 |
| Influenza and pneumonia                   | 1,822    | 5                 |

\*Malignant neoplasms were the leading cause of death in Greene County, in comparison to heart disease in Illinois. Heart Disease, Chronic lower respiratory disease, and accidents were included in the top 4 causes of

death. Source: Illinois Department of Public Health, Statewide Leading Causes of Death by Resident County, Illinois Residents, 2023.

Leading causes of death 2022 and 2023



# Health Indicator- Chronic Disease

| HEALTH STATUS                                                          |                | Estimated Population | Weighted Percentage | 95% Confidence Interval | Number of Respondents |
|------------------------------------------------------------------------|----------------|----------------------|---------------------|-------------------------|-----------------------|
| GENERAL HEALTH STATUS                                                  | Excellent      | 1,831                | 14.2%               | 9.0%-21.7%              | 46                    |
|                                                                        | Very Good      | *                    | *                   | *                       | *                     |
|                                                                        | Good           | 2,878                | 22.3%               | 16.7%-29.2%             | 124                   |
|                                                                        | Fair           | 2,452                | 19.0%               | 13.0%-27.0%             | 81                    |
|                                                                        | Poor           | 773                  | 6.0%                | 3.7%-9.7%               | 30                    |
| GENERAL HEALTH (COLLAPSED)                                             | Good or Better | 9,670                | 75.0%               | 66.6%-81.9%             | 290                   |
|                                                                        | Fair or Poor   | 3,225                | 25.0%               | 18.1%-33.4%             | 111                   |
| NUMBER OF DAYS PHYSICAL HEALTH NOT GOOD                                | None           | 8,383                | 65.2%               | 56.0%-73.4%             | 237                   |
|                                                                        | 1-7 Days       | 2,239                | 17.4%               | 12.5%-23.8%             | 75                    |
|                                                                        | 8+ Days        | 2,228                | 17.3%               | 11.9%-24.7%             | 86                    |
| NUMBER OF DAYS MENTAL HEALTH NOT GOOD                                  | None           | 7,997                | 62.3%               | 52.5%-71.1%             | 256                   |
|                                                                        | 1-7 Days       | 2,841                | 22.1%               | 15.7%-30.2%             | 82                    |
|                                                                        | 8+ Days        | 2,005                | 15.6%               | 10.4%-22.9%             | 61                    |
| NUMBER OF DAYS PHYSICAL/MENTAL HEALTH AFFECTED ACTIVITIES <sup>1</sup> | None           | 9,746                | 75.6%               | 67.2%-82.5%             | 305                   |
|                                                                        | 1-7 Days       | 1,357                | 10.5%               | 7.1%-15.4%              | 43                    |
|                                                                        | 8+ Days        | 1,781                | 13.8%               | 8.5%-21.6%              | 53                    |
| NUMBER OF DAYS PAIN AFFECTED ACTIVITIES                                | None           | 7,821                | 60.9%               | 51.0%-70.0%             | 214                   |
|                                                                        | 1-7 Days       | 2,263                | 17.6%               | 11.7%-25.6%             | 79                    |
|                                                                        | 8+ Days        | 2,752                | 21.4%               | 15.3%-29.2%             | 106                   |
| NUMBER OF DAYS PHYSICAL HEALTH NOT GOOD                                | 0-13 Days      | 11,071               | 86.2%               | 79.4%-91.0%             | 329                   |
|                                                                        | 14+ Days       | 1,780                | 13.8%               | 9.0%-20.6%              | 69                    |
| NUMBER OF DAYS MENTAL HEALTH NOT GOOD                                  | 0-13 Days      | 11,429               | 89.0%               | 82.4%-93.3%             | 358                   |
|                                                                        | 14+ Days       | 1,415                | 11.0%               | 6.7%-17.6%              | 41                    |
| NUMBER OF DAYS PHYSICAL/MENTAL HEALTH AFFECTED ACTIVITIES <sup>1</sup> | 0-13 Days      | 11,966               | 92.9%               | 88.3%-95.8%             | 364                   |
|                                                                        | 14+ Days       | 918                  | 7.1%                | 4.2%-11.7%              | 37                    |
| NUMBER OF DAYS PAIN AFFECTED ACTIVITIES                                | 0-13 Days      | 10,692               | 83.3%               | 76.0%-88.7%             | 323                   |
|                                                                        | 14+ Days       | 2,145                | 16.7%               | 11.3%-24.0%             | 76                    |

Illinois County Behavioral Risk Factor Survey, Round 7 (Collected 2020-2023) \*Indicates data does not meet standards of reliability and has been suppressed

## Behavioral Risk Surveillance System:

The Behavioral Risk Factor Surveillance System (BRFSS) is a state-based program that gathers information on risk factors among Illinois adults 18 years of age and older through monthly telephone surveys. BRFSS is a collaborative effort between the U.S. Centers for Disease Control and Prevention (CDC) and state health departments. Not all BRFSS topics are available in the report, which focuses on those indicators that may contribute to Greene County's leading causes of mortality. Illinois Youth Behavior Survey was also completed in 2026, providing a youth data source relating to chronic disease indicators.

## Obesity:

| OBESITY                       |                       | Estimated Population | Weighted Percentage | 95% Confidence Interval | Number of Respondents |
|-------------------------------|-----------------------|----------------------|---------------------|-------------------------|-----------------------|
| BODY MASS INDEX <sup>15</sup> | Normal or Underweight | 2,878                | 22.7%               | 16.4%-30.5%             | 104                   |
|                               | Overweight            | 3,836                | 30.2%               | 22.2%-39.8%             | 122                   |
|                               | Obese                 | *                    | *                   | *                       | *                     |
| OVERWEIGHT OR OBESE           | No                    | 2,878                | 22.7%               | 16.4%-30.5%             | 104                   |
|                               | Yes                   | 9,810                | 77.3%               | 69.5%-83.6%             | 288                   |

15. BMI calculated from reported height and weight. BMI Categories: Underweight <18.5, Normal >=18.5 and <25, Overweight >=25 and <30, Obese >=30.

Illinois County Behavioral Risk Factor Survey, Round 7 (Collected 2020-2023) \*Indicates data does not meet standards of reliability and has been suppressed

## BMI (Body Mass Index) Categories based on CDC guidelines\*:

|                | 8th  |    | 10th |    | 12th |    |
|----------------|------|----|------|----|------|----|
|                | %    | N  | %    | N  | %    | N  |
| Underweight    | 1%   | 1  | 4%   | 2  | 0%   | 0  |
| Healthy weight | 59%  | 44 | 65%  | 37 | 75%  | 44 |
| Overweight     | 27%  | 20 | 18%  | 10 | 14%  | 8  |
| Obese          | 13%  | 10 | 14%  | 8  | 12%  | 7  |
| Total          | 100% | 75 | 100% | 57 | 100% | 59 |

\*Body Mass Index categories as calculated by self-reported height and weight

Increases in overweight and obese categories from 2020, a decrease in percentage in 10th and 12th grades.

Source: Illinois Youth Survey 2026 County Report

## Food Insecurity

The 2026 County Health Rankings used 2023 data for this measure: the percentage of the population that lacks adequate access to food. Greene: 1,700; approximately 14.7% of the population is food insecure, which has increased since 2021. Source: County Health Rankings & Roadmaps 2026

| FOOD INSECURITY                                                                                          |                      | Estimated Population | Weighted Percentage | 95% Confidence Interval | Number of Respondents |
|----------------------------------------------------------------------------------------------------------|----------------------|----------------------|---------------------|-------------------------|-----------------------|
| FOOD BOUGHT JUST DIDN'T LAST                                                                             | Often/Sometimes True | 2,551                | 19.7%               | 13.4%-28.1%             | 67                    |
|                                                                                                          | Never True           | 10,368               | 80.3%               | 71.9%-86.6%             | 334                   |
| COULDN'T AFFORD TO EAT BALANCED MEALS                                                                    | Often/Sometimes True | 2,519                | 19.5%               | 13.7%-26.9%             | 68                    |
|                                                                                                          | Never True           | 10,405               | 80.5%               | 73.1%-86.3%             | 334                   |
| ANY FOOD INSECURITY <sup>3</sup>                                                                         | Yes                  | 3,241                | 25.1%               | 18.0%-33.8%             | 85                    |
|                                                                                                          | No                   | 9,677                | 74.9%               | 66.2%-82.0%             | 316                   |
| 3. Food insecurity is identified when the answer to either question is "often true" or "sometimes true." |                      |                      |                     |                         |                       |

Illinois County Behavioral Risk Factor Survey, Round 7 (Collected 2020-2023)

## Exercise

| EXERCISE                                        |                                            | Estimated Population | Weighted Percentage | 95% Confidence Interval | Number of Respondents |
|-------------------------------------------------|--------------------------------------------|----------------------|---------------------|-------------------------|-----------------------|
| ANY PHYSICAL ACTIVITY PAST 30 DAYS <sup>4</sup> | Yes                                        | *                    | *                   | *                       | *                     |
|                                                 | No                                         | *                    | *                   | *                       | *                     |
| PHYSICAL ACTIVITY LEVEL                         | Highly Active (301+ Minutes/Week)          | *                    | *                   | *                       | *                     |
|                                                 | Active (150-300 Minutes/Week)              | 650                  | 6.0%                | 3.6%-10.1%              | 30                    |
|                                                 | Insufficiently Active (1-149 Minutes/Week) | 978                  | 9.1%                | 5.4%-14.9%              | 25                    |
|                                                 | Inactive (0 Minutes/Week)                  | *                    | *                   | *                       | *                     |
| MEETS AEROBIC RECOMMENDATIONS <sup>5</sup>      | Yes                                        | *                    | *                   | *                       | *                     |
|                                                 | No                                         | *                    | *                   | *                       | *                     |
| MEETS STRENGTH RECOMMENDATIONS <sup>6</sup>     | Yes                                        | *                    | *                   | *                       | *                     |
|                                                 | No                                         | *                    | *                   | *                       | *                     |
| MEETS AEROBIC/STRENGTH RECOMMENDATIONS          | Met Both                                   | 2,340                | 20.7%               | 13.8%-29.8%             | 80                    |
|                                                 | Met Aerobic                                | 2,595                | 22.9%               | 16.1%-31.5%             | 95                    |
|                                                 | Met Strengthening                          | *                    | *                   | *                       | *                     |
|                                                 | Met Neither                                | *                    | *                   | *                       | *                     |
| MEETS BOTH AEROBIC/STRENGTH RECOMMENDATIONS     | Yes                                        | 2,340                | 20.7%               | 13.8%-29.8%             | 80                    |
|                                                 | No                                         | 8,983                | 79.3%               | 70.2%-86.2%             | 254                   |

4. Respondent indicating participation in physical activities but reports 0 minutes of activity are reported as No.  
 5. Respondent indicating participation in at least 150 minutes per week of moderate-intensity activity, or at least 75 minutes per week of vigorous-intensity activity, or an equivalent combination of moderate-intensity and vigorous-intensity activity (multiplied by 2) totaling at least 150 minutes per week.  
 6. Respondent reports participation in muscle-strengthening activities at least 2 times per week.

Illinois County Behavioral Risk Factor Survey, Round 7 (Collected 2020-2023)

\*Indicates data does not meet standards of reliability and has been suppressed

## Tobacco and E-cigarettes

| TOBACCO & E-CIGARETTES                       |                      | Estimated Population | Weighted Percentage | 95% Confidence Interval | Number of Respondents |
|----------------------------------------------|----------------------|----------------------|---------------------|-------------------------|-----------------------|
| CALCULATED SMOKING STATUS <sup>19</sup>      | Smoker               | 1,946                | 15.6%               | 10.3%-22.8%             | 60                    |
|                                              | Former Smoker        | 2,361                | 18.9%               | 13.9%-25.1%             | 109                   |
|                                              | Never Smoked         | 8,195                | 65.6%               | 56.4%-73.7%             | 218                   |
| QUIT SMOKING (FORMER SMOKERS) <sup>20</sup>  | Past Year            | *                    | *                   | *                       | *                     |
|                                              | More than 1 Year Ago | *                    | *                   | *                       | *                     |
| USE SMOKELESS TOBACCO <sup>21</sup>          | No                   | 11,611               | 91.7%               | 83.2%-96.1%             | 367                   |
|                                              | Yes                  | 1,046                | 8.3%                | 3.9%-16.8%              | 22                    |
| CALCULATED E-CIGARETTES STATUS <sup>22</sup> | Current User         | 457                  | 3.6%                | 1.9%-6.6%               | 13                    |
|                                              | Not Currently Using  | 2,427                | 19.2%               | 12.7%-27.9%             | 58                    |
|                                              | Never Used           | 9,773                | 77.2%               | 68.4%-84.2%             | 318                   |

19. Calculated smoking status from tobacco questions.  
 20. Asked only if respondent reported smoking 100+ cigarettes and reported frequency is not at all.  
 21. Smokeless tobacco includes chewing tobacco, snuff, or snus.  
 22. Calculated e-cigarette status from e-cigarette questions.

Illinois County Behavioral Risk Factor Survey, Round 7 (Collected 2020-2023) \*Indicates data does not meet standards of reliability and has been suppressed

## Cancer:

Cancer incidence data for Greene County were reviewed using the Illinois Department of Public Health's Illinois State Cancer Registry (ISCR). ISCR is the only population-based source for cancer incidence information in Illinois. Cancer cases are reported to ISCR by hospitals, free-standing clinics, radiation treatment

facilities, laboratories, physician offices, and through data exchange agreements with other state cancer registries.

The most recent published county-level data available from IDPH at the time of this assessment are for 2018–2022. Because Greene County has a relatively small population, IDPH presents county cancer incidence using five-year aggregate counts and average annual age-adjusted rates. Rates are expressed per 100,000 population and age-adjusted to the 2000 U.S. standard population.

During 2018–2022, Greene County's age-adjusted incidence rate for all cancer sites combined was 577.3 per 100,000, compared with 464.2 per 100,000 for Illinois. Lung and bronchus cancer was particularly elevated in Greene County, with an incidence rate of 102.4 per 100,000, compared with 57.8 per 100,000 statewide. Kidney and renal pelvis cancer was also higher in Greene County at 44.4 per 100,000, compared with 18.2 per 100,000 statewide. Melanoma of the skin was 26.6 per 100,000 in Greene County compared with 23.8 statewide, while leukemia was 20.0 compared with 13.8 statewide.

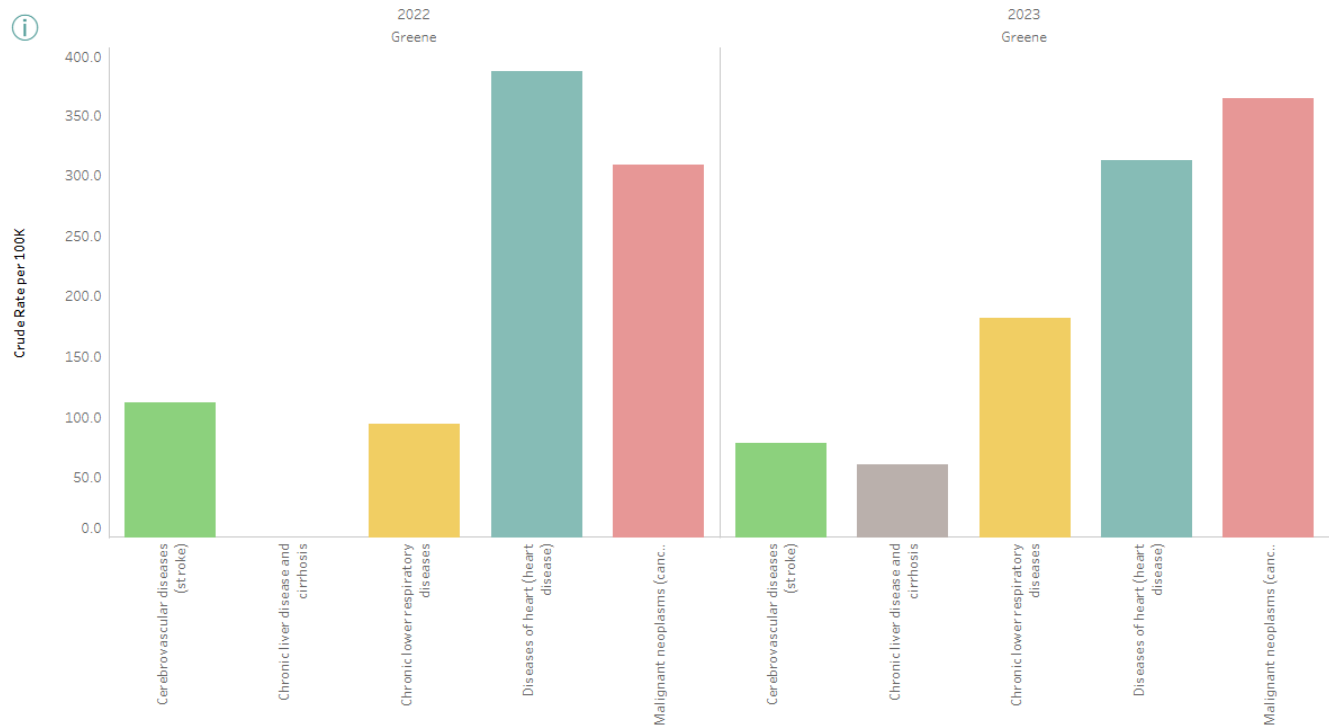
Female breast cancer incidence in Greene County was 116.4 per 100,000, compared with 135.5 per 100,000 statewide, demonstrating that not all cancer sites have higher incidence locally.

The current data reinforce the importance of cancer prevention, early detection, screening, risk-factor reduction, and access to appropriate health care services in Greene County. Cancer incidence should be interpreted cautiously in a small rural population, where relatively small changes in the number of cases can produce substantial changes in rates. IDPH recommends using actual cancer incidence data from the ISCR for tracking incidence rather than relying on projected estimates.

*Source: Illinois Department of Public Health Cancer Statistics Review Incidence 2014-2018*

| Cancer Site           | Greene County | Illinois | Difference  |
|-----------------------|---------------|----------|--------------------------------------------------------------------------------------------------|
| All Sites             | 577.3         | 464.2    | +113.1                                                                                           |
| Lung & Bronchus       | 102.4         | 57.8     | +44.6                                                                                            |
| Kidney & Renal Pelvis | 44.4          | 18.2     | +26.2                                                                                            |
| Leukemia              | 20.0          | 13.8     | +6.2                                                                                             |
| Melanoma              | 26.6          | 23.8     | +2.8                                                                                             |
| Female Breast         | 116.4         | 135.5    | -19.1                                                                                            |
| Colon & Rectum        | 46.3          | 39.1     | +7.2                                                                                             |

## Subcategory Comparison



**IQUERY**  
**2021-2023**

## Substance Use

### (2) Drug Prevalence and Behaviors

#### 2026 Substance Use Rates by Grade - Part 1 of 3

| Substance Used                                                                                                                                    | 8th Grade | 10th Grade | 12th Grade |
|---------------------------------------------------------------------------------------------------------------------------------------------------|-----------|------------|------------|
| <b>Used Past Year</b>                                                                                                                             |           |            |            |
| Any common substance (including alcohol, inhalants or marijuana)                                                                                  | 20%       | 31%        | 39%        |
| Any common substances plus vaping (including alcohol, tobacco products, e-cigarettes or other vaping products, inhalants, or marijuana)           | 21%       | 33%        | 41%        |
| Alcohol                                                                                                                                           | 19%       | 30%        | 37%        |
| E-cigarettes or other vaping products                                                                                                             | 10%       | 18%        | 16%        |
| Any Tobacco Product (including smokeless tobacco, tobacco smoked through cigarettes or cigars/cigarillos, or tobacco used in a hookah water pipe) | 7%        | 12%        | 5%         |
| Inhalants                                                                                                                                         | 3%        | 2%         | 0%         |
| Marijuana                                                                                                                                         | 7%        | 16%        | 9%         |
| Synthetic marijuana                                                                                                                               | 3%        | 1%         | 0%         |
| Alcohol and marijuana at the same time                                                                                                            | 3%        | 14%        | 5%         |
| Alcohol and energy drinks at the same time                                                                                                        | 5%        | 7%         | 12%        |
| <b>Any Illicit Drugs (excluding marijuana)</b>                                                                                                    | 0%        | 2%         | 0%         |
| Crack/Cocaine                                                                                                                                     | 0%        | 1%         | 0%         |
| Hallucinogens/LSD                                                                                                                                 | 0%        | 1%         | 0%         |
| Ecstasy/MDMA                                                                                                                                      | 0%        | 0%         | 0%         |
| Methamphetamine                                                                                                                                   | 0%        | 0%         | 0%         |
| Heroin                                                                                                                                            | 0%        | 0%         | 0%         |
| <b>Any Prescription Drugs to get high</b>                                                                                                         | 2%        | 1%         | 0%         |
| Prescription Painkillers                                                                                                                          | 2%        | 1%         | 0%         |
| Other Prescription Drugs                                                                                                                          | 1%        | 0%         | 0%         |
| Prescription pain medicine without prescription or differently than prescribed                                                                    | 4%        | 0%         | 0%         |
| Prescription drugs not prescribed to you                                                                                                          | 2%        | 1%         | 4%         |
| Over-the-Counter Drugs                                                                                                                            | 2%        | 0%         | 0%         |
| <b># of Respondents</b>                                                                                                                           | 107       | 85         | 83         |

Source: Illinois Youth Survey 2026 County Report

**SUBSTANCE USE CONSEQUENCES: During the past 12 months:**

|                                                                                                                                                        | 10th       | 12th      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-----------|
| Did you ever use alcohol or drugs to relax, feel better about yourself, or fit in                                                                      | 12%        | 9%        |
| Did you ever use alcohol or drugs while you were by yourself, alone                                                                                    | 11%        | 5%        |
| Did you ever forget things you did while using alcohol or drugs                                                                                        | 11%        | 2%        |
| Did your family or friends ever tell you that you should cut down on your drinking or drug use                                                         | 2%         | 2%        |
| Have you gotten into trouble while you were using alcohol or drugs                                                                                     | 4%         | 1%        |
| Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs                                 | 11%        | 7%        |
| <b>Experienced 2 or more consequences (indicating the potential need for substance use disorder assessment according to the CRAFFT Screening Test)</b> | <b>11%</b> | <b>7%</b> |

Source: Illinois Youth Survey 2026 County Report

Compared to 2020 data, there was a decrease in many risk factors. There have been many community- and state-focused efforts in schools through programming, generational changes, and community support systems that impact recovery-focused work. Our schools have seen an increase in mental health supports, programs, and activities that don't focus solely on sports.

See the Illinois Youth Behavior Survey for more details, but we are ecstatic that all three school districts, as well as the private school, participated, and that there was a decline in percentages across all three grade levels: 8th, 10th, and 12th.

Alcohol usage and marijuana use may be monitored; although vape usage is down slightly based on responses, we can utilize some promotion on marijuana vape risks.

**MARIJUANA METHOD OF USE: Among users in the past 30 days, how have you used marijuana\*:**

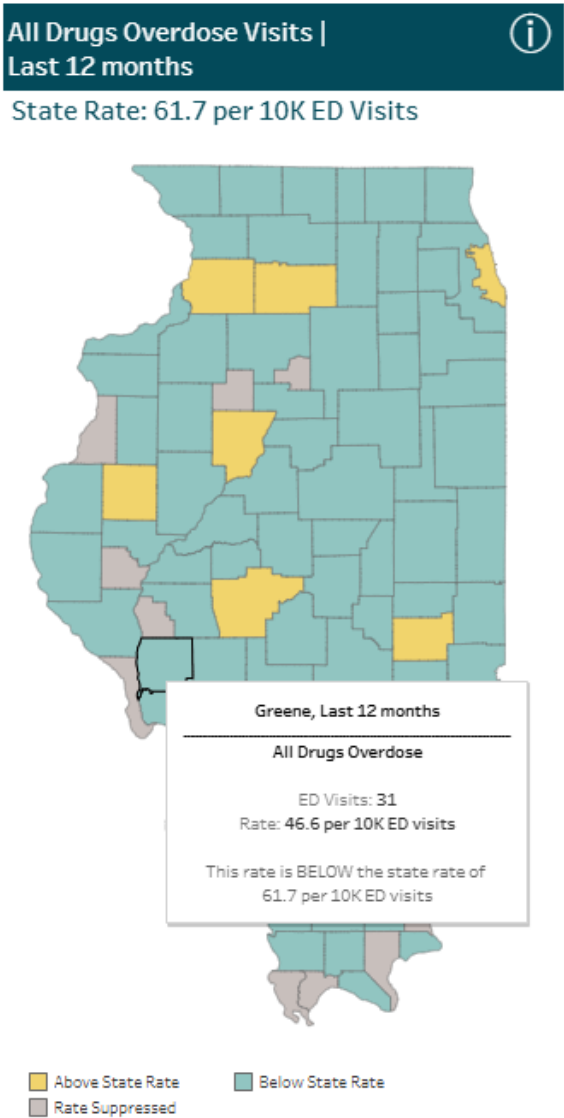
|                                                 | 8th Grade | 10th Grade | 12th Grade |
|-------------------------------------------------|-----------|------------|------------|
| Smoked it (in a joint, bong, pipe, blunt)       | 100%      | 75%        | 75%        |
| Vaporized it (e.g., vapor pen)                  | 0%        | 92%        | 75%        |
| Ate it (in brownies, cakes, candy, etc.)        | 33%       | 50%        | 0%         |
| Dabbed it                                       | 0%        | 42%        | 25%        |
| Drank it (in a THC drink)**                     | 0%        | 8%         | 0%         |
| <b># of Marijuana Users in the Past 30 days</b> | <b>3</b>  | <b>12</b>  | <b>4</b>   |

\*If you see an **N/R (Not Reported)** noted in this table, it means that at least 50% of students skipped the question for no known reason, making the results too biased to report

\*\*New question added in 2026

IDPH Opioid Dashboard

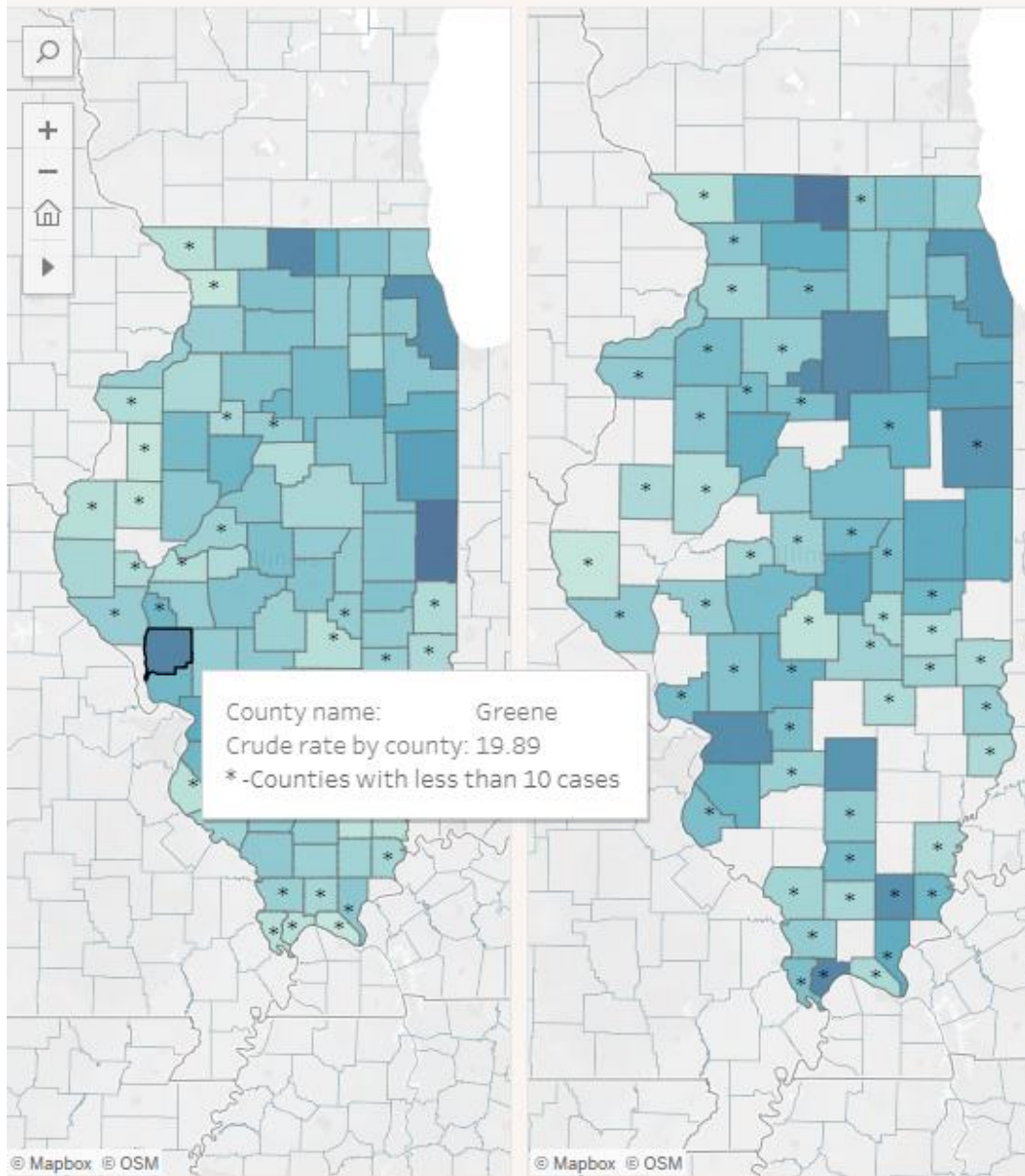
Unfortunately, Greene County data is now suppressed under fatal and non-fatal overdose rates in 2023. Previous IPLAN data was available as crude rates from 2019 and is maintained in our report, as this remains a high community need. Suppression is not exactly helpful when monitoring trends and community information, especially when previous information was documented and is now no longer available. There has been a vast effort by the Greene County Health Department to educate using evidence-based practices, reduce stigma, and improve recovery capital. There has been a specific effort to assist in medication-assisted treatment through MARNow and increased education at the hospital system level on the need to treat substance use disorder as a chronic disease. In 2025, Greene County distributed 627 Naloxone kits, assisted 32 people with medication-assisted treatment, and helped coordinate 26 individuals to treatment. These numbers reflect the community's needs, including 575 resource navigations. Death rates have decreased based on the support developed and other correlating factors. If we were able to compare the crude rates of overdose, they have likely decreased directly, largely due to the coordination and support the health department has provided, along with our partnering organizations, and correlated with many other external factors related to the opioid crisis.



Hover over the map to see details for individual areas.

Non-Fatal Overdose Rate 2019

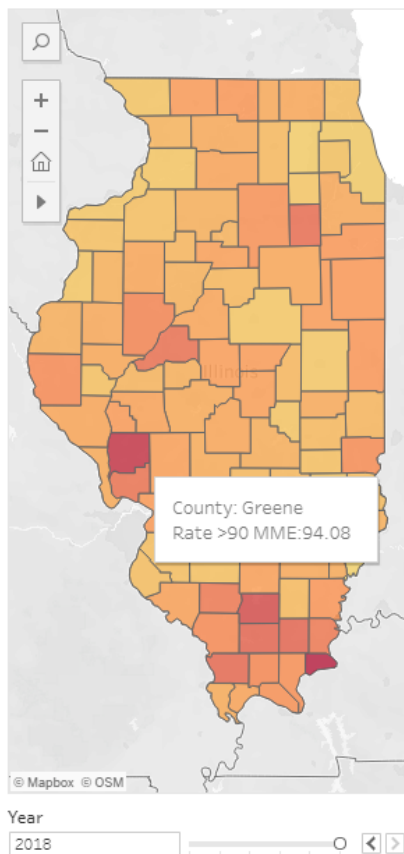
Fatal Overdose Rate 2019



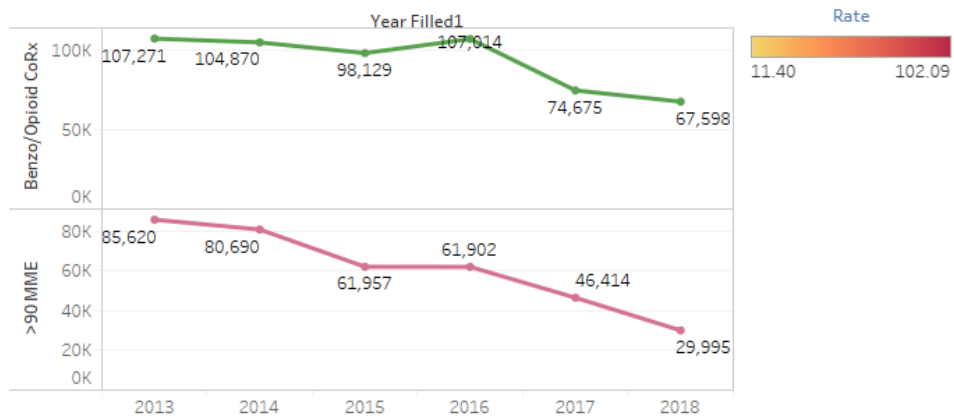
# Illinois

| Average Days' Supply | Total patients | Total Prescriptions |
|----------------------|----------------|---------------------|
| 101                  | 2,102,727      | 4,850,691           |

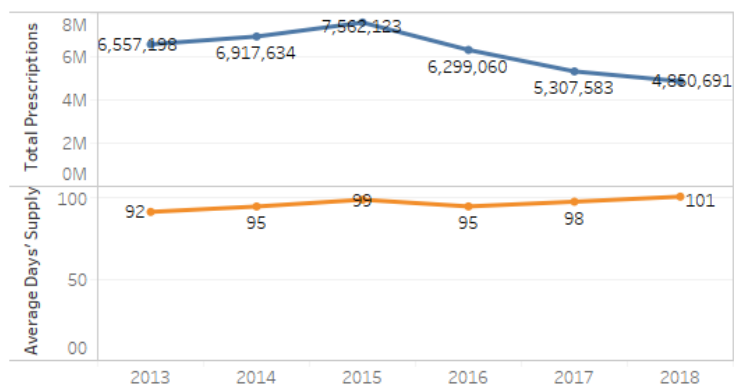
>90 MME Rate 2018



High Risk Patient Populations



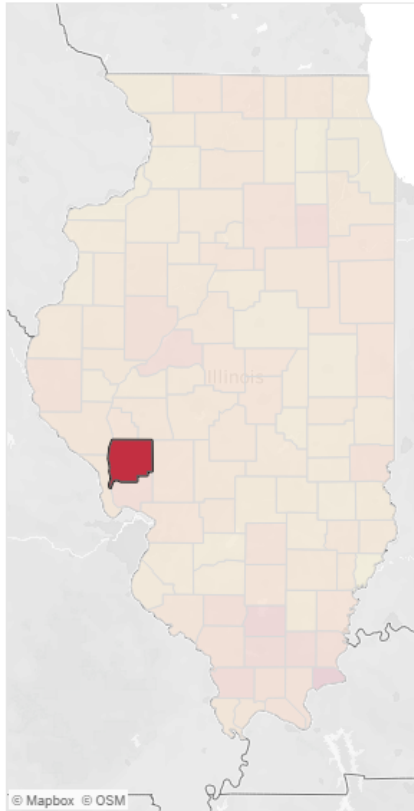
Total Rx's & Average Days' Supply



## Greene County

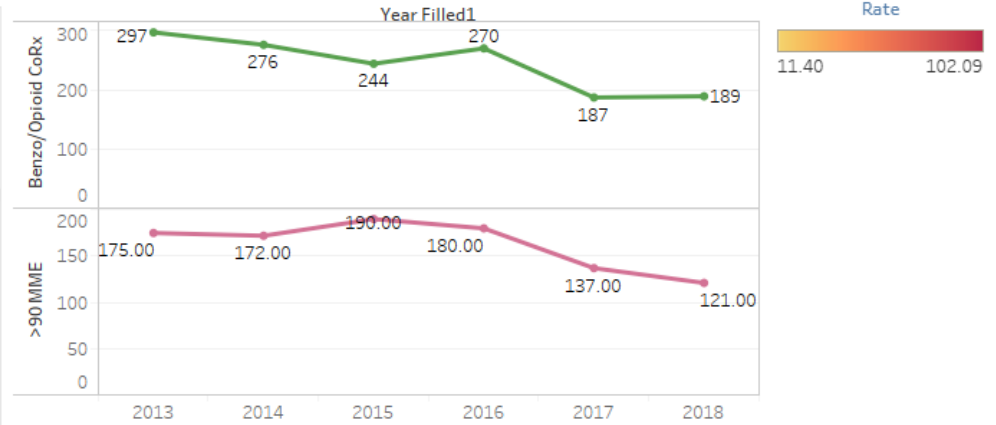
| Average Days' Supply | Total patients | Total Prescriptions |
|----------------------|----------------|---------------------|
| 121                  | 3,622          | 11,286              |

>90 MME Rate 2018

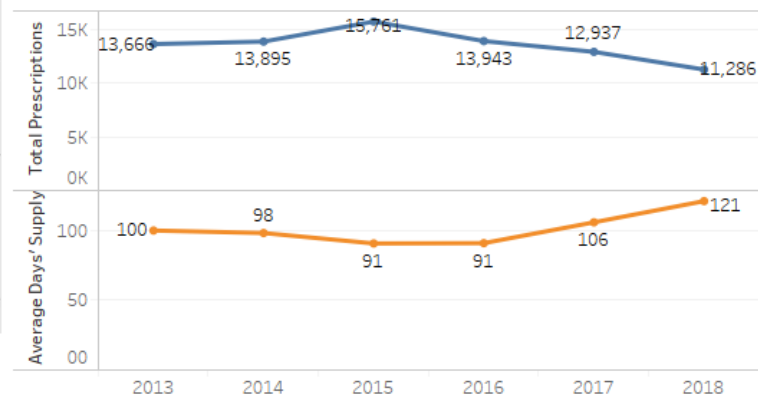


Year  
2018

High Risk Patient Populations



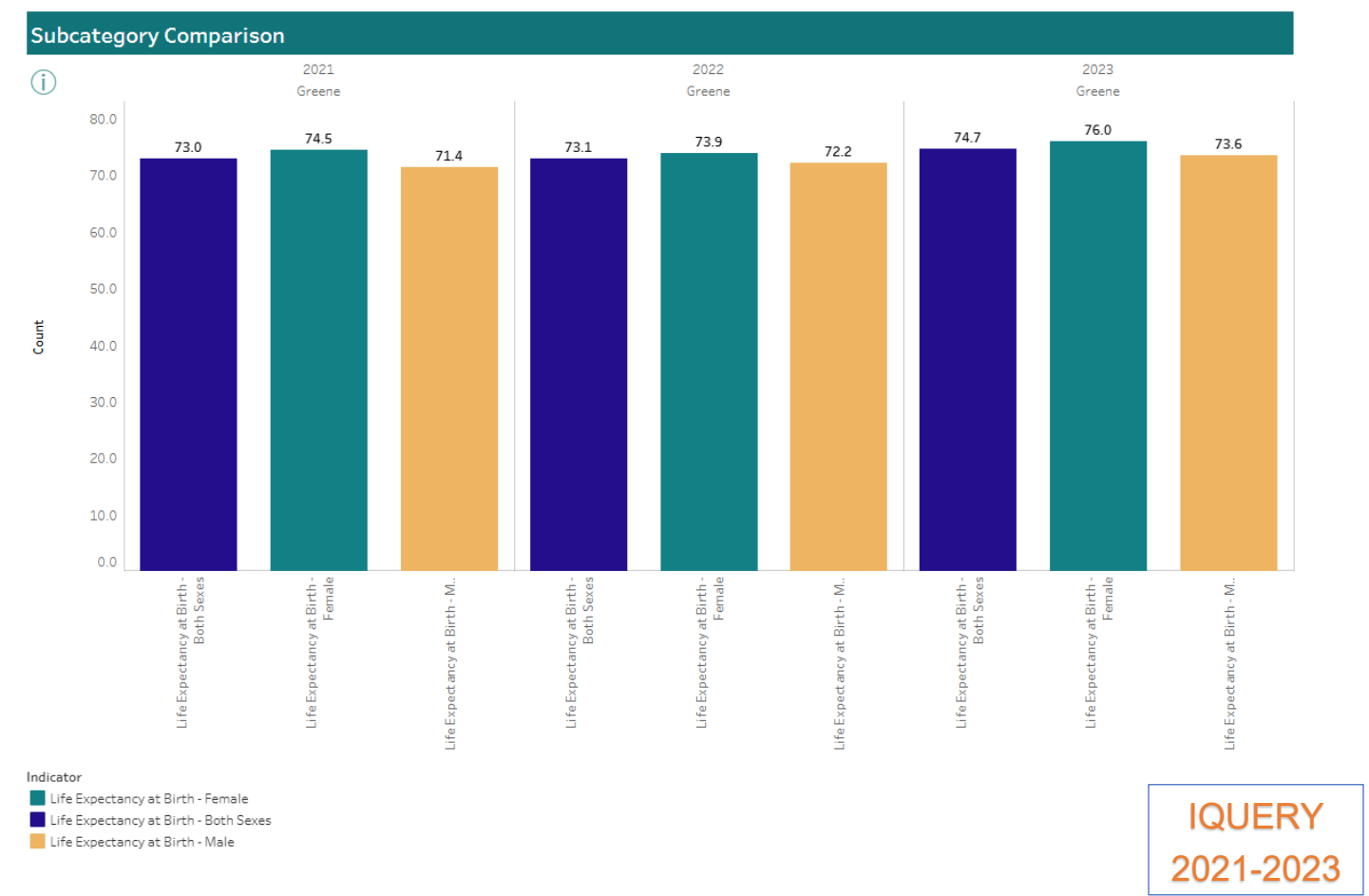
Total Rx's & Average Days' Supply



# Health Indicator- Maternal and Child Care

## Life Expectancy at Birth

Life expectancy at birth in Greene County is lower than the Illinois average. The most recent County Health Rankings & Roadmaps county-level data indicate an overall life expectancy of approximately **74.7 years** in Greene County. Current publicly available county-level data do not provide a comparable sex-specific estimate through the same methodology; therefore, sex-specific estimates from the previous IPLAN are not carried forward. Statewide data demonstrate the continued difference in life expectancy between males and females, with Illinois males historically experiencing shorter life expectancy than females.



## Birth Characteristics

In 2023, 115 births were recorded among Greene County residents. IDPH reported 11 preterm births (9.6%), compared with approximately 10.6% statewide. Greene County also recorded 6 low-birth-weight births and 1 very-low-birth-weight birth. Because Greene County has a small number of annual births, individual-year percentages can fluctuate substantially and should be interpreted cautiously.

In 2023, 49 Greene County births (42.6%) were to unmarried mothers, compared with 39.7% statewide. IDPH also reported that 103 Greene County births, or 89.6%, met the measure for adequate prenatal care. This statistic alone is important based on the lack of childcare access and the growing need for daycare centers in rural communities like Greene. Lack of childcare impacts the ability to secure employment, especially in single-parent homes.

The birth data demonstrate the importance of continued access to prenatal care, maternal health services, early childhood resources, and coordinated family support. In a rural community with a relatively small number of births each year, maintaining accessible local services and strong referral connections is particularly important.

Source: Illinois Department of Health, Birth Characteristics By Resident County

**Corrected 2023 Birth Characteristics Table**

| Birth Characteristic                 | Illinois              | Greene County      |
|--------------------------------------|-----------------------|--------------------|
| <b>Total Births</b>                  | <b>124,871</b>        | <b>115</b>         |
| Low Birth Weight (<2,500 grams)      | 11,109 (8.9%)         | 6*                 |
| Very Low Birth Weight (<1,500 grams) | 1,763 (1.4%)          | 1*                 |
| <b>Preterm (&lt;37 weeks)</b>        | <b>13,433 (10.8%)</b> | <b>11 (9.6%)</b>   |
| Cesarean Section                     | 38,713 (31.0%)        | 36 (31.3%)         |
| <b>Mother Unmarried</b>              | <b>49,538 (39.7%)</b> | <b>49 (42.6%)</b>  |
| Not H.S. Graduate, Age 20+**         | 8,702 (7.5%)          | 8*                 |
| <b>Adequate Prenatal Care**</b>      | <b>95,800 (78.2%)</b> | <b>103 (89.6%)</b> |

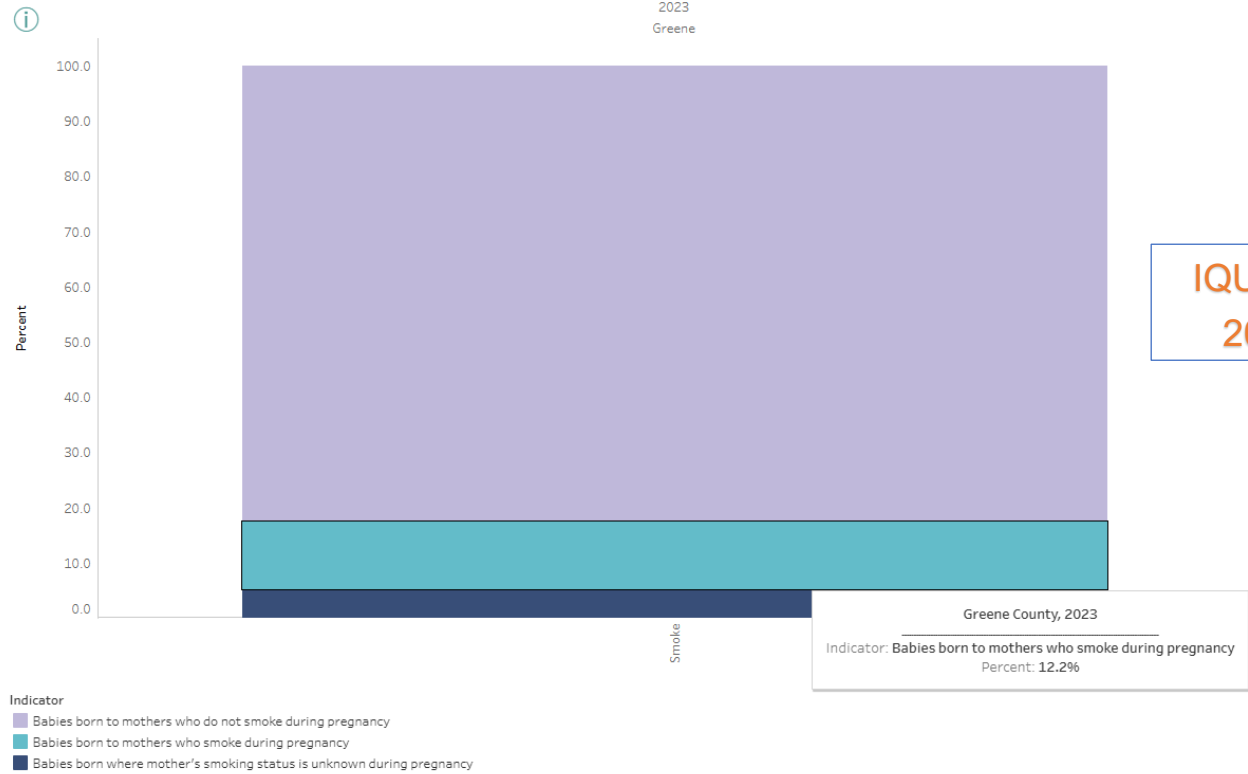
## Teen Births

|                          |         |       |       |
|--------------------------|---------|-------|-------|
| <b>Illinois</b>          | 124,871 | 1,114 | 3,200 |
| <b>Greene County, IL</b> | 115     | 0     | 9     |

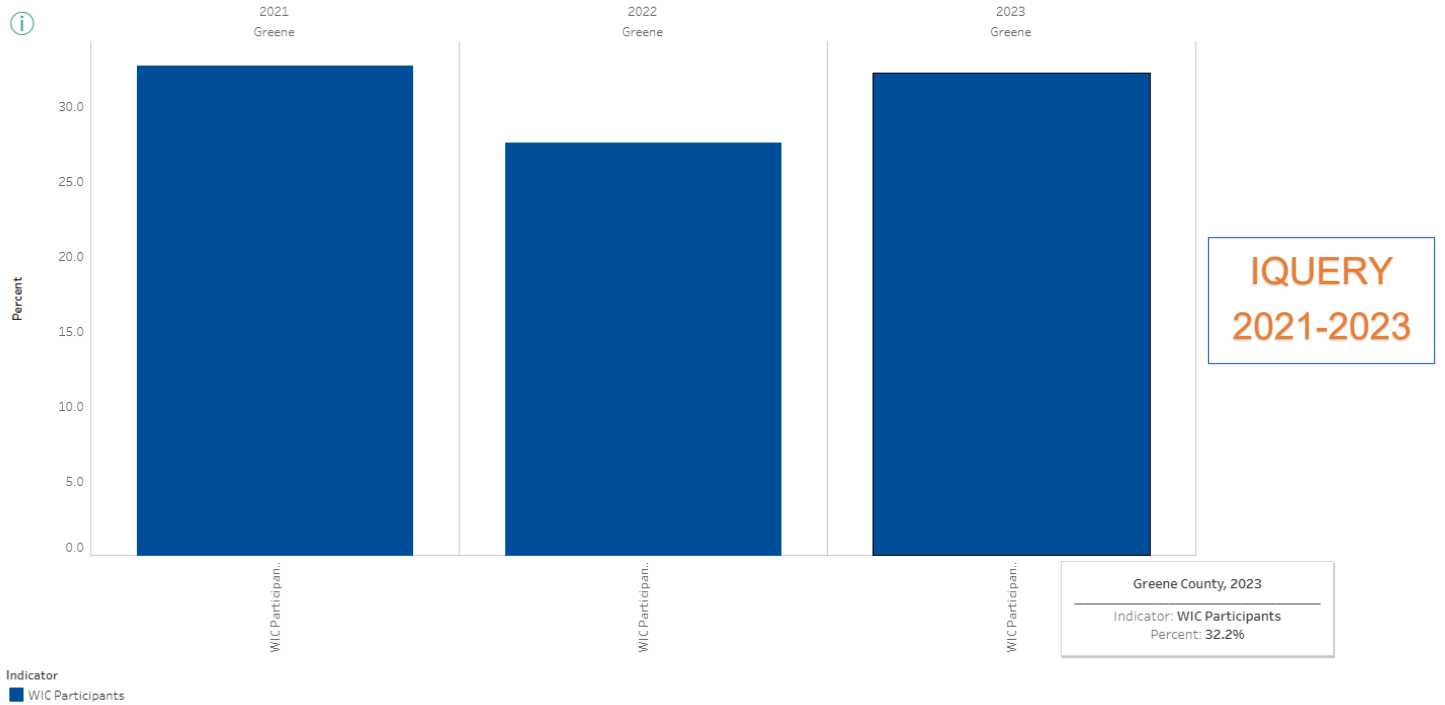
Percent of teen births in Greene County 7.8% above the Illinois average of 3.5%

Source: Illinois Department of Health, Vital Statistics ([www.dph.illinois.gov](http://www.dph.illinois.gov)).

## Subcategory Comparison



## Subcategory Comparison



# Health Indicator- Infectious Disease

## Sexually Transmitted Infections

The number of reported sexually transmitted infections available through the IDPH IQuery and County Comp Reporting shows that chlamydia is the most frequently reported sexually transmitted infection in Greene County and Illinois, followed by Gonorrhea.

**Reported Cases of Sexually Transmitted Infections  
2017-2022**

|                 |      | Greene | Illinois |
|-----------------|------|--------|----------|
| Chlamydia       | 2017 | 29     | 75,518   |
|                 | 2018 | 23     | 77,325   |
|                 | 2019 | 25     | 81,012   |
|                 | 2020 | 11     | 52,016   |
|                 | 2021 | 35     | 71,836   |
|                 | 2022 | 29     | 71,564   |
| Early Syphilis* | 2021 | 2      | 2,653    |
|                 | 2022 | 1      | 2,722    |
| Gonorrhea       | 2017 | 2      | 23,859   |
|                 | 2018 | 2      | 25,422   |
|                 | 2019 | 9      | 29,272   |
|                 | 2020 | 2      | 20,570   |
|                 | 2021 | 14     | 30,454   |
|                 | 2022 | 5      | 26,442   |

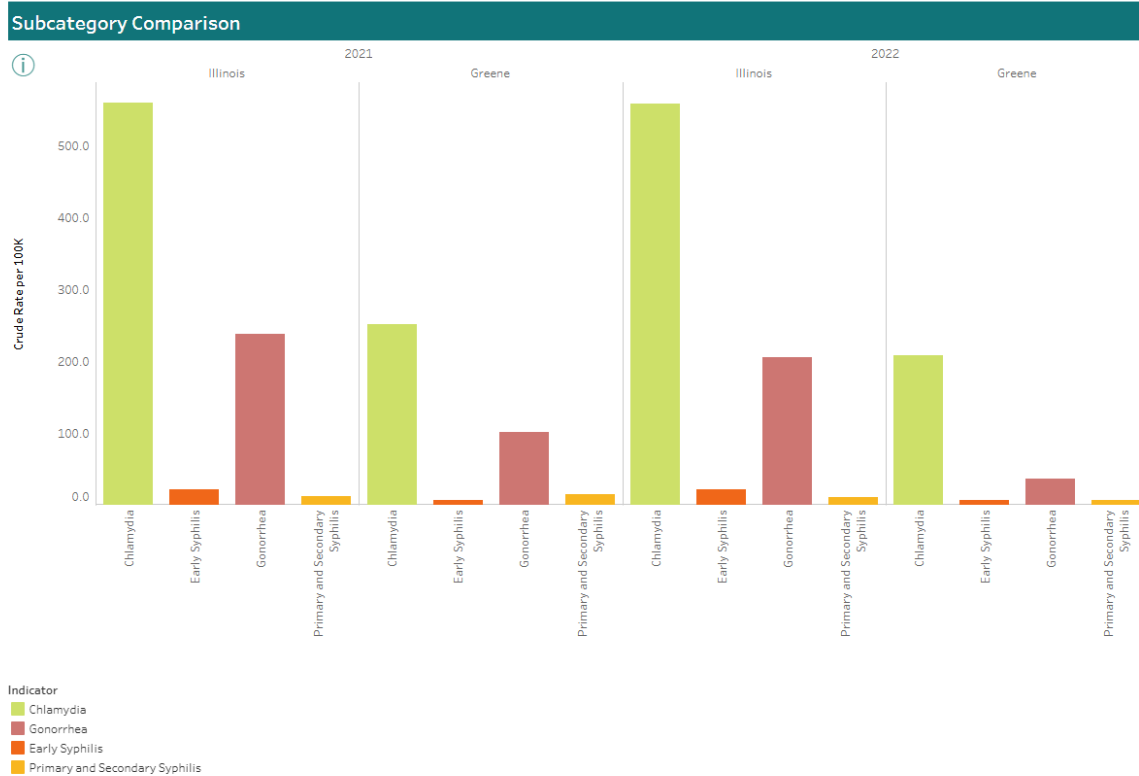
Source: Illinois Department of Public Health, STD County –  
Comp Reporting

\*No additional county-level data available

**Number of Sexually Transmitted Infections  
Reported in  
Greene County in 2022**

|           |    |
|-----------|----|
| Chlamydia | 29 |
| Gonorrhea | 5  |

*Source: Illinois Department of Public Health, STD  
County – Comp Reporting*



**QUERY  
2021-2022**

**Reportable Infectious Diseases:**

Greene County data is collected and reported monthly.

**2025 Communicable Disease Investigations YTD**

|                                     |    |
|-------------------------------------|----|
| Campylobacter                       | 4  |
| Chickenpox/Varicella                | 0  |
| Chlamydia                           | 13 |
| Cluster Illness                     | 1  |
| Cryptosporidiosis                   | 0  |
| Enteric Escherichia coli Infections | 0  |
| Gonorrhea                           | 1  |

|                                             |    |
|---------------------------------------------|----|
| Haemophilus Influenza Meningitis/invasive   | 1  |
| Hepatitis A                                 | 1  |
| Hepatitis B                                 | 9  |
| Hepatitis B Case Management ---NEW---       | 0  |
| Hepatitis C                                 | 11 |
| Influenza - ICU, Death or Novel             | 0  |
| Legionellosis                               | 0  |
| Lyme Disease                                | 1  |
| Mumps                                       | 0  |
| Rabies, potential human exposure            | 3  |
| Salmonellosis                               | 9  |
| Shigellosis                                 | 0  |
| Streptococcal Infections, Group A, Invasive | 1  |
| Early Syphilis                              | 2  |
| Consultations TB/ Immunizations             | 21 |



# Health Indicator- Injuries & Environmental Health

Transportation remains an important consideration in Greene County because residents frequently travel outside their immediate communities to obtain employment, health care, groceries, education, and other essential resources, with a population density of 22.1 people/square mile. The U.S. Census Bureau reports a mean travel time to work of 29.0 minutes for Greene County workers age 16. Most crashes happened on Friday at 7 PM.

Recent County concerns related to Highway 67, 5 miles north of Carrollton, have indicated it as a dangerous section of the county, which has resulted in many injuries and deaths. Signage has been installed and is currently under evaluation for safety concerns.

## Motor Vehicle Crashes

| Motor Vehicle Crash Data 2023 |              |                     |                      |
|-------------------------------|--------------|---------------------|----------------------|
|                               | # of Crashes | # of Persons Killed | # of Persons Injured |
| Greene County, IL             | 132          | 3                   | 40                   |
| State of Illinois             | 303,913      | 1,178               | 89,023               |

Source: Illinois Department of Transportation

## Fatal Occupational Injuries:

County-level occupational fatality data are not routinely available for Greene County; therefore, Illinois data are used to provide context regarding occupational safety risks. According to the U.S. Bureau of Labor Statistics Census of Fatal Occupational Injuries, 156 fatal occupational injuries occurred among Illinois workers in 2024, compared with 145 in 2023. The statewide fatal occupational injury rate was 2.7 deaths per 100,000 full-time equivalent workers.

Transportation incidents were the leading category of fatal occupational injury in Illinois in 2024, accounting for 55 deaths (35%). Other major categories included falls, slips and trips (30 deaths), violent acts (36 deaths), and contact incidents (20 deaths). Agriculture, forestry, fishing and hunting accounted for 15 fatal occupational injuries, while construction accounted for 26. Transportation and warehousing accounted for 34 fatal occupational injuries.

These statewide findings are relevant to Greene County because of the county's rural economy and occupational patterns that include agriculture, construction, transportation, public safety, and other occupations involving physical work, machinery, vehicles, and environmental hazards. While statewide occupational fatality data cannot be used to estimate Greene County's occupational fatality rate, they demonstrate the importance of workplace safety education, injury prevention, emergency preparedness, and access to appropriate occupational health resources.

## Illinois 2024 occupational fatalities

| Indicator                                | Illinois 2024 |
|------------------------------------------|---------------|
| Total fatal occupational injuries        | 156           |
| Male                                     | 140 (90%)     |
| Female                                   | 16 (10%)      |
| Wage & salary                            | 119 (76%)     |
| Self-employed                            | 37 (24%)      |
| Transportation incidents                 | 55 (35%)      |
| Falls, slips & trips                     | 30 (19%)      |
| Violent acts                             | 36 (23%)      |
| Contact incidents                        | 20 (13%)      |
| Agriculture, forestry, fishing & hunting | 15 (10%)      |
| Construction                             | 26 (17%)      |
| Transportation & warehousing             | 34 (22%)      |

Source: U.S. Department of Labor, Bureau of Labor Statistics, Census of Fatal Occupational Injuries, in cooperation with the Illinois Department of Public Health.

\*Standard Occupational Classification Manual

NOTE: Numbers and percentages may not add to totals due to exclusion of categories that do not meet publication criteria.

## **Environmental Health**

According to U.S. Environmental Protection Agency (USEPA) estimates that approximately 21,000 deaths each year are attributable to radon-induced lung cancer. The U.S. Surgeon General has warned that radon gas is the second leading cause of lung cancer in the United States (second only to smoking), and first among non-smokers. Individuals who smoke and are exposed to high levels of radon are especially vulnerable.

Radon remains an important environmental health consideration for Greene County. The U.S. Environmental Protection Agency's Map of Radon Zones identifies Greene County as a Zone 1 county, representing the highest category of predicted radon potential, with predicted average indoor screening levels greater than 4 pCi/L.

Continued radon education, testing, and mitigation outreach remain appropriate environmental health activities for Greene County, particularly as housing conditions, building age, and the presence of basements or other areas susceptible to radon entry can vary throughout the county.

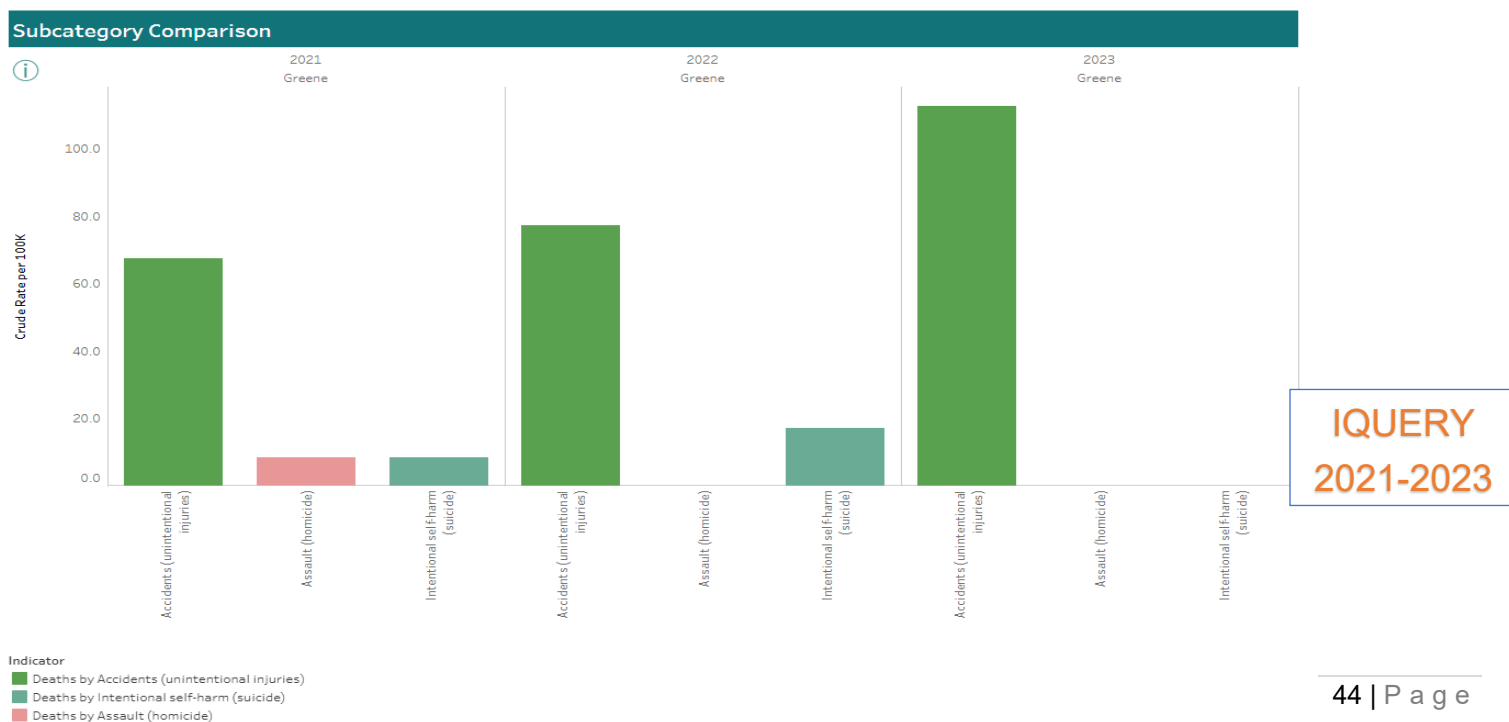
There are three zones based on radon potential:

- Zone 1: Counties with predicted average indoor radon screening levels greater than 4 pCi/L
- Zone 2: Counties with predicted average indoor radon screening levels from 20 to 4 pCi/L
- Zone 3: Counties with predicted average indoor radon screening levels less than 2 pCi/L

According to the EPA, Greene County is located in Zone 1, which has the highest potential for radon levels.

Other Current important community factors:

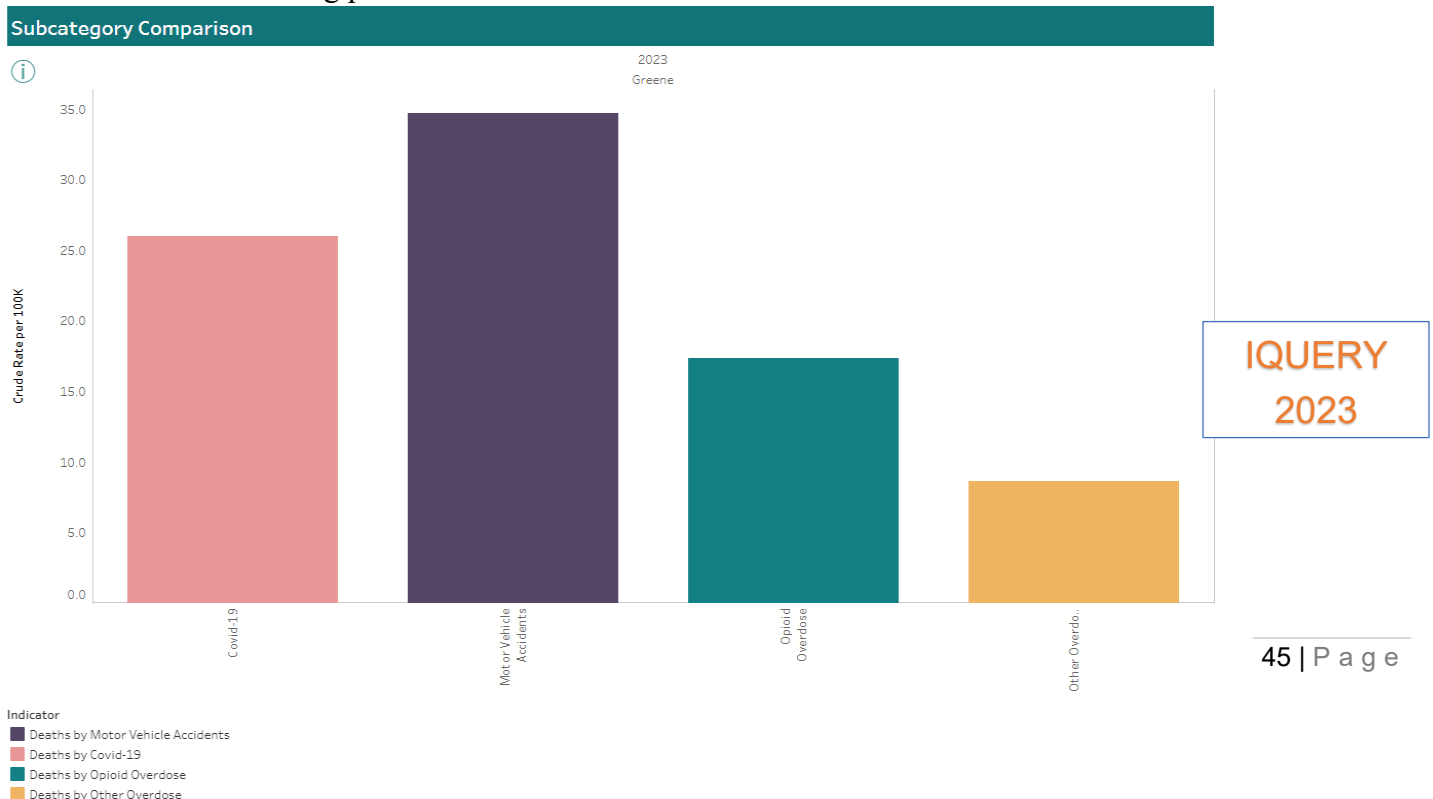
- Greene County currently has limited ordinances, permits, and building inspection processes. Generally, permitting is free, with fees collected to ensure standards and practices. Limited standards are evaluated for safety, code requirements, and accessibility. This limits enforcement and standard practices.
- Buildings and structures, including the Boyd Memorial Hospital, were built in the 1940s. Current standards for Medicare require more access and updated standards than can be implemented in older spaces. This general example is related to infrastructure limits in a multitude of services and access sites, including our jail, fire departments, police, schools, and cities and towns, etc. Managing sustainable urban improvement on rural budgets and revenue sources is extremely difficult.
- Rural community economies can't keep up with wages and pay rate structures to maintain workforces such as nurses, doctors, and other civil jobs like police and fire. A limited tax base, Medicare funding shifts, and tax caps limit competitive wages along with economic inflation.



# Health Indicator- Sentinel Event

Since our last IPLAN cycle, many nationwide changes have occurred that we feel are important to include as sentinel events as they relate to environmental changes in our community and national landscape. Although these changes are not necessarily county-level specific, they have changed much of the way we live and operate and may contribute to overall health outcomes and data trends in the coming years. There has been a boom in technology, along with shifts in social norms and political, policy, and health priorities.

1. COVID-19 and the transition to recovery: In 2021, the health department was responding to COVID-19 mass vaccination efforts. There was also a major focus on mental health, and prevention efforts were prioritized as the community transitioned from the acute phase of the COVID-19 pandemic.
2. Changes in technology and processes: Technology and service-delivery processes have changed significantly. The increased use of app-based processes, such as Walmart pickup and telehealth, along with less interaction with associates or people in general, has created greater access and convenience and contributed to a faster-paced society, while also creating new burdens related to technology access and use.
3. Changes in the public health and policy environment: The political and policy environment has become increasingly fast-paced and ever-changing, including changes affecting federal public health agencies such as the Centers for Disease Control and Prevention and the National Institutes of Health.
4. Changes in data availability and collection: During this cycle of data review for 2027–2031, changes were identified in the data collection process, ease of access, and availability of indicators. Many data points that were previously used were no longer available through the Census or other data sources. Also, reduced public access to data made compiling information more time-consuming. Changes in available data and collection variables, including data suppression and data County combinations, also affected the ability to make direct comparisons with previous IPLAN cycles and may reflect changes in the information being prioritized and collected.



# Health Indicator- Access to Care

Greene County has important community assets, but their sustainability and accessibility are vulnerable to rural population density, aging infrastructure, workforce shortages, limited funding, transportation barriers, and the geographic distribution of services.

## **Health Care Facilities:**

### **Home Health Agencies**

Greene County Health Department, 310 Fifth Street, Carrollton  
(217) 942-6961

### **Hospitals**

Thomas H. Boyd Memorial Hospital, 800 School Street, Carrollton  
(217) 942-6346

### **Nursing Homes**

EverVella of White Hall, 620 W. Bridgeport Street, White Hall  
(217) 374-2144

### **Rural Health Centers**

Boyd-Fillager Clinic, 712 College Street, Greenfield, IL  
(217) 942-6569

Carrollton Rural Health Walk-in Clinic, 803 Fifth St. Carrollton, IL  
(217) 942-6569

Greene County Rural Health Clinic, 727 9<sup>th</sup> Street, Carrollton, IL  
(217) 942-6569

JCH Medical Group Carrollton, 523 S. Main Street, Carrollton, IL  
(217) 942-3326

JCH Medical Group Roodhouse, 41 State Street, Roodhouse, IL  
(217) 589-4383

Rural Health Center of Roodhouse, 312 W. Lorton, Roodhouse, IL  
(217) 589-4629

Thomas H. Boyd Rural Health Clinic, 800 School Street, Carrollton, IL  
(217) 942-3600

**Shelter Care**    ***Closed 2021 – since last IPLAN cycle***

# Community Survey

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The Greene County community survey was compiled from November 2025 through February 2026. Both online and paper copies of the survey were provided to the community. The survey was shared in press releases, on Facebook, on the Greene County HD website, and through email partners of food establishments, Greene County community leaders, and other business owners. A QR code was generated to make it easy for individuals to participate. During this time, the health department conducted flu and home health visits for the Greene County residents. Results from Greene and Scott County Recovery Council surveys were also reviewed. See Appendix B & C for survey questions and formal analysis of results. Online access to the Thomas H. Boyd Memorial Hospital Community Health Needs Assessment completed in 2025, the Birth to Five 2024 Mental & Behavioral Health Needs Assessment, and the 2023 Early Childhood Needs Assessment were also reviewed as a supplemental source of information to provide additional context regarding regional and community health needs.

[boydhcs.org/\\_files/ugd/988460\\_a949a5aec8294ea9b7f0438f0ea196e4.pdf](https://boydhcs.org/_files/ugd/988460_a949a5aec8294ea9b7f0438f0ea196e4.pdf)

[https://www.birthtofiveil.com/s/R-MBH\\_Region40\\_English.pdf](https://www.birthtofiveil.com/s/R-MBH_Region40_English.pdf)

[https://www.birthtofiveil.com/s/Region\\_40\\_Needs\\_Assessment.pdf](https://www.birthtofiveil.com/s/Region_40_Needs_Assessment.pdf)

The survey results included the top three behaviors indicated to have the greatest impact on overall community health were:

1. Drug abuse- 74%
2. Poor eating habits/food choices- 54%
3. Alcohol abuse- 32%

Top five barriers to healthy living in Greene County:

1. Limited or unaffordable healthy food options-63%
2. Lack of awareness of services available- 52%
3. Inability to afford services- 51%
4. Drug Use- 48%
5. Lack of transportation-47%
6. Lack of financial resources-46%

Top five health problems in Greene County:

1. Drug use- 77%
2. Mental Health- 75%
3. Alcohol use- 35%
4. Cancer and Obesity both at- 31.3%
5. Aging issues-33.1%

# Stakeholder Focus Groups

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Focus groups were completed in person at the Greene County Health Department, allowing each small community to be represented by stakeholders who shared awareness of community needs. The focus groups were facilitated by Public Health Administrator Molly Peters.

## **Focus Group 1- February 19, 2026:**

Andy Stumpf – Superintendent, Greenfield School District  
Daniel Stepp– Recovery Navigator, Recovery Corp  
Daniel Woodlock, D.D.S.– SIUE, School of Dentistry, Board of Health  
Jackie Kuchy – Superintendent, North Greene School District  
Jake Sexton – Pretrial Services Officer, Department of Pretrial Services  
Nate Aldefer – Chief of Police-Greenfield  
Nicole Eldred– Public Service Administrator, Department of Child & Family Services  
Pam Panier–Library Board Member, Community Member-Christ United Methodist Church  
Penny Eiler, Lead Educator, Bright Futures  
Earlene Castleberry – Chairwoman, Greene County Board

## **Greene County Team:**

Molly Peters-L.E.H.P., Public Health Administrator, Facilitator  
Chelsea Bierman- Office Manager, Notetakers/Timekeeper  
Amanda Morrow- Community Health ROSC Coordinator, Notetaker  
Amanda McKinley- Community Health Engagement Specialist, Scribe  
BreAnna Buchanan- Community Health ROSC Navigator, Notetaker  
Krista Burrows- Recovery Navigator Staff, Observer

## **Focus Group 2- February 26, 2026:**

Becky Hoaglin-R.N.–Boyd Hospital Senior Life Solutions Program  
Beth Burrus–RPh., Retired Pharmacist  
Karen Daum – R.N., Retired– Greene County Board of Health  
Karley Tucker, Director of Marketing–Boyd Memorial Hospital  
Liz Killan, CEO, Killan Communication  
Sydney Hopper, Greenfield Home Visitor, Babies and Books

## **Greene County Team:**

Molly Peters-L.E.H.P.– Public Health Administrator, Facilitator  
Amber Costello-L.P.N.– Personal Health Services L.P.N., Notetaker  
Chelsea Bierman– Office Manager, Notetaker  
Emily Hart– Personal Health Services Intake Clerk, Timekeeper  
Halley Duba- R.N.–Personal Health Services R.N., Scribe

**Focus Group 3- March 5, 2026:**

Anne Sprague, BSW–Community Educator, Crisis Center Foundation  
Billy Springman–Greene County School Board, Community Member  
Corrine Briscoe–Director of Probation and Court Services, Macoupin, Greene, Scott Probation Districts  
Julie Geers, Ed.D - Guidance Counselor, Carrollton School District  
Honorable Judge Zachary Schmidt– Greene County Judge  
Sarah Stone – Child Protection Specialist, Department of Child and Family Services  
Rob McMillen – Greene County Sheriff

**Greene County Team:**

Molly Peters-L.E.H.P.– Public Health Administrator, Facilitator  
Beth Tepen- R.N.– Manager, Home Health, Notetaker  
Chelsea Bierman– Office Manager, Notetaker  
Emily Hart– Personal Health Services Intake Clerk, Timekeeper  
Halley Duba- R.N.–Personal Health Services R.N., Scribe

# Focus Group Results

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During the focus group discussions, it was clear across all three groups that community resources are important to residents. Participants expressed pride in the growth of resources available through the health department, stating, “Proud of how the resources have grown at the health department.” Groups were also encouraged by entrepreneurship and community innovation projects that have expanded opportunities and contributed to improvements in the community over the last several years. Participants described the community as safe and expressed confidence in the collaboration among local police and judicial teams.

Appendix D includes the focus group agenda and discussion questions that guided the conversations. Greene County Health Department team members served as facilitators, notetakers, scribes, and observers, with team members also responsible for organizing information recorded on flip charts. Discussions were documented for review and analysis. Facilitators used leading questions to identify barriers, concerns, strengths, and positive community attributes. Following each discussion, the Greene County Health Department team reviewed the information to identify common needs and emerging themes.

As the discussions progressed, the focus moved beyond individual health topics and toward the underlying factors connecting many of the concerns identified by participants. During the first focus group, facilitators explored the identified needs more deeply. By the second and third focus groups, a consistent theme emerged: the community needs a stronger driving force to address the social determinants of health and the barriers that prevent residents from accessing available resources.

The discussions demonstrated that the community has moved beyond simply identifying individual health concerns and recognizes the need to make a difference at the individual level by reducing barriers and improving connections to resources. A healthy community not only has resources available but also has the ability to ensure that residents can access, navigate, and use those resources effectively. At the same time, participants identified rural access, infrastructure, and workforce constraints as significant barriers to achieving a healthy community.

The focus group discussions allowed participants to brainstorm the root causes and effects of identified barriers, concerns, and urgent trends. At the conclusion of the brainstorming session, each participant identified their top three urgent public health concerns for the community. Overall, the three focus groups identified similar needs and concerns. As the top areas of concern emerged, discussions continued to go deeper into the barriers, obstacles, and urgent concerns within each topic area. This process helped the health department move from identifying broad health concerns to identifying the underlying community conditions and system-level barriers that should guide the 2027–2031 IPLAN priorities.

Urgent Concerns identified in three February-March 2026 Focus Groups:

- Community navigation needs
- Behavioral health access and needs

- Rural community infrastructure needs
- Substance use needs
- Access to transportation
- Access to care

Focus group participants identified the following concerns and root-cause themes during facilitated discussions. Responses are presented by general topic area and reflect participant perceptions and experiences. These themes were reviewed collectively with Community Survey findings, statistical data, leadership discussions, and organizational assessment findings to inform selection of the four 2027–2031 IPLAN priority areas.

### Key Themes Identified through Focus Group Discussion

|                                                                                                                                                                                                                                                |                                                                                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| <b>Community Navigation Needs- Root Cause Themes:</b>                                                                                                                                                                                          | Navigation of access to medication, food, providers, and treatment- overwhelming systems                                  |
| Centralized resources- needs                                                                                                                                                                                                                   | “Shifting needs”- Changing individual and family circumstances that require navigation services to adapt as needs change. |
| Limited health and systems literacy, including generational differences in knowledge and experience navigating available resources; resources may exist, but individuals may lack the knowledge or support needed to successfully access them. | Misinformation and social media platforms increasing need for navigation so much to sift through                          |
| Limited attendance in parent or general community education that is needed                                                                                                                                                                     | Changes in healthcare structures and complexity; people need clear instruction and step-by-step processing                |
| Need for individualized, one-on-one navigation based on each person's needs, addressing barriers step-by-step.                                                                                                                                 | “Patient-centered” Need for clear, individualized health information and messaging from trusted sources.                  |

|                                                                                                           |                                                                                                                                                                                                                                                                                                              |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Behavioral Health Access- Root Cause Themes:</b>                                                       | No centralized resource, cross-provider care communication, and navigation of needs/advocates                                                                                                                                                                                                                |
| Lack of providers, wait times, and general provider expertise- missing postpartum and adolescent services | Lack of facilities across the state                                                                                                                                                                                                                                                                          |
| Lack of transportation to services                                                                        | Significant behavioral health needs among the jail and justice-involved population with limited “nonexistent” access to appropriate in-person mental health assessment, treatment, and ongoing care; participants expressed concern that telehealth alone may be insufficient for some high-risk individuals |

|                                                                                                                                                                                                                                                                                                 |                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| Lack of insurance – denial of services while in crisis                                                                                                                                                                                                                                          | Lack of sustainable funding                                    |
| Limited availability of timely mental health and crisis care, including both immediate and ongoing services; participants described situations in which individuals had nowhere appropriate to obtain timely care or experienced difficulty maintaining medication and treatment. “Nonexistent” | No support for medication management                           |
| Lack of preventative measures leading to crisis-trauma- limited services, assessments, and follow-up                                                                                                                                                                                            | Generational struggles: stigma, lack of education, and support |

|                                                                                                                                                                                                         |                                                                                                                                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Rural Community Infrastructure- Themes:</b>                                                                                                                                                          | Funding limitations, tax caps, lack of numbers, revenue concerns                                                                               |
| Wait times for services (large communities receiving funds for crisis management), limited workforce, time to travel to resources                                                                       | Transportation- travel time needed to go to food, specialized health services, connections to social services- job/time/income loss            |
| Increasing mandates and unrealistic expectations that are unattainable for rural communities and aging facilities                                                                                       | Childcare limited ability to provide 2-parent income as there are no child centers and a lack of daycare or available people to care for youth |
| Lack of jobs; workforce willing to do community work at lower pay. Managing and maintaining these workforces EMS, Fire, Police, Hospital Care, Educators—Can’t compete with pay in higher-funded areas. | Lack of affordable housing, shelters, rental spaces, specialized care, behavioral health                                                       |
| Lack of food access- stores have limited revenue, and the general cost of food is increasing                                                                                                            | Aging materials, resources, and buildings- sidewalks, healthy parks, and environmental spaces                                                  |

|                                                                                               |                                                                                                                                                                                                 |
|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Substance Use - Root Cause Themes:</b>                                                     | Lack of treatment and sober living facilities- insurance barriers to getting help                                                                                                               |
| Treating behavioral health symptoms with substances                                           | Lack of specialized providers willing to see the whole person as well as substance use disorder, lack of reliable providers with evidence-based information; misinformation shared by providers |
| Misinformation                                                                                | Generational experiences- small community; hard to remove connections                                                                                                                           |
| Changes in drug use: polysubstance users, Kratom, laced substances- lack of knowledge of this | Lack of support and connections                                                                                                                                                                 |
| Vaping, marijuana, alcohol- increased potency                                                 | Trauma- untreated                                                                                                                                                                               |

|                                                                                      |                                                                                                              |
|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <b>Lack of access to transportation- Overlapping Root Causes Themes:</b>             | Impacts all aspects to access in a rural community- food, resources, healthcare, mental health, treatment    |
| Lack of income creates cyclical barriers                                             | Lack of jobs in the community perpetuates cycles of disparity in access                                      |
| No other means or modes of transportation besides car; no bike trails or bus systems | Current rural system isn't reliable, requires planning, and isn't allowable for distances and certain areas. |

|                                                        |                                                                                                                   |
|--------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|
| <b>Access to Care- Overlapping Root Causes Themes:</b> | Affordability of services                                                                                         |
| Insurance costs increasing                             | Medicare Advantage, payment models for insurance providers rural communities are barely able to maintain services |

# Data Review

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From November 2025 through July 2026, Greene County conducted an assessment of community needs within the seven required IPLAN data system areas, as well as other urgent concerns identified by the community. Additionally, as part of the IPLAN process, an organizational capacity assessment was conducted and reviewed through several Strengths, Weaknesses, Opportunities, and Threats (SWOT) analyses in August 2025. Data collected regarding the Greene County community were organized, reviewed, and analyzed to identify the most urgent and actionable areas of need for the Greene County community.

Data from the focus groups built upon the previous Community Survey assessment. Appendices A and C were provided as a basis for discussion for all focus group participants. In general, key concerns were identified consistently across the Community Survey and all three focus groups. These findings were also supported by available statistical data. To determine the priority areas, the IPLAN core team reviewed and compared quantitative and qualitative information gathered throughout the assessment process, looking for common themes, contributing factors, community strengths, and barriers that could be addressed through coordinated public health action.

During the focus group process, participants identified concerns, barriers, resources, and opportunities affecting the health and well-being of Greene County residents. Participants generated individual concerns through a brainstorming and post-it exercise, and the responses were then organized into common themes based on the relationships among the concerns identified. The themes included childcare, employment and economic opportunity, transportation, housing, food access, mental health, access to resources and navigation, and substance use. The exercise demonstrated that participants viewed many health concerns as interconnected rather than as isolated health conditions.

The focus group findings were particularly important in identifying the underlying factors contributing to community health concerns. Concerns related to childcare, employment, transportation, housing, food access, workforce, funding, and other community systems demonstrated the importance of Rural Community Infrastructure & Sustainability as a foundational priority. These conditions affect residents' ability to meet basic needs, access health care and community resources, and maintain overall health. At the same time, participants identified the need for improved connections to existing resources, supporting Community Health Navigation as a strategy to help residents overcome barriers and access and use available services.

Mental health concerns were consistently identified throughout the assessment process and focus group discussions. The discussions demonstrated that residents recognize the importance of access to behavioral health services, prevention, early intervention, and supportive community resources. These findings, along with available statistical and community survey data, supported Behavioral Health Services as a priority area. Substance use was also identified as a consistent concern throughout the assessment. Focus group participants identified the continued need for prevention, education, early intervention, recovery supports, and connections

to appropriate services. These findings, combined with the statistical and community-level data, supported Substance Use Disorder Prevention as a priority area.

The focus group process also demonstrated that the four priority areas are interconnected. Rural infrastructure and sustainability influence the availability of services, workforce, transportation, housing, food access, and other resources. Community Health Navigation can help residents identify and access those resources. Behavioral health services address mental health needs that may affect an individual's ability to function, seek assistance, and maintain stability. Substance Use Disorder Prevention addresses factors contributing to substance use while strengthening prevention, early intervention, and connections to support.

Local Community Health Activity Data: Greene County Health Department also reviewed locally collected Community Health Monthly Activity data to better understand resident interactions with community health staff and the types of assistance being provided. During 2025, staff documented substantial resource navigation and connection activity, including 575 resource navigation contacts/interactions, 109 connections to identified resource goals, 26 connections to treatment centers, and 18 connections to housing, in addition to behavioral health, recovery, outreach, education, and other community support activities. These locally collected data demonstrate both existing navigation capacity and continued community demand for individualized assistance connecting to health and social resources.

Together, the four priorities address both individual health needs and the broader community conditions that influence health outcomes.

During this IPLAN process, Greene County has recovered from the acute COVID-19 response; however, the community is currently experiencing concerning funding shifts and uncertainty regarding long-term sustainable funding. Sentinel events include not only the effects of COVID-19, but also changes in the political environment, rural health care challenges, wage inflation, workforce limitations, and aging infrastructure. During the focus group sessions, these challenges were identified as significant concerns. As the data were reviewed alongside the community input, it became clear that rural infrastructure and sustainability are foundational to the community's ability to maintain services, support its workforce, and respond to other identified health concerns.

The statistical data, Community Survey, focus group assessments, organizational capacity assessment, and SWOT analyses were analyzed by the IPLAN core team, which included Molly Peters, Chelsea Bierman, Halley Duba, Amber Costello, and Amanda McKinley. The team recommended four priority areas because they represented the strongest convergence of community-identified concerns, available statistical evidence, organizational capacity, and opportunities for public health action. The four priorities also provide an opportunity to address Greene County's morbidity and mortality while addressing the social and structural conditions that influence health.

# 2027-2031 Greene County Priority Areas

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PRIORITY 1: Community Health Navigation

PRIORITY 2: Behavioral Health

PRIORITY 3: Substance Use Disorder Prevention

PRIORITY 4: Rural Community Infrastructure &  
Sustainability

These priorities reflect the community's identified needs while recognizing that many health outcomes are influenced by interconnected social, economic, behavioral, and system-level factors. The priorities are intended to guide coordinated action, strengthen community connections, improve access to services and resources, and support the long-term health and sustainability of Greene County.

The Board of Health reviewed and approved the four priority areas on August 24, 2026.

# Board of Health Approval Letter



**Greene County  
Health Department**

310 Fifth Street • Carrollton, IL 62016 • (217) 942-6961 • Fax: (217) 942-3904

Daniel Woodlock, D.D.S.  
BOARD OF HEALTH PRESIDENT

Molly Peters, B.S., L.E.H.P.  
PUBLIC HEALTH ADMINISTRATOR

August 24, 2026

Illinois Department of Public Health  
Attn: JoAnne Bardwell  
Division of Health Data and Policy  
525 West Jefferson Street, Floor 2  
Springfield, Illinois 62761

Dear Ms. Bardwell:

The Greene County Health Department Board of Health has been kept informed regarding the preparation of the Illinois Project for Local Assessment of Needs (IPLAN) in conjunction with the Community Committee and staff.

The IPLAN was presented and reviewed by the Board of Health, with final approval at the August 24, 2026, Board of Health Meeting. The Board of Health reviewed the Organizational Capacity Self-Assessment and adopted the Community Health Plan.

For additional information, please contact Molly Peters at [mpeters@greencountyhd.org](mailto:mpeters@greencountyhd.org) or (217) 942-6961 ext.4101.

Respectfully,

Daniel Woodlock, DDS, President  
Greene County Board of Health

Molly Peters, B.S., L.E.H.P.  
Public Health Administrator

# Community Health Navigation

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## Health Problem

Greene County residents experience barriers navigating an increasingly complex health care and human services system. Access to a resource does not necessarily result in access to care or improved health when individuals do not know where to begin, do not understand eligibility requirements, cannot complete complicated applications, lack transportation, or are required to navigate multiple agencies and systems independently.

Residents may need assistance with health care, insurance, food access, transportation, housing, employment, driver's licenses and identification, Social Security, public benefits, behavioral health services, substance use resources, and other basic needs that influence health. Increasingly, many services require online applications, electronic communication, multiple forms of documentation, and the ability to independently follow a series of steps across different systems. For individuals with limited resources, transportation, technology access, health literacy, or support systems, these processes can become significant barriers to obtaining assistance.

These challenges are particularly significant in a rural community where services and resources may be geographically dispersed, workforce capacity is limited, transportation options are restricted, and individuals may have fewer informal support systems to assist them. Participants in the Greene County focus groups identified resource access and navigation as interconnected with housing, transportation, food access, employment, childcare, behavioral health, and substance use concerns.

The health impact extends beyond an individual's immediate need. When individuals are unable to successfully navigate systems, needs may remain unresolved, health conditions may worsen, preventive care may be delayed, and individuals may become disconnected from services. A referral or resource list alone may not be sufficient for an individual who does not know how to complete the next steps. In these circumstances, the difference between having a resource available and being able to successfully access and use that resource can have a meaningful impact on health.

The focus group discussions also identified concerns related to individuals and families who may lack established support systems to help them learn how to navigate health care, government benefits, employment, housing, transportation, and other community systems. This may contribute to repeated unmet needs and difficulty developing the knowledge and confidence needed to independently navigate systems. These concerns should be understood as a community-identified barrier rather than as a condition that can be attributed to individuals or families.

Community Health Workers (CHWs) are well positioned to address this gap. The Illinois Department of Public Health describes CHWs as frontline public health workers who serve as a bridge between the community and health and social services. Their role includes facilitating access to services, providing social support and advocacy, and building individual and community capacity through increased health knowledge and self-sufficiency. Illinois also identifies service coordination and navigation, capacity-building, advocacy,

communication, relationship building, and understanding health systems among the core competencies for CHW training.

Illinois' Community Health Worker Certification and Reimbursement Act was established to strengthen the CHW workforce and create a pathway toward sustainable reimbursement for certified CHW services. The state's current CHW workforce development efforts also recognize the need for consistent training, workforce development, and meaningful measures of CHW impact.

For Greene County, Community Health Navigation is therefore more than making a referral. It is providing individualized, person-centered assistance that helps residents identify their goals, understand available resources, navigate complex systems, overcome barriers, complete necessary steps, and successfully connect with services. The goal is not only to resolve an immediate need but also to build an individual's knowledge, confidence, and ability to navigate systems more independently.

**Outcome Objective:**

**By July 2031, increase successful connections to health and social resources among residents to improve access and reduce barriers related to social drivers of health.**

**By July 2031, reduce identified barriers that prevent residents from accessing resources addressing food, housing, transportation, health care, and other social drivers of health.**

**By July 2031, increase achievement of individualized health and social needs goals among residents receiving navigation services.**

Baseline: 2025 GCHD data documented 575 resource navigation interactions and 109 connections to identified resource goals. Resource connections included 18 housing connections and 26 treatment-center connections; however, a standardized successful-connection or goal-achievement rate had not yet been established. Tracking of unsuccessful connections also requires development to establish a comprehensive baseline.

GCHD will establish standardized successful-connection, unsuccessful-connection/barrier, and goal-achievement measures in 2027 and use the established baseline to measure improvement through 2031. Community Health Navigation alone cannot control population-level measures such as transportation availability, distance to services, housing availability, or food insecurity; however, navigation can directly improve residents' ability to identify resources, overcome barriers, successfully connect to services, and achieve individualized goals.

**Impact Objectives:**

**Objective 1—Build the system:**

By January 2028, establish and maintain a standardized, coordinated Community Health Navigation system that provides individualized assessment, goal setting, resource connection and referral, follow-up, documentation of successful and unsuccessful connections, and assistance in overcoming barriers to health and social services.

**Objective 2 – Make the system sustainable:**

By July 2029, maintain a trained Community Health Worker/navigation workforce and implement at least one sustainable funding, reimbursement, contractual, or partnership mechanism to support continued Community Health Navigation services in Greene County.

**Objective 3 – Demonstrate that it makes a difference:**

By July 2031, demonstrate an increase from the 2027 baseline in the percentage of residents receiving Community Health Navigation services who successfully connect to identified resources and achieve one or more individualized goals related to health care, food access, housing, transportation, employment, public benefits, behavioral health, or other identified social drivers of health.

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| <p><b><u>Key Measurements:</u></b></p> <ul style="list-style-type: none"> <li>• Residents assessed; needs/barriers identified</li> <li>• Individualized goals</li> <li>• Navigation assistance provided</li> <li>• Successful connection rate</li> <li>• Successful vs. unsuccessful connections</li> <li>• Individual goal achievement</li> <li>• Active partners/resources</li> <li>• CHWs trained/certified</li> <li>• Funding/reimbursement mechanisms</li> <li>• Barriers/gaps identified</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <p><b><u>Risk Factors:</u></b></p> <ol style="list-style-type: none"> <li>1. <b>Chronic disease and complications</b>, including delayed prevention, screening, treatment, and disease management</li> <li>2. <b>Economic and basic-needs instability</b>, including food insecurity, housing, transportation, employment, and financial needs</li> <li>3. <b>Behavioral health conditions</b>, including mental health needs and difficulty accessing timely services</li> <li>4. <b>Substance use and overdose risk</b>, including access to prevention, treatment, recovery, and supportive services</li> <li>5. <b>Maternal, child, and family health needs</b>, including access to prenatal/postpartum care, health care, nutrition, insurance, and family supports</li> </ol>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <p><b><u>Contributing Factors 1&amp;2 (direct (D) &amp; indirect (I):</u></b></p> <p><b>Rural Infrastructure (D)</b><br/> (I) Limited availability of social services<br/> (I) Lack of childcare infrastructure<br/> (I) Limited sustainable funding for rural services</p> <p><b>Difficulty identifying, accessing, &amp; coordinating care (D)</b><br/> (I) Fragmented health systems<br/> (I) Overwhelmed consumers- limited knowledge of available services.<br/> (I) Limited centralized resource coordination</p> <p><b>Food, housing, employment, or financial instability competing with health and family needs. (D)</b><br/> (I) Limited affordable housing and food resources<br/> (I) Limited employment opportunities and household income<br/> (I) Missed appointments, screenings, treatment, and management of disease</p> <p><b>Transportation (D)</b><br/> (I) Rural Geography- transportation limits/service limits, distance of travel<br/> (I) Limited household financial resources for transportation<br/> (I) Lack of driver's license, reliable vehicle, or other transportation options.</p> <p><b>Lack of Knowledge/Education (D)</b><br/> (I) Survival skills vs. life skills- limited health literacy<br/> (I) Generational experiences and limited exposure to systems/resources</p> | <p><b><u>Proven Intervention Strategy:</u></b></p> <ul style="list-style-type: none"> <li>• Establish a standardized Community Health Navigation process that includes individualized assessment, goal setting, resource connection, follow-up, and assistance overcoming barriers.</li> <li>• Utilize Community Health Workers and other trained navigation staff to provide individualized, person-centered assistance based on each resident's identified needs and goals.</li> <li>• Develop consistent screening and documentation processes to identify health and social needs including food, housing, transportation, health care, behavioral health, employment, public benefits, and other social drivers of health.</li> <li>• Provide active navigation and warm connections to community resources rather than relying solely on resource lists or traditional referrals.</li> <li>• Assist residents with applications, eligibility requirements, documentation, scheduling, transportation coordination, technology needs, and other steps necessary to successfully access services.</li> <li>• Establish follow-up processes to determine whether residents successfully connected to identified resources and identify additional assistance needed when connections are unsuccessful.</li> <li>• Track successful and unsuccessful resource connections to identify recurring barriers, unmet needs, unavailable services, and gaps within community systems.</li> </ul> |

(I) Limited opportunities to develop skills needed to independently navigate complex systems

**Complex Application (D)**

(I) Fragmented systems and differing requirements

(I) Changing policy/practice/guidelines

(I) Barriers in requirements- lack of ID, education, and understanding

- Establish individualized goal-setting and follow-up processes to measure whether residents achieve identified health and social needs goals.
- Strengthen coordinated referral relationships among health care providers, behavioral health providers, schools, social service organizations, local government, employers, community organizations, and other resource partners.
- Maintain and improve current community resource information and referral pathways to ensure navigation staff and community partners have accurate information regarding available services and eligibility requirements.
- Increase awareness among residents and community partners regarding available Community Health Navigation and CHW services and how to access assistance.
- Strengthen the Community Health Worker workforce through training, professional development, applicable certification, and development of consistent navigation competencies.
- Develop documentation and data collection processes that demonstrate navigation outcomes, successful connections, goal achievement, unmet needs, and community-level service gaps.
- Utilize navigation data to identify recurring system barriers and support collaborative problem-solving, program development, funding requests, and advocacy for needed community resources.
- Pursue Medicaid reimbursement, grants, partnerships, contracts, and other sustainable funding opportunities to maintain and expand Community Health Navigation services.
- Collaborate with community partners to address identified gaps that cannot be resolved through individual navigation and support broader efforts to champion rural community systems change

**Resources Available:**

Greene County Health Department Community Health Workers/navigation staff  
Greene County food pantries and community food resources  
Thomas H. Boyd Memorial Hospital  
Jersey Community Hospital and regional health care providers  
Behavioral health and substance use treatment/recovery providers  
Greene County schools and school districts  
Local law enforcement and judicial partners

**Barriers:**

- Development and maintenance of sustainable funding and reimbursement models
- Complexity of insurance reimbursement, documentation, billing, certification, and compliance requirements
- Limited staff capacity within rural organizations where employees often perform multiple roles
- Changing or emerging CHW certification, training, and reimbursement requirements
- Limited availability of services to which residents can be referred, particularly in rural areas

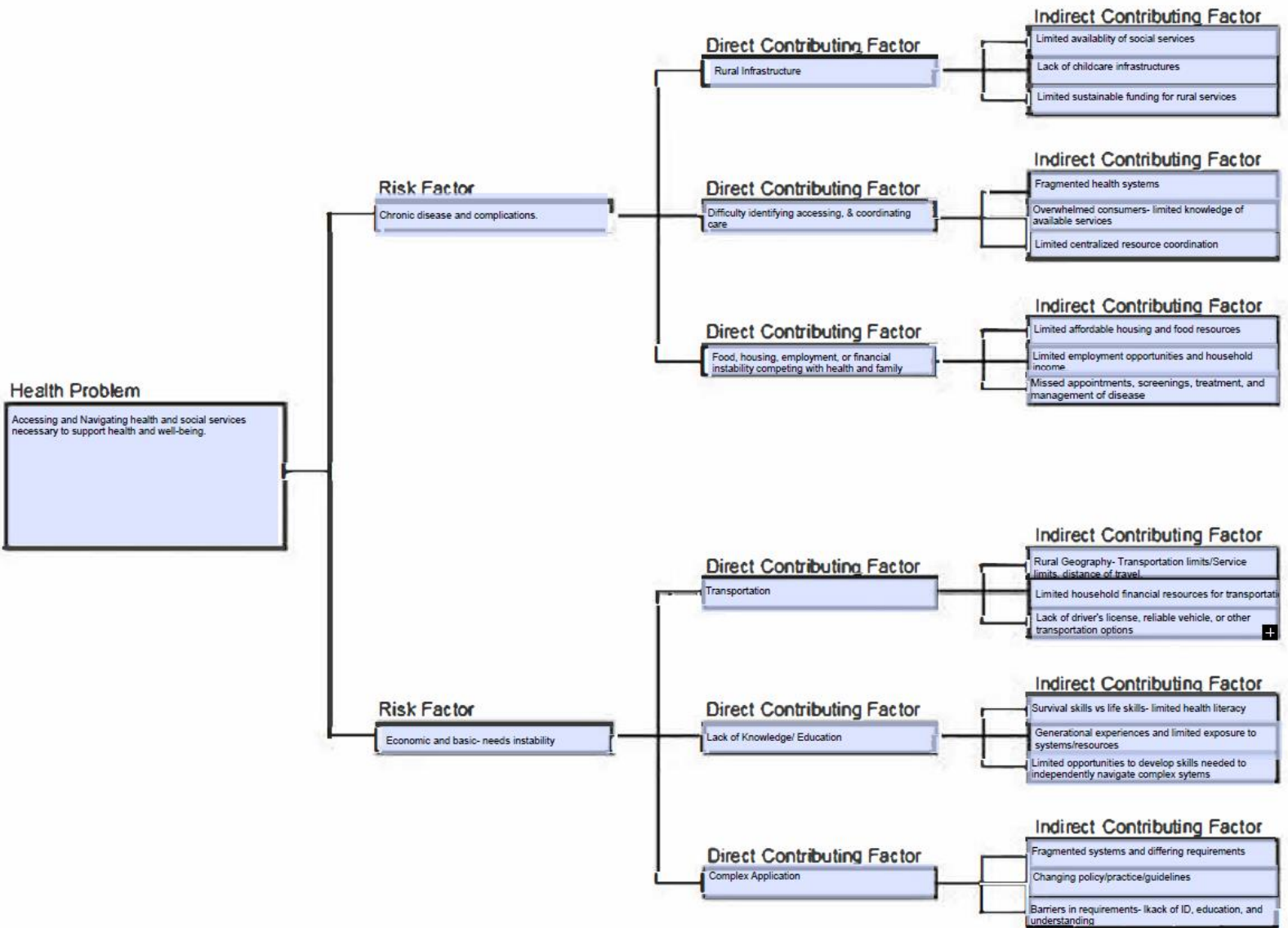
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| <p>Local government and municipal partners</p> <p>University of Illinois Extension</p> <p>Illinois Department of Public Health</p> <p>Illinois Public Health Association</p> <p>Illinois Public Health Institute</p> <p>Illinois Department of Human Services and benefit/resource programs</p> <p>Community and faith-based organizations</p> <p>Regional transportation, housing, employment, and social service resources</p> <p>Other local health departments and regional hospital/health systems</p> <p>Existing referral/resource coordination systems and community partnerships</p> | <ul style="list-style-type: none"> <li>• Transportation, workforce, housing, childcare, and other system gaps that cannot be resolved through navigation alone</li> <li>• Potential duplication or fragmentation of navigation services as additional organizations enter the CHW/navigation system without adequate coordination</li> <li>• Risk that expansion of navigation programs may increase the number of referral entities without increasing the availability or intensity of services residents actually need</li> <li>• Dependence on grants or short-term funding that may not support long-term workforce and program sustainability</li> </ul> |
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**Public Awareness & Health Education:** GCHD will promote awareness of Community Health Navigation and available health and social resources through community partners, health care providers, hospitals, social media, outreach activities, community events, printed/electronic resources, and direct client interactions. Education will emphasize how residents can access individualized assistance and navigation support.

**Estimated Funding Needs:** Personnel/CHW salaries and benefits, training and certification, EMR/CDP and referral-system costs, transportation/resource assistance, outreach/education, and program administration. Funding needs will vary annually based on staffing and reimbursement development.

**Anticipated Funding Sources:** GCHD operating funds, Medicaid/insurance reimbursement as available, IDPH/IPHA opportunities, federal/state grants, hospital/community-benefit partnerships, contracts, foundations, and other public/private funding opportunities. Barriers include low reimbursement, billing teams' capacity to navigate systems, and payers unwilling to work with rural communities.

## HEALTH PROBLEM ANALYSIS WORKSHEET



## Community Health Navigation Plan

### **Description of the health problem, risk factors, and contributing factors (including high-risk populations, and current and projected statistical trends.)**

Greene County residents experience difficulty identifying, accessing, and successfully navigating health and social services needed to support health and well-being. Rural geography, transportation limitations, complex application and eligibility processes, limited health and systems literacy, fragmented resources, technology barriers, and changing individual needs can make available services difficult to use. Individualized Community Health Navigation is needed to help residents understand their options, overcome barriers, complete necessary steps, successfully connect to resources, and build greater ability to navigate systems over time.

### **Healthy People 2030 Objectives related to Community Health Navigation**

|         |                                                                                  |
|---------|----------------------------------------------------------------------------------|
| AHS-01  | Increase the proportion of people with health insurance.                         |
| AHS-04  | Reduce the proportion of people who cannot get medical care when they need it.   |
| AHS-07  | Increase the proportion of people with a usual source of care.                   |
| NWS-01  | Reduce household food insecurity and hunger.                                     |
| SDOH-04 | Reduce the proportion of families that spend more than 30% of income on housing. |

### **SHIP 2028 Objectives related to Community Health Navigation**

Cross-Cutting Issues (Social and Structural Determinants of Health & Public Health Infrastructure): The SHIP highlights that public health progress is consistently held back by a lack of access to healthcare and wraparound services. Navigation acts as the infrastructure to bridge these gaps.

### **Corrective Actions to reduce the level of indirect contributing factors:**

1. Develop and maintain coordinated referral and resource networks among health care, behavioral health, social service, government, and community organizations.
2. Strengthen transportation connections and solutions for residents needing access to health care, employment, food, benefits, and other essential resources.
3. Simplify access to services by assisting residents with applications, eligibility requirements, identification, documentation, scheduling, and enrollment processes.
4. Improve community awareness and understanding of available resources through outreach, education, centralized resource information, and Community Health Workers.
5. Increase coordination and communication between organizations to reduce fragmented systems, duplication of services, and unsuccessful referrals.
6. Strengthen health, digital, and systems literacy by helping residents understand and use health information, technology, benefits, insurance, and other service systems. Healthy People 2030

specifically recognizes both personal and organizational responsibility for making information and services easier to find, understand, and use.

7. Identify and address gaps in rural service availability, including health care, behavioral health, childcare, housing, food, transportation, and other essential supports.
8. Develop and sustain the CHW/navigation workforce through training, certification, partnerships, reimbursement, and sustainable funding.
9. Track unsuccessful connections and recurring barriers to identify where community systems, policies, eligibility requirements, workforce shortages, or unavailable resources prevent residents from receiving assistance.
10. Use navigation and community data to support system improvement, funding, partnership development, and advocacy for services and infrastructure needed in Greene County.

### **Proposed community organization (s) to provide and coordinate the activities:**

Greene County Health Department will serve as the primary coordinating organization for Community Health Navigation, building upon existing Community Health Worker services and current referral and navigation partnerships. GCHD will continue to strengthen use of IRIS-Illinois Collaboration and Action Network for coordinated community referrals and establish documentation and tracking processes through its CDP electronic medical record (EMR) to support consistent assessment, navigation, follow-up, and measurement of successful and unsuccessful resource connections.

GCHD will work with Jersey Community Hospital, Thomas H. Boyd Memorial Hospital/Boyd Healthcare Services, health care providers, behavioral health providers, social-service agencies, schools, judicial and public-safety partners, and other community organizations to develop and strengthen coordinated referral pathways. The goal will be to improve communication between organizations, reduce fragmented referrals, create effective warm connections, and ensure residents receive individualized follow-up when barriers prevent successful access to services.

Partnership development will also focus on increasing participation in community referral networks, maintaining accurate resource information, identifying gaps in available services, and using shared referral and navigation data to guide community planning and systems improvement.

### **Evaluation plan to measure progress towards reaching objectives:**

Evaluate through standardized tracking of navigation encounters, identified needs and barriers, successful and unsuccessful resource connections, individualized goal achievement, referral follow-up, partner participation, CHW workforce capacity, and sustainable funding. Navigation data will be reviewed monthly to identify recurring barriers and community system gaps and to determine whether corrective actions are improving residents' ability to successfully access and utilize needed resources. Systems are currently in place but will need to be updated to meet the need for required documentation and objective baseline data needs.

# Behavioral Health Services Priority Plan

## **Health Problem:**

Greene County residents experience limited access to timely and appropriate behavioral health services across the continuum of prevention, early intervention, treatment, crisis response, medication management, and ongoing care. Rural provider shortages, limited specialized services, transportation barriers, insurance and reimbursement limitations, wait times, and fragmented systems can delay or prevent individuals from receiving care when it is needed.

Community assessment and focus-group discussions identified particular concerns regarding access to crisis and chronic mental health care, medication management, adolescent and postpartum behavioral health services, services for justice-involved individuals, and coordination among providers. When appropriate care is unavailable or delayed, behavioral health needs may worsen, contribute to crisis, interfere with physical health and daily functioning, increase substance use risk, and place additional strain on families, health care, law enforcement, schools, and other community systems.

The 2027–2031 priority therefore expands the previous IPLAN focus on Mental Health Services to Behavioral Health Services, recognizing the need for a coordinated continuum that strengthens prevention, early identification, timely treatment, crisis response, recovery/support, and connections between behavioral health and other health and community services.

Constant communication with our law enforcement, jails, and judicial teams indicates many barriers in behavioral health treatment, medication, and crisis support. Voluntary versus involuntary assistance: many individuals are unnecessarily impacted by law enforcement, but only because there is nowhere for individuals to receive care.

### **Outcome Objective:**

By July 2031, increase the percentage of Greene County residents receiving behavioral health navigation who successfully connect to appropriate behavioral health services, compared with the standardized baseline established during implementation.

By July 2031, increase successful connections to behavioral health prevention, early intervention, treatment, crisis, medication management, and ongoing support services based on identified community needs.

By July 2031, increase coordinated behavioral health referrals and successful connections among health care, behavioral health, schools, judicial/public safety, social service, and community partners.

Baseline: Community Survey findings, three focus groups, leadership discussions, and available health data consistently identified behavioral health access as a

### **Impact Objectives:**

#### **Objective 1 – Improve access and early intervention:**

By January 2028, strengthen coordinated behavioral health screening, referral, and service pathways to increase early identification and timely connection to appropriate behavioral health services for Greene County residents.

IRIS-ICAN Referral pathway is established to support referral monitoring once fully implemented. EMR established, and data collection processes are currently under review.

#### **Objective 2 – Strengthen the rural behavioral health system:**

By July 2029, establish or expand at least two local or regional behavioral health service partnerships or service pathways addressing identified Greene County service

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| <p>continuing community concern. Focus-group participants identified limited provider availability, wait times, transportation, insurance barriers, limited crisis and ongoing behavioral health services, medication-management needs, limited specialized services, fragmented care coordination, and sustainable funding as barriers.</p> <p>2025 GCHD local data documented 14 crisis-support interactions and 520 interactions with individuals experiencing a mental health disorder. Standardized measures for behavioral health referrals, successful and unsuccessful connections, service availability, wait times, and barriers to access have not yet been established. GCHD will further standardize these measures during implementation and use established baseline measures to demonstrate improvement through 2031.</p>                                                                                                                                                                      | <p>gaps through partnerships, workforce development, local or regional service connections, and sustainable funding or reimbursement opportunities.</p> <p><b>Objective 3 – Improve successful connection and continuity of care:</b></p> <p>By July 2031, demonstrate an increase from the established baseline in the percentage of residents with identified behavioral health needs who successfully connect to appropriate prevention, treatment, crisis, medication management, or ongoing behavioral health services and supports.</p> <p><b>Objective 4 – Address high-risk and underserved populations:</b></p> <p>By July 2031, establish or strengthen behavioral health referral and service pathways for at least three populations experiencing identified service gaps, including children and adolescents, maternal/postpartum populations, individuals experiencing crisis or serious mental illness, and justice-involved individuals.</p> |
| <p><b>Key Measurements</b></p> <ul style="list-style-type: none"> <li>• Behavioral health needs identified</li> <li>• Behavioral health referrals and navigation assistance provided</li> <li>• Successful and unsuccessful behavioral health service connections</li> <li>• Referral-to-service wait time, when measurable</li> <li>• Crisis and urgent behavioral health connections</li> <li>• Behavioral health prevention/early-intervention activities</li> <li>• Medication-management connections</li> <li>• Adolescent, maternal/postpartum, and other specialized service connections</li> <li>• Justice-involved individuals connected to appropriate behavioral health services</li> <li>• Active behavioral health providers and referral partners</li> <li>• Coordinated referral/care pathways established</li> <li>• New or expanded behavioral health services</li> <li>• Barriers and service gaps identified</li> <li>• Sustainable funding/reimbursement mechanisms established</li> </ul> | <p><b><u>Risk Factors:</u></b></p> <ol style="list-style-type: none"> <li>1. Behavioral health crisis and suicide risk, including acute mental health needs requiring timely assessment and intervention</li> <li>2. Trauma, chronic stress, and social instability, including behavioral health impacts associated with housing, financial hardship, family instability, social isolation, justice involvement, and other social drivers of health</li> <li>3. Mental health conditions, including depression, anxiety, serious mental illness, and other behavioral health needs</li> <li>4. Substance use and co-occurring disorders, including individuals experiencing both mental health and substance use needs</li> <li>5. Maternal, child, and adolescent behavioral health needs, including postpartum mental health, childhood/adolescent concerns, trauma, and family behavioral health needs</li> </ol>                                         |
| <p><b><u>Contributing Factors (direct (D) &amp; indirect (I):</u></b></p> <p><b>Limited Provider Availability (D)</b></p> <p>(I) Rural behavioral health workforce shortages</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <p><b><u>Proven Intervention Strategy:</u></b></p> <ul style="list-style-type: none"> <li>• Strengthen local and regional behavioral health referral pathways to improve timely access to appropriate services.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

- (I) Limited patient volume and reimbursement needed to financially sustain rural services
- (I) Geographic concentration of specialty behavioral health services outside Greene County

### **Limited Timely Access to Behavioral Health and Crisis Care (D)**

- (I) Provider wait times and limited appointment availability
- (I) Limited local crisis and higher-level treatment capacity
- (I) Distance and transportation required to reach services - Limited across the region/state

### **Fragmented Behavioral Health Systems and Continuity of Care (D)**

- (I) Limited communication across behavioral health, primary care, hospitals, schools, judicial, and social service systems
- (I) Lack of centralized behavioral health resource coordination
- (I) Limited follow-up after crisis, hospitalization, incarceration, or referral

### **Insurance, Affordability & Reimbursement Barriers (D)**

- (I) Lack of insurance or inadequate behavioral health coverage
- (I) Reimbursement structures that make rural service delivery difficult to sustain
- (I) Out-of-pocket costs and other financial barriers to care

### **Limited Specialized Behavioral Health Services (D)**

- (I) Limited adolescent and child behavioral health services
- (I) Limited maternal/postpartum behavioral health resources
- (I) Limited treatment capacity for justice-involved/high-risk populations

### **Stigma, Knowledge & Help-Seeking Barriers (D)**

- (I) Generational experiences and beliefs regarding mental health
- (I) Limited understanding of behavioral health symptoms and when to seek assistance
- (I) Misinformation regarding mental illness and treatment

- Increase behavioral health screening, early identification, education, and connection to care within health and community settings.
- Strengthen integration and coordination of behavioral health services with primary care, public health, hospitals, schools, social services, and other community systems.
- Increase access to behavioral health providers through local, co-located, regional, and telehealth service models when appropriate.
- Strengthen behavioral health crisis pathways to help residents access timely assessment, stabilization, treatment, and follow-up.
- Improve access to ongoing medication management and continuity of behavioral health treatment.
- Develop and strengthen behavioral health services and referral pathways for children, adolescents, maternal/postpartum populations, and other populations with specialized needs.
- Strengthen behavioral health assessment, treatment connections, and continuity of care for justice-involved individuals.  
Utilize Community Health Workers, peer support, navigation, and other appropriate workforce models to assist residents in successfully connecting to behavioral health services.
- Develop coordinated referral and follow-up processes to identify whether behavioral health connections were successful and why connections were unsuccessful.
- Increase behavioral health education and prevention activities to improve understanding, reduce stigma, recognize concerns earlier, and encourage appropriate help-seeking.
- Strengthen trauma-informed approaches across health, behavioral health, schools, justice, and community systems.
- Improve communication and coordination among behavioral health providers and community partners within applicable privacy and information-sharing requirements.
- Track behavioral health access barriers, wait times, unsuccessful connections, service gaps, and emerging needs to guide community planning.
- Collaborate with hospitals and regional providers to expand access to services that cannot be sustainably provided by a single rural organization.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
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|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <ul style="list-style-type: none"> <li>• Pursue grants, reimbursement opportunities, contracts, partnerships, and other sustainable financing strategies to maintain and expand behavioral health services.</li> <li>• Utilize local behavioral health data and community experience to support funding, advocacy, workforce development, and broader efforts to champion rural community systems change.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b><u>Resources Available:</u></b><br><br>AL anon/Alcoholics Anonymous/Wells Center Greene<br>County Drug Task Force & Sheriff's Office<br>Greene County Health Department<br>Greene County Family Violence Prevention Coalition<br>Greene County School Districts<br>Hobby Horse and Bright Futures Parenting Programs<br>Locust Street Resource Center<br>Illinois Department of Aging<br>Illinois Dept. of Public Health & Human Services<br>Agencies<br>Illinois Department of Veterans Affairs<br>Oasis Women's Center<br>Private Physicians<br>Police Departments<br>Thomas Boyd Memorial Hospital<br>The Job Center<br>University of Illinois Extension Office in Greene County | <b><u>Barriers:</u></b> <ul style="list-style-type: none"> <li>• Limited availability of behavioral health providers and specialists in rural communities</li> <li>• Difficulty recruiting and retaining qualified behavioral health professionals</li> <li>• Long wait times and limited appointment availability</li> <li>• Limited local crisis, inpatient, and higher-level behavioral health services</li> <li>• Transportation and geographic distance to regional services</li> <li>• Insurance coverage, reimbursement, and affordability limitations</li> <li>• Limited sustainable funding for rural behavioral health programs</li> <li>• Fragmented referral, communication, and follow-up systems</li> <li>• Limited child, adolescent, maternal/postpartum, and other specialized behavioral health services</li> <li>• Limited medication-management capacity</li> <li>• Stigma, misinformation, and reluctance to seek behavioral health care</li> <li>• High needs among individuals with complex mental health, substance use, social, or justice-system involvement</li> <li>• Telehealth limitations for individuals requiring more intensive assessment or treatment</li> <li>• Limited staffing capacity among rural organizations to develop and maintain additional programs</li> <li>• Increasing demand for behavioral health services without a corresponding increase in local workforce or treatment capacity</li> <li>• Dependence on regional and state systems for services that cannot be maintained locally</li> </ul> |

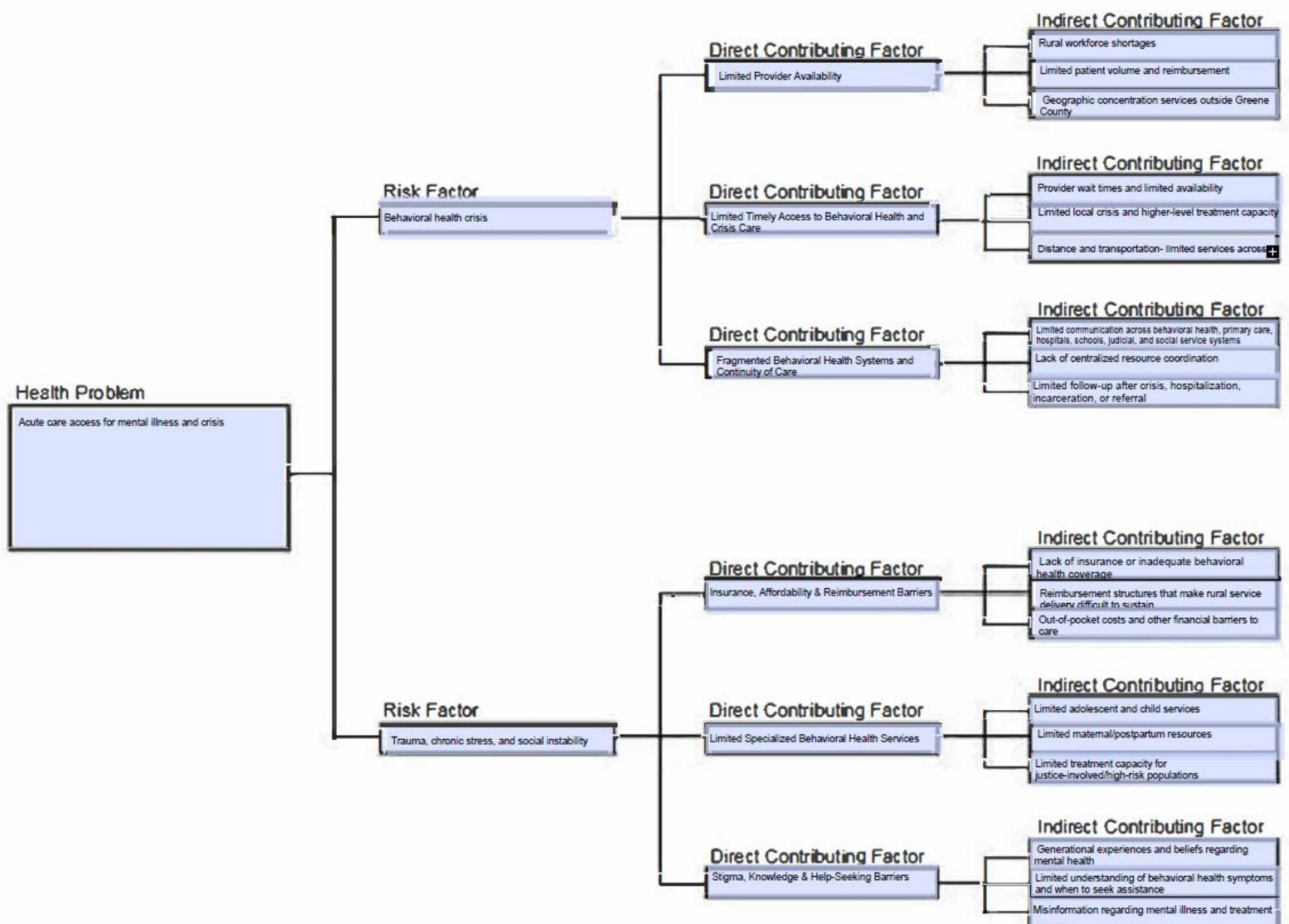
**Public Awareness & Health Education:** GCHD and partners will increase awareness of available behavioral health prevention, treatment, crisis, medication-management, and support services through community

education, health care providers, schools, community organizations, public safety partners, social media, outreach activities, and referral networks.

**Estimated Funding Needs:** Personnel/CHW/Peer Support salaries and benefits, training and certification, EMR/CDP and referral-system costs, transportation/resource assistance, outreach/education, and program administration. Funding needs will vary annually based on staffing and reimbursement development.

**Anticipated Funding Sources:** GCHD operating funds, Medicaid/insurance reimbursement as available, IDPH/IPHA opportunities, federal/state grants, hospital/community-benefit partnerships, contracts, foundations, and other public/private funding opportunities.

## HEALTH PROBLEM ANALYSIS WORKSHEET



## Behavioral Health Community Plan

### **Description of the health problem, risk factors, and contributing factors (including high-risk populations, and current and projected statistical trends.)**

Locust Street Resource Center maintains 1-3 professionals on staff but has limited staff to serve Greene County. The lack of sustainable funding, lack of experts, and maintaining staffing in rural communities limit access and resources to apply for funding sources. In 2025, we began tracking data related to social determinants of health and behavioral health needs, but data capture remains limited. Capacity of data collection has increased due to the Integrated Referral System and Illinois Coordinated Action Network (ICAN- IRIS platforms). As referral processes are developed, more data tracking will be established to understand behavioral health needs. High needs currently experienced in the community include the need for services and transportation to the Behavioral Health specialty center. Limited capacity and availability in Illinois are adding pressure on hospital and jail systems.

### **Healthy People 2030 Objectives related to Behavioral Health**

|          |                                                                                                             |
|----------|-------------------------------------------------------------------------------------------------------------|
| MHMD-01  | Reduce suicide rate                                                                                         |
| MHMD-02  | Reduce suicide attempts by adolescents                                                                      |
| MHMD-03  | Increase the proportion of children with mental health problems who get treatment                           |
| MHMD-04  | Increase the proportion of adults with serious mental illness who get treatment                             |
| MHMD-05  | Increase the proportion of adults with depression who get treatment                                         |
| MHMD-06  | Increase the proportion of adolescents with depression who get treatment                                    |
| MHMD-07  | Increase the proportion of people with substance use and mental health disorders who get treatment for both |
| MHMD-08  | Increase the proportion of primary care visits where adolescents and adults are screened for depression     |
| MHMD-D01 | Increase the number of children and adolescents with serious emotional disturbance who get treatment        |
| AH-D02   | Increase the proportion of children and adolescents with symptoms of trauma who get treatment               |

### **SHIP 2028 Objectives related to Behavioral Health**

Infrastructure and System Enhancement: Improving the mental health and substance use disorder system's infrastructure to support, expand, and integrate prevention and treatment.

Community-Based Access: Increasing access to age-appropriate, community-based care to decrease reliance on institutionalized treatment settings and reduce unnecessary incarceration.

### **Corrective Actions to reduce the level of indirect contributing factors:**

1. Expand behavioral health services available within Greene County by strengthening partnerships with local hospitals and regional behavioral health providers to bring counseling, assessment, psychiatric, medication-management, and other services closer to residents.
2. Develop a coordinated behavioral health access pathway among GCHD, hospitals, primary care, behavioral health providers, schools, law enforcement, the judicial system, and social-service partners so residents are not left to independently navigate multiple providers and systems.
3. Improve access to immediate and crisis behavioral health care by clearly identifying where residents can receive assessment and stabilization and strengthening communication and follow-up after emergency department, crisis, hospitalization, or law-enforcement involvement.
4. Increase behavioral health services for children, adolescents, and maternal/postpartum populations, specifically addressing service gaps identified through Greene County's assessment and connecting families to regional services when appropriate local care is unavailable.
5. Improve access to psychiatric and medication-management services, including partnerships that allow residents with chronic or serious mental illness to maintain treatment and medication rather than waiting until needs escalate to crisis.
6. Strengthen behavioral health services for the Greene County jail and justice-involved population through appropriate assessment, treatment connections, medication continuity, reentry planning, and coordination among the jail, courts, probation, health care, behavioral health, and community partners.
7. Reduce transportation-related loss of behavioral health care by increasing local and co-located services, coordinating available transportation assistance, and using telehealth when clinically appropriate while recognizing that telehealth alone may not meet the needs of individuals requiring intensive or high-risk care.
8. Increase prevention, early identification, and community education through schools, health care settings, public health, and trusted community partners to address stigma, trauma, misinformation, behavioral health literacy, and recognition of concerns before they become crises.
9. Recruit, share, and retain behavioral health workforce capacity across local and regional organizations, recognizing that Greene County may not independently sustain every specialty needed and will require collaborative provider, co-location, regional, and shared-service models.
10. Use Greene County behavioral health access data to advocate for sustainable rural services, including tracking wait times, unsuccessful referrals, unavailable services, insurance denials/barriers, transportation needs, provider shortages, and populations unable to obtain appropriate care to support funding, reimbursement reform, service development, and rural advocacy.

### **Proposed community organization (s) to provide and coordinate the activities:**

Greene County Health Department will serve as the primary coordinating organization in partnership with Thomas H. Boyd Memorial Hospital, Jersey Community Hospital, behavioral health providers, schools, law enforcement and the judicial system, EMS, CHWs/peer support, ICAN/IRIS, social-service organizations, and state and regional partners. Coordination will focus on strengthening prevention, early identification, referral pathways through IRIS/ICAN, crisis response, treatment access, follow-up, and identification of behavioral health service gaps.

**Evaluation plan to measure progress towards reaching objectives:**

Progress will be evaluated by tracking behavioral health needs identified, successful and unsuccessful service connections, wait times, crisis and medication-management connections, access for identified high-need populations, active providers and referral pathways, service expansions, funding sustainability, and recurring barriers to care. Data and partner feedback will be reviewed annually to identify gaps and guide continued behavioral health system improvements.

# Substance Use Disorder Prevention Priority Plan

## **Health Problem:**

Substance use continues to affect the health and well-being of individuals, families, and communities in Greene County. Although significant progress has been made in expanding prevention, overdose response, peer recovery support, treatment navigation, naloxone access, medications for addiction treatment, and community partnerships, substance use remains a complex and evolving public health concern.

Community assessment findings identified continued concerns related to polysubstance use, alcohol, marijuana, vaping, kratom, and emerging substances, increasingly potent or contaminated substances, misinformation, untreated trauma and behavioral health conditions, and generational patterns of substance use. Residents may also experience difficulty accessing appropriate treatment, specialized providers, sober or supportive housing, transportation, insurance coverage, and long-term recovery supports.

Greene County has developed stronger systems to help individuals enter treatment and recovery; however, successful connection to treatment does not ensure long-term stability or recovery. Housing, employment, transportation, behavioral health treatment, social support, and continued peer connection can significantly influence an individual's ability to maintain recovery.

The 2027–2031 Substance Use Prevention priority will build on Greene County's existing prevention and recovery infrastructure while focusing on preventing emerging substance use, sustainable peer and Community Health Worker services, successful treatment and recovery connections, overdose prevention, supportive housing and basic needs, and long-term recovery stability.

### **Outcome Objective:**

By July 2031, demonstrate improvement in locally monitored substance-use prevention and harm-reduction indicators, including overdose prevention, naloxone distribution, treatment engagement, and emerging substance-use concerns, compared with available baseline data.

By July 2031, increase the percentage of individuals receiving substance-use navigation or peer/CHW services who successfully connect to evidence-based substance use treatment, medications for addiction treatment, peer recovery support, behavioral health care, or other identified recovery services, compared with the standardized baseline established during implementation.

By July 2031, increase access to housing, transportation, employment, health care, and other supports that

### **Impact Objective:**

#### **Objective 1 – Sustain the recovery support system**

By January 2028, establish and maintain a standardized, coordinated substance use prevention and recovery-support system that provides prevention, peer/CHW support, individualized navigation, overdose prevention, treatment connection, follow-up, and ongoing recovery support.

#### **Objective 2 – Strengthen recovery stability**

By July 2029, establish or strengthen at least three coordinated resource pathways addressing housing, behavioral health care, transportation, employment, treatment, or other identified barriers affecting treatment engagement and recovery stability.

contribute to treatment engagement and long-term recovery stability.

By July 2031, increase successful connections among individuals receiving substance-use navigation or peer/CHW services to identified housing, transportation, employment, health care, and other resources that support treatment engagement and recovery stability, compared with the standardized baseline established during implementation.

By July 2031, maintain and strengthen peer recovery and CHW-based support services as a sustainable component of Greene County's substance-use response.

Baseline: 2025 Recovery supported service appointments 5710, Transportation access support 594, Alcohol substance of concern 77, Methamphetamine substance of concern 345, Opioid Substance of concern 118, Crisis support 14, Jail visits 105, field visits 36, resource navigation for clients 575, MAR Support 32, Connection to treatment 26, Connection to housing 18, connection to resource goal 109.

**Key Measurements:**

- Individuals receiving peer/CHW recovery support
- Individualized recovery/resource goals established.
- Successful and unsuccessful treatment connections
- Medications for addiction treatment (MAR/MOUD) connections
- Behavioral health connections
- Housing and supportive/sober housing connections.
- Transportation, employment, benefits, and other recovery-resource connections
- Individualized goal achievement
- Continued engagement/follow-up after treatment or justice-system release
- Naloxone distributed and overdose-prevention education provided
- Overdose and overdose-fatality trends
- Emerging substance-use trends identified
- Prevention and community education activities
- Justice-involved individuals connected to treatment/recovery services
- Peer/CHW workforce trained and retained
- Sustainable reimbursement/funding mechanisms developed

**Objective 3 – Make peer/CHW services sustainable**

By July 2030, maintain a trained peer recovery/Community Health Worker workforce and implement at least one sustainable reimbursement, funding, contractual, partnership, or service-delivery mechanism to support continued recovery services in Greene County.

**Objective 4 – Demonstrate improved outcomes**

By July 2031, demonstrate an increase from the standardized baseline in the percentage of individuals receiving substance-use navigation or peer/CHW services who successfully connect to treatment, recovery, housing, behavioral health, or other identified recovery goals and maintain engagement with appropriate supports when follow-up is available.

**Risk Factors:**

1. Substance use disorder and progression of substance use, including opioid, stimulant, alcohol, marijuana, polysubstance, and emerging substance use
2. Housing, economic, and social instability, including homelessness/housing insecurity, unemployment, transportation barriers, and limited recovery-support networks
3. Co-occurring behavioral health conditions and untreated trauma, which may contribute to substance use, recurrence of use, and difficulty maintaining recovery
4. Overdose, poisoning, and substance-related death, including risks associated with increasingly potent, contaminated, or combined substances
5. Youth, family, and generational substance-use risk, including vaping, alcohol, marijuana, misinformation, family/community exposure, and normalization of substance use

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| <ul style="list-style-type: none"> <li>• Recurring treatment, housing, and recovery-system gaps identified</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <p><b><u>Contributing Factors (direct (D) &amp; indirect (I):</u></b></p> <p><b>Limited Stable Housing &amp; Recovery Environment (D)</b></p> <p>(I) Limited affordable housing and rental availability or sober/supportive living<br/> (I) Financial instability and unemployment<br/> (I) Returning to environments where substance use is present or normalized</p> <p><b>Behavioral Health &amp; Trauma Needs (D)</b></p> <p>(I) Limited access to timely behavioral health treatment-untreated trauma<br/> (I) Substance use as a means of coping with behavioral health symptoms<br/> (I) Limited continuity between behavioral health, general practitioners, and substance-use treatment</p> <p><b>Limited Treatment &amp; Recovery Service Availability (D)</b></p> <p>(I) Lack of local residential treatment and sober-living facilities<br/> (I) Geographic distance to specialized treatment<br/> (I) Rural provider/workforce shortages</p> <p><b>Changing Substance Use &amp; Misinformation (D)</b></p> <p>(I) Polysubstance use and changing drug supply<br/> (I) Increasing potency of some substances<br/> (I) Emerging substances such as kratom and changing patterns of use</p> <p><b>Generational, Social &amp; Community Influences (D)</b></p> <p>(I) Substance use within family or social networks<br/> (I) Stigma associated with substance use disorder and treatment<br/> (I) Small-community social connections that may make changing environments difficult<br/> (I) Normalization of alcohol, marijuana, vaping, or other substance use<br/> (I) Limited positive social/recovery networks for some individuals</p> <p><b>Difficulty Maintaining Long-Term Recovery Supports (D)</b></p> | <p><b><u>Proven Intervention Strategy:</u></b></p> <ul style="list-style-type: none"> <li>• Maintain and strengthen peer recovery and CHW-based services that provide individualized, person-centered support before, during, and after treatment.</li> <li>• Integrate peer recovery and Community Health Worker competencies to provide broader assistance with treatment, health care, housing, transportation, employment, benefits, behavioral health, and other recovery needs.</li> <li>• Provide active treatment navigation, warm connections, follow-up, and continued engagement rather than referral alone.</li> <li>• Increase successful connections to evidence-based treatment and medications for addiction treatment.</li> <li>• Maintain naloxone distribution, overdose-prevention education, harm-reduction strategies, and connections to appropriate treatment and recovery services.</li> <li>• Strengthen prevention and education regarding alcohol, marijuana, vaping, opioids, stimulants, polysubstance use, emerging substances, and changes in the illicit drug supply.</li> <li>• Provide accurate, evidence-based information to counter misinformation regarding substances, treatment, medications for addiction treatment, and recovery.</li> <li>• Strengthen connections between substance-use treatment and behavioral health services to address trauma, mental health, and co-occurring conditions.</li> <li>• Develop stronger pathways to stable housing and pursue partnerships and funding opportunities for sober, supportive, transitional, and other appropriate housing options.</li> <li>• Assist individuals with employment, transportation, identification, benefits, health care, and other social drivers that influence recovery stability.</li> <li>• Strengthen recovery support and treatment connections for individuals involved with the Greene County jail, courts, probation, and other justice systems, including transition and follow-up after release.</li> <li>• Continue Overdose Fatality Review and use findings to identify system gaps and opportunities for prevention and intervention.</li> </ul> |

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| <p>(I) Grant-dependent peer/recovery programs</p> <p>(I) Limited reimbursement mechanisms for peer and CHW services</p> <p>(I) Transportation and geographic barriers</p> <p>(I) Fragmentation between treatment, recovery, behavioral health, health care, and social services</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <ul style="list-style-type: none"> <li>• Strengthen coordination among health care, EMS, law enforcement, judicial partners, behavioral health, treatment providers, peer recovery, and community organizations.</li> <li>• Track successful and unsuccessful treatment, housing, behavioral health, and recovery-resource connections to identify barriers and unmet community needs.</li> <li>• Track individualized recovery goals and longer-term engagement with treatment and recovery supports.</li> <li>• Strengthen the peer/CHW workforce through training, certification, supervision, professional development, and appropriate integration into health and community systems.</li> <li>• Pursue Medicaid and other reimbursement, grants, contracts, hospital/community partnerships, and sustainable funding mechanisms for peer and CHW recovery services.</li> <li>• Utilize local data, Overdose Fatality Review findings, navigation outcomes, and community experience to advocate for treatment, housing, workforce, and sustainable rural recovery infrastructure.</li> </ul>                                                                                                               |
| <p><b>Resources Available:</b></p> <p>AL anon/Alcoholics Anonymous/Wells Center<br/>Hobby Horse and Bright Futures Parenting Programs<br/>Greene County Health Department peer recovery and Community Health Worker staff<br/>Greene County ROSC and recovery-support partnerships<br/>Recovery Corps and other recovery workforce partnerships<br/>Greene County Overdose Fatality Review Team<br/>Greene County Sheriff's Office and Jail<br/>Local police departments<br/>Greene County judicial system, probation, State's Attorney, and Public Defender<br/>Thomas H. Boyd Memorial Hospital/Boyd Healthcare Services<br/>Jersey Community Hospital<br/>Local and regional medication-for-addiction-treatment providers<br/>Regional substance-use treatment providers<br/>EMS and emergency response partners<br/>Naloxone and harm-reduction resources<br/>Illinois Department of Human Services<br/>Illinois Department of Public Health<br/>Illinois Public Health Association<br/>Community Health Worker training and workforce-development resources<br/>Local housing, food, transportation, employment, and social-service resources</p> | <p><b>Barriers:</b></p> <ul style="list-style-type: none"> <li>• Lack of local sober, supportive, transitional, and affordable housing</li> <li>• Limited residential and specialized substance-use treatment within Greene County</li> <li>• Transportation and distance to treatment and recovery services</li> <li>• Behavioral health provider shortages and limited co-occurring treatment</li> <li>• Insurance eligibility, authorization, reimbursement, and treatment limitations</li> <li>• Dependence on short-term grants to sustain peer and recovery-support positions \</li> <li>• Developing reimbursement systems for peer and CHW services</li> <li>• Workforce recruitment, retention, training, certification, and supervision requirements</li> <li>• Limited rural service volume and funding needed to sustain specialized programs</li> <li>• Stigma and misinformation regarding substance use disorder, medications for addiction treatment, harm reduction, and recovery</li> <li>• Changing drug-use patterns and emerging substances</li> <li>• Difficulty maintaining recovery when individuals return to unstable housing or environments where substance use continues</li> </ul> |

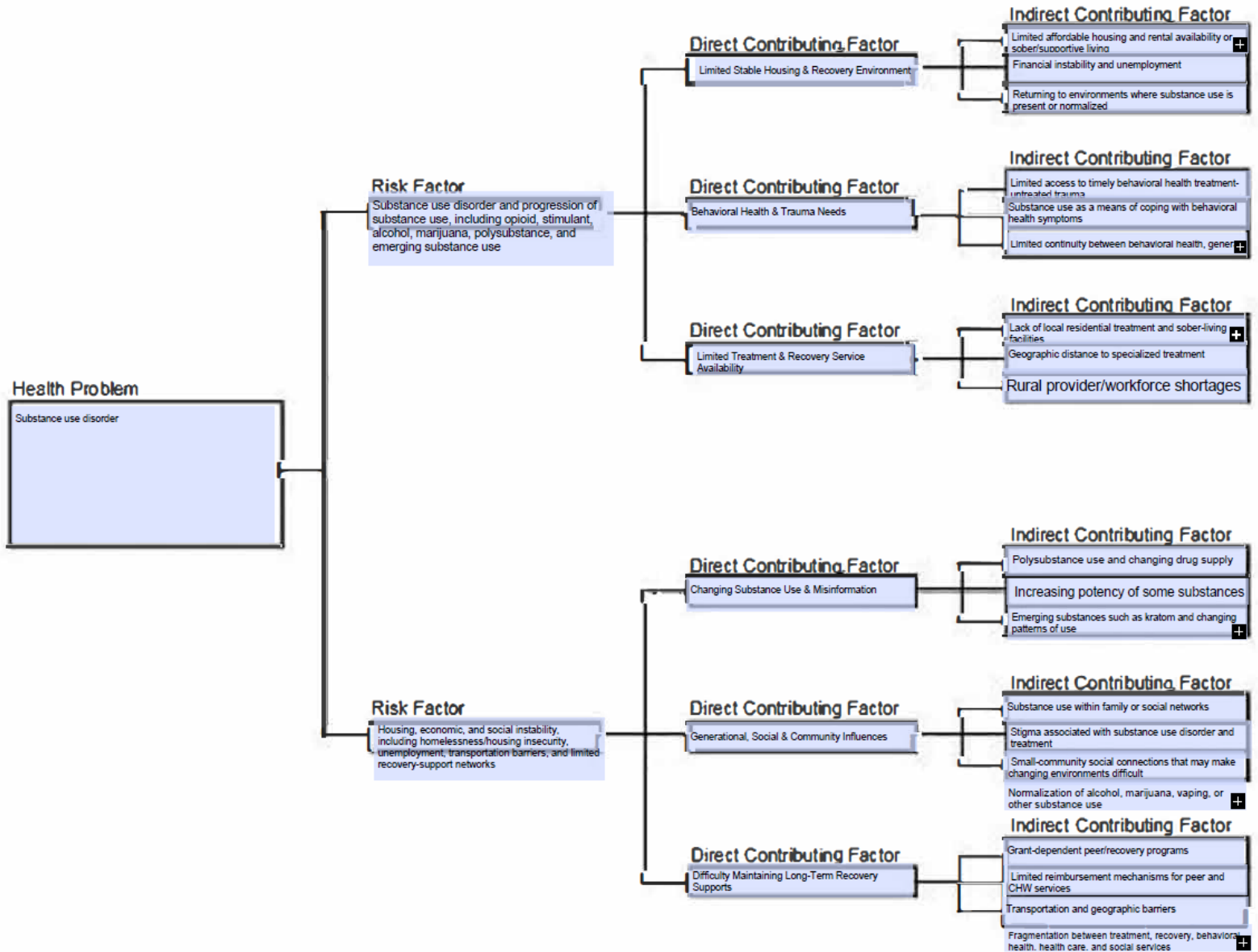
|                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>ICAN/IRIS and other coordinated referral partnerships<br/>Schools, community organizations, faith-based organizations, and other prevention partners</p> | <ul style="list-style-type: none"> <li>• Employment, transportation, food, financial, and other basic-needs instability</li> <li>• Fragmentation between treatment, behavioral health, health care, justice, housing, and social-service systems</li> <li>• Limited ability of one rural organization or county to independently maintain the full continuum of substance-use treatment and recovery services</li> </ul> |
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**Public Awareness & Health Education:** GCHD and partners will provide community education and outreach regarding substance-use prevention, emerging substances, overdose prevention, naloxone, treatment/MAR, peer recovery services, behavioral health, recovery resources and stigma reduction through schools, community organizations, health care, ROSC, public safety partners, social media, events, and direct outreach.

**Estimated Funding Needs:** Personnel/CHW/Peer Support salaries and benefits, training and certification, EMR/CDP and referral-system costs, transportation/resource assistance, outreach/education, and program administration. Funding needs will vary annually based on staffing and reimbursement development.

**Anticipated Funding Sources:** GCHD operating funds, Medicaid/insurance reimbursement as available, IDPH/IPHA opportunities, federal/state grants, hospital/community-benefit partnerships, contracts, foundations, and other public/private funding opportunities.

## HEALTH PROBLEM ANALYSIS WORKSHEET



## Substance Use Disorder Prevention Community Health Plan

### **Description of the health problem, risk factors, and contributing factors (including high-risk populations, and current and projected statistical trends.)**

Substance use continues to impact individuals, families, and community systems in Greene County despite significant progress in prevention, treatment connections, overdose prevention, and peer recovery support. Changing substance-use patterns, polysubstance use, overdose risk, untreated behavioral health and trauma needs, limited treatment and recovery housing, and barriers to long-term recovery remain concerns. Continued prevention efforts are needed while strengthening sustainable peer/CHW support, treatment and behavioral health connections, housing, and other resources that help individuals achieve and maintain recovery.

Continued decrease in trends is desired to see a comparison of 2014 data, 2020, and current 2026 data available.

**2014 Substance Use Rates by Grade**

| Substance Used                                                                | 10th Grade | 12th Grade |
|-------------------------------------------------------------------------------|------------|------------|
| <b>Used Past Year</b>                                                         |            |            |
| <b>Any Substance (including alcohol, cigarettes, inhalants, or marijuana)</b> | <b>53%</b> | <b>52%</b> |
| Alcohol                                                                       | 51%        | 51%        |
| Cigarettes                                                                    | 11%        | 31%        |
| Inhalants                                                                     | 4%         | 3%         |
| Marijuana                                                                     | 11%        | 21%        |
| <b>Any Illicit Drugs (Excluding Marijuana)</b>                                | <b>5%</b>  | <b>7%</b>  |
| Crack/Cocaine                                                                 | 4%         | 1%         |
| Hallucinogens/LSD                                                             | 4%         | 3%         |
| Ecstasy/MDMA                                                                  | 2%         | 3%         |
| Methamphetamine                                                               | 2%         | 1%         |
| Heroin                                                                        | 2%         | 3%         |
| <b>Any Prescription Drugs to get high</b>                                     | <b>5%</b>  | <b>6%</b>  |
| Steroids                                                                      | 4%         | 3%         |
| Prescription Painkillers                                                      | 2%         | 6%         |
| Other Prescription Drugs                                                      | 2%         | 3%         |
| Prescription drugs not prescribed to you                                      | 14%        | 7%         |
| Over-the-Counter Drugs                                                        | 2%         | 4%         |

## (2) Drug Prevalence and Behaviors

### 2020 Substance Use Rates by Grade - Part 1 of 3

| Substance Used                                                                                                                                       | 8th Grade | 10th Grade |
|------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|------------|
| <b>Used Past Year</b>                                                                                                                                |           |            |
| Any common substance (including alcohol, cigarettes, inhalants or marijuana) Comparable to 2018                                                      | 41%       | 43%        |
| Any common substances plus vaping (including alcohol, tobacco products, cigarettes, e-cigarettes or other vaping products, inhalants, or marijuana)* | 41%       | 44%        |
| Alcohol                                                                                                                                              | 39%       | 48%        |
| Cigarettes                                                                                                                                           | 5%        | 9%         |
| E-cigarettes or other vaping products**                                                                                                              | 17%       | 27%        |
| Any Tobacco Product (including smokeless tobacco, tobacco smoked through cigarettes or cigars/cigarillos, or tobacco used in a hookah water pipe)**  | 6%        | 19%        |
| Inhalants                                                                                                                                            | 6%        | 2%         |
| Marijuana                                                                                                                                            | 11%       | 18%        |
| Synthetic marijuana**                                                                                                                                | 2%        | 0%         |
| Alcohol and marijuana at the same time**                                                                                                             | 5%        | 10%        |
| Alcohol and energy drinks at the same time**                                                                                                         | 2%        | 11%        |
| <b>Any Illicit Drugs (excluding marijuana)</b>                                                                                                       | 0%        | 3%         |
| Crack/Cocaine                                                                                                                                        | 0%        | 2%         |
| Hallucinogens/LSD                                                                                                                                    | 0%        | 0%         |
| Ecstasy/MDMA                                                                                                                                         | 0%        | 2%         |
| Methamphetamine                                                                                                                                      | 0%        | 0%         |
| Heroin                                                                                                                                               | 0%        | 2%         |
| <b>Any Prescription Drugs to get high</b>                                                                                                            | 2%        | 2%         |
| Prescription Painkillers                                                                                                                             | 0%        | 2%         |
| Other Prescription Drugs                                                                                                                             | 2%        | 2%         |
| Prescription <b>pain medicine</b> without prescription or differently than prescribed                                                                | 8%        | 2%         |
| Prescription drugs not prescribed to you                                                                                                             | 5%        | 3%         |
| Over-the-Counter Drugs                                                                                                                               | 3%        | 2%         |
| <b># of Respondents</b>                                                                                                                              | <b>66</b> | <b>69</b>  |

\*New calculated variable in 2020

\*\*New question added in 2020

\*\*\*In 2020 wording changed from "electronic cigarette" to "e-cigarette or other vaping product". Note that in 2020, questions about tobacco products were separated from e-cigarettes and other vaping products throughout the survey

## (2) Drug Prevalence and Behaviors

### 2026 Substance Use Rates by Grade - Part 1 of 3

| Substance Used                                                                                                                                    | 8th Grade  | 10th Grade | 12th Grade |
|---------------------------------------------------------------------------------------------------------------------------------------------------|------------|------------|------------|
| <b>Used Past Year</b>                                                                                                                             |            |            |            |
| Any common substance (including alcohol, inhalants or marijuana)                                                                                  | 20%        | 31%        | 39%        |
| Any common substances plus vaping (including alcohol, tobacco products, e-cigarettes or other vaping products, inhalants, or marijuana)           | 21%        | 33%        | 41%        |
| Alcohol                                                                                                                                           | 19%        | 30%        | 37%        |
| E-cigarettes or other vaping products                                                                                                             | 10%        | 18%        | 16%        |
| Any Tobacco Product (including smokeless tobacco, tobacco smoked through cigarettes or cigars/cigarillos, or tobacco used in a hookah water pipe) | 7%         | 12%        | 5%         |
| Inhalants                                                                                                                                         | 3%         | 2%         | 0%         |
| Marijuana                                                                                                                                         | 7%         | 16%        | 9%         |
| Synthetic marijuana                                                                                                                               | 3%         | 1%         | 0%         |
| Alcohol and marijuana at the same time                                                                                                            | 3%         | 14%        | 5%         |
| Alcohol and energy drinks at the same time                                                                                                        | 5%         | 7%         | 12%        |
| <b>Any Illicit Drugs (excluding marijuana)</b>                                                                                                    | 0%         | 2%         | 0%         |
| Crack/Cocaine                                                                                                                                     | 0%         | 1%         | 0%         |
| Hallucinogens/LSD                                                                                                                                 | 0%         | 1%         | 0%         |
| Ecstasy/MDMA                                                                                                                                      | 0%         | 0%         | 0%         |
| Methamphetamine                                                                                                                                   | 0%         | 0%         | 0%         |
| Heroin                                                                                                                                            | 0%         | 0%         | 0%         |
| <b>Any Prescription Drugs to get high</b>                                                                                                         | 2%         | 1%         | 0%         |
| Prescription Painkillers                                                                                                                          | 2%         | 1%         | 0%         |
| Other Prescription Drugs                                                                                                                          | 1%         | 0%         | 0%         |
| Prescription pain medicine without prescription or differently than prescribed                                                                    | 4%         | 0%         | 0%         |
| Prescription drugs not prescribed to you                                                                                                          | 2%         | 1%         | 4%         |
| Over-the-Counter Drugs                                                                                                                            | 2%         | 0%         | 0%         |
| <b># of Respondents</b>                                                                                                                           | <b>107</b> | <b>85</b>  | <b>83</b>  |

## Healthy People 2030 Objectives related to Substance Use Disorder Prevention

|         |                                                                                                             |
|---------|-------------------------------------------------------------------------------------------------------------|
| SU-01   | Increase the proportion of adolescents who think substance abuse is risky                                   |
| SU-03   | Reduce drug overdose deaths                                                                                 |
| SU-04   | Reduce adolescent alcohol use.                                                                              |
| SU-06   | Reduce adolescent marijuana use.                                                                            |
| SU-12   | Reduce the proportion of people who misused prescription drugs in the past year                             |
| IVP-20  | Reduce overdose deaths involving opioids                                                                    |
| MHMD-07 | Increase the proportion of people with substance use and mental health disorders who get treatment for both |

## SHIP 2028 Objectives related to Substance Use Disorder Prevention

Key objectives under Healthy Illinois 2028 aimed at substance use prevention focus on enhancing system infrastructure, reducing mortality through harm reduction, increasing community-based care, and fostering resilience in communities affected by violence. These strategies aim to address the root causes and impacts of substance misuse across the state.

### **Corrective Actions to reduce the level of indirect contributing factors:**

1. Maintain and strengthen peer/CHW recovery support, including sustainable reimbursement and funding so established recovery services are not lost when grant funding ends.
2. Increase successful connections to evidence-based treatment and MAR/MOUD, with active peer/CHW follow-up before, during, and after treatment.
3. Strengthen housing and recovery-stability supports, including development of partnerships and funding opportunities for sober, supportive, transitional, and affordable housing.
4. Maintain overdose-prevention and naloxone efforts while using Overdose Fatality Review findings to identify preventable gaps in Greene County's response system.
5. Strengthen behavioral health and trauma connections for individuals with substance use and co-occurring mental health needs.
6. Improve continuity following jail release, emergency care, treatment, or crisis, coordinating peers/CHWs, hospitals, judicial partners, treatment providers, and community resources.
7. Expand youth and community prevention education addressing vaping, alcohol, marijuana, polysubstance use, kratom, emerging substances, drug potency/contamination, and misinformation.
8. Track unsuccessful treatment, housing, behavioral health, and recovery connections and use those findings to address rural service gaps, pursue funding, and advocate for sustainable services.

### **Proposed community organization (s) to provide and coordinate the activities:**

Greene County Health Department (GCHD) will serve as the primary coordinating public health organization for Substance Use Prevention activities in collaboration with the Greene and Scott Recovery-Oriented System of Care (ROSC) Council, peer recovery/Community Health Worker staff, Greene County Overdose Fatality

Review/Overdose Response Team, Greene County Drug Court team, Greene County Sheriff's Office and Jail, local law enforcement, Greene County judicial partners, Coroner, EMS, hospitals, behavioral health and substance-use treatment providers, schools, and other community and social-service partners. The existing Greene and Scott ROSC is housed through GCHD and is specifically focused on strengthening recovery connections, reducing stigma, education, and improving recovery outcomes.

Current coordinated activities:

- GCHD/Peer Recovery & CHW Team: Coordinate prevention, peer support, individualized navigation, naloxone distribution, treatment and MAR/MOUD connections, behavioral health connections, housing/resource navigation, follow-up, and recovery-support services.
- Greene and Scott ROSC Council: Maintain the broader recovery-oriented community network, strengthen community partnerships, reduce stigma, provide education, identify service gaps, and engage individuals with lived experience in improving the local recovery system.
- Overdose Fatality Review/Overdose Response Team: Review overdose deaths and available local information to identify missed prevention opportunities, system gaps, emerging concerns, and recommendations for community action. This follows Illinois' OFR model of bringing public health, law enforcement, medical/coroner, health care, and community partners together to identify preventable system failures.
- Greene County Drug Court Team: Coordinate treatment, recovery support, judicial supervision, peer/CHW navigation, behavioral health services, and community-resource connections for justice-involved individuals while supporting recovery and reducing recurrence of substance-related justice involvement.
- Greene County Sheriff's Office/Jail, law enforcement, courts and probation: Strengthen screening, MAR/MOUD and treatment connections, overdose prevention, naloxone access, peer engagement, discharge/reentry planning, and continuity of services following release. Illinois has specifically identified medication-assisted recovery in county jails as an important strategy for a population at elevated overdose risk, and we have been working directly with partners to make this happen, including MARNow.
- Thomas H. Boyd Memorial Hospital and Jersey Community Hospital: Strengthen emergency-department and health-care referral pathways, overdose follow-up, naloxone access, treatment/MAR connections, behavioral health coordination, and connections to peer/CHW services. Continued support and promotion is needed.
- Treatment & Behavioral Health Providers: Provide evidence-based substance-use treatment, medications for addiction treatment, counseling, psychiatric/behavioral health services, and coordinated care for individuals with co-occurring conditions.
- Schools & Community Partners: Strengthen prevention and education addressing vaping, alcohol, marijuana, opioids, polysubstance use, emerging substances, overdose risk, misinformation, stigma, and early identification.

- Housing, employment, transportation & social-service partners: Address the conditions that can interfere with treatment engagement and sustained recovery, with particular emphasis during this IPLAN cycle on stable, supportive, sober, transitional, and affordable housing options.
- State and Regional Partners: Work with IDPH, IDHS and other technical-assistance/funding partners to strengthen overdose prevention, workforce development, treatment/recovery connections, data use, and sustainable funding. Illinois' statewide overdose strategy similarly emphasizes collaboration among health care, local agencies, law enforcement, community organizations, and other partners.

### **Evaluation plan to measure progress towards reaching objectives:**

1. Track the number of individuals receiving peer recovery and CHW support services and the type and frequency of services provided.
2. Monitor successful and unsuccessful connections to substance use treatment, MAR/MOUD, behavioral health services, housing, transportation, employment, benefits, and other recovery resources.
3. Measure individualized goal achievement and continued engagement with treatment and recovery supports when follow-up data are available.
4. Track housing needs and successful housing connections, including barriers related to sober, supportive, transitional, and affordable housing.
5. Monitor naloxone distribution, overdose-prevention activities, overdose trends, and overdose fatalities using available local and state data.
6. Utilize Overdose Fatality Review findings to identify recurring system gaps and document implementation of recommended prevention or system improvements.
7. Track justice-involved individuals connected to treatment, MAR/MOUD, peer support, and community resources, including post-release follow-up when feasible.
8. Monitor youth and community prevention activities and emerging concerns related to vaping, alcohol, marijuana, polysubstance use, kratom, and other changing substance-use trends.
9. Evaluate peer/CHW workforce sustainability, including staff training/certification, retention, reimbursement, grants, contracts, and other sustainable funding mechanisms.
10. Review data at least annually with community partners to assess progress, identify emerging needs and service gaps, modify strategies, and determine priorities for funding and systems advocacy.

# Rural Community Infrastructure & Sustainability Priority Plan

## **Health Problem:**

Greene County's rural population depends on a limited number of health care, public health, emergency response, public safety, social service, food, housing, childcare, transportation, and other community systems to meet essential needs. Aging facilities, limited workforce availability, rural geography, funding constraints, competitive wages in larger communities, transportation barriers, and increasing service and regulatory requirements can threaten the long-term sustainability and accessibility of these services.

Community Survey findings, focus-group discussions, and leadership input identified concerns related to transportation, childcare, employment, housing, food access, health care, behavioral health, workforce shortages, funding limitations, aging buildings and community spaces, and the ability of rural organizations to meet increasing expectations with limited resources. Participants emphasized that loss or reduction of essential services can affect not only access to care, but also employment, economic stability, emergency response, community safety, and overall quality of life.

Rural Community Infrastructure & Sustainability therefore focuses on strengthening the people, places, systems, funding, partnerships, and environmental conditions necessary to maintain essential services and support a healthy, safe, and sustainable Greene County.

### **Outcome Objective:**

By July 2031, strengthen Greene County's ability to maintain accessible essential health, public safety, social service, transportation, food, housing, childcare, and community resources necessary to support population health.

By July 2031, improve the sustainability and accessibility of rural community infrastructure, including facilities, workforce, transportation, environmental conditions, and systems supporting health and safety.

By July 2031, strengthen the recruitment, retention, and sustainability of the workforce needed to maintain essential rural services, including health care, public health, emergency response, public safety, education, and other community services.

By July 2031, increase coordinated planning, funding, and advocacy efforts that support long-term rural infrastructure and service sustainability in Greene County.

**Baseline:** The 2026 Community Survey, three focus groups, leadership discussions, statistical data, and

### **Impact Objective:**

#### **Objective 1 – Strengthen coordinated rural infrastructure planning**

By January 2028, establish and maintain a coordinated process among community leaders and organizations to identify, prioritize, track, and address infrastructure, workforce, service, and sustainability needs affecting the health and safety of Greene County residents.

#### **Objective 2 – Support essential service and workforce sustainability**

By July 2029, establish or expand at least three partnerships, workforce strategies, shared-service models, or funding initiatives addressing identified workforce or essential-service sustainability needs in Greene County.

#### **Objective 3 – Improve physical and environmental infrastructure**

By July 2030, advance at least three identified physical or environmental infrastructure priorities through documented planning, funding applications, resource

organizational assessment identified transportation, childcare, employment, housing, food access, health and behavioral health services, workforce shortages, funding limitations, aging facilities, and long-term sustainability as interconnected community concerns. Current data regarding population decline, transportation, housing, workforce, broadband, food insecurity, and environmental conditions provide additional baseline indicators. Additional infrastructure and service-capacity measures will be established during implementation where standardized local data are not currently available.

During 2027, GCHD and community partners will establish standardized measures for identified infrastructure/service needs, actions taken, workforce initiatives, funding pursued and secured, services maintained or expanded, and systems improvements to provide a baseline for measuring progress through 2031.

#### **Key Measurements:**

- Infrastructure and sustainability needs identified
- Essential services maintained, expanded, or restored
- Workforce vacancies and recruitment/retention concerns identified
- Workforce development or shared-service strategies implemented
- Funding applications submitted and funding secured
- Capital/facility improvement projects supported
- Community facilities assessed for accessibility, safety, or service needs
- Transportation barriers and solutions identified
- Housing, childcare, food-access, and other infrastructure gaps documented
- Environmental health/code-enforcement concerns identified and addressed
- Active community and regional partners participating
- Cross-sector planning meetings and collaborative projects
- New or expanded service partnerships
- Policy or systems changes resulting from community advocacy
- Infrastructure needs incorporated into local, regional, or state funding initiatives
- Community Health Navigation data used to identify recurring infrastructure gaps
- Population, housing, transportation, workforce, broadband, and other community-condition indicators monitored over time

development, partnership action, facility/community improvement, or policy and systems change.

#### **Objective 4 – Demonstrate systems improvement**

By July 2031, demonstrate measurable progress on at least five identified rural infrastructure and sustainability priorities through funding secured, policy or systems improvements, services maintained or expanded, facility or environmental improvements, workforce initiatives, or other documented community actions.

Partnerships already developed align with collected and advancing this work as a more coordinated approach. Advocacy breakfasts and leadership gatherings were initiated in 2026.

#### **Risk Factors:**

1. Loss or reduced availability of essential health and community services, including health care, public health, emergency response, public safety, behavioral health, and social services
2. Economic and workforce instability, including workforce shortages, unemployment, loss of local jobs, and inability to recruit or retain essential personnel
3. Transportation and geographic isolation, affecting access to health care, food, employment, education, treatment, and community resources
4. Housing and environmental health risks, including aging housing/buildings, unsafe conditions, limited affordable housing, accessibility concerns, and environmental hazards
5. Food, childcare, and basic-needs instability, which can affect employment, family stability, health care access, and overall health

### **Contributing Factors (direct (D) & indirect (I):**

#### **Aging & Inadequate Physical Infrastructure (D)**

- (I) Aging hospitals, public health, fire, police, and other community facilities
- (I) Increasing accessibility, safety, technology, and regulatory requirements
- (I) Limited capital funding available for rural facility replacement or renovation
- (I) Smaller population and tax base available to support infrastructure
- (I) Deferred maintenance due to competing operational needs

#### **Rural Workforce Shortages (D)**

- (I) Wage competition with larger and better-funded communities
- (I) Limited local workforce pool
- (I) Difficulty recruiting nurses, behavioral health professionals, EMS, police, fire, educators, public health staff, and other essential workers
- (I) Limited advancement or specialty opportunities in rural settings
- (I) Employees performing multiple roles because of limited staffing

#### **Limited & Unsustainable Funding (D)**

- (I) Small population and limited local revenue
- (I) Tax caps and limited community financial capacity
- (I) Dependence on short-term grants
- (I) Funding formulas that may favor larger population centers
- (I) Increasing operating, wage, insurance, equipment, and construction costs

#### **Transportation & Geographic Barriers (D)**

- (I) Long distances between communities and services
- (I) Limited public or rural transportation options
- (I) Dependence on personal vehicles
- (I) Fuel, vehicle, and transportation costs

#### **Limited Housing, Childcare & Basic Community Resources (D)**

- (I) Limited affordable rental and housing stock
- (I) Limited childcare centers and available childcare providers
- (I) Limited supportive, transitional, shelter, or specialized housing

### **Proven Intervention Strategy:**

- Establish a coordinated rural infrastructure and sustainability planning process involving health care, public health, public safety, local government, schools, economic development, businesses, and community organizations.
- Identify and maintain a prioritized inventory of community infrastructure, workforce, facility, transportation, housing, childcare, environmental, and essential-service needs.
- Utilize community data, leadership input, navigation data, and partner experience to identify services and infrastructure at greatest risk of loss or inadequate capacity.
- Support collaborative funding applications, capital-development opportunities, grants, public-private partnerships, and other financing strategies for rural infrastructure improvements.
- Advocate for state and federal funding formulas, reimbursement structures, and policies that recognize the cost and importance of maintaining essential services in rural communities.
- Strengthen regional and shared-service partnerships when Greene County cannot independently sustain a specialized workforce or service.
- Support recruitment and retention strategies for nurses, behavioral health professionals, EMS, fire, police, public health, educators, and other essential rural workers.
- Explore workforce pipelines, internships, training partnerships, scholarships, local recruitment, shared staffing, and other strategies that encourage residents and professionals to work in rural communities.
- Support facility planning and improvements that increase accessibility, safety, efficiency, privacy, and the ability to provide modern health and community services.
- Strengthen transportation coordination and pursue solutions that improve access to employment, health care, behavioral health, food, treatment, education, and other resources.
- Support development and preservation of affordable, safe, supportive, transitional, and accessible housing.
- Support childcare development and partnerships that allow parents and caregivers to participate in employment, health care, treatment, and community life.

(I) Limited grocery/food retail sustainability in low-population communities  
 (I) Economic conditions affecting business and service viability

### **Increasing Rural Service Expectations & Regulatory Requirements (D)**

(I) State and federal requirements designed for larger systems or facilities  
 (I) Limited rural staff available to meet administrative and compliance demands  
 (I) Costs of maintaining technology, equipment, training, licensure, and facilities  
 (I) Limited ability to spread operational costs across a large population  
 (I) Difficulty maintaining services that may be essential but financially unprofitable

### **Environmental & Built-Environment Conditions (D)**

(I) Aging housing and building stock  
 (I) Limited local code-enforcement capacity  
 (I) Sidewalk, park, accessibility, and community-space maintenance needs  
 (I) Environmental hazards such as radon, lead and other housing-related risks  
 (I) Limited funding for prevention, remediation, and community improvements

- Support local food-access and community food-system initiatives that help maintain sustainable access to nutritious food.
- Strengthen environmental health, code-enforcement, healthy-housing, radon, and built-environment initiatives that improve community safety and quality of life.
- Support parks, sidewalks, recreational spaces, accessibility improvements, and other community environments that encourage physical activity and social connection.
- Use unsuccessful Community Health Navigation connections to identify recurring infrastructure and service gaps requiring broader community action.
- Develop local and regional partnerships to maintain essential services when a single rural organization cannot independently support the full cost or workforce required.
- Monitor population, workforce, housing, transportation, food access, environmental, and service-availability trends to identify emerging sustainability concerns.
- Utilize identified needs and community data to support advocacy, funding requests, policy development, and efforts to champion rural community systems change.

### **Resources Available:**

Greene County Health Department  
 Greene County Board of Health  
 Greene County government and elected officials  
 Municipal governments and village/city leadership  
 Thomas H. Boyd Memorial Hospital/Boyd Healthcare Services  
 Jersey Community Hospital and regional health systems  
 Greene County EMS and emergency response organizations  
☐ Greene County Sheriff's Office and local police departments  
 Local fire departments and protection districts  
 Greene County school districts  
 Greene County economic and community development partners  
 Local businesses and employers  
 University of Illinois Extension  
 Illinois Department of Public Health  
 Illinois Department of Transportation  
 Illinois Department of Commerce and Economic Opportunity

### **Barriers:**

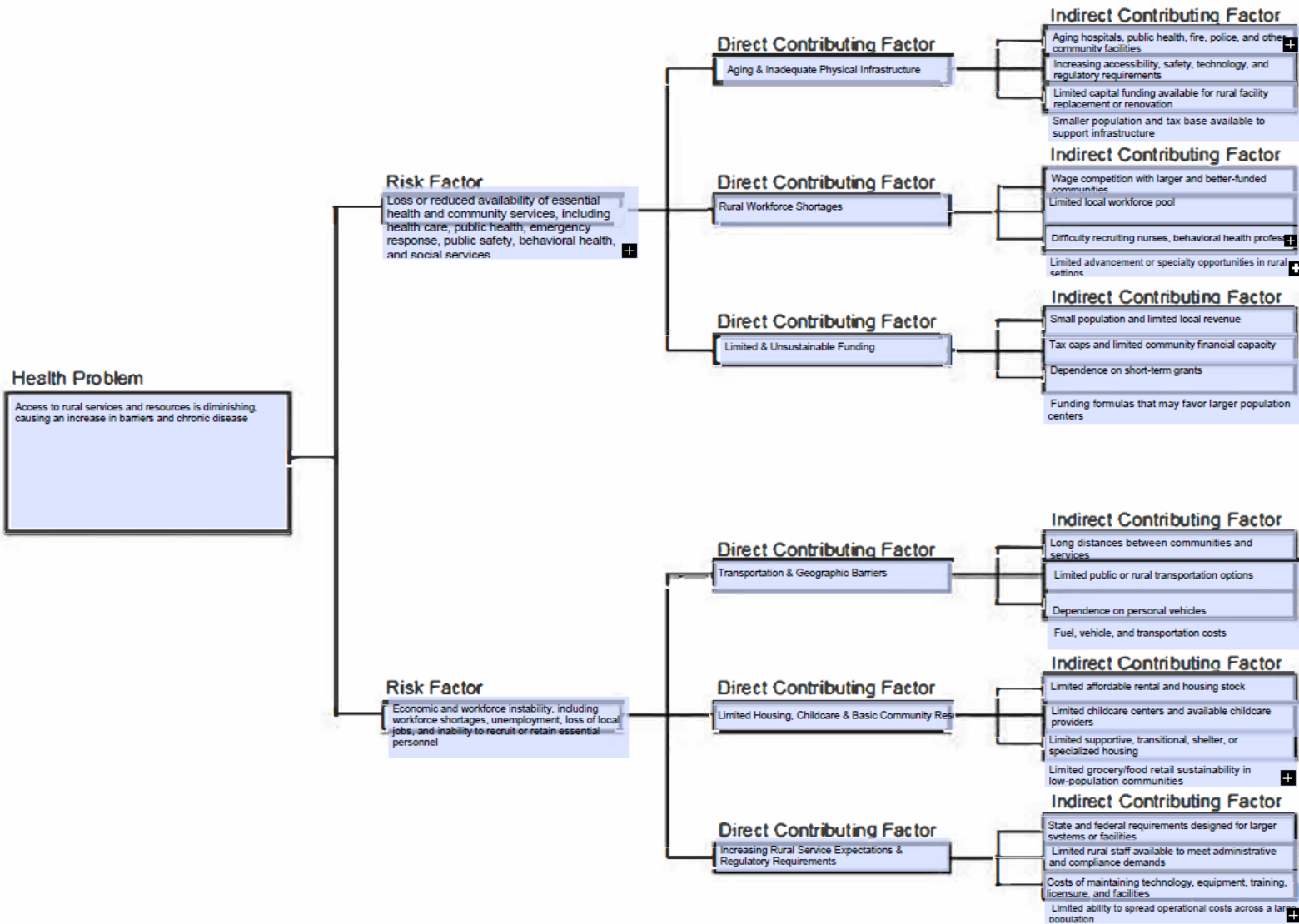
- Declining and dispersed rural population
- Limited local tax base and revenue
- Aging buildings, facilities, equipment, and infrastructure
- High cost of renovation, construction, equipment, and regulatory compliance
- Difficulty recruiting and retaining nurses, behavioral health professionals, EMS, police, firefighters, public health staff, educators, and other essential workers
- Wage competition with larger communities and health systems
- Limited affordable and available housing
- Limited childcare capacity
- Transportation and geographic distance
- Limited food retail and other essential businesses in small population centers
- Dependence on grants and short-term funding
- Funding formulas that may not adequately account for rural service-delivery costs
- Increasing state/federal mandates and administrative requirements

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Illinois Housing Development Authority and housing partners</p> <p>Illinois Public Health Association</p> <p>Regional planning and development organizations</p> <p>Local and regional transportation providers</p> <p>Food banks, food pantries, farmers markets, growers, and food-access partners</p> <p>Housing, childcare, social-service, and community organizations</p> <p>Faith-based and civic organizations</p> <p>Community Health Workers and ICAN/IRIS referral partners</p> <p>State and federal rural-health and infrastructure funding programs</p> <p>Local foundations, private donors, businesses, and philanthropic partners</p> | <ul style="list-style-type: none"> <li>• Limited staff time and capacity within rural organizations</li> <li>• Difficulty maintaining financially unprofitable but essential services</li> <li>• Fragmentation among agencies, jurisdictions, and funding systems</li> <li>• Limited code-enforcement and environmental-health capacity</li> <li>• Resistance to regional or shared-service approaches when local identity or jurisdictional boundaries create barriers</li> <li>• Long timelines required for capital projects and infrastructure improvements</li> <li>• Competition among rural communities for limited workforce and funding</li> <li>• Lack of standardized local data for some infrastructure and sustainability needs</li> </ul> |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**Public Awareness & Health Education:** GCHD and community partners will increase awareness of available public health and community services while sharing information regarding emerging rural health, workforce, infrastructure and resource needs. Community education and outreach will support use of existing services, community engagement, advocacy, funding opportunities, and awareness of initiatives designed to strengthen Greene County's health and sustainability.

**Estimated Funding Needs and Anticipated Funding Sources:** Funding needs vary significantly by project and may include substantial capital investment beyond the financial capacity of GCHD.

## HEALTH PROBLEM ANALYSIS WORKSHEET



## Rural Community Infrastructure & Sustainability Community Health Plan

### **Description of the health problem, risk factors, and contributing factors (including high-risk populations, and current and projected statistical trends.)**

Greene County's ability to maintain essential services and healthy community conditions is challenged by aging infrastructure, workforce shortages, limited transportation, housing and childcare availability, funding constraints, and the increasing cost and complexity of maintaining rural services. These challenges can reduce access to health care, public health, emergency response, public safety, food, employment, and other essential resources and threaten the long-term health and sustainability of the community.

The current Census data reinforce that context: Greene County's estimated population declined to about 11,313 in 2025, population density is only 22.1 persons per square mile, mean travel time to work is 29 minutes, and employer employment declined 5% from 2022 to 2023. Illinois's current Rural Health Transformation Program also specifically prioritizes rural health infrastructure, geographic barriers, EMS, workforce, and hospital transformation, making this a timely direction for the IPLAN.

### **Healthy People 2030 Objectives related to Rural Community Infrastructure & Sustainability**

|                                        |                                                                                                                                                |
|----------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|
| PHI-R06                                | Increase the proportion of local public health agencies that have a minimum package of public health services                                  |
| AHS-04                                 | Reduce the proportion of people who can't get medical care when they need it                                                                   |
| SDOH-02                                | Increase employment in working-age people                                                                                                      |
| SDPH-04                                | Reduce the proportion of families that spend more than 30 percent of income on housing.                                                        |
| Public Health Infrastructure Objective | Strengthen local public health capacity, workforce, planning, partnerships, and systems necessary to provide essential public health services. |
| Housing and Transportation Objectives  | Promote healthy and safe home environments and safe, accessible transportation and built environments.                                         |

*These Healthy People 2030 objectives support Greene County's broader focus on maintaining the social, physical, economic, workforce, and service infrastructure necessary for a healthy rural community.*

### **SHIP Objectives related to Rural Community Infrastructure & Sustainability**

Public Health & Healthcare Ecosystem Infrastructure: SHIP objectives prioritize strengthening health delivery networks in underserved areas. This ties directly into programs like the Rural Health Transformation Program, which funds infrastructural upgrades for rural EMS, mobile crisis units, telehealth platforms, and health information technology systems to ensure remote communities stay connected and sustainable.

Built Environment & Transportation: A primary emphasis of the SHIP framework is addressing geographic barriers. Improving rural public transportation networks and local transit routing is vital for enabling consistent community access to basic resources, employment, and essential medical care

**Corrective Actions to reduce the level of indirect contributing factors:**

1. Develop a Greene County rural infrastructure priority list identifying critical facility and service needs, including Boyd Hospital, GCHD facilities, EMS, fire, police, community buildings, housing, transportation, and other essential infrastructure.
2. Coordinate Greene County partners to pursue state, federal, foundation, and rural transformation funding for facility improvements, equipment, transportation, housing, childcare, workforce, and essential-service sustainability.
3. Develop local and regional workforce strategies to recruit and retain nurses, behavioral health providers, EMS, firefighters, police, public health staff, educators, childcare workers, and other difficult-to-fill rural positions.
4. Support development of housing and childcare capacity as workforce and health infrastructure, recognizing that employees cannot remain or work in Greene County without affordable housing and dependable childcare.
5. Strengthen transportation solutions and regional partnerships for residents who must travel outside Greene County for specialty health care, behavioral health, treatment, employment, food, and other services.
6. Support preservation and improvement of essential community facilities and environments, including health care/public health facilities, emergency services, housing conditions, sidewalks, parks, accessibility, environmental health, and code-enforcement capacity.
7. Advocate collectively for rural funding and policies that recognize Greene County's small population but high cost of maintaining essential services, using local data and documented service gaps to demonstrate need.

**Proposed community organization (s) to provide and coordinate the activities:**

Greene County Health Department, in partnership with Greene County elected officials, municipal leaders, state and federal legislators, health care organizations, schools, public safety agencies, economic and community development organizations, businesses, and other community leaders, will support coordination of Rural Community Infrastructure & Sustainability activities. The focus will be on strengthening relationships across sectors and levels of government so that Greene County can collectively identify needs, share resources, pursue funding, and advocate for the sustainability of essential rural services.

Existing quarterly community leadership gatherings will provide an important opportunity for leaders to share emerging concerns, identify common priorities, coordinate resources, develop collaborative solutions, and strengthen relationships. These discussions will help move identified needs beyond individual organizations and toward coordinated community action.

- Strengthen relationships with local, state, and federal elected officials and legislators to increase understanding of Greene County's rural infrastructure, workforce, health care, public safety, transportation, housing, childcare, and funding needs.

- Develop shared advocacy priorities so community organizations and elected leaders can communicate consistent messages regarding the needs of Greene County and rural Illinois.
- Coordinate grant writing and funding opportunities across organizations when shared applications, partnerships, letters of support, data, or other resources can strengthen funding requests.
- Develop stronger relationships among health care, local government, schools, public safety, economic development, businesses, and community organizations to reduce duplication and increase opportunities to share workforce, facilities, expertise, data, and other resources.
- Maintain and prioritize identified community infrastructure and sustainability needs so Greene County is prepared when state, federal, philanthropic, or other funding opportunities become available.
- Engage Thomas H. Boyd Memorial Hospital/Boyd Healthcare Services, Jersey Community Hospital, GCHD, EMS, fire, police, schools, municipalities, and other essential-service organizations in planning for workforce, facility, service, and long-term sustainability needs.
- Connect local leaders with state agencies, associations, regional organizations, and technical-assistance resources that can support infrastructure planning, workforce development, grant opportunities, and rural systems improvement.
- Use local data, Community Health Navigation findings, community assessment results, and partner experience to demonstrate where infrastructure or service gaps are affecting residents and support evidence-based funding and advocacy.
- Build relationships before a crisis or funding opportunity occurs, allowing Greene County leaders to respond collectively when essential services, facilities, workforce, or other community resources are threatened.
- Advocate for policies, reimbursement models, funding formulas, and regulatory approaches that recognize rural realities, including smaller populations, limited tax bases, workforce shortages, geographic distance, aging facilities, and the cost of maintaining essential services.
- Share Greene County successes and challenges with policymakers and statewide partners to help inform rural policy and champion rural community systems change.

#### **Evaluation plan to measure progress towards reaching objectives:**

Annually track identified infrastructure needs, projects initiated or completed, funding pursued and secured, essential services maintained or expanded, workforce vacancies and recruitment efforts, housing/childcare/transportation improvements, regional partnerships, and documented system or policy changes. Review findings with community partners annually to establish priorities for the following year.

# Sources and Links

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Behavioral Risk Factor Surveillance Systems:

<https://www.cdc.gov/brfss/index.html>

Illinois Department of Public Health:

<https://www.dph.illinois.gov/data-statistics>

Illinois Youth Survey Greene:

[https://youthsurveytest.web.illinois.edu/wp-content/uploads/2026/07/Cnty26\\_Greene.html](https://youthsurveytest.web.illinois.edu/wp-content/uploads/2026/07/Cnty26_Greene.html)

Illinois Department of Transportation Crash Data:

<https://idot.illinois.gov/travel-and-maps/safety/crash.html>

Institute of Health Metrics and Evaluation, University of Washington:

<http://www.healthdata.org/data-visualization/us-health-map>

Greene County, IL Census: <https://www.census.gov/quickfacts/fact/table/US/PST045225>

Opioid dashboard:

<https://dph.illinois.gov/topics-services/opioids/idph-data-dashboard.html>

The United States Census Data:

<https://data.census.gov/cedsci/>

Robert Wood Johnson:

<https://www.countyhealthrankings.org/app/illinois/2021/rankings/greene/county/outcomes/overall/snapshot>

<https://www.countyhealthrankings.org/health-data/compare-counties?compareCounties=17061&year=2025>

State of Illinois Office of Health Care Regulation, IL Data Portal: <https://www.dph.illinois.gov/topics-services/health-care-regulation>

Youth Risk Behavior Survey:

<https://www.cdc.gov/healthyyouth/data/yrbs/index.htm>

United States Bureau of Labor and Statistics, Injuries, Illnesses, and Fatalities Census of Fatal Occupational Injuries:

<https://www.bls.gov/iif/oshcfoi1.htm>

## APPENDIX A- NEEDS ASSESSMENT DATA POSTERS AND QUICK FACTS

## APPENDIX B-COMMUNITY SURVEY QUESTIONS

## APPENDIX C- COMMUNITY SURVEY ANALYSIS

## APPENDIX D- FOCUS GROUP AGENDA AND FACILITATOR GUIDE

## APPENDIX E- GREENE COUNTY RESOURCE GUIDE

## APPENDIX A- NEEDS ASSESSMENT DATA POSTERS AND QUICK FACTS

# GREENE COUNTY HEALTH CONCERNS



Greene County is ranked among the least healthy Counties in Illinois (Lowest 0%-25%).



## STATISTICAL ANALYSIS

### Adult Smoking

Greene: 23%  
Illinois: 16%

There's one primary care physician per 6,520 people in Greene County.

### Access to Exercise Opportunities

Greene: 56%  
Illinois: 91%

The median household income was \$52,100. Illinois was \$69,200.

### Food Insecurity

Greene: 12%  
Illinois: 10%

There were 24 teen births per 1,000 females ages 15-19.

### Children in Poverty

Greene: 19%  
Illinois: 16%

6% of people had low incomes and did not live close to a grocery store, limiting their ability to access healthy foods.

## Greene County, IL

### Quick Facts

#### Demographics

| Data Indicator          | Indicator Variable               | Greene County | State of IL  |
|-------------------------|----------------------------------|---------------|--------------|
| Total Population (2024) | Population                       | 11,417        | 12,710,158   |
|                         | Land Area (2020)                 | 543.04        | 3,533,038.28 |
|                         | Population Density (per sq mile) | 22.1          | 93.8         |
| Population Change       | April 2020 Census                | 11,985        |              |
|                         | Population % Change              | -4.7%         |              |
| Population by Age       | Persons Under 18 %               | 21.2%         | 21.5%        |
|                         | Persons 65 and older %           | 21.9%         | 18.0%        |
|                         | Persons Between 18 and 65        | 56.9%         | 60.5%        |

#### Income and Economics

| Data Indicator | Indicator Variable                             | Greene County | State of IL |
|----------------|------------------------------------------------|---------------|-------------|
| Households     | Total Number of Households                     | 4,452         | 129,227,496 |
|                | Median Household Income                        | \$62,192      | \$80,734    |
|                | Unemployment Rate                              | 4.1%          | 4.6%        |
| Poverty        | Persons in Poverty %                           | 14.0%         | 10.6%       |
|                | Children in Poverty                            | 18%           | 16%         |
|                | Students eligible for free/reduced price lunch | 46%           | 46%         |

## Physical Environment

| Data Indicator                    | Indicator Variable                                       | Greene County | State of IL |
|-----------------------------------|----------------------------------------------------------|---------------|-------------|
| Built Environment                 | Total Population (2024)                                  | 11,417        | 12,710,158  |
|                                   | Access to Broadband                                      | 81%           | 88%         |
| Recreation and Fitness Facilities | Access to Exercise Opportunities                         | 48%           | 91%         |
|                                   | Number of Establishments (gyms)                          | 4             | 1857        |
| Food Environment                  | Number of Grocery Stores                                 | 2             |             |
|                                   | Number of Restaurants (Includes year-round and seasonal) | 77            |             |
|                                   | Other (Dollar General, Family Dollar)                    | 4             |             |

## Health Behaviors

| Data Indicator    | Indicator Variable                                   | Greene County | State of IL |
|-------------------|------------------------------------------------------|---------------|-------------|
| Alcohol / Smoking | Excessive Alcohol consumption                        | 17%           | 18%         |
|                   | Alcohol Impaired Driving Deaths                      | 22%           | 28%         |
|                   | Adult Smoking                                        | 20%           | 13%         |
| Adult Obesity     | Obesity                                              | 37%           | 34%         |
|                   | Physical Inactivity                                  | 29%           | 26%         |
|                   | Insufficient Sleep                                   | 33%           | 32%         |
| Sexual Behaviors  | Sexually Transmitted Infections                      | 295.5         | 566.9       |
|                   | Teen Births per 1,000 females (age 15-19, 2016-2022) | 18            | 15          |

## Health Outcomes

| Data Indicator    | Indicator Variable                                             | Greene County          | State of IL              |
|-------------------|----------------------------------------------------------------|------------------------|--------------------------|
| Quality of Life   | Poor or Fair Health                                            | 16%                    | 14%                      |
|                   | Low Birthweight (2016-2022)                                    | 8%                     | 8%                       |
|                   | Premature Death (prior to age 75 2019-2021) per 100,000 people | 9,000 yrs of life lost | 7,500 years of life lost |
| Frequent Distress | Physical Distress (2021)                                       | 12%                    | 10%                      |
|                   | Mental Distress (2021)                                         | 17%                    | 14%                      |
| Deaths            | Suicides                                                       | 24                     | 11                       |
|                   | Firearm Fatalities                                             | 17                     | 13                       |
|                   | Motor Vehicle Deaths                                           | 19                     | 9                        |

## Resources

[Greene, Illinois | County Health Rankings & Roadmaps](#)

[U.S. Census Bureau QuickFacts: Greene County, Illinois; United States](#)

## Greene-Scott County Summary - ICBRFS Round 7

| DEMOGRAPHICS       |                             | Estimated Population | Weighted Percentage | 95% Confidence Interval | Number of Respondents |
|--------------------|-----------------------------|----------------------|---------------------|-------------------------|-----------------------|
| TOTAL              | Green-Scott Counties Adults | 12,938               |                     |                         | 403                   |
| AGE                | 18-24                       | 909                  | 7.1%                | 2.9%-16.1%              | 10                    |
|                    | 25-44                       | 3,891                | 30.3%               | 19.7%-43.5%             | 65                    |
|                    | 45-64                       | 4,608                | 35.9%               | 27.2%-45.7%             | 144                   |
|                    | 65+                         | 3,434                | 26.7%               | 19.7%-35.2%             | 180                   |
| SEX                | Male                        | 6,440                | 49.8%               | 39.3%-60.3%             | 196                   |
|                    | Female                      | 6,498                | 50.2%               | 39.7%-60.7%             | 207                   |
| RACE & ETHNICITY   | White Non-Hispanic          | 12,604               | 97.6%               | 94.7%-99.0%             | 394                   |
|                    | Black Non-Hispanic          | 13                   | 0.1%                | 0.0%-0.8%               | 1                     |
|                    | Other Non-Hispanic          | 226                  | 1.7%                | 0.7%-4.4%               | 6                     |
|                    | Hispanic                    | 68                   | 0.5%                | 0.1%-3.7%               | 1                     |
| SEXUAL ORIENTATION | Straight                    | 12,267               | 97.8%               | 93.5%-99.3%             | 388                   |
|                    | Lesbian/Gay/Bisexual        | 270                  | 2.2%                | 0.7%-6.5%               | 7                     |
| MARITAL STATUS     | Married                     | 7,675                | 59.3%               | 49.1%-68.8%             | 233                   |
|                    | Widowed                     | 1,173                | 9.1%                | 6.3%-12.9%              | 68                    |
|                    | Divorced/Separated          | 1,759                | 13.6%               | 7.9%-22.4%              | 51                    |
|                    | Never Married               | 1,978                | 15.3%               | 9.5%-23.6%              | 41                    |
|                    | Unmarried Couple            | 355                  | 2.7%                | 1.1%-6.7%               | 10                    |
| EDUCATION          | Less than High School       | 393                  | 3.0%                | 1.2%-7.5%               | 9                     |
|                    | High School Grad/GED        | 3,746                | 29.0%               | 21.8%-37.3%             | 153                   |
|                    | Some Post High School       | 4,558                | 35.2%               | 26.3%-45.3%             | 128                   |
|                    | College Graduate            | 4,241                | 32.8%               | 22.1%-45.6%             | 113                   |
| INCOME             | Less than \$35,000          | 3,523                | 29.6%               | 21.6%-39.1%             | 128                   |
|                    | \$35,000 - \$75,000         | 2,579                | 21.7%               | 15.4%-29.6%             | 112                   |
|                    | \$75,000 or More            | 5,809                | 48.8%               | 37.5%-60.2%             | 129                   |
| EMPLOYMENT         | Employed                    | 7,663                | 59.2%               | 49.1%-68.6%             | 189                   |
|                    | Out of Work                 | 516                  | 4.0%                | 1.6%-9.8%               | 14                    |
|                    | Homemaker/Student           | 792                  | 6.1%                | 2.6%-13.6%              | 22                    |
|                    | Retired                     | 2,771                | 21.4%               | 15.2%-29.3%             | 147                   |
|                    | Unable to Work              | 1,196                | 9.2%                | 5.1%-16.2%              | 31                    |
| HOME               | Own Home                    | 10,074               | 78.1%               | 68.4%-85.4%             | 343                   |
|                    | Rent Home                   | 1,839                | 14.3%               | 8.9%-22.1%              | 47                    |
|                    | Other Arrangement           | 991                  | 7.7%                | 3.3%-16.7%              | 12                    |

Illinois County Behavioral Risk Factor Survey, Round 7 (Collected 2020-2023)

\*Indicates data does not meet standards of reliability and has been suppressed.

NOTE: While the ICBRFS weighting methodology is designed to yield data that reflects the census population, users are advised against utilizing the demographic information from this table to characterize the studied population. For a more accurate depiction of the population, data sourced directly from the census is recommended. The demographics provided by ICBRFS serve to illustrate the representation of survey participants.

| HEALTH STATUS                                                          |                | Estimated Population | Weighted Percentage | 95% Confidence Interval | Number of Respondents |
|------------------------------------------------------------------------|----------------|----------------------|---------------------|-------------------------|-----------------------|
| GENERAL HEALTH STATUS                                                  | Excellent      | 1,831                | 14.2%               | 9.0%-21.7%              | 46                    |
|                                                                        | Very Good      | *                    | *                   | *                       | *                     |
|                                                                        | Good           | 2,878                | 22.3%               | 16.7%-29.2%             | 124                   |
|                                                                        | Fair           | 2,452                | 19.0%               | 13.0%-27.0%             | 81                    |
|                                                                        | Poor           | 773                  | 6.0%                | 3.7%-9.7%               | 30                    |
| GENERAL HEALTH (COLLAPSED)                                             | Good or Better | 9,670                | 75.0%               | 66.6%-81.9%             | 290                   |
|                                                                        | Fair or Poor   | 3,225                | 25.0%               | 18.1%-33.4%             | 111                   |
| NUMBER OF DAYS PHYSICAL HEALTH NOT GOOD                                | None           | 8,383                | 65.2%               | 56.0%-73.4%             | 237                   |
|                                                                        | 1-7 Days       | 2,239                | 17.4%               | 12.5%-23.8%             | 75                    |
|                                                                        | 8+ Days        | 2,228                | 17.3%               | 11.9%-24.7%             | 86                    |
| NUMBER OF DAYS MENTAL HEALTH NOT GOOD                                  | None           | 7,997                | 62.3%               | 52.5%-71.1%             | 256                   |
|                                                                        | 1-7 Days       | 2,841                | 22.1%               | 15.7%-30.2%             | 82                    |
|                                                                        | 8+ Days        | 2,005                | 15.6%               | 10.4%-22.9%             | 61                    |
| NUMBER OF DAYS PHYSICAL/MENTAL HEALTH AFFECTED ACTIVITIES <sup>1</sup> | None           | 9,746                | 75.6%               | 67.2%-82.5%             | 305                   |
|                                                                        | 1-7 Days       | 1,357                | 10.5%               | 7.1%-15.4%              | 43                    |
|                                                                        | 8+ Days        | 1,781                | 13.8%               | 8.5%-21.6%              | 53                    |
| NUMBER OF DAYS PAIN AFFECTED ACTIVITIES                                | None           | 7,821                | 60.9%               | 51.0%-70.0%             | 214                   |
|                                                                        | 1-7 Days       | 2,263                | 17.6%               | 11.7%-25.6%             | 79                    |
|                                                                        | 8+ Days        | 2,752                | 21.4%               | 15.3%-29.2%             | 106                   |
| NUMBER OF DAYS PHYSICAL HEALTH NOT GOOD                                | 0-13 Days      | 11,071               | 86.2%               | 79.4%-91.0%             | 329                   |
|                                                                        | 14+ Days       | 1,780                | 13.8%               | 9.0%-20.6%              | 69                    |
| NUMBER OF DAYS MENTAL HEALTH NOT GOOD                                  | 0-13 Days      | 11,429               | 89.0%               | 82.4%-93.3%             | 358                   |
|                                                                        | 14+ Days       | 1,415                | 11.0%               | 6.7%-17.6%              | 41                    |
| NUMBER OF DAYS PHYSICAL/MENTAL HEALTH AFFECTED ACTIVITIES <sup>1</sup> | 0-13 Days      | 11,966               | 92.9%               | 88.3%-95.8%             | 364                   |
|                                                                        | 14+ Days       | 918                  | 7.1%                | 4.2%-11.7%              | 37                    |
| NUMBER OF DAYS PAIN AFFECTED ACTIVITIES                                | 0-13 Days      | 10,692               | 83.3%               | 76.0%-88.7%             | 323                   |
|                                                                        | 14+ Days       | 2,145                | 16.7%               | 11.3%-24.0%             | 76                    |

1. Respondents reporting 0 days with mental and physical health problems in the past month were not asked this question, but are included as 0 days.

| HEALTH CARE                            |     | Estimated Population | Weighted Percentage | 95% Confidence Interval | Number of Respondents |
|----------------------------------------|-----|----------------------|---------------------|-------------------------|-----------------------|
| HAVE HEALTH CARE COVERAGE <sup>2</sup> | No  | 611                  | 4.7%                | 2.4%-9.0%               | 16                    |
|                                        | Yes | 12,327               | 95.3%               | 91.0%-97.6%             | 387                   |

Illinois County Behavioral Risk Factor Survey, Round 7 (Collected 2020-2023)

\*Indicates data does not meet standards of reliability and has been suppressed.

|                                                                |                               |        |       |             |     |
|----------------------------------------------------------------|-------------------------------|--------|-------|-------------|-----|
| HEALTH CARE COVERAGE TYPE                                      | Private Non-Governmental Plan | *      | *     | *           | *   |
|                                                                | Medicare                      | 3,560  | 27.6% | 20.0%-36.7% | 156 |
|                                                                | Other Plan                    | 1,800  | 13.9% | 9.0%-20.9%  | 52  |
|                                                                | No Coverage                   | 611    | 4.7%  | 2.4%-9.0%   | 16  |
| HAVE PERSONAL DOCTOR                                           | No                            | 1,524  | 11.8% | 7.8%-17.5%  | 46  |
|                                                                | Yes                           | 11,387 | 88.2% | 82.5%-92.2% | 355 |
| UNABLE TO VISIT DOCTOR DUE TO COST                             | No                            | 12,008 | 92.8% | 88.1%-95.8% | 373 |
|                                                                | Yes                           | 931    | 7.2%  | 4.2%-11.9%  | 30  |
| DELAYED GETTING NEEDED MEDICAL CARE IN PAST 12 MONTHS          | Yes                           | 3,323  | 25.7% | 18.9%-33.9% | 106 |
|                                                                | No                            | 9,616  | 74.3% | 66.1%-81.1% | 297 |
| LAST ROUTINE CHECKUP                                           | Past Year                     | 10,477 | 81.0% | 72.9%-87.1% | 329 |
|                                                                | Past 2 Years (>1yr, <2yrs)    | 581    | 4.5%  | 2.7%-7.3%   | 30  |
|                                                                | More than 2 Years             | 1,880  | 14.5% | 9.0%-22.6%  | 44  |
| ANY TIME IN PAST 12 MONTHS DID NOT HAVE HEALTH INSURANCE       | Yes                           | 848    | 6.6%  | 3.8%-11.0%  | 25  |
|                                                                | No                            | 12,091 | 93.4% | 89.0%-96.2% | 378 |
| TIMES BEEN TO HEALTH PROFESSIONAL IN PAST 12 MONTHS            | None                          | 1,434  | 11.2% | 6.2%-19.3%  | 36  |
|                                                                | Once                          | 1,873  | 14.7% | 10.1%-20.8% | 60  |
|                                                                | 2-3 times                     | *      | *     | *           | *   |
|                                                                | 4 to 6 times                  | *      | *     | *           | *   |
|                                                                | 7 to 12 times                 | 1,035  | 8.1%  | 5.3%-12.3%  | 49  |
|                                                                | > 12 times                    | 607    | 4.7%  | 2.7%-8.2%   | 28  |
| COULD NOT FILL PRESCRIPTION DUE TO COST                        | No                            | 12,358 | 95.5% | 91.5%-97.7% | 378 |
|                                                                | Yes                           | 580    | 4.5%  | 2.3%-8.5%   | 25  |
| CURRENTLY PAYING OFF ANY MEDICAL BILLS OVER TIME               | Yes                           | *      | *     | *           | *   |
|                                                                | No                            | *      | *     | *           | *   |
| DIFFICULTY UNDERSTANDING INFORMATION FROM HEALTH PROFESSIONALS | Very/Somewhat Easy            | 11,181 | 86.4% | 78.9%-91.5% | 355 |
|                                                                | Very/Somewhat Difficult       | 1,758  | 13.6% | 8.5%-21.1%  | 48  |

2. Health Care Coverage is reported as No Coverage if the response to either question indicates a lack of coverage or specifies no coverage when inquiring about the type of coverage.

| DENTAL CARE           |                            | Estimated Population | Weighted Percentage | 95% Confidence Interval | Number of Respondents |
|-----------------------|----------------------------|----------------------|---------------------|-------------------------|-----------------------|
| LAST DENTAL VISIT     | Past Year                  | 8,528                | 65.9%               | 56.4%-74.3%             | 247                   |
|                       | Past 2 Years (>1yr, <2yrs) | 1,312                | 10.1%               | 5.6%-17.7%              | 44                    |
|                       | More than 2 Years          | 3,098                | 23.9%               | 17.4%-32.0%             | 112                   |
| HAVE DENTAL INSURANCE | No                         | 3,344                | 25.9%               | 19.3%-33.7%             | 155                   |

Illinois County Behavioral Risk Factor Survey, Round 7 (Collected 2020-2023)  
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|                                                                                                          |                                      |                      |                     |                         |                       |
|----------------------------------------------------------------------------------------------------------|--------------------------------------|----------------------|---------------------|-------------------------|-----------------------|
| COVERAGE                                                                                                 | Yes                                  | 9,577                | 74.1%               | 66.3%-80.7%             | 246                   |
| LAST TIME HAD TEETH CLEANED                                                                              | Past Year                            | 7,889                | 61.9%               | 52.1%-70.9%             | 220                   |
|                                                                                                          | Past 2 Years (>1yr, <2yrs)           | 1,201                | 9.4%                | 5.0%-17.0%              | 46                    |
|                                                                                                          | More than 2 Years                    | 3,650                | 28.7%               | 21.4%-37.2%             | 132                   |
| NUMBER OF PERMANENT TEETH REMOVED                                                                        | 1 to 5                               | 3,082                | 24.0%               | 17.4%-32.2%             | 123                   |
|                                                                                                          | 6+, But Not All                      | 2,095                | 16.3%               | 10.4%-24.6%             | 66                    |
|                                                                                                          | All Teeth                            | 822                  | 6.4%                | 4.0%-10.1%              | 41                    |
|                                                                                                          | None                                 | *                    | *                   | *                       | *                     |
| FOOD INSECURITY                                                                                          |                                      | Estimated Population | Weighted Percentage | 95% Confidence Interval | Number of Respondents |
| FOOD BOUGHT JUST DIDN'T LAST                                                                             | Often/Sometimes True                 | 2,551                | 19.7%               | 13.4%-28.1%             | 67                    |
|                                                                                                          | Never True                           | 10,368               | 80.3%               | 71.9%-86.6%             | 334                   |
| COULDN'T AFFORD TO EAT BALANCED MEALS                                                                    | Often/Sometimes True                 | 2,519                | 19.5%               | 13.7%-26.9%             | 68                    |
|                                                                                                          | Never True                           | 10,405               | 80.5%               | 73.1%-86.3%             | 334                   |
| ANY FOOD INSECURITY <sup>3</sup>                                                                         | Yes                                  | 3,241                | 25.1%               | 18.0%-33.8%             | 85                    |
|                                                                                                          | No                                   | 9,677                | 74.9%               | 66.2%-82.0%             | 316                   |
| 3. Food insecurity is identified when the answer to either question is "often true" or "sometimes true." |                                      |                      |                     |                         |                       |
| INADEQUATE SLEEP                                                                                         |                                      | Estimated Population | Weighted Percentage | 95% Confidence Interval | Number of Respondents |
| INADEQUATE SLEEP                                                                                         | Short Sleep Duration (<7 hrs)        | *                    | *                   | *                       | *                     |
|                                                                                                          | Optimal Sleep (7-9 hrs)              | *                    | *                   | *                       | *                     |
|                                                                                                          | Long Sleep Duration (>9 hrs)         | 267                  | 2.1%                | 1.2%-3.5%               | 22                    |
| TROUBLE FALLING/STAYING ASLEEP OR TOO MUCH SLEEP IN PAST 2 WEEKS                                         | None                                 | *                    | *                   | *                       | *                     |
|                                                                                                          | Several Days (1-6 Days)              | 2,451                | 19.0%               | 13.6%-25.8%             | 95                    |
|                                                                                                          | Half of the Time or More (7-13 Days) | 1,161                | 9.0%                | 6.0%-13.2%              | 55                    |
|                                                                                                          | Every day (14 Days)                  | 2,334                | 18.1%               | 12.2%-25.9%             | 68                    |
| EXERCISE                                                                                                 |                                      | Estimated Population | Weighted Percentage | 95% Confidence Interval | Number of Respondents |
| ANY PHYSICAL ACTIVITY PAST 30 DAYS <sup>4</sup>                                                          | Yes                                  | *                    | *                   | *                       | *                     |
|                                                                                                          | No                                   | *                    | *                   | *                       | *                     |
| PHYSICAL ACTIVITY LEVEL                                                                                  | Highly Active (301+ Minutes/Week)    | *                    | *                   | *                       | *                     |
|                                                                                                          | Active (150-300 Minutes/Week)        | 650                  | 6.0%                | 3.6%-10.1%              | 30                    |

Illinois County Behavioral Risk Factor Survey, Round 7 (Collected 2020-2023)

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|                                                   |                                                  |       |       |             |     |
|---------------------------------------------------|--------------------------------------------------|-------|-------|-------------|-----|
|                                                   | Insufficiently Active<br>(1-149<br>Minutes/Week) | 978   | 9.1%  | 5.4%-14.9%  | 25  |
|                                                   | Inactive (0<br>Minutes/Week)                     | *     | *     | *           | *   |
| MEETS AEROBIC<br>RECOMMENATIONS <sup>5</sup>      | Yes                                              | *     | *     | *           | *   |
|                                                   | No                                               | *     | *     | *           | *   |
| MEETS STRENGTH<br>RECOMMENDATIONS <sup>6</sup>    | Yes                                              | *     | *     | *           | *   |
|                                                   | No                                               | *     | *     | *           | *   |
| MEETS<br>AEROBIC/STRENGTH<br>RECOMMENDATIONS      | Met Both                                         | 2,340 | 20.7% | 13.8%-29.8% | 80  |
|                                                   | Met Aerobic                                      | 2,595 | 22.9% | 16.1%-31.5% | 95  |
|                                                   | Met Strengthening                                | *     | *     | *           | *   |
|                                                   | Met Neither                                      | *     | *     | *           | *   |
| MEETS BOTH<br>AEROBIC/STRENGTH<br>RECOMMENDATIONS | Yes                                              | 2,340 | 20.7% | 13.8%-29.8% | 80  |
|                                                   | No                                               | 8,983 | 79.3% | 70.2%-86.2% | 254 |

4. Respondent indicating participation in physical activities but reports 0 minutes of activity are reported as No.  
5. Respondent indicating participation in at least 150 minutes per week of moderate-intensity activity, or at least 75 minutes per week of vigorous-intensity activity, or an equivalent combination of moderate-intensity and vigorous-intensity activity (multiplied by 2) totaling at least 150 minutes per week.  
6. Respondent reports participation in muscle-strengthening activities at least 2 times per week.

| HYPERTENSION                                          |     | Estimated Population | Weighted Percentage | 95% Confidence Interval | Number of Respondents |
|-------------------------------------------------------|-----|----------------------|---------------------|-------------------------|-----------------------|
| EVER TOLD HAVE<br>HIGH BLOOD<br>PRESSURE <sup>7</sup> | No  | *                    | *                   | *                       | *                     |
|                                                       | Yes | *                    | *                   | *                       | *                     |

7. Respondents reporting yes but only during pregnancy OR told borderline/pre hypertensive are included as No.

| CHOLESTEROL                               |                                 | Estimated Population | Weighted Percentage | 95% Confidence Interval | Number of Respondents |
|-------------------------------------------|---------------------------------|----------------------|---------------------|-------------------------|-----------------------|
| EVER HAD<br>CHOLESTEROL<br>CHECKED        | Yes                             | 11,973               | 93.3%               | 86.1%-96.9%             | 380                   |
|                                           | No                              | 865                  | 6.7%                | 3.1%-13.9%              | 18                    |
| LAST CHOLESTEROL<br>TEST <sup>8</sup>     | Past Year                       | *                    | *                   | *                       | *                     |
|                                           | Past 5 Years (>1 yr,<br><5 yrs) | *                    | *                   | *                       | *                     |
|                                           | 5+ Years Ago                    | 920                  | 7.2%                | 3.1%-15.8%              | 16                    |
|                                           | Never                           | 865                  | 6.7%                | 3.1%-13.9%              | 18                    |
| TOLD CHOLESTEROL<br>WAS HIGH <sup>9</sup> | No                              | 7,944                | 66.4%               | 56.5%-75.1%             | 225                   |
|                                           | Yes                             | 4,019                | 33.6%               | 24.9%-43.5%             | 154                   |

8. Asked only of those who report ever having cholesterol checked, respondents reporting No to having cholesterol checked included as Never.

9. Asked only of those who report ever having cholesterol checked.

| CARDIOVASCULAR DISEASE |  | Estimated Population | Weighted Percentage | 95% Confidence Interval | Number of Respondents |
|------------------------|--|----------------------|---------------------|-------------------------|-----------------------|
|------------------------|--|----------------------|---------------------|-------------------------|-----------------------|

|                                                                   |     |        |       |             |     |
|-------------------------------------------------------------------|-----|--------|-------|-------------|-----|
| EVER TOLD HAVE CORONARY HEART DISEASE (CHD)                       | No  | 12,199 | 94.5% | 90.8%-96.7% | 362 |
|                                                                   | Yes | 711    | 5.5%  | 3.3%-9.2%   | 38  |
| EVER TOLD HAD HEART ATTACK (MI)                                   | No  | 11,983 | 93.0% | 88.7%-95.7% | 365 |
|                                                                   | Yes | 903    | 7.0%  | 4.3%-11.3%  | 36  |
| EVER TOLD HAD STROKE                                              | No  | 12,390 | 95.8% | 91.6%-97.9% | 383 |
|                                                                   | Yes | 548    | 4.2%  | 2.1%-8.4%   | 20  |
| REPORT CORONARY HEART DISEASE (CHD) OR MYOCARDIAL INFARCTION (MI) | No  | 11,676 | 90.7% | 86.0%-94.0% | 344 |
|                                                                   | Yes | 1,194  | 9.3%  | 6.0%-14.0%  | 55  |
| HISTORY OF CVD <sup>10</sup>                                      | No  | 11,450 | 89.0% | 83.8%-92.7% | 336 |
|                                                                   | Yes | 1,419  | 11.0% | 7.3%-16.2%  | 63  |

10. History of CVD calculated when respondent answers yes to any cardiovascular disease history questions.

| CHRONIC HEALTH CONDITIONS               |                     | Estimated Population | Weighted Percentage | 95% Confidence Interval | Number of Respondents |
|-----------------------------------------|---------------------|----------------------|---------------------|-------------------------|-----------------------|
| HAS ASTHMA NOW                          | Yes                 | 1,603                | 12.4%               | 7.7%-19.4%              | 43                    |
|                                         | No                  | 11,336               | 87.6%               | 80.6%-92.3%             | 360                   |
| EVER TOLD COPD                          | Yes                 | 1,178                | 9.1%                | 5.2%-15.5%              | 44                    |
|                                         | No                  | 11,761               | 90.9%               | 84.5%-94.8%             | 359                   |
| EVER TOLD HAD SKIN CANCER               | Yes                 | 831                  | 6.4%                | 4.3%-9.5%               | 47                    |
|                                         | No                  | 12,107               | 93.6%               | 90.5%-95.7%             | 356                   |
| EVER TOLD HAD OTHER TYPE OF CANCER      | Yes                 | 978                  | 7.6%                | 5.1%-11.2%              | 51                    |
|                                         | No                  | 11,894               | 92.4%               | 88.8%-94.9%             | 350                   |
| EVER TOLD ARTHRITIS                     | Yes                 | 3,763                | 29.1%               | 21.7%-37.8%             | 171                   |
|                                         | No                  | 9,154                | 70.9%               | 62.2%-78.3%             | 231                   |
| EVER TOLD HAVE KIDNEY DISEASE           | Yes                 | 291                  | 2.2%                | 1.4%-3.7%               | 23                    |
|                                         | No                  | 12,648               | 97.8%               | 96.3%-98.6%             | 380                   |
| EVER TOLD DEPRESSIVE DISORDER           | Yes                 | 3,110                | 24.1%               | 17.3%-32.5%             | 93                    |
|                                         | No                  | 9,805                | 75.9%               | 67.5%-82.7%             | 309                   |
| EVER TOLD HAVE DIABETES <sup>11</sup>   | No                  | 11,503               | 88.9%               | 84.3%-92.3%             | 330                   |
|                                         | Yes                 | 1,436                | 11.1%               | 7.7%-15.7%              | 73                    |
| CHRONIC HEALTH CONDITIONS <sup>12</sup> | No Chronic Disease  | *                    | *                   | *                       | *                     |
|                                         | Chronic Disease     | *                    | *                   | *                       | *                     |
| CHRONIC HEALTH CONDITIONS <sup>12</sup> | No Chronic Disease  | *                    | *                   | *                       | *                     |
|                                         | 1 Chronic Disease   | *                    | *                   | *                       | *                     |
|                                         | 2+ Chronic Diseases | 3,556                | 27.8%               | 20.9%-36.1%             | 158                   |

11. Respondents reporting yes but only during pregnancy OR told pre-diabetes or borderline diabetes are included as No.  
12. Chronic Health Conditions calculated from CVD (heart attack/stroke/angina), current asthma, cancer, COPD, arthritis, depression, kidney disease, and diabetes questions.

| MENTAL HEALTH | Estimated Population | Weighted Percentage | 95% Confidence Interval | Number of Respondents |
|---------------|----------------------|---------------------|-------------------------|-----------------------|
|---------------|----------------------|---------------------|-------------------------|-----------------------|

Illinois County Behavioral Risk Factor Survey, Round 7 (Collected 2020-2023)

\*Indicates data does not meet standards of reliability and has been suppressed.

|                                                         |                                       |       |       |             |     |
|---------------------------------------------------------|---------------------------------------|-------|-------|-------------|-----|
| FELT DOWN,<br>DEPRESSED, OR<br>HOPELESS PAST 2<br>WEEKS | Never                                 | 8,871 | 68.6% | 59.6%-76.4% | 264 |
|                                                         | One Day/Several<br>Days               | 3,028 | 23.4% | 17.0%-31.4% | 107 |
|                                                         | More than Half or<br>Nearly Every Day | 1,026 | 7.9%  | 4.4%-13.8%  | 31  |
| FELT NERVOUS,<br>ANXIOUS, OR ON<br>EDGE PAST 2 WEEKS    | Never                                 | *     | *     | *           | *   |
|                                                         | One Day/Several<br>Days               | *     | *     | *           | *   |
|                                                         | More than Half or<br>Nearly Every Day | 1,002 | 7.8%  | 5.0%-12.0%  | 36  |
| CONFUSION OR<br>MEMORY LOSS<br>WORSENING                | Yes                                   | 518   | 6.4%  | 3.7%-10.9%  | 28  |
|                                                         | No                                    | 7,570 | 93.6% | 89.1%-96.3% | 295 |

| DIABETES                                                                     |     | Estimated<br>Population | Weighted<br>Percentage | 95%<br>Confidence<br>Interval | Number of<br>Respondents |
|------------------------------------------------------------------------------|-----|-------------------------|------------------------|-------------------------------|--------------------------|
| EVER TOLD HAVE<br>DIABETES <sup>11</sup>                                     | No  | 11,503                  | 88.9%                  | 84.3%-92.3%                   | 330                      |
|                                                                              | Yes | 1,436                   | 11.1%                  | 7.7%-15.7%                    | 73                       |
| PAST THREE YEARS<br>HAD A HIGH BLOOD<br>SUGAR/DIABETES<br>TEST <sup>13</sup> | Yes | *                       | *                      | *                             | *                        |
|                                                                              | No  | *                       | *                      | *                             | *                        |
| EVER TOLD YOU HAVE<br>BORDERLINE/PRE-<br>DIABETES <sup>14</sup>              | Yes | 742                     | 6.5%                   | 3.6%-11.4%                    | 27                       |
|                                                                              | No  | 10,679                  | 93.5%                  | 88.6%-96.4%                   | 295                      |

11. Respondents reporting yes but only during pregnancy OR told pre-diabetes or borderline diabetes are included as No.  
13. Asked only of respondents who did not report ever being told they have diabetes.  
14. Asked only of respondents who did not report ever being told they have diabetes or borderline/pre-diabetes.

| OBESITY                       |                          | Estimated<br>Population | Weighted<br>Percentage | 95%<br>Confidence<br>Interval | Number of<br>Respondents |
|-------------------------------|--------------------------|-------------------------|------------------------|-------------------------------|--------------------------|
| BODY MASS INDEX <sup>15</sup> | Normal or<br>Underweight | 2,878                   | 22.7%                  | 16.4%-30.5%                   | 104                      |
|                               | Overweight               | 3,836                   | 30.2%                  | 22.2%-39.8%                   | 122                      |
|                               | Obese                    | *                       | *                      | *                             | *                        |
| OVERWEIGHT OR<br>OBESE        | No                       | 2,878                   | 22.7%                  | 16.4%-30.5%                   | 104                      |
|                               | Yes                      | 9,810                   | 77.3%                  | 69.5%-83.6%                   | 288                      |

15. BMI calculated from reported height and weight. BMI Categories: Underweight <18.5, Normal >=18.5 and <25, Overweight >=25 and <30, Obese >=30.

| DISABILITY STATUS                      |               | Estimated<br>Population | Weighted<br>Percentage | 95%<br>Confidence<br>Interval | Number of<br>Respondents |
|----------------------------------------|---------------|-------------------------|------------------------|-------------------------------|--------------------------|
| FUNCTIONAL<br>DISABILITY <sup>16</sup> | No Disability | 8,506                   | 66.7%                  | 57.0%-75.2%                   | 250                      |
|                                        | Disability    | 4,245                   | 33.3%                  | 24.8%-43.0%                   | 145                      |

16. Functional disability status defined by responses to the six functional disability questions (sight, hearing, decisions, walking/climbing stairs, bathing/dressing, doing errands).

| ALCOHOL CONSUMPTION                           |             | Estimated Population | Weighted Percentage | 95% Confidence Interval | Number of Respondents |
|-----------------------------------------------|-------------|----------------------|---------------------|-------------------------|-----------------------|
| DRANK ALCOHOL PAST 30 DAYS                    | Yes         | *                    | *                   | *                       | *                     |
|                                               | No          | *                    | *                   | *                       | *                     |
| BINGE DRINKING (CALCULATED) <sup>17</sup>     | Not At Risk | 10,677               | 85.2%               | 78.5%-90.0%             | 333                   |
|                                               | At Risk     | 1,859                | 14.8%               | 10.0%-21.5%             | 57                    |
| HEAVY DRINKING (CALCULATED) <sup>18</sup>     | Not At Risk | 12,128               | 97.0%               | 93.7%-98.6%             | 378                   |
|                                               | At Risk     | 372                  | 3.0%                | 1.4%-6.3%               | 10                    |
| ALCOHOL RELATED RISK (BINGE OR HEAVY DRINKER) | Not At Risk | 10,642               | 85.0%               | 78.4%-89.8%             | 331                   |
|                                               | At Risk     | 1,880                | 15.0%               | 10.2%-21.6%             | 58                    |

17. Calculated at risk for men having 5+ drinks on one occasion and women having 4+ drinks on one occasion.

18. Calculated at risk for men having >2 drinks per day and women having >1 drink per day.

| TOBACCO & E-CIGARETTES                       |                      | Estimated Population | Weighted Percentage | 95% Confidence Interval | Number of Respondents |
|----------------------------------------------|----------------------|----------------------|---------------------|-------------------------|-----------------------|
| CALCULATED SMOKING STATUS <sup>19</sup>      | Smoker               | 1,946                | 15.6%               | 10.3%-22.8%             | 60                    |
|                                              | Former Smoker        | 2,361                | 18.9%               | 13.9%-25.1%             | 109                   |
|                                              | Never Smoked         | 8,195                | 65.6%               | 56.4%-73.7%             | 218                   |
| QUIT SMOKING (FORMER SMOKERS) <sup>20</sup>  | Past Year            | *                    | *                   | *                       | *                     |
|                                              | More than 1 Year Ago | *                    | *                   | *                       | *                     |
| USE SMOKELESS TOBACCO <sup>21</sup>          | No                   | 11,611               | 91.7%               | 83.2%-96.1%             | 367                   |
|                                              | Yes                  | 1,046                | 8.3%                | 3.9%-16.8%              | 22                    |
| CALCULATED E-CIGARETTES STATUS <sup>22</sup> | Current User         | 457                  | 3.6%                | 1.9%-6.6%               | 13                    |
|                                              | Not Currently Using  | 2,427                | 19.2%               | 12.7%-27.9%             | 58                    |
|                                              | Never Used           | 9,773                | 77.2%               | 68.4%-84.2%             | 318                   |

19. Calculated smoking status from tobacco questions.

20. Asked only if respondent reported smoking 100+ cigarettes and reported frequency is not at all.

21. Smokeless tobacco includes chewing tobacco, snuff, or snus.

22. Calculated e-cigarette status from e-cigarette questions.

| MARIJUANA                                    |                                             | Estimated Population | Weighted Percentage | 95% Confidence Interval | Number of Respondents |
|----------------------------------------------|---------------------------------------------|----------------------|---------------------|-------------------------|-----------------------|
| PAST 30 DAYS - ANY MARIJUANA/CANNABIS USE    | No                                          | 10,831               | 85.7%               | 77.7%-91.1%             | 349                   |
|                                              | Yes                                         | 1,812                | 14.3%               | 8.9%-22.3%              | 39                    |
| PAST 30 DAYS - REASON USING MARIJUANA        | Medical Reasons                             | *                    | *                   | *                       | *                     |
|                                              | Non-Medical Reasons                         | *                    | *                   | *                       | *                     |
|                                              | Both Medical And Non-Medical Reasons        | *                    | *                   | *                       | *                     |
| PAST 30 DAYS - MOST COMMON WAY USE MARIJUANA | Smoke It (In A Joint, Bong, Pipe, Or Blunt) | *                    | *                   | *                       | *                     |
|                                              | Other                                       | *                    | *                   | *                       | *                     |

Illinois County Behavioral Risk Factor Survey, Round 7 (Collected 2020-2023)

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| IMMUNIZATION                                                                                                                               |                 | Estimated Population | Weighted Percentage | 95% Confidence Interval | Number of Respondents |
|--------------------------------------------------------------------------------------------------------------------------------------------|-----------------|----------------------|---------------------|-------------------------|-----------------------|
| HAD INFLUENZA VACCINATION PAST 12 MONTHS                                                                                                   | Yes             | *                    | *                   | *                       | *                     |
|                                                                                                                                            | No              | *                    | *                   | *                       | *                     |
| ADULTS AGED 65+ HAD INFLUENZA VACCINATION PAST 12 MONTHS                                                                                   | Yes             | *                    | *                   | *                       | *                     |
|                                                                                                                                            | No              | *                    | *                   | *                       | *                     |
| EVER HAD PNEUMONIA VACCINATION                                                                                                             | Yes             | 3,894                | 31.4%               | 23.5%-40.5%             | 172                   |
|                                                                                                                                            | No              | 8,500                | 68.6%               | 59.5%-76.5%             | 209                   |
| ADULTS AGED 65+ EVER HAD PNEUMONIA VACCINATION                                                                                             | Yes             | *                    | *                   | *                       | *                     |
|                                                                                                                                            | No              | *                    | *                   | *                       | *                     |
| EVER HAD HPV VACCINATION (AGE 18-49)                                                                                                       | Yes             | *                    | *                   | *                       | *                     |
|                                                                                                                                            | No              | *                    | *                   | *                       | *                     |
| NUMBER OF HPV SHOTS RECEIVED (AGE 18-49)                                                                                                   | None            | *                    | *                   | *                       | *                     |
|                                                                                                                                            | 1-2 Shots       | *                    | *                   | *                       | *                     |
|                                                                                                                                            | All Shots       | *                    | *                   | *                       | *                     |
| EVER HAD SHINGLES/ZOSTER VACCINATION (AGE 50+)                                                                                             | Yes             | 1,775                | 24.1%               | 17.4%-32.4%             | 87                    |
|                                                                                                                                            | No              | 5,587                | 75.9%               | 67.6%-82.6%             | 211                   |
| INJURY                                                                                                                                     |                 | Estimated Population | Weighted Percentage | 95% Confidence Interval | Number of Respondents |
| HAD A FALL PAST 12 MONTHS (AGE 45+)                                                                                                        | Yes             | *                    | *                   | *                       | *                     |
|                                                                                                                                            | No              | *                    | *                   | *                       | *                     |
| TIMES FALLEN IN PAST 12 MONTHS (AGE 45+)                                                                                                   | 1 Fall          | 565                  | 7.0%                | 4.4%-10.9%              | 37                    |
|                                                                                                                                            | 2 or More Falls | *                    | *                   | *                       | *                     |
|                                                                                                                                            | None            | *                    | *                   | *                       | *                     |
| HAD INJURY FROM THE FALL (AGE 45+)                                                                                                         | Yes             | *                    | *                   | *                       | *                     |
|                                                                                                                                            | No              | *                    | *                   | *                       | *                     |
| DRIVEN AFTER DRINKING TOO MUCH IN THE PAST 30 DAYS <sup>23</sup>                                                                           | Yes             | 149                  | 1.2%                | 0.4%-3.4%               | 5                     |
|                                                                                                                                            | No              | 12,431               | 98.8%               | 96.6%-99.6%             | 385                   |
| 23. Respondents who answered No to drinking any alcohol in the past 30 days are not asked this question but are included as a No response. |                 |                      |                     |                         |                       |
| HIV/STD/SEXUAL BEHAVIOR                                                                                                                    |                 | Estimated Population | Weighted Percentage | 95% Confidence Interval | Number of Respondents |
| EVER HAD HIV TEST                                                                                                                          | Yes             | *                    | *                   | *                       | *                     |
|                                                                                                                                            | No              | *                    | *                   | *                       | *                     |
| DO ANY HIGH RISK SITUATIONS APPLY                                                                                                          | Yes             | 622                  | 4.9%                | 2.3%-10.1%              | 11                    |

Illinois County Behavioral Risk Factor Survey, Round 7 (Collected 2020-2023)  
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| No                                                      |                     | 12,034               | 95.1%               | 89.9%-97.7%             | 378                   |
|---------------------------------------------------------|---------------------|----------------------|---------------------|-------------------------|-----------------------|
| BREAST AND CERVICAL CANCER SCREENING                    |                     | Estimated Population | Weighted Percentage | 95% Confidence Interval | Number of Respondents |
| HAD MAMMOGRAM PAST 2 YEARS                              | Yes                 | 3,451                | 73.8%               | 64.2%-81.6%             | 124                   |
| (WOMEN AGE 40+) <sup>24</sup>                           | No                  | 1,223                | 26.2%               | 18.4%-35.8%             | 56                    |
| HAD MAMMOGRAM PAST 2 YEARS (WOMEN AGE 50-74)            | Yes                 | *                    | *                   | *                       | *                     |
|                                                         | No                  | *                    | *                   | *                       | *                     |
| HAD PAP IN PAST 3 YEARS (WOMEN AGE 21-65) <sup>25</sup> | Yes                 | *                    | *                   | *                       | *                     |
|                                                         | No                  | *                    | *                   | *                       | *                     |
| LAST HPV TEST                                           | Within Past 5 Years | *                    | *                   | *                       | *                     |
|                                                         | 5+ Years Ago        | *                    | *                   | *                       | *                     |
|                                                         | Never               | *                    | *                   | *                       | *                     |
| HAD HYSTERECTOMY                                        | Yes                 | *                    | *                   | *                       | *                     |
|                                                         | No                  | *                    | *                   | *                       | *                     |

24. Asked only if reporting Yes to having mammogram, includes those responding as No as Never.  
25. Asked only if reporting Yes to having pap smear, includes those responding as No as Never.

| PROSTATE CANCER SCREENING                                   |     | Estimated Population | Weighted Percentage | 95% Confidence Interval | Number of Respondents |
|-------------------------------------------------------------|-----|----------------------|---------------------|-------------------------|-----------------------|
| EVER HAD PSA TEST (MALES AGE 40+)                           | Yes | *                    | *                   | *                       | *                     |
|                                                             | No  | *                    | *                   | *                       | *                     |
| MEN 40+ WHO HAVE HAD PSA TEST IN PAST 2 YEARS <sup>26</sup> | Yes | *                    | *                   | *                       | *                     |
|                                                             | No  | *                    | *                   | *                       | *                     |

26. Respondents that reported never having a PSA test are included as No.

| COLORECTAL CANCER SCREENING                                  |     | Estimated Population | Weighted Percentage | 95% Confidence Interval | Number of Respondents |
|--------------------------------------------------------------|-----|----------------------|---------------------|-------------------------|-----------------------|
| HAD BLOOD STOOL TEST IN PAST YEAR (AGED 50-75) <sup>27</sup> | Yes | *                    | *                   | *                       | *                     |
|                                                              | No  | *                    | *                   | *                       | *                     |
| HAD COLONOSCOPY PAST 10 YEARS (AGED 50-75) <sup>27</sup>     | Yes | *                    | *                   | *                       | *                     |
|                                                              | No  | *                    | *                   | *                       | *                     |
| HAD SIGMOIDOSCOPY PAST 5 YEARS (AGED 50-75) <sup>27</sup>    | Yes | 31                   | 1.0%                | 0.2%-4.3%               | 2                     |
|                                                              | No  | 2,893                | 99.0%               | 95.7%-99.8%             | 100                   |
| FULLY MET 2016 USPSTF CRC SCREENING RECOMMENDATION           | Yes | *                    | *                   | *                       | *                     |
|                                                              | No  | *                    | *                   | *                       | *                     |

27. Type of exam and when was the last exam only asked if respondent reported they had ever had an exam.



## QuickFacts

### Greene County, Illinois; Illinois

QuickFacts provides statistics for all states and counties. Also for cities and towns with a population of 5,000 or more.

 Enter state, county, city, town, or zip code

 -- Select a fact --


## Table

|                                                                                        |                         |            |
|----------------------------------------------------------------------------------------|-------------------------|------------|
| All Topics                                                                             | Greene County, Illinois | Illinois   |
| Population estimates, July 1, 2025, (V2025)                                            | 11,313                  | 12,719,141 |
| PEOPLE                                                                                 |                         |            |
| Population                                                                             |                         |            |
| Population estimates, July 1, 2025, (V2025)                                            | 11,313                  | 12,719,141 |
| Population estimates base, April 1, 2020, (V2025)                                      | 11,975                  | 12,821,741 |
| Population, percent change - April 1, 2020 (estimates base) to July 1, 2025, (V2025)   | -5.5%                   | -0.8%      |
| Population, Census, April 1, 2020                                                      | 11,985                  | 12,812,508 |
| Population, Census, April 1, 2010                                                      | 13,886                  | 12,830,632 |
| Age and Sex                                                                            |                         |            |
| Persons under 5 years, percent                                                         | 4.9%                    | 5.1%       |
| Persons under 18 years, percent                                                        | 21.6%                   | 20.6%      |
| Persons 65 years and over, percent                                                     | 23.3%                   | 18.7%      |
| Female persons, percent                                                                | 50.1%                   | 50.9%      |
| Race and Hispanic Origin                                                               |                         |            |
| White alone, percent                                                                   | 96.2%                   | 72.4%      |
| Black alone, percent (a)                                                               | 0.5%                    | 14.5%      |
| American Indian and Alaska Native alone, percent (a)                                   | 0.2%                    | 2.0%       |
| Asian alone, percent (a)                                                               | 0.3%                    | 7.0%       |
| Native Hawaiian and Other Pacific Islander alone, percent (a)                          | 0.0%                    | 0.1%       |
| Two or More Races, percent                                                             | 2.8%                    | 3.9%       |
| Hispanic or Latino, percent (b)                                                        | 1.4%                    | 19.9%      |
| White alone, not Hispanic or Latino, percent                                           | 95.1%                   | 56.7%      |
| Population Characteristics                                                             |                         |            |
| Veterans, 2020-2024                                                                    | 675                     | 478,196    |
| Foreign-born persons, percent, 2020-2024                                               | 0.2%                    | 14.7%      |
| Housing                                                                                |                         |            |
| Housing Units, July 1, 2025, (V2025)                                                   | 5,765                   | 5,504,295  |
| Owner-occupied housing unit rate, 2020-2024                                            | 78.2%                   | 67.1%      |
| Median value of owner-occupied housing units, 2020-2024                                | \$95,200                | \$263,300  |
| Median selected monthly owner costs - with a mortgage, 2020-2024                       | \$1,165                 | \$1,987    |
| Median selected monthly owner costs - without a mortgage, 2020-2024                    | \$506                   | \$792      |
| Median gross rent, 2020-2024                                                           | \$754                   | \$1,274    |
| Building Permits, 2025                                                                 | 2                       | 18,551     |
| Families & Living Arrangements                                                         |                         |            |
| Households, 2020-2024                                                                  | 4,452                   | 5,036,449  |
| Persons per household, 2020-2024                                                       | 2.58                    | 2.46       |
| Living in the same house 1 year ago, percent of persons age 1 year+ , 2020-2024        | 92.0%                   | 88.9%      |
| Language other than English spoken at home, percent of persons age 5 years+, 2020-2024 | 1.4%                    | 24.0%      |
| Computer and Internet Use                                                              |                         |            |
| Households with a computer, percent, 2020-2024                                         | 93.9%                   | 95.2%      |
| Households with a broadband Internet subscription, percent, 2020-2024                  | 88.3%                   | 90.8%      |
| Education                                                                              |                         |            |
| High school graduate or higher, percent of persons age 25 years+, 2020-2024            | 91.2%                   | 90.5%      |

# U.S. Census Bureau QuickFacts: Greene County, Illinois; Illinois

|                                                                                   |          |             |
|-----------------------------------------------------------------------------------|----------|-------------|
| 📌 Bachelor's degree or higher, percent of persons age 25 years+, 2020-2024        | 19.0%    | 37.8%       |
| <b>Health</b>                                                                     |          |             |
| 📌 With a disability, under age 65 years, percent, 2020-2024                       | 11.4%    | 8.2%        |
| 📌 Persons without health insurance, under age 65 years, percent                   | ⚠️ 7.3%  | ⚠️ 8.1%     |
| <b>Economy</b>                                                                    |          |             |
| 📌 In civilian labor force, total, percent of population age 16 years+, 2020-2024  | 58.0%    | 64.8%       |
| 📌 In civilian labor force, female, percent of population age 16 years+, 2020-2024 | 55.2%    | 60.6%       |
| 📌 Total accommodation and food services sales, 2022 (\$1,000) (c)                 | D        | 41,754,998  |
| 📌 Total health care and social assistance receipts/revenue, 2022 (\$1,000) (c)    | 30,037   | 125,256,366 |
| 📌 Total transportation and warehousing receipts/revenue, 2022 (\$1,000) (c)       | D        | 73,661,560  |
| 📌 Total retail sales, 2022 (\$1,000) (c)                                          | 172,440  | 244,721,614 |
| 📌 Total retail sales per capita, 2022 (c)                                         | \$14,814 | \$19,449    |
| <b>Transportation</b>                                                             |          |             |
| 📌 Mean travel time to work (minutes), workers age 16 years+, 2020-2024            | 29.0     | 27.8        |
| <b>Income &amp; Poverty</b>                                                       |          |             |
| 📌 Median households income (in 2024 dollars), 2020-2024                           | \$62,192 | \$83,390    |
| 📌 Per capita income in past 12 months (in 2024 dollars), 2020-2024                | \$33,635 | \$46,406    |
| 📌 Persons in poverty, percent                                                     | ⚠️ 14.0% | ⚠️ 11.6%    |
| <b>BUSINESSES</b>                                                                 |          |             |
| <b>Businesses</b>                                                                 |          |             |
| 📌 Total employer establishments, 2023                                             | 215      | 322,415     |
| 📌 Total employment, 2023                                                          | 1,472    | 5,661,761   |
| 📌 Total annual payroll, 2023 (\$1,000)                                            | 68,953   | 409,899,088 |
| 📌 Total employment, percent change, 2022-2023                                     | -5.0%    | 2.3%        |
| 📌 Total nonemployer establishments, 2023                                          | 729      | 1,120,413   |
| 📌 All employer firms, Reference year 2023                                         | 267      | 238,091     |
| 📌 Male-owned employer firms, Reference year 2023                                  | S        | 151,621     |
| 📌 Female-owned employer firms, Reference year 2023                                | S        | 52,815      |
| 📌 Minority-owned employer firms, Reference year 2023                              | S        | 50,183      |
| 📌 Nonminority-owned employer firms, Reference year 2023                           | S        | 173,766     |
| 📌 Veteran-owned employer firms, Reference year 2023                               | S        | 8,170       |
| 📌 Nonveteran-owned employer firms, Reference year 2023                            | S        | 215,732     |
| <b>GEOGRAPHY</b>                                                                  |          |             |
| <b>Geography</b>                                                                  |          |             |
| 📌 Population per square mile, 2020                                                | 22.1     | 230.8       |
| 📌 Population per square mile, 2010                                                | 25.6     | 231.1       |
| 📌 Land area in square miles, 2020                                                 | 543.04   | 55,513.18   |
| 📌 Land area in square miles, 2010                                                 | 543.02   | 55,518.93   |
| 📌 FIPS Code                                                                       | 17061    | 17          |

[About datasets used in this table](#)

## Value Notes

⚠️ Methodology differences may exist between data sources, and so estimates from different sources are not comparable.

Some estimates presented here come from sample data, and thus have sampling errors that may render some apparent differences between geographies statistically indistinguishable. Click the Quick Info ⓘ icon to the left of each item to learn about sampling error.

The vintage year (e.g., V2025) refers to the final year of the series (2020 thru 2025). Different vintage years of estimates are not comparable.

Users should exercise caution when comparing 2020-2024 ACS 5-year estimates to other ACS estimates. For more information, please visit the [2024 5-year ACS Comparison Guidance](#) page.

Follow the [U.S. Census Bureau citation guidelines](#) to help credit your data sources correctly.

## Fact Notes

- (a) Includes persons reporting only one race
- (b) Hispanics may be of any race, so also are included in applicable race categories
- (c) Economic Census - Puerto Rico data are not comparable to U.S. Economic Census data

## Value Flags

- D Suppressed to avoid disclosure of confidential information
- F Fewer than 25 firms
- FN Footnote on this item in place of data
- NA Not available
- S Suppressed; does not meet publication standards
- X Not applicable
- Z Value greater than zero but less than half unit of measure shown

## APPENDIX B-COMMUNITY SURVEY QUESTIONS



You are being asked to fill out a survey about your opinions of the current health needs of Greene County. You are also being asked to provide demographic information. Your responses will be used for Greene County community needs assessment which helps target projects and grant funds that address our community needs. Your answers are anonymous. The data and any reports will not have any information about you.

The survey should take about 10-15 minutes to complete. It is voluntary. You can skip questions or stop any time you like. You will not receive compensation.

You may contact Molly Peters ([mpeters@greencountyhd.org](mailto:mpeters@greencountyhd.org)) with any questions.

Thank you in advance for participating !

Q1. From the following list, please identify the five (5) most important "health problems" in Greene County. (please select up to 5).

- ☐ Aging issues (e.g. arthritis, hearing loss, vision loss)
- ☐ Alzheimer Disease / Dementia
- ☐ Alcohol abuse
- ☐ Drug abuse
- ☐ Prescription drug abuse
- ☐ Cancer
- ☐ Child abuse / neglect
- ☐ Dental problems
- ☐ Diabetes
- ☐ Domestic violence

- ☐ Early sexual activity
- ☐ Firearm-related injuries
- ☐ Heart disease / heart attack
- ☐ HIV / AIDS
- ☐ Infectious disease (e.g. flu, pneumonia, hepatitis, TB)
- ☐ Mental health problems (e.g. depression, hopelessness, anger)
- ☐ Motor vehicle injuries
- ☐ Obesity
- ☐ Need for obstetrics & gynecology services
- ☐ Rape / sexual assault
- ☐ Respiratory / lung disease (e.g. asthma, COPD)
- ☐ Sexually transmitted diseases
- ☐ Suicide
- ☐ Teenage pregnancy
- ☐ Tobacco use
- ☐ Stroke
- ☐ Other:

Q2. What do you believe are the barriers to being healthy in Greene County? (select all that apply)

- ☐ Unaware of services, programs, and resources available for your specific concern
- ☐ Services and programs are hard to navigate alone
- ☐ Inability to afford available services
- ☐ Limited or unaffordable healthy food options
- ☐ Lack of activities to promote health and exercise
- ☐ Lack of activities for seniors
- ☐ Lack of financial resources
- ☐ Lack of transportation options
- ☐ Unemployment
- ☐ Lack of job opportunities
- ☐ Limited time due to commuting for work
- ☐ Difficulty scheduling with local providers

- ☐ Distance needed to get desired medical care
- ☐ Not able to establish annual, routine care
- ☐ Lack of local mental health services
- ☐ Reckless driving
- ☐ Tobacco use
- ☐ Drug use
- ☐ Prescription drug abuse
- ☐ Alcohol abuse
- ☐ Poor eating habits
- ☐ Lack of caring or concern about personal health
- ☐ Lack of motivation
- ☐ Inability to maintain positive progress
- ☐ Domestic violence
- ☐ Child abuse / neglect
- ☐ Limited health education in schools
- ☐ Lack of access to birth control
- ☐ Lack of engagement by representatives in local government
- ☐ High levels of stress affecting all areas of life
- ☐ Not as many community activities as in past
- ☐ Lack of reliable sources of information
- ☐ Other:

Q3. What are three (3) behaviors that have the greatest impact on overall community health in Greene County? (please select up to 3)

- ☐ Alcohol abuse
- ☐ Drug abuse
- ☐ Prescription drug abuse
- ☐ Tobacco abuse
- ☐ E-cig and vaping
- ☐ Lack of exercise
- ☐ Elder abuse (e.g. physical, emotional, financial, sexual)
- ☐ Child abuse or neglect

Discrimination (e.g. racism, sexism)

Overeating

Poor eating habits and unhealthy food choices

Not getting vaccines

Failing to follow state and local health department guidance

Reckless driving

Texting and/or cell phone use while driving

Not using seat belts and/or child safety seats

Not using or lack of access to birth control

Risky sexual behaviors

Other:

Q4. In your opinion, what services or programs would most improve health in our community?

☐ More health screenings (blood pressure, diabetes, cancer)

☐ Mental health & addiction services

☐ School-based health education

☐ Nutrition and exercise programs

☐ Maternal & child health programs

☐ Community events for wellness (health fairs, exercise groups)

☐ Other: \_\_\_\_\_

Q5. What is the single most important health issue you would like the Health Department to focus on?

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Q6. Do you have any other comments or suggestions?

Q7. When you get sick, where do you typically go to be seen? (mark all that apply)

Clinic / doctor's office  
Urgent care  
Emergency Department  
Other  
I don't seek medical attention

Q8. How long since your last doctor visit for a wellness checkup, not because you were already sick?

Within last year  
1-2 years ago  
3-5 years ago  
5 or more years ago  
I don't go unless I'm sick

Q9. In the last year, has there been a time you needed medical care, but were unable to get it?

- ☐ Yes  
☐ No

Q10. If yes to the prior question, why were you unable to get care (mark all that apply)

- ☐ I didn't have health insurance  
☐ I couldn't afford my co-pay or deductible  
☐ I didn't have transportation  
☐ The provider would not accept my insurance  
☐ The provider had no available appointments  
☐ Other:

Q11. How long since your last visit with a dentist not for an emergency?

- ☐ Within last year  
☐ 1-2 years ago  
☐ 3-5 years ago  
☐ 5 or more years ago  
☐ I don't go unless for an emergency

Q12. In the last year, has there been a time when you needed dental care, but were unable to get it?

- ☐ Yes  
☐ No

Q13. If yes to the prior question, why were you unable to get care? (mark all that apply)

- ☐ I didn't have health insurance

- ☐ I couldn't afford my co-pay or deductible
- ☐ I didn't have transportation
- ☐ The provider would not accept my insurance
- ☐ The provider had no available appointments
- ☐ Other:

Q14. In the last year, has there been a time you needed a prescription medication, but were unable to get it?

- ☐ Yes
- ☐ No

Q15. If yes to the prior question, why were you unable to get the prescription medication? (mark all that apply)

- ☐ I didn't have health insurance
- ☐ I couldn't afford my co-pay or deductible
- ☐ I didn't have transportation
- ☐ The pharmacy would not accept my insurance
- ☐ I pay cash and was unable to afford
- ☐ Other:

Q16. In the last year, has there been a time you needed mental health services, but were unable to get them?

- ☐ Yes
- ☐ No

Q17. If yes to the prior question, why were you unable to get care? (mark all that apply)

- ☐ I didn't have health insurance

- ☐ I couldn't afford my co-pay or deductible
- ☐ I didn't have transportation
- ☐ The provider would not accept my insurance
- ☐ The provider had no available appointments
- ☐ I didn't know how to find a provider
- ☐ Fear
- ☐ Embarrassment
- ☐ Concerned about confidentiality
- ☐ Other:

Q18. Have you ever utilized telemedicine (e.g. Zoom, Facetime, etc.) to be seen by a provider?

- ☐ Yes
- ☐ No

Q19. If you have utilized telemedicine, were you satisfied with the experience?

- ☐ Yes
- ☐ No

Q20. If you have utilized telemedicine and were satisfied with the experience, why?

Q21. If you have utilized telemedicine but were not satisfied with the experience, why?

Q22. If you have not utilized telemedicine, what has been the barrier? (mark all that apply)

- ☐ Lack of awareness of available telemedicine services
- ☐ Lack of reliable internet access
- ☐ Lack of capable device (computer, laptop, smartphone, tablet, etc.)
- ☐ Lack of trust in process
- ☐ Prefer in-person visit for personal connection
- ☐ Believe it results in lower quality care
- ☐ Lack of insurance coverage for telemedicine
- ☐ Inability to pay for telemedicine services
- ☐ Other:

Q23. If you have not utilized telemedicine, would you utilize such services if they were available?

- ☐ Yes
- ☐ No
- ☐ Maybe

Q24. If you would or might utilize telemedicine, for which services would you be likely to utilize? (mark all that apply)

- ☐ Primary care / non-urgent visit
- ☐ Prescription refill visit
- ☐ Receiving lab and test results
- ☐ Mental health services
- ☐ Social worker visit
- ☐ Other:

Q25. Please indicate your level of agreement with each of the following statements:

Greene County is a healthy place to live.

- ☐ Strongly Agree
- ☐ Somewhat Agree
- ☐ Neither Agree nor Disagree
- ☐ Somewhat Disagree
- ☐ Strongly Disagree

Greene County has adequate exercise and wellness activities.

- ☐ Strongly Agree
- ☐ Somewhat Agree
- ☐ Neither Agree nor Disagree
- ☐ Somewhat Disagree
- ☐ Strongly Disagree

I am access to the doctors and medical specialists I need.

- ☐ Strongly Agree
- ☐ Somewhat Agree
- ☐ Neither Agree nor Disagree
- ☐ Somewhat Disagree
- ☐ Strongly Disagree

I am satisfied with the medical care I receive in Greene County.

- ☐ Strongly Agree
- ☐ Somewhat Agree
- ☐ Neither Agree nor Disagree
- ☐ Somewhat Disagree
- ☐ Strongly Disagree

I have access to the social services I need.

- ☐ Strongly Agree
- ☐ Somewhat Agree
- ☐ Neither Agree nor Disagree
- ☐ Somewhat Disagree
- ☐ Strongly Disagree

#### Demographic Information:

Please provide the following information. It will be used for demographic purposes only. You will NOT be identified in any way with your answers. You do not need to answer the following questions for the rest of your survey to be considered, but answering these questions is important to helping the Greene County Health Department understand the public health needs of Greene County. Specifically, it helps identify unique needs for different groups (e.g. age, insurance status, etc.).

Q26. Zip Code:

Q27. Gender:

- ☐ Male
- ☐ Female
- ☐ Non-binary / third gender
- ☐ Prefer not to answer

Q28. Age:

- ☐ 18-25
- ☐ 26-39
- ☐ 40-54
- ☐ 55-64

- ☐ 65-80
- ☐ Over 80
- ☐ Prefer not to answer

Q29. Marital status:

- ☐ Never married
- ☐ Married / cohabitating
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Prefer not to answer
- ☐ Other:

Q30. Which would you say best represents your race?

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Pacific Islander
- ☐ Other
- ☐ Two or more races
- ☐ Prefer not to answer
- ☐ Other:

Q31. Ethnicity?

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Prefer not to answer

Q32. Household income before taxes for the last year

- ☐ Less than \$20,000
- ☐ \$20,000 - \$29,999
- ☐ \$30,000 - \$39,999
- ☐ \$40,000 - \$49,999
- ☐ \$50,000 - \$59,999
- ☐ \$60,000 - \$69,999
- ☐ \$70,000 - \$79,999
- ☐ \$80,000 - \$89,999
- ☐ \$90,000 - \$99,999
- ☐ \$100,000 - \$124,999
- ☐ \$125,000 - \$149,999
- ☐ Greater than \$150,000
- ☐ Prefer not to answer

Q33. Your highest education level?

- ☐ Less than high school graduate
- ☐ High school / GED
- ☐ Some college (no degree)
- ☐ Associate's degree
- ☐ Trade school
- ☐ Bachelor's degree
- ☐ Master's degree or higher
- ☐ Prefer not to answer
- ☐ Other:

Q34. Insurance status / How do you pay for you health care? (select all that apply)

- ☐ I have private health insurance
- ☐ I have Medicare

- ☐ I have Medicaid
- ☐ Veterans Administration
- ☐ Indian Health Services
- ☐ I have no health insurance
- ☐ Prefer not to answer
- ☐ Other:

Q35. If you work outside of the home, how long is your commute?

- ☐ Less than 30 minutes
- ☐ 30 to 60 minutes
- ☐ 60 to 90 minutes
- ☐ Greater than 90 minutes
- ☐ Prefer not to answer

Q36. Do you rent or own where you live?

- ☐ Rent
- ☐ Own
- ☐ Prefer not to answer
- ☐ Other:

Q37. What is your job status?

- ☐ Employed, full-time
- ☐ Employed, part-time
- ☐ Self-employed
- ☐ Unemployed
- ☐ Temporary work
- ☐ Homemaker
- ☐ Retired

- ☐ Disabled
- ☐ Student
- ☐ Currently serving in the Armed Forces
- ☐ Prefer not to answer
- ☐ Other:

## 2025 ROSC Survey

The purpose of this survey is to measure public opinion on issues related to recovery. The information collected will be used to identify areas for improvement in our community. Your responses are confidential so please answer the questions honestly and to the best of your ability. Thank you for completing this survey!

**Instructions:** For the following questions, please indicate how much you agree or disagree with each statement using the scale below: 1 – Strongly Disagree 2 – Disagree 3 – Neutral 4 – Agree 5 – Strongly Agree

**1. People who use drugs deserve respect.**

- ☐ 1- Strongly Disagree
- ☐ 2-Disagree
- ☐ 3-Neither Agree nor Disagree/Neutral
- ☐ 4-Agree
- ☐ 5-Strongly Agree

**2. There is a stigma in my community about people who have a substance use disorder.**

- ☐ 1-Strongly Disagree
- ☐ 2-Disagree
- ☐ 3-Neither Agree nor Disagree/Neutral
- ☐ 4-Agree
- ☐ 5-Strongly Agree

**3. People with mental illness deserve respect.**

- ☐ 1-Strongly Disagree
- ☐ 2-Disagree
- ☐ 3-Neither Agree nor Disagree/Neutral
- ☐ 4-Agree
- ☐ 5-Strongly Agree

**4. People with mental illness deserve the resources to help them get into recovery.**

- ☐ 1-Strongly Disagree
- ☐ 2-Disagree
- ☐ 3-Neither Agree nor Disagree/Neutral
- ☐ 4-Agree
- ☐ 5-Strongly Agree

**5. Medication Assisted Recovery- MAR (which is the use of medications to treat substance use disorders e.g. methadone and buprenorphine to treat opioid use disorder) is an effective treatment for substance use disorders.**

- ☐ 1-Strongly Disagree
- ☐ 2-Disagree
- ☐ 3-Neither Agree nor Disagree/Neutral
- ☐ 4-Agree
- ☐ 5-Strongly Agree

**6. It is difficult to find healthcare providers who offer Medication Assisted Recovery-MAR (which is the use of medications to treat substance use disorders e.g. methadone and buprenorphine to treat opioid use disorder) in my community.**

- ☐ 1-Strongly Disagree
- ☐ 2-Disagree
- ☐ 3-Neither Agree nor Disagree/Neutral
- ☐ 4-Agree
- ☐ 5-Strongly Agree

**7. It is difficult to find mental health and substance use treatment services in my community.**

- ☐ 1-Strongly Disagree
- ☐ 2-Disagree
- ☐ 3-Neither Agree nor Disagree/Neutral
- ☐ 4-Agree
- ☐ 5-Strongly Agree

**8. Harm reduction services like Narcan and syringe service programs reduce the risks of drug use.**

- ☐ 1-Strongly Disagree
- ☐ 2-Disagree
- ☐ 3-Neither Agree nor Disagree/Neutral
- ☐ 4-Agree
- ☐ 5-Strongly Agree

**9. Narcan should be free and accessible in my community.**

- ☐ 1-Strongly Disagree
- ☐ 2-Disagree
- ☐ 3-Neither Agree nor Disagree/Neutral
- ☐ 4-Agree
- ☐ 5-Strongly Agree

**10. It is difficult to find harm reduction services like Narcan and syringe service programs in my community.**

- ☐ 1-Strongly Disagree
- ☐ 2-Disagree
- ☐ 3-Neither Agree nor Disagree/Neutral
- ☐ 4-Agree
- ☐ 5-Strongly Agree

**11. We should increase government funding on treatment options for mental health and substance use disorders.**

- ☐ 1-Strongly Disagree
- ☐ 2-Disagree
- ☐ 3-Neither Agree nor Disagree/Neutral
- ☐ 4-Agree
- ☐ 5-Strongly Agree

**12. Everyone in my community can get help for mental health regardless of income level, insurance status, race, ethnicity, primary language, disabilities, gender identity, sexual orientation, or citizenship status.**

- ☐ 1-Strongly Disagree
- ☐ 2-Disagree
- ☐ 3-Neither Agree nor Disagree/Neutral
- ☐ 4-Agree
- ☐ 5-Strongly Agree

**13. Everyone in my community can get help for substance use regardless of income level, insurance status, race, ethnicity, primary language, disabilities, gender identity, sexual orientation, or citizenship status.**

- ☐ 1-Strongly Disagree
- ☐ 2-Disagree
- ☐ 3-Neither Agree nor Disagree/Neutral
- ☐ 4-Agree
- ☐ 5-Strongly Agree

**14. People who use drugs deserve the resources to help them get into recovery.**

- ☐ 1-Strongly Disagree
- ☐ 2-disagree
- ☐ 3-Neither Agree nor Disagree/Neutral
- ☐ 4-Agree
- ☐ 5-Strongly Agree

**Other Questions:**

**1. I know someone with a substance use disorder.**

- ☐ Yes
- ☐ No
- ☐ I am a person in Recovery.

**2. I know someone with a mental illness.**

- ☐ Yes
- ☐ No
- ☐ I am a person with a mental illness

**3. Have you ever been trained to administer Narcan?**

- ☐ Yes
- ☐ No

**4. Do you have any Children?**

- ☐ Yes
- ☐ No

**5. Did you Graduate High School?**

- ☐ Yes
- ☐ No
- ☐ GED
- ☐ Enrolled

**Demographics**

**Circle your answer.**

**1. What is your age group?**

(Under 18, 18-24, 25-34, 35-44, 45-54, 55-64, 65+)

**2. What is your income level?**

(Under \$24,999, \$25,000-\$49,999, \$50,000-\$99,999, \$100,000 and over)

**3. What is your gender?**

(Male, Female, Gender Fluid, Nonbinary)

**4. What county do you reside in? \_\_\_\_\_**

**5. What is your zip code? \_\_\_\_\_**

**6. What is your ethnicity?**

(Hispanic or Latino / Non-Hispanic)

**7. What is your race?**

(African American/Black, Asian, White, Native American, Pacific Islander, Two or more races)

**8. What is your primary language?**

(English, Spanish, Mandarin, French, Arabic, Other)

**9. What do you think is the most important support for someone who is new in Recovery?  
(Rank from 1-6 with 1 being the most important) [Rank Order, please enter numbers in the  
square brackets in order]**

☐ Peer/Group Support

☐ Housing

☐ Professional Counselling

☐ Food

☐ Jobs

☐ Transportation

**10. Would you like to get involved with the local ROSC - Recovery Oriented System of Care  
Council?**

☐ Yes

☐ No

**11. If you answered yes to Question 10, please provide your contact information below:**

**(Name, Phone number, Email)**

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## **APPENDIX C- COMMUNITY SURVEY ANALYSIS**

# GREENE COUNTY COMMUNITY SURVEY ANALYSIS

Informing the 2027–2031 IPLAN Priorities



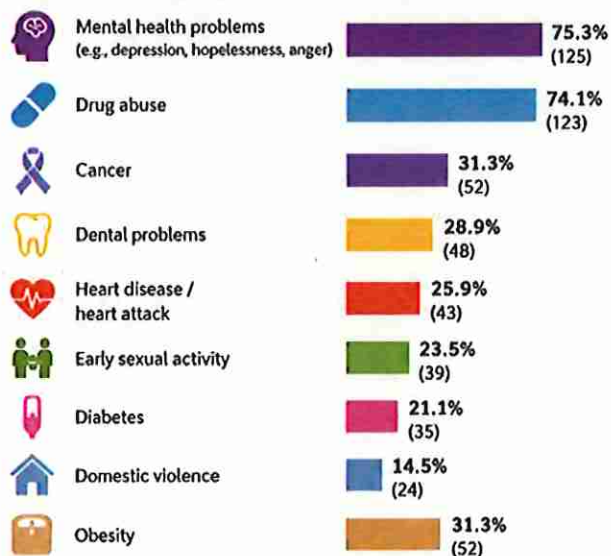
**GREENE COUNTY**  
HEALTH DEPARTMENT  
*Protect. Promote. Prevent.*

  
**166**  
RESPONDENTS

The Greene County Community Survey was conducted as part of the 2027–2031 IPLAN Community Health Needs Assessment.

Responses represent a diverse group of residents across multiple communities, ages, income levels, education levels, insurance types, and employment situations.

## TOP COMMUNITY HEALTH CONCERNS (Percentage of Respondents)



(See page 3 for full list of concerns)

## BARRIERS TO ACCESSING HEALTH CARE (Among those who reported barriers)



(See page 14 for full list)

## TELEMEDICINE FINDINGS

### BARRIERS TO TELEMEDICINE



### INTEREST IN TELEMEDICINE

- ☒ Primary care / non-urgent visits
- ☒ Prescription refills
- ☒ Laboratory results
- ☒ Mental health services
- ☒ Social worker visits

(See page 29–30 for details)

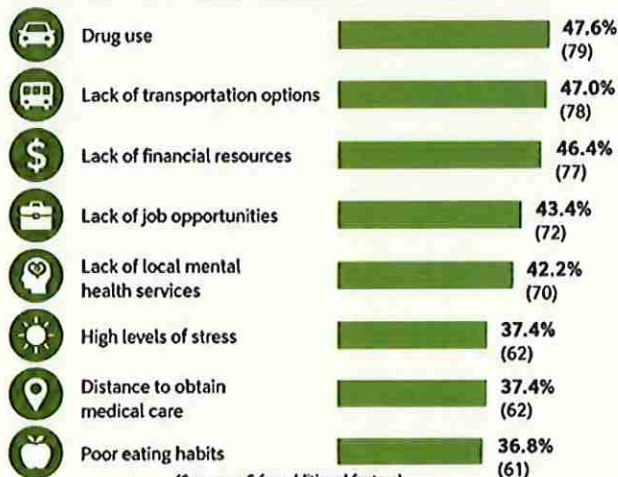
## KEY TAKEAWAYS

-  Mental health and substance use are the most pressing concerns in Greene County.
-  Transportation, financial stability, job opportunities, and access to services strongly influence health.
-  Barriers to care and behavioral health services include provider availability, cost, insurance, transportation, and stigma.
-  Residents want more mental health and addiction services, wellness opportunities, health education, and preventive services.
-  Community Health Navigation is essential to help individuals find, understand, and successfully connect to the resources they need.

## OUR 2027–2031 IPLAN PRIORITIES

-  **Community Health Navigation**  
Helping residents overcome barriers and connect to the services they need.
-  **Behavioral Health Services**  
Improving access to mental health and behavioral health care.
-  **Substance Use Prevention**  
Promoting prevention, recovery, and support for individuals and families.
-  **Rural Community Infrastructure & Sustainability**  
Strengthening the systems, services, and resources that support healthy rural living.

## TOP CONTRIBUTING FACTORS AFFECTING HEALTH IN OUR COMMUNITY



(See page 5 for additional factors)

## BARRIERS TO ACCESSING BEHAVIORAL HEALTH SERVICES



(See page 20 for full list)

## ADDITIONAL HEALTH DEPARTMENT PROGRAMS RESIDENTS WOULD LIKE TO SEE



(See page 55 for full list)

## MOVING FORWARD TOGETHER

 These survey results, combined with focus groups, statistical data, and partner input, guide our 2027–2031 IPLAN priorities and help us focus on solutions that address both individual needs and the systems that impact health in Greene County.

 By working together, we can strengthen services, remove barriers, and build a healthier, more sustainable community for all who live, work, and raise families in Greene County.



Your voice matters. Together, we can create a healthier Greene County.

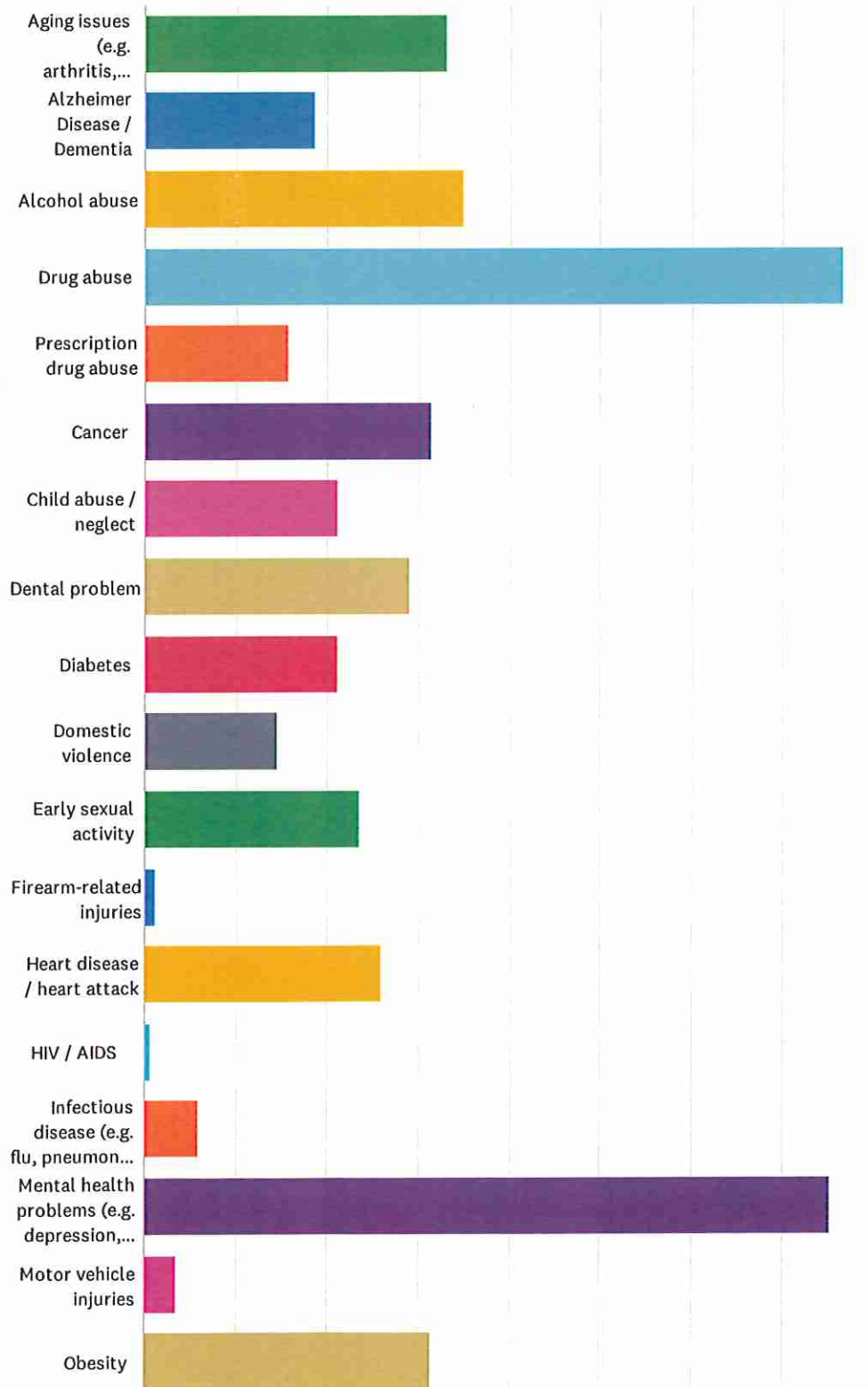
Survey responses: 166

Full survey report pages referenced: 1–3, 5–7, 14–31, 55–58

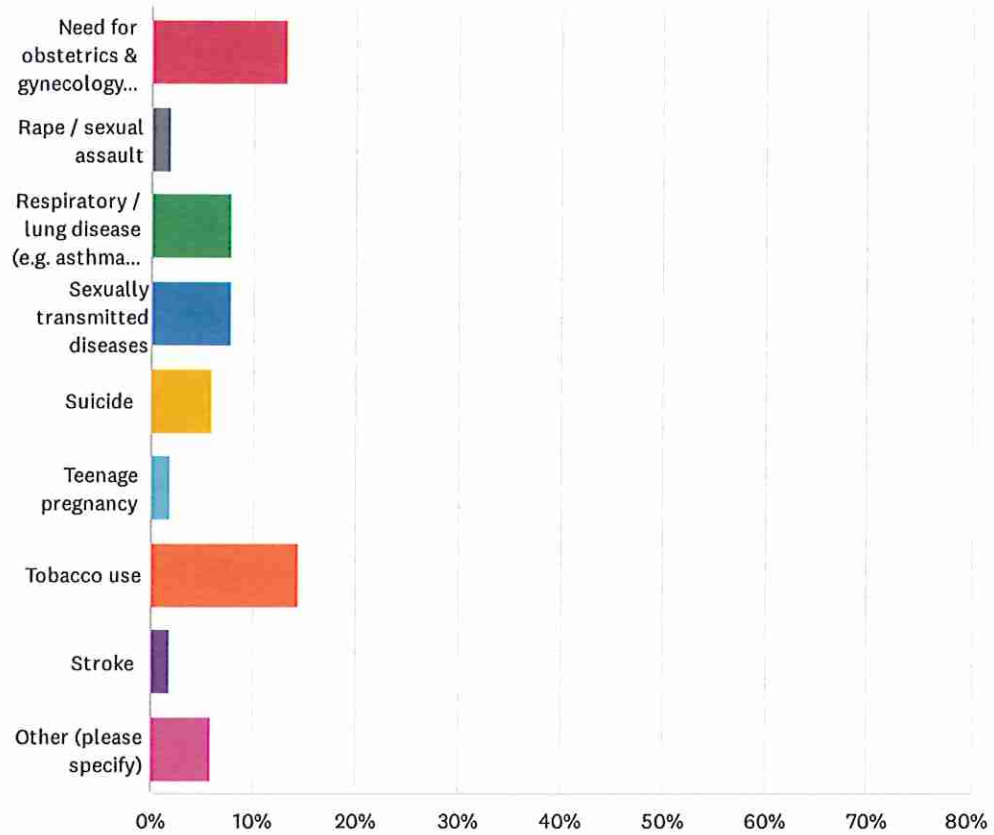
Greene County Community Needs Assessment

Q1 From the following list, please identify the five (5) most important "health problems" in Greene County. (please select up to 5).

Answered: 166 Skipped: 0



## Greene County Community Needs Assessment



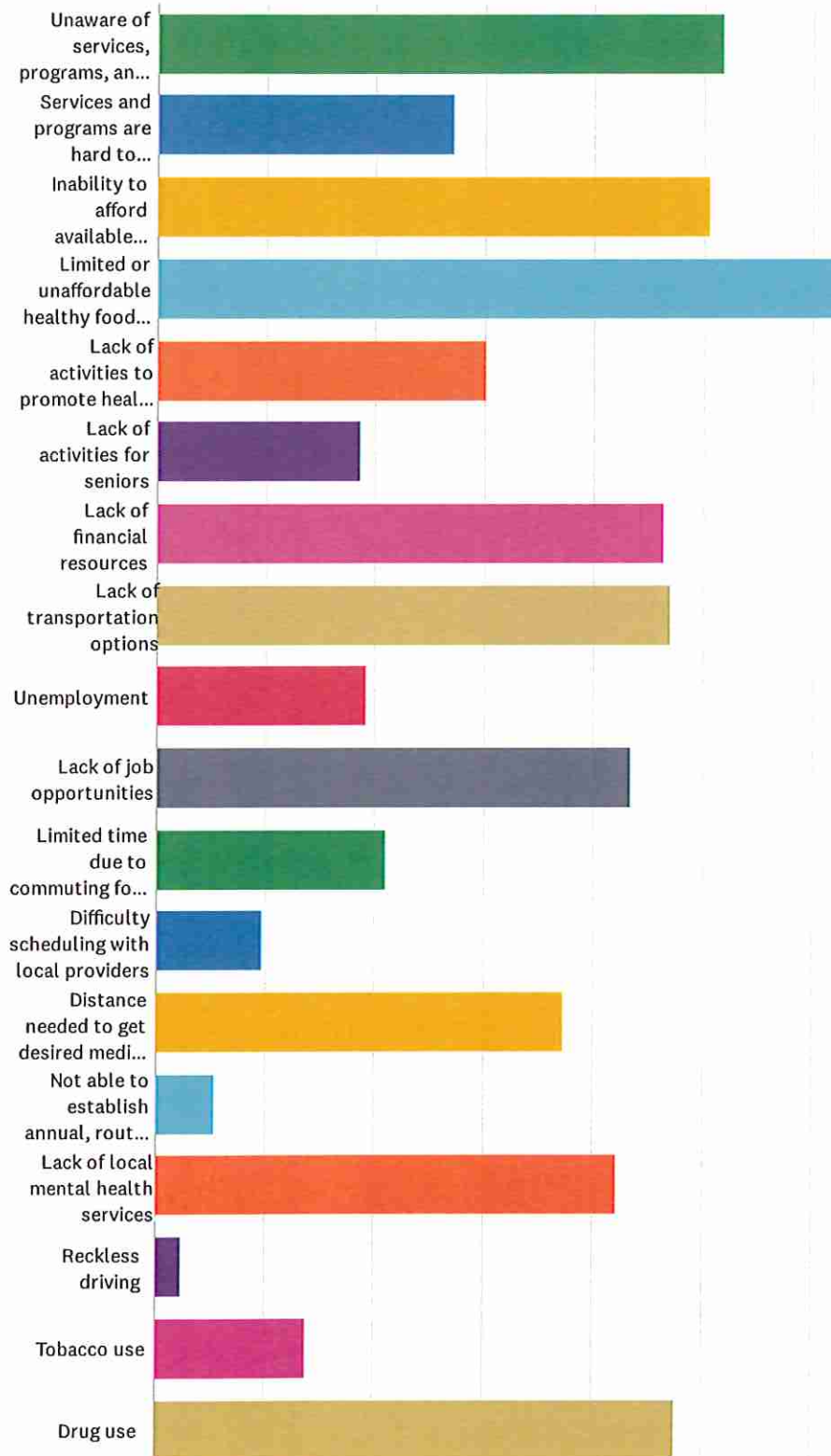
## Greene County Community Needs Assessment

| <b>ANSWER CHOICES</b>                                         | <b>RESPONSES</b> |     |
|---------------------------------------------------------------|------------------|-----|
| Aging issues (e.g. arthritis, hearing loss, vision loss)      | 33.13%           | 55  |
| Alzheimer Disease / Dementia                                  | 18.67%           | 31  |
| Alcohol abuse                                                 | 34.94%           | 58  |
| Drug abuse                                                    | 76.51%           | 127 |
| Prescription drug abuse                                       | 15.66%           | 26  |
| Cancer                                                        | 31.33%           | 52  |
| Child abuse / neglect                                         | 21.08%           | 35  |
| Dental problem                                                | 28.92%           | 48  |
| Diabetes                                                      | 21.08%           | 35  |
| Domestic violence                                             | 14.46%           | 24  |
| Early sexual activity                                         | 23.49%           | 39  |
| Firearm-related injuries                                      | 1.20%            | 2   |
| Heart disease / heart attack                                  | 25.90%           | 43  |
| HIV / AIDS                                                    | 0.60%            | 1   |
| Infectious disease (e.g. flu, pneumonia, hepatitis, TB)       | 6.02%            | 10  |
| Mental health problems (e.g. depression, hopelessness, anger) | 75.30%           | 125 |
| Motor vehicle injuries                                        | 3.61%            | 6   |
| Obesity                                                       | 31.33%           | 52  |
| Need for obstetrics & gynecology services                     | 13.25%           | 22  |
| Rape / sexual assault                                         | 1.81%            | 3   |
| Respiratory / lung disease (e.g. asthma, COPD)                | 7.83%            | 13  |
| Sexually transmitted diseases                                 | 7.83%            | 13  |
| Suicide                                                       | 6.02%            | 10  |
| Teenage pregnancy                                             | 1.81%            | 3   |
| Tobacco use                                                   | 14.46%           | 24  |
| Stroke                                                        | 1.81%            | 3   |
| Other (please specify)                                        | 6.02%            | 10  |
| Total Respondents: 166                                        |                  |     |

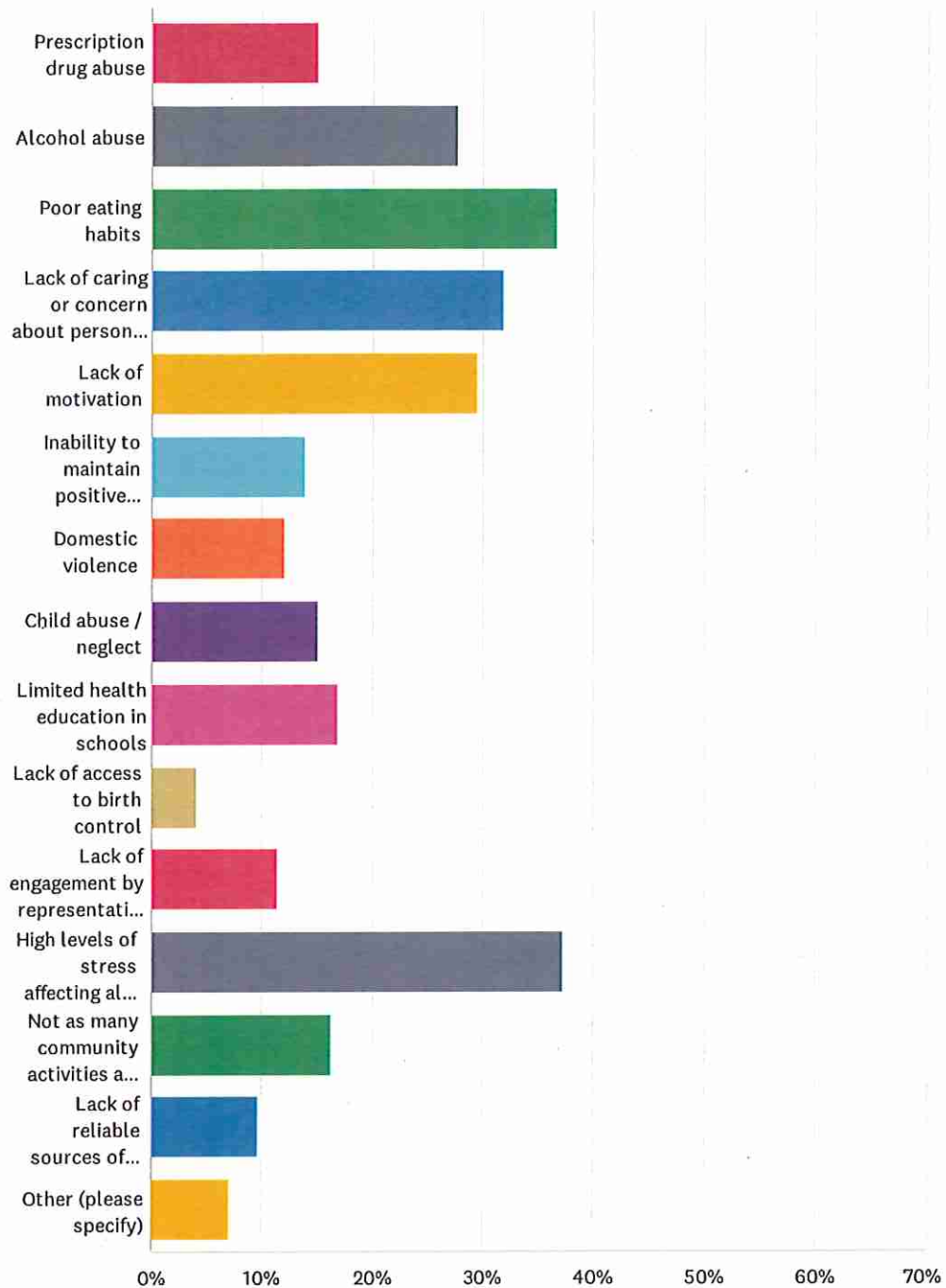
# Greene County Community Needs Assessment

## Q2 What do you believe are the barriers to being healthy in Greene County? (select all that apply)

Answered: 166 Skipped: 0



## Greene County Community Needs Assessment



## Greene County Community Needs Assessment

| <b>ANSWER CHOICES</b>                                                            | <b>RESPONSES</b> |     |
|----------------------------------------------------------------------------------|------------------|-----|
| Unaware of services, programs, and resources available for your specific concern | 51.81%           | 86  |
| Services and programs are hard to navigate alone                                 | 27.11%           | 45  |
| Inability to afford available services                                           | 50.60%           | 84  |
| Limited or unaffordable healthy food options                                     | 62.65%           | 104 |
| Lack of activities to promote health and exercise                                | 30.12%           | 50  |
| Lack of activities for seniors                                                   | 18.67%           | 31  |
| Lack of financial resources                                                      | 46.39%           | 77  |
| Lack of transportation options                                                   | 46.99%           | 78  |
| Unemployment                                                                     | 19.28%           | 32  |
| Lack of job opportunities                                                        | 43.37%           | 72  |
| Limited time due to commuting for work                                           | 21.08%           | 35  |
| Difficulty scheduling with local providers                                       | 9.64%            | 16  |
| Distance needed to get desired medical care                                      | 37.35%           | 62  |
| Not able to establish annual, routine care                                       | 5.42%            | 9   |
| Lack of local mental health services                                             | 42.17%           | 70  |
| Reckless driving                                                                 | 2.41%            | 4   |
| Tobacco use                                                                      | 13.86%           | 23  |
| Drug use                                                                         | 47.59%           | 79  |
| Prescription drug abuse                                                          | 15.06%           | 25  |
| Alcohol abuse                                                                    | 27.71%           | 46  |
| Poor eating habits                                                               | 36.75%           | 61  |
| Lack of caring or concern about personal health                                  | 31.93%           | 53  |
| Lack of motivation                                                               | 29.52%           | 49  |
| Inability to maintain positive progress                                          | 13.86%           | 23  |
| Domestic violence                                                                | 12.05%           | 20  |
| Child abuse / neglect                                                            | 15.06%           | 25  |
| Limited health education in schools                                              | 16.87%           | 28  |
| Lack of access to birth control                                                  | 4.22%            | 7   |
| Lack of engagement by representatives in local government                        | 11.45%           | 19  |
| High levels of stress affecting all areas of life                                | 37.35%           | 62  |
| Not as many community activities as in past                                      | 16.27%           | 27  |
| Lack of reliable sources of information                                          | 9.64%            | 16  |

## Greene County Community Needs Assessment

Other (please specify)  
Total Respondents: 166

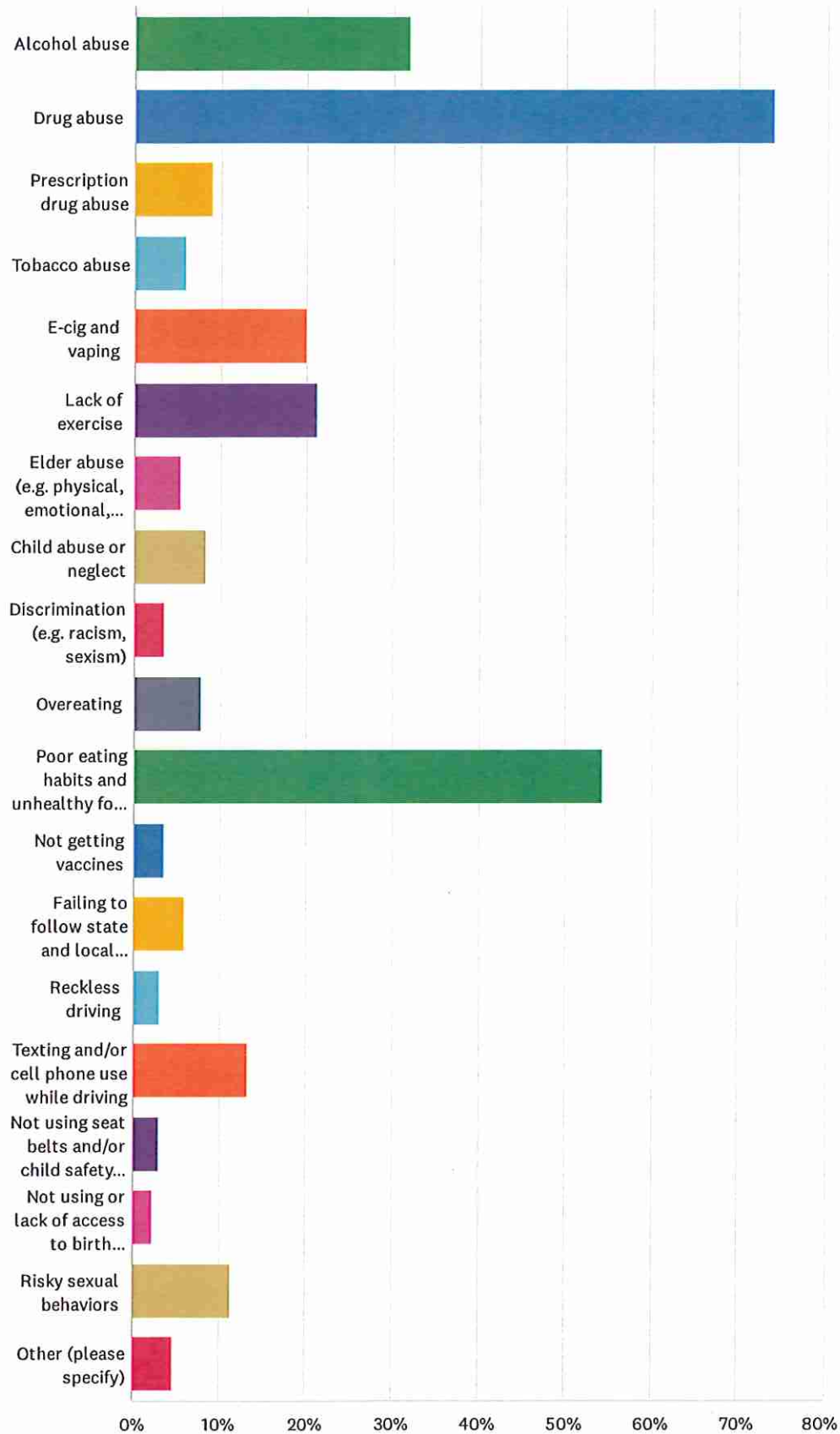
7.23%

12

Q3 What are three (3) behaviors that have the greatest impact on overall community health in Greene County? (please select up to 3)

Answered: 166    Skipped: 0

## Greene County Community Needs Assessment



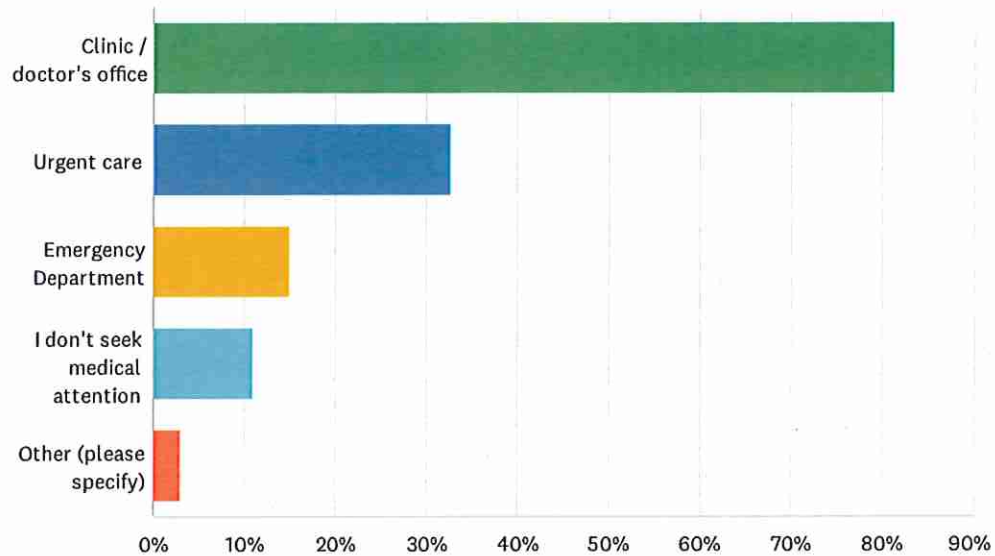
## Greene County Community Needs Assessment

| <b>ANSWER CHOICES</b>                                        | <b>RESPONSES</b> |     |
|--------------------------------------------------------------|------------------|-----|
| Alcohol abuse                                                | 31.93%           | 53  |
| Drug abuse                                                   | 74.10%           | 123 |
| Prescription drug abuse                                      | 9.04%            | 15  |
| Tobacco abuse                                                | 6.02%            | 10  |
| E-cig and vaping                                             | 19.88%           | 33  |
| Lack of exercise                                             | 21.08%           | 35  |
| Elder abuse (e.g. physical, emotional, financial, sexual)    | 5.42%            | 9   |
| Child abuse or neglect                                       | 8.43%            | 14  |
| Discrimination (e.g. racism, sexism)                         | 3.61%            | 6   |
| Overeating                                                   | 7.83%            | 13  |
| Poor eating habits and unhealthy food choices                | 54.22%           | 90  |
| Not getting vaccines                                         | 3.61%            | 6   |
| Failing to follow state and local health department guidance | 6.02%            | 10  |
| Reckless driving                                             | 3.01%            | 5   |
| Texting and/or cell phone use while driving                  | 13.25%           | 22  |
| Not using seat belts and/or child safety seats               | 3.01%            | 5   |
| Not using or lack of access to birth control                 | 2.41%            | 4   |
| Risky sexual behaviors                                       | 11.45%           | 19  |
| Other (please specify)                                       | 4.82%            | 8   |
| Total Respondents: 166                                       |                  |     |

# Greene County Community Needs Assessment

## Q4 When you get sick, where do you typically go to be seen? (mark all that apply)

Answered: 166 Skipped: 0



### ANSWER CHOICES

### RESPONSES

Clinic / doctor's office

81.33%

135

Urgent care

32.53%

54

Emergency Department

15.06%

25

I don't seek medical attention

10.84%

18

Other (please specify)

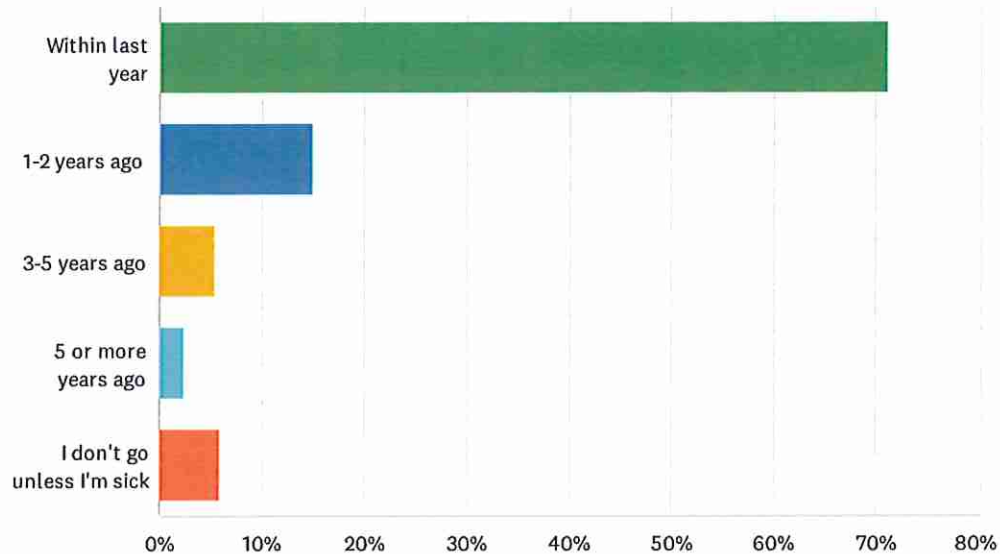
3.01%

5

Total Respondents: 166

## Q5 How long since your last doctor visit for a wellness checkup, not because you were already sick?

Answered: 166 Skipped: 0

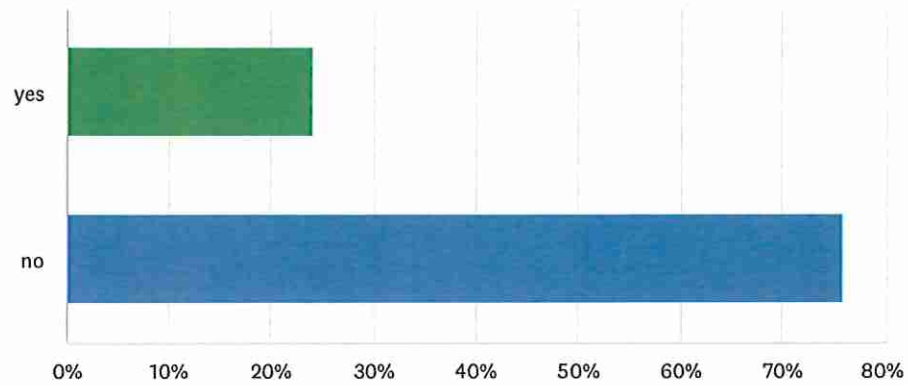


| ANSWER CHOICES             | RESPONSES |     |
|----------------------------|-----------|-----|
| Within last year           | 71.08%    | 118 |
| 1-2 years ago              | 15.06%    | 25  |
| 3-5 years ago              | 5.42%     | 9   |
| 5 or more years ago        | 2.41%     | 4   |
| I don't go unless I'm sick | 6.02%     | 10  |
| TOTAL                      |           | 166 |

Greene County Community Needs Assessment

Q6 In the last year, has there been a time you needed medical care, but were unable to get it?

Answered: 166 Skipped: 0

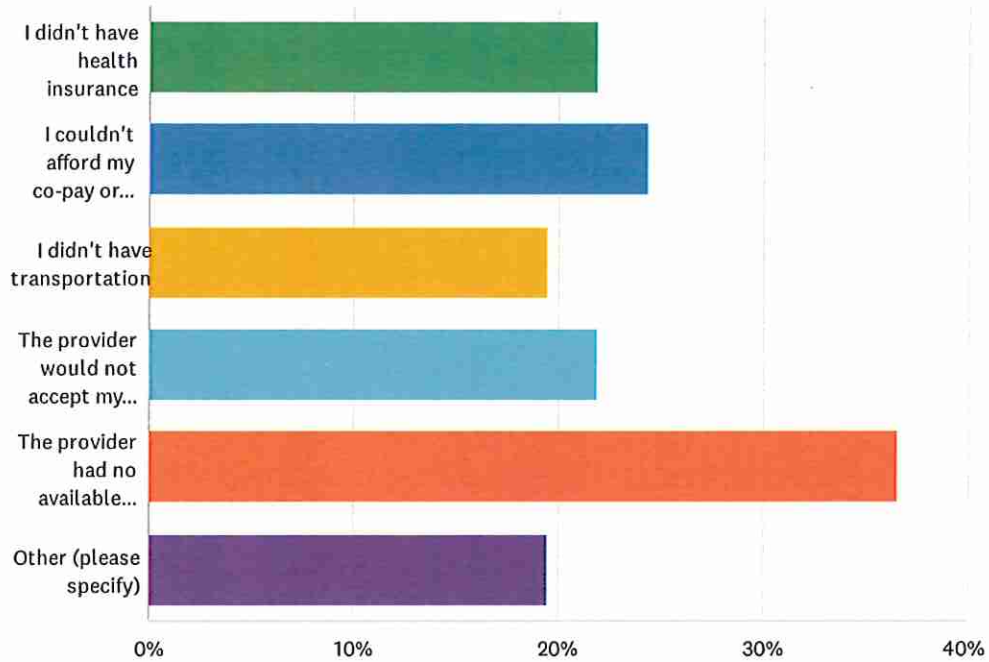


| ANSWER CHOICES | RESPONSES |     |
|----------------|-----------|-----|
| yes            | 24.10%    | 40  |
| no             | 75.90%    | 126 |
| TOTAL          |           | 166 |

## Greene County Community Needs Assessment

Q7 If yes to the prior question, why were you unable to get care (mark all that apply)

Answered: 41 Skipped: 125

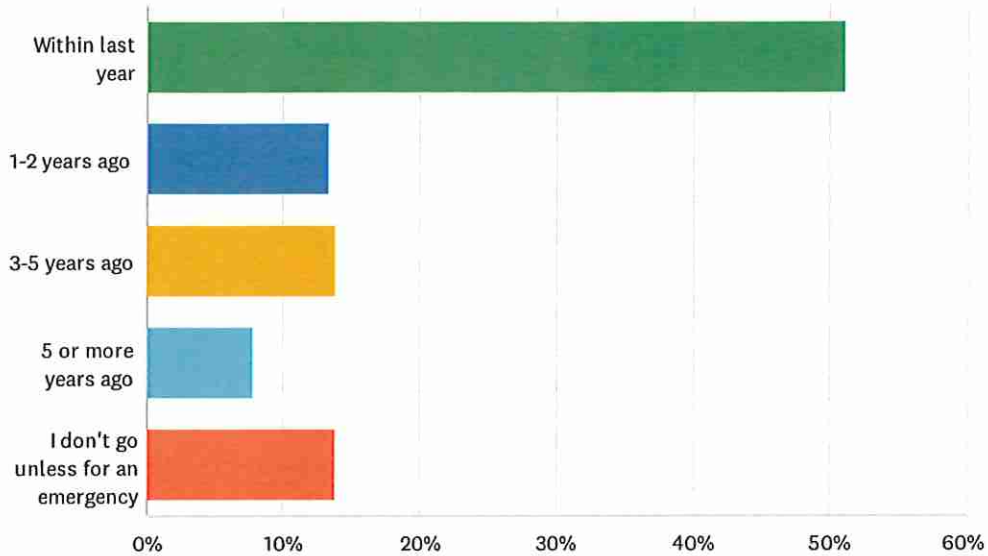


| ANSWER CHOICES                             | RESPONSES |    |
|--------------------------------------------|-----------|----|
| I didn't have health insurance             | 21.95%    | 9  |
| I couldn't afford my co-pay or deductible  | 24.39%    | 10 |
| I didn't have transportation               | 19.51%    | 8  |
| The provider would not accept my insurance | 21.95%    | 9  |
| The provider had no available appointments | 36.59%    | 15 |
| Other (please specify)                     | 19.51%    | 8  |
| Total Respondents: 41                      |           |    |

# Greene County Community Needs Assessment

## Q8 How long since your last visit with a dentist not for an emergency?

Answered: 166 Skipped: 0

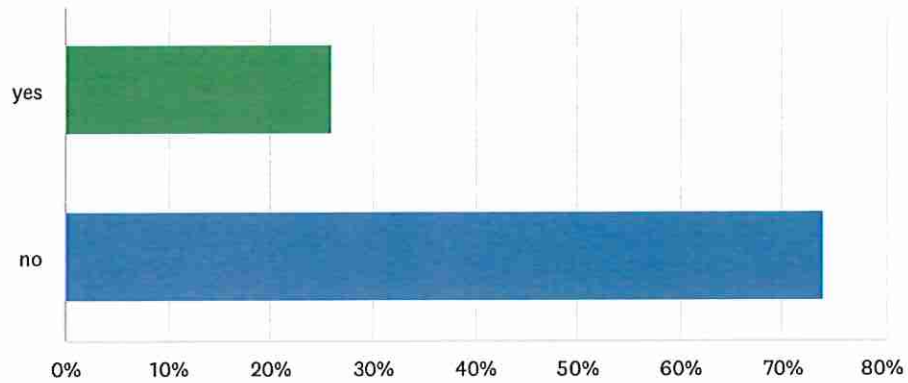


| ANSWER CHOICES                     | RESPONSES |     |
|------------------------------------|-----------|-----|
| Within last year                   | 51.20%    | 85  |
| 1-2 years ago                      | 13.25%    | 22  |
| 3-5 years ago                      | 13.86%    | 23  |
| 5 or more years ago                | 7.83%     | 13  |
| I don't go unless for an emergency | 13.86%    | 23  |
| TOTAL                              |           | 166 |

Greene County Community Needs Assessment

Q9 In the last year, has there been a time when you needed dental care, but were unable to get it?

Answered: 166 Skipped: 0

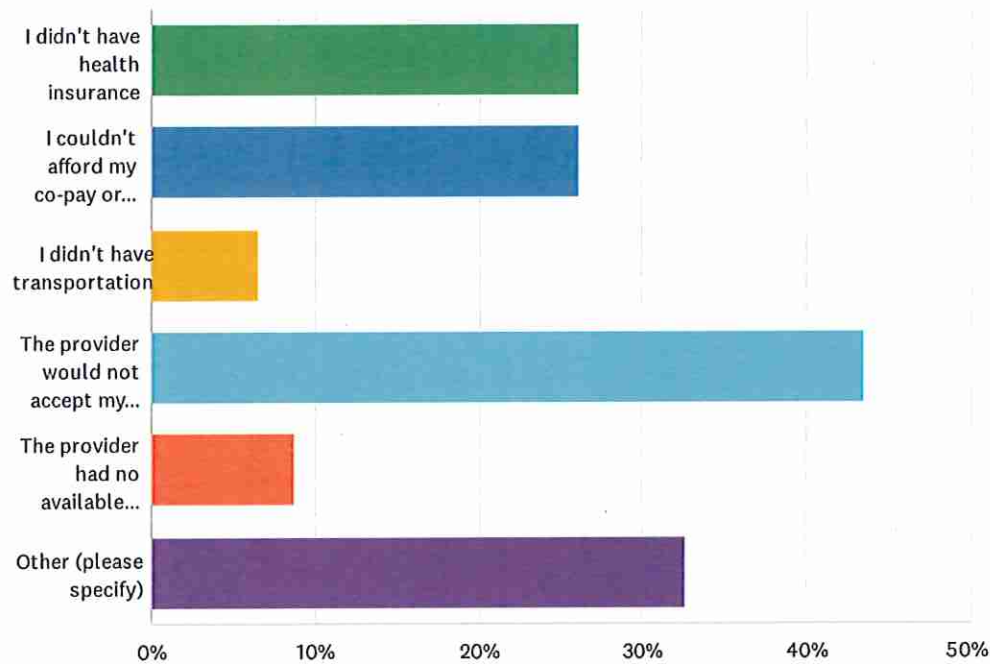


| ANSWER CHOICES | RESPONSES |     |
|----------------|-----------|-----|
| yes            | 25.90%    | 43  |
| no             | 74.10%    | 123 |
| TOTAL          |           | 166 |

## Greene County Community Needs Assessment

Q10 If yes to the prior question, why were yo unable to get care? (mark all that apply)

Answered: 46 Skipped: 120



### ANSWER CHOICES

### RESPONSES

I didn't have health insurance

26.09%

12

I couldn't afford my co-pay or deductible

26.09%

12

I didn't have transportation

6.52%

3

The provider would not accept my insurance

43.48%

20

The provider had no available appointments

8.70%

4

Other (please specify)

32.61%

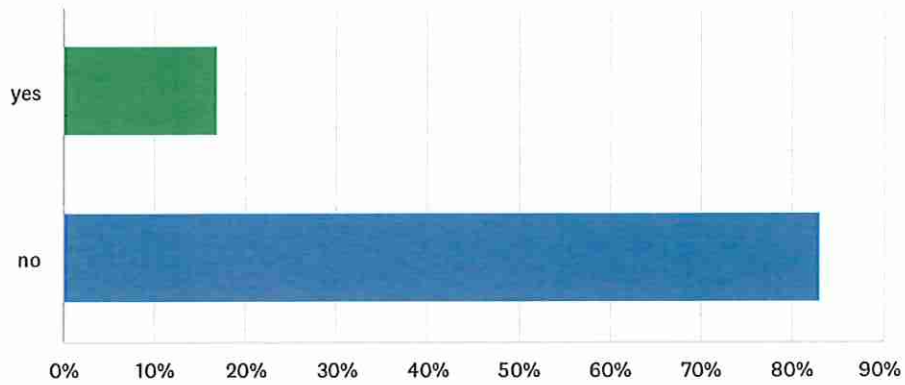
15

Total Respondents: 46

Greene County Community Needs Assessment

Q11 In the last year, has there been a time you needed a prescription medication, but were unable to get it?

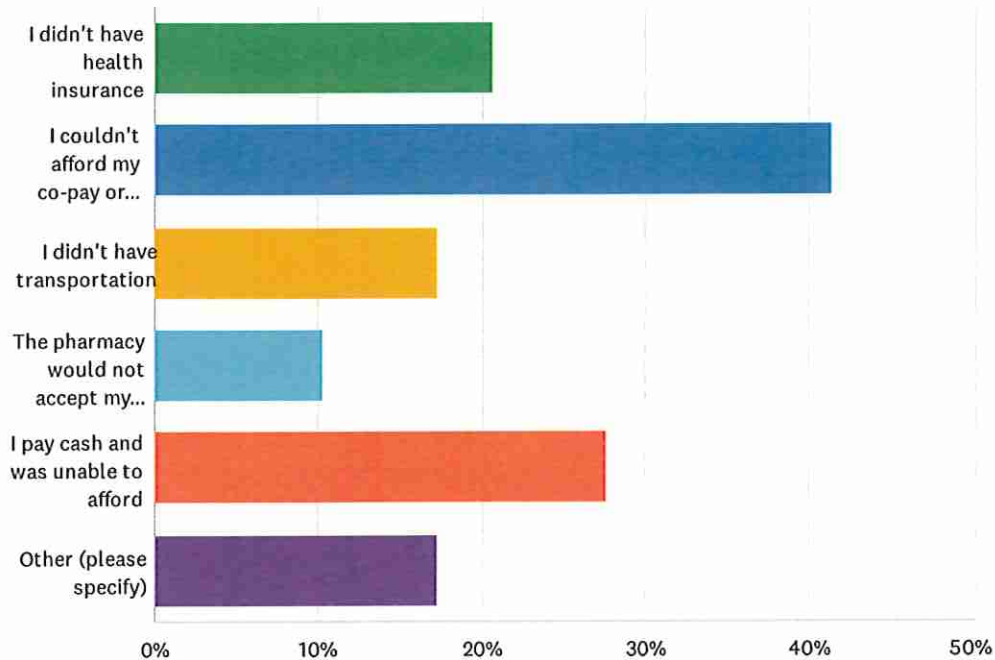
Answered: 166 Skipped: 0



| ANSWER CHOICES | RESPONSES |     |
|----------------|-----------|-----|
| yes            | 16.87%    | 28  |
| no             | 83.13%    | 138 |
| TOTAL          |           | 166 |

## Q12 If yes to the prior question, why were you unable to get the prescription medication? (mark all that apply)

Answered: 29 Skipped: 137

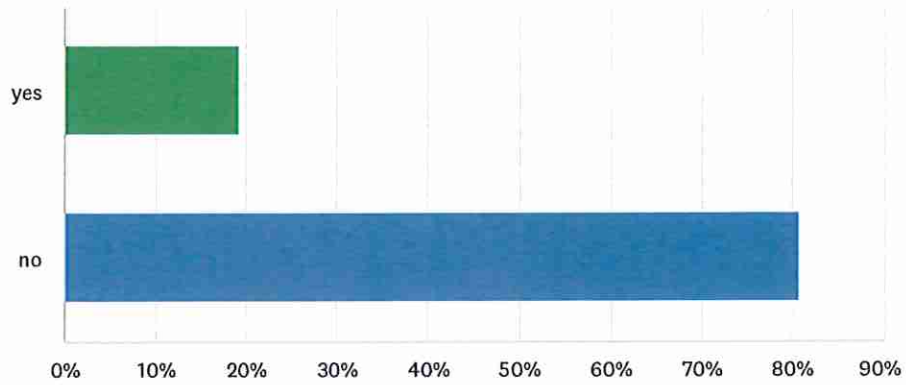


| ANSWER CHOICES                             | RESPONSES |    |
|--------------------------------------------|-----------|----|
| I didn't have health insurance             | 20.69%    | 6  |
| I couldn't afford my co-pay or deductible  | 41.38%    | 12 |
| I didn't have transportation               | 17.24%    | 5  |
| The pharmacy would not accept my insurance | 10.34%    | 3  |
| I pay cash and was unable to afford        | 27.59%    | 8  |
| Other (please specify)                     | 17.24%    | 5  |
| Total Respondents: 29                      |           |    |

Greene County Community Needs Assessment

Q13 In the last year, has there been a time you needed mental health services, but were unable to get them?

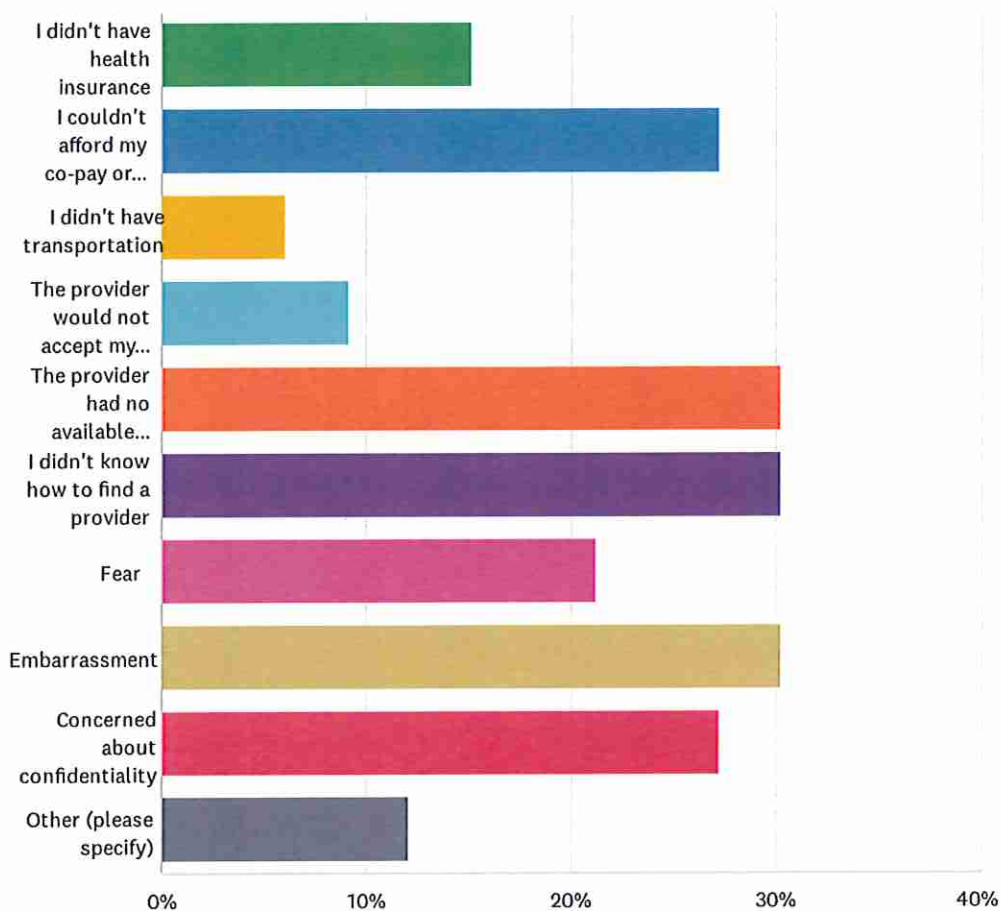
Answered: 166 Skipped: 0



| ANSWER CHOICES | RESPONSES |     |
|----------------|-----------|-----|
| yes            | 19.28%    | 32  |
| no             | 80.72%    | 134 |
| TOTAL          |           | 166 |

Q14 If yes to the prior question, why were you unable to get care? (mark all that apply)

Answered: 33 Skipped: 133



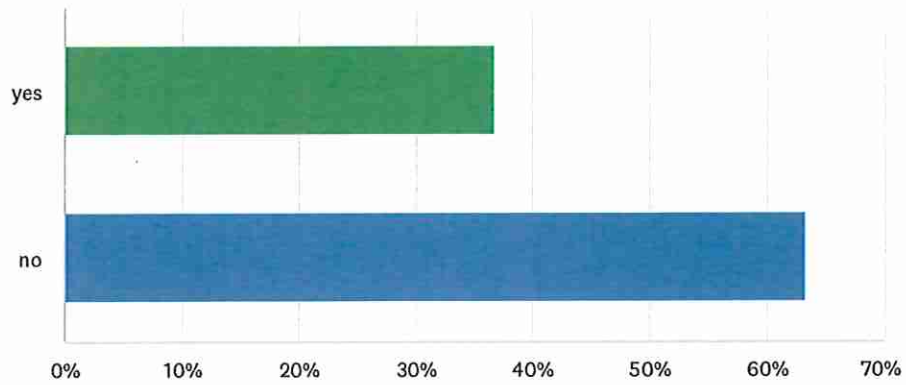
## Greene County Community Needs Assessment

| ANSWER CHOICES                             | RESPONSES |    |
|--------------------------------------------|-----------|----|
| I didn't have health insurance             | 15.15%    | 5  |
| I couldn't afford my co-pay or deductible  | 27.27%    | 9  |
| I didn't have transportation               | 6.06%     | 2  |
| The provider would not accept my insurance | 9.09%     | 3  |
| The provider had no available appointments | 30.30%    | 10 |
| I didn't know how to find a provider       | 30.30%    | 10 |
| Fear                                       | 21.21%    | 7  |
| Embarrassment                              | 30.30%    | 10 |
| Concerned about confidentiality            | 27.27%    | 9  |
| Other (please specify)                     | 12.12%    | 4  |
| Total Respondents: 33                      |           |    |

Greene County Community Needs Assessment

Q15 Have you ever utilized telemedicine (e.g. Zoom, Facetime, etc.) to be seen by a provider?

Answered: 166 Skipped: 0



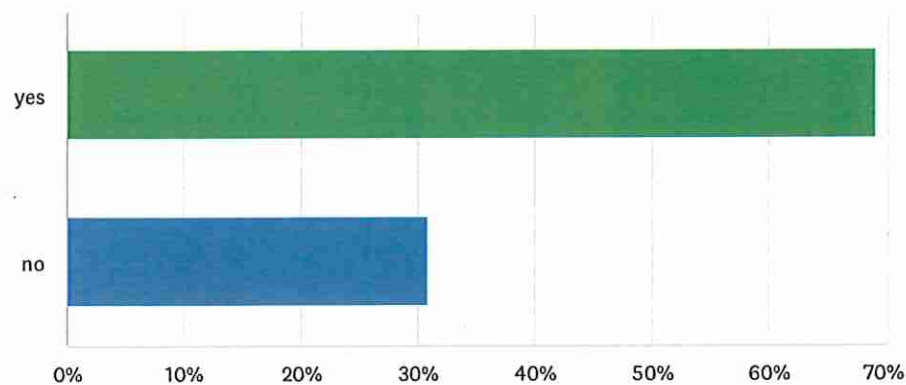
ANSWER CHOICES

RESPONSES

|       |        |     |
|-------|--------|-----|
| yes   | 36.75% | 61  |
| no    | 63.25% | 105 |
| TOTAL |        | 166 |

Q16 If you have utilized telemedicine, were you satisfied with the experience?

Answered: 68    Skipped: 98



| ANSWER CHOICES | RESPONSES |    |
|----------------|-----------|----|
| yes            | 69.12%    | 47 |
| no             | 30.88%    | 21 |
| TOTAL          |           | 68 |

## Q17 If you have utilized telemedicine and were satisfied with the experience, why?

Answered: 36 Skipped: 130

| #  | RESPONSES                                                                                                                                                               | DATE               |
|----|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|
| 1  | It's more convenient because of transportation issues                                                                                                                   | 1/29/2026 1:57 PM  |
| 2  | I could just do it over the phone. saved me from going there.                                                                                                           | 1/27/2026 1:31 PM  |
| 3  | It saves us several trips to Springfield to meet with my son's pediatrician for his ADHD medicine.                                                                      | 1/27/2026 11:35 AM |
| 4  | It was quick and efficient for an ear infection and strep throat. Didn't have to miss work.                                                                             | 1/27/2026 9:30 AM  |
| 5  | it was easy, and served my needs, while not requiring me to be anxious about going to an office                                                                         | 1/27/2026 9:15 AM  |
| 6  | Saved me having to drive 30 minutes or more to see a provider to talk.                                                                                                  | 1/27/2026 9:10 AM  |
| 7  | Because it was with my established doctor.                                                                                                                              | 1/26/2026 8:18 AM  |
| 8  | Simple process and it's always available.                                                                                                                               | 1/26/2026 6:53 AM  |
| 9  | Easy and convenient                                                                                                                                                     | 1/12/2026 12:35 PM |
| 10 | I used this for psychiatric care and I felt that my counseling was just as effective virtual. I also didn't have to drive and expose myself during high illness season. | 1/11/2026 5:52 AM  |
| 11 | ease of access                                                                                                                                                          | 1/10/2026 9:22 AM  |
| 12 | Convenient                                                                                                                                                              | 1/9/2026 6:26 PM   |
| 13 | Easy                                                                                                                                                                    | 1/8/2026 3:41 PM   |
| 14 | I felt they listened and were extra careful to diagnose                                                                                                                 | 1/6/2026 8:32 PM   |
| 15 | Convenient                                                                                                                                                              | 1/6/2026 2:36 PM   |
| 16 | Convenient                                                                                                                                                              | 12/21/2025 8:29 AM |
| 17 | Convenient                                                                                                                                                              | 12/9/2025 10:36 AM |
| 18 | It was a quick and easy way to get the medication I needed without having to miss work, which is a big deal!                                                            | 12/8/2025 8:57 AM  |
| 19 | More convenient                                                                                                                                                         | 12/8/2025 6:44 AM  |
| 20 | Ease and prescription was given easy                                                                                                                                    | 12/7/2025 9:41 PM  |
| 21 | No,prefer real face to face to oriented care                                                                                                                            | 12/5/2025 9:10 AM  |
| 22 | It was ok.                                                                                                                                                              | 12/4/2025 8:05 PM  |
| 23 | Convince                                                                                                                                                                | 12/4/2025 12:09 AM |
| 24 | Easy to get appointment and seen quickly                                                                                                                                | 12/3/2025 11:15 PM |
| 25 | It was an accessible way to get the care I needed which reduced the stress of even trying to do see a health professional                                               | 12/3/2025 9:49 PM  |
| 26 | It was easy, convenient, and free with my insurance                                                                                                                     | 12/3/2025 9:26 PM  |
| 27 | It was necessary during covid dangers                                                                                                                                   | 12/3/2025 9:26 PM  |
| 28 | Easy- convenient                                                                                                                                                        | 12/3/2025 9:23 PM  |
| 29 | Ease of access                                                                                                                                                          | 12/3/2025 9:19 PM  |

## Greene County Community Needs Assessment

|    |                                                                                                                       |                    |
|----|-----------------------------------------------------------------------------------------------------------------------|--------------------|
| 30 | It was just a follow up during COVID so not a lot of hands on needed                                                  | 12/3/2025 9:18 PM  |
| 31 | It was easier staying at home than going to the dr's office.                                                          | 12/3/2025 9:17 PM  |
| 32 | Easy to access and use                                                                                                | 12/3/2025 9:17 PM  |
| 33 | It was convenient to be seen by zoom for my daughters neurology appt, rather than drive to Springfield for a recheck. | 12/3/2025 8:44 PM  |
| 34 | Not the same as in person but is okay.                                                                                | 12/3/2025 8:40 PM  |
| 35 | Only during COVID                                                                                                     | 12/3/2025 7:56 PM  |
| 36 | It was just for a 6 mo check and I didn't have to travel.                                                             | 11/19/2025 8:19 AM |

# Greene County Community Needs Assessment

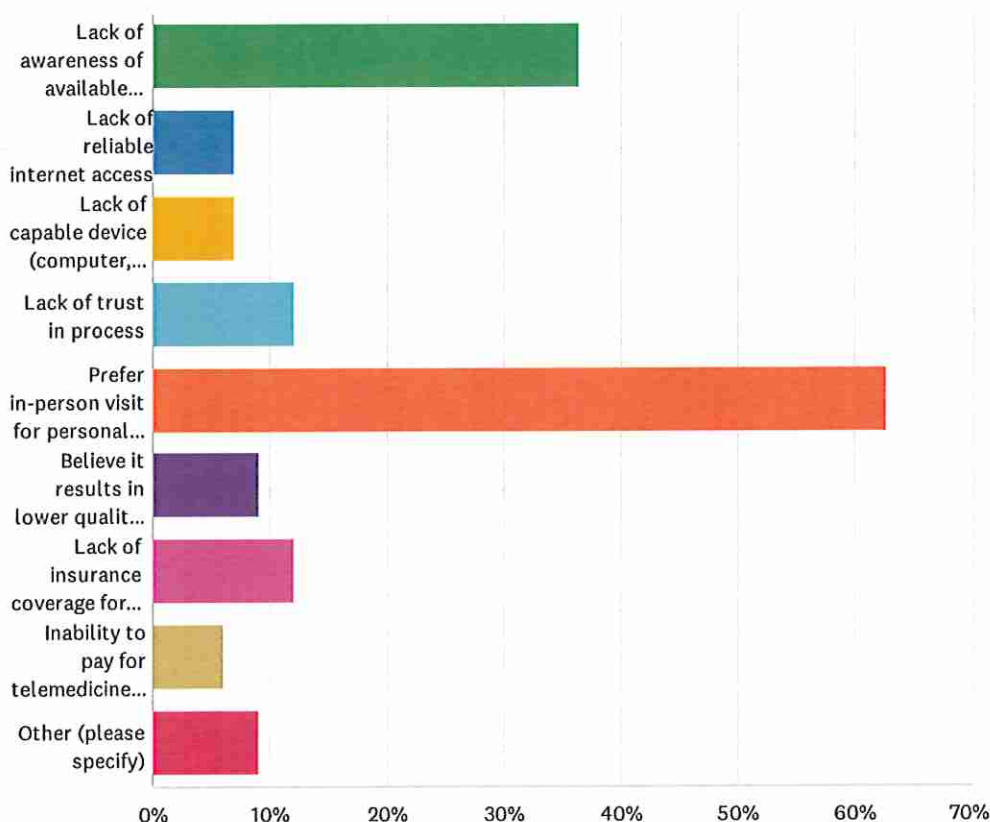
## Q18 If you have utilized telemedicine but were not satisfied with the experience, why?

Answered: 11 Skipped: 155

| #  | RESPONSES                                                                                                                                                                                                   | DATE                |
|----|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| 1  | I could not access to who I wanted to meet with and only had so many times we could meet.                                                                                                                   | 1/28/2026 11:17 AM  |
| 2  | I prefer an in-person experience.                                                                                                                                                                           | 1/27/2026 12:16 PM  |
| 3  | Reception poor                                                                                                                                                                                              | 1/13/2026 10:57 PM  |
| 4  | Poor internet connection on my end                                                                                                                                                                          | 1/10/2026 4:14 PM   |
| 5  | they couldn't even prescribe antibiotics - over zoom                                                                                                                                                        | 1/10/2026 2:44 PM   |
| 6  | Didn't get the help that was fully needed                                                                                                                                                                   | 12/10/2025 12:36 PM |
| 7  | It's great in some situations but not applicable for a lot                                                                                                                                                  | 12/6/2025 12:20 AM  |
| 8  | The doctor was no help at all when I was struggling to breathe with COVID-19. He suggested going to the pharmacy and getting some over the counter medicine. Two hours later I went by ambulance to the ER. | 12/4/2025 10:11 AM  |
| 9  | I was unable to use it because of lack of interest and poor cell phone reception.                                                                                                                           | 12/4/2025 5:40 AM   |
| 10 | Hard to stay engaged                                                                                                                                                                                        | 12/3/2025 7:43 PM   |
| 11 | They told me to go to an urgent care                                                                                                                                                                        | 12/3/2025 7:05 PM   |

## Q19 If you have not utilized telemedicine, what has been the barrier? (mark all that apply)

Answered: 99 Skipped: 67



### ANSWER CHOICES

### RESPONSES

Lack of awareness of available telemedicine services

36.36% 36

Lack of reliable internet access

7.07% 7

Lack of capable device (computer, laptop, smartphone, tablet, etc.)

7.07% 7

Lack of trust in process

12.12% 12

Prefer in-person visit for personal connection

62.63% 62

Believe it results in lower quality care

9.09% 9

Lack of insurance coverage for telemedicine

12.12% 12

Inability to pay for telemedicine services

6.06% 6

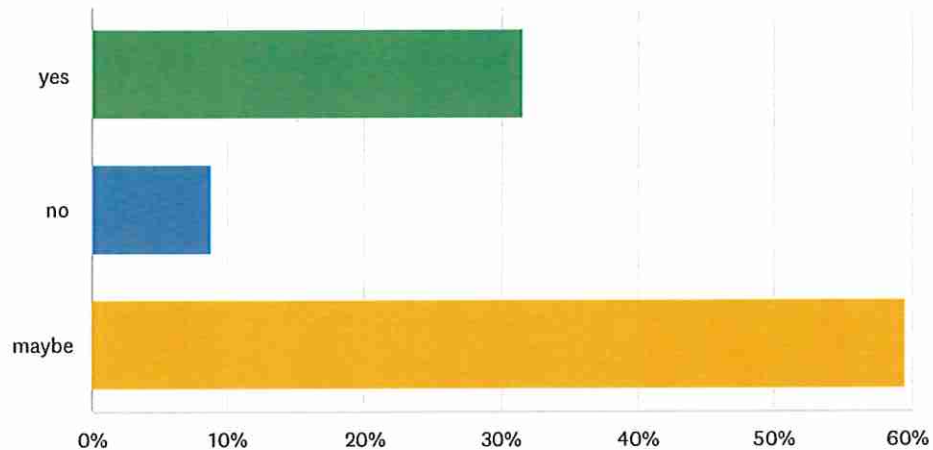
Other (please specify)

9.09% 9

Total Respondents: 99

## Q20 If you have not utilized telemedicine, would you utilize such services if they were available?

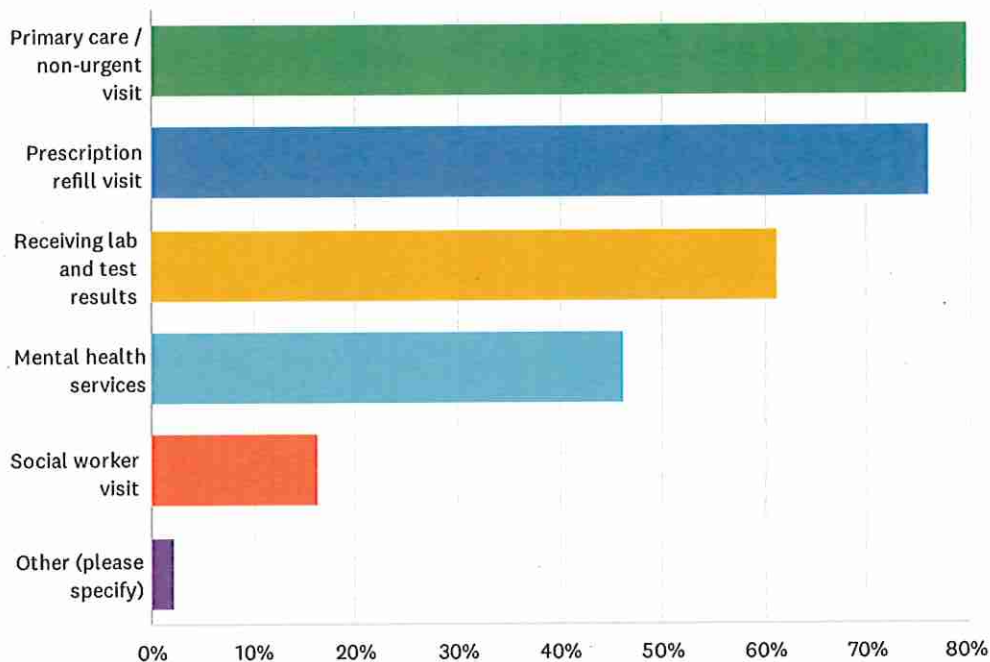
Answered: 114 Skipped: 52



| ANSWER CHOICES | RESPONSES |     |
|----------------|-----------|-----|
| yes            | 31.58%    | 36  |
| no             | 8.77%     | 10  |
| maybe          | 59.65%    | 68  |
| TOTAL          |           | 114 |

## Q21 If you would or might utilize telemedicine, for which services would you be likely to utilize? (mark all that apply)

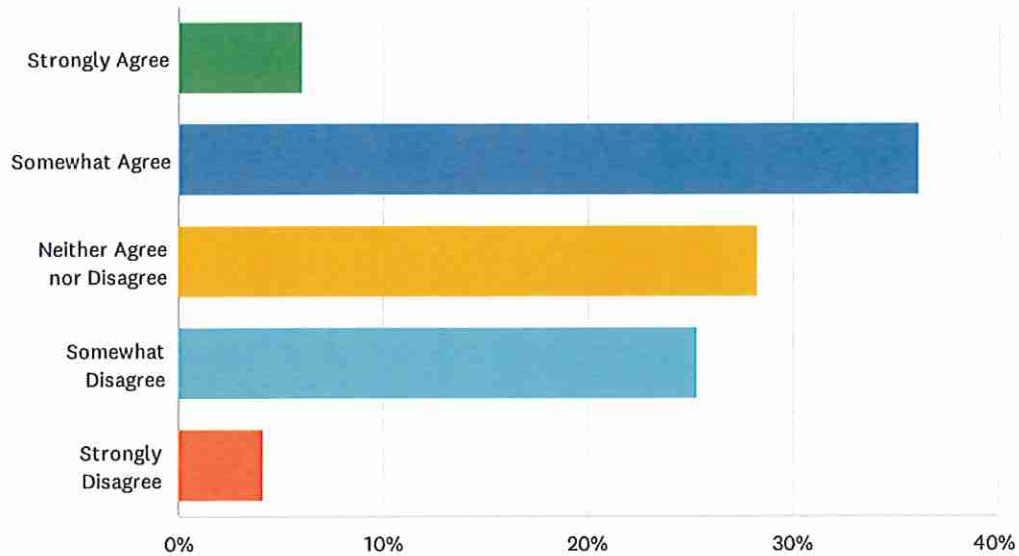
Answered: 134 Skipped: 32



| ANSWER CHOICES                  | RESPONSES |     |
|---------------------------------|-----------|-----|
| Primary care / non-urgent visit | 79.85%    | 107 |
| Prescription refill visit       | 76.12%    | 102 |
| Receiving lab and test results  | 61.19%    | 82  |
| Mental health services          | 46.27%    | 62  |
| Social worker visit             | 16.42%    | 22  |
| Other (please specify)          | 2.24%     | 3   |
| Total Respondents: 134          |           |     |

Q22 Please indicate your level of agreement with each of the following statements: Greene County is a healthy place to live.

Answered: 166 Skipped: 0

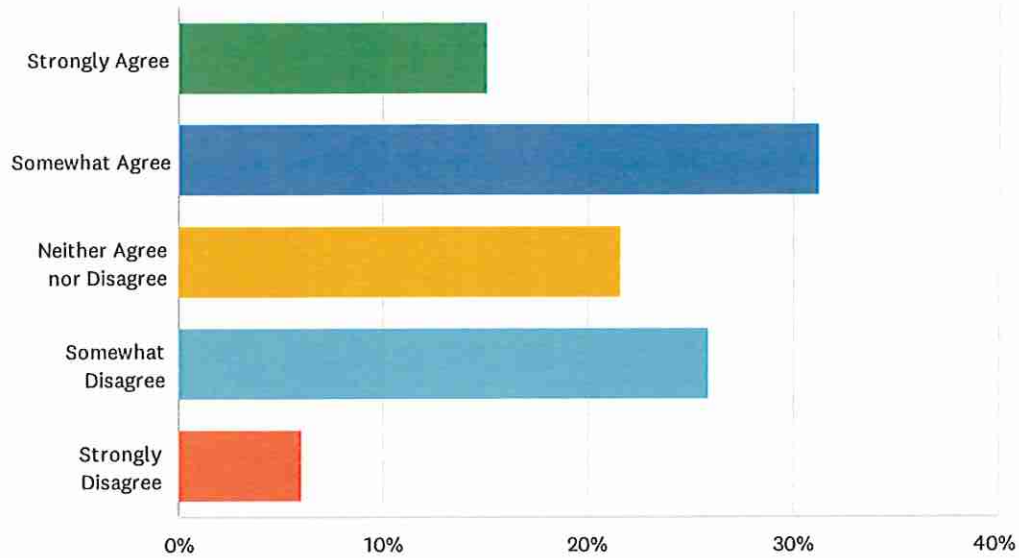


| ANSWER CHOICES             | RESPONSES |     |
|----------------------------|-----------|-----|
| Strongly Agree             | 6.02%     | 10  |
| Somewhat Agree             | 36.14%    | 60  |
| Neither Agree nor Disagree | 28.31%    | 47  |
| Somewhat Disagree          | 25.30%    | 42  |
| Strongly Disagree          | 4.22%     | 7   |
| TOTAL                      |           | 166 |

## Greene County Community Needs Assessment

### Q23 Greene County has adequate exercise and wellness activities.

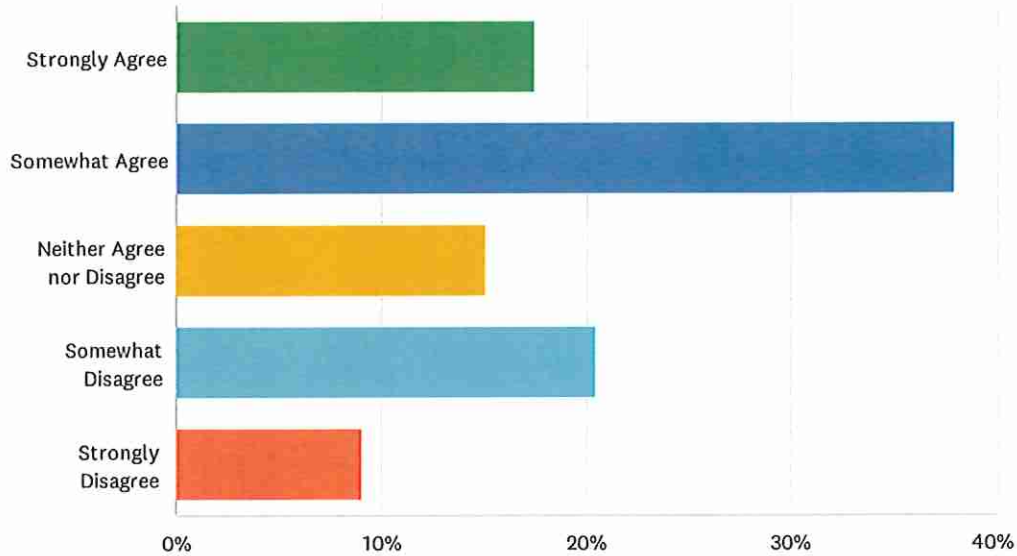
Answered: 166 Skipped: 0



| ANSWER CHOICES             | RESPONSES |     |
|----------------------------|-----------|-----|
| Strongly Agree             | 15.06%    | 25  |
| Somewhat Agree             | 31.33%    | 52  |
| Neither Agree nor Disagree | 21.69%    | 36  |
| Somewhat Disagree          | 25.90%    | 43  |
| Strongly Disagree          | 6.02%     | 10  |
| TOTAL                      |           | 166 |

## Q24 I am access to the doctors and medical specialists I need.

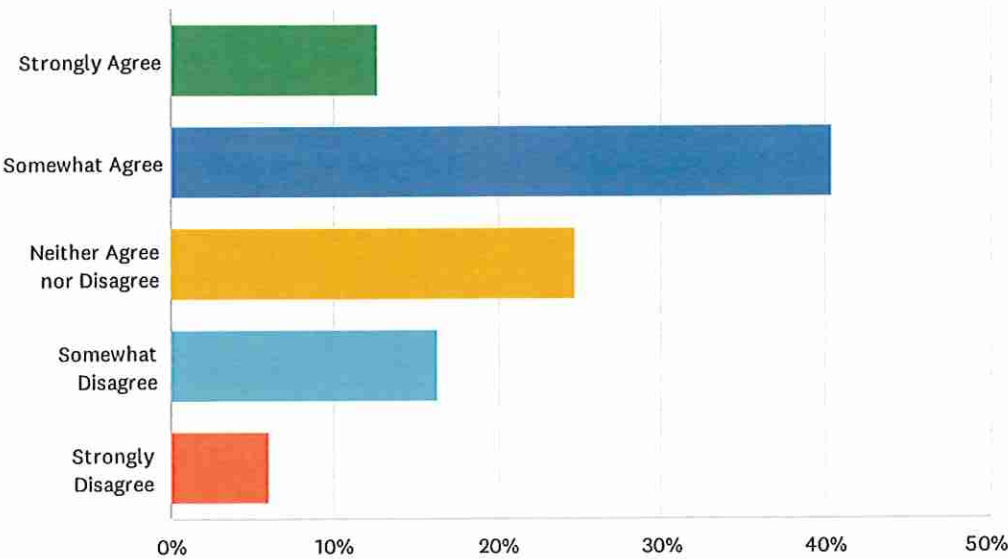
Answered: 166 Skipped: 0



| ANSWER CHOICES             | RESPONSES |     |
|----------------------------|-----------|-----|
| Strongly Agree             | 17.47%    | 29  |
| Somewhat Agree             | 37.95%    | 63  |
| Neither Agree nor Disagree | 15.06%    | 25  |
| Somewhat Disagree          | 20.48%    | 34  |
| Strongly Disagree          | 9.04%     | 15  |
| TOTAL                      |           | 166 |

Q25 I am satisfied with the medical care I receive in Greene County.

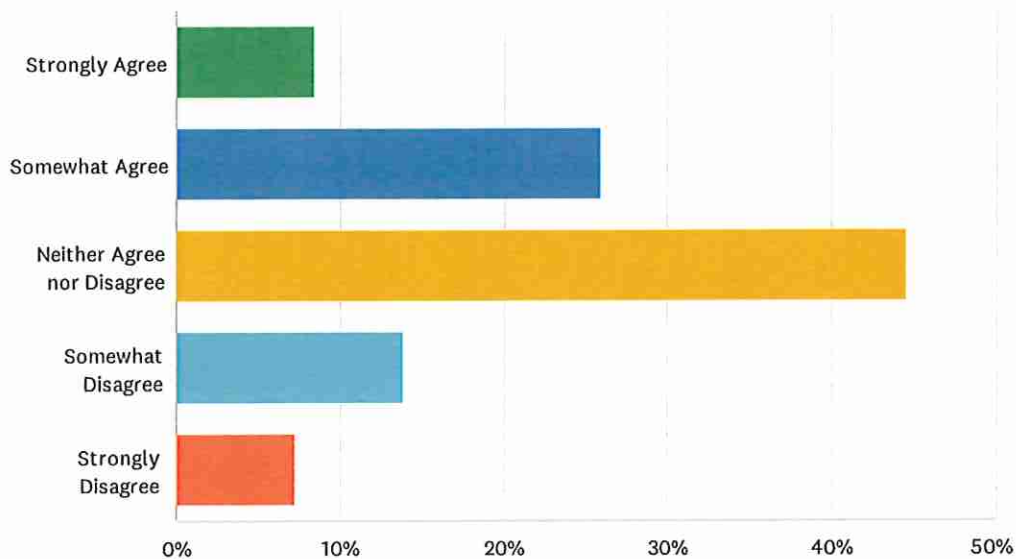
Answered: 166 Skipped: 0



| ANSWER CHOICES             | RESPONSES |     |
|----------------------------|-----------|-----|
| Strongly Agree             | 12.65%    | 21  |
| Somewhat Agree             | 40.36%    | 67  |
| Neither Agree nor Disagree | 24.70%    | 41  |
| Somewhat Disagree          | 16.27%    | 27  |
| Strongly Disagree          | 6.02%     | 10  |
| TOTAL                      |           | 166 |

## Q26 I have access to the social services I need.

Answered: 166 Skipped: 0



| ANSWER CHOICES             | RESPONSES |     |
|----------------------------|-----------|-----|
| Strongly Agree             | 8.43%     | 14  |
| Somewhat Agree             | 25.90%    | 43  |
| Neither Agree nor Disagree | 44.58%    | 74  |
| Somewhat Disagree          | 13.86%    | 23  |
| Strongly Disagree          | 7.23%     | 12  |
| TOTAL                      |           | 166 |

**Q27 Demographic Information:**Please provide the following information. It will be used for demographic purposes only. You will NOT be identified in any way with your answers. You do not need to answer the following questions for the rest of your survey to be considered, but answering these questions is important to helping the Greene County Health Department understand the public health needs of Greene County. Specifically, it helps identify unique needs for different groups (e.g. age, insurance status, etc.).ZIP Code:

Answered: 166 Skipped: 0

| #  | RESPONSES | DATE               |
|----|-----------|--------------------|
| 1  | 62016     | 1/30/2026 6:27 PM  |
| 2  | 62092     | 1/30/2026 6:00 PM  |
| 3  | 62002     | 1/30/2026 1:19 PM  |
| 4  | 62016     | 1/30/2026 5:43 AM  |
| 5  | 62098     | 1/30/2026 4:16 AM  |
| 6  | 62078     | 1/29/2026 7:14 PM  |
| 7  | 62016     | 1/29/2026 6:59 PM  |
| 8  | 62016     | 1/29/2026 4:47 PM  |
| 9  | 62082     | 1/29/2026 1:57 PM  |
| 10 | 62050     | 1/29/2026 10:17 AM |
| 11 | 62092     | 1/29/2026 8:39 AM  |
| 12 | 62016     | 1/29/2026 6:24 AM  |
| 13 | 62052     | 1/28/2026 3:21 PM  |
| 14 | 62016     | 1/28/2026 11:17 AM |
| 15 | 62016     | 1/28/2026 10:05 AM |
| 16 | 62016     | 1/28/2026 7:41 AM  |
| 17 | 62016     | 1/27/2026 4:07 PM  |
| 18 | 62044     | 1/27/2026 3:06 PM  |
| 19 | 62016     | 1/27/2026 1:55 PM  |
| 20 | 62082     | 1/27/2026 1:31 PM  |
| 21 | 62014     | 1/27/2026 1:24 PM  |
| 22 | 62016     | 1/27/2026 1:10 PM  |
| 23 | 62016     | 1/27/2026 12:16 PM |
| 24 | 62092     | 1/27/2026 11:35 AM |
| 25 | 62092     | 1/27/2026 10:19 AM |

# Greene County Community Needs Assessment

|    |       |                    |
|----|-------|--------------------|
| 26 | 62050 | 1/27/2026 9:30 AM  |
| 27 | 62092 | 1/27/2026 9:25 AM  |
| 28 | 62092 | 1/27/2026 9:15 AM  |
| 29 | 62082 | 1/27/2026 9:10 AM  |
| 30 | 62044 | 1/26/2026 8:18 AM  |
| 31 | 62016 | 1/26/2026 8:16 AM  |
| 32 | 62092 | 1/26/2026 7:14 AM  |
| 33 | 62092 | 1/26/2026 7:10 AM  |
| 34 | 62016 | 1/26/2026 6:53 AM  |
| 35 | 62044 | 1/23/2026 8:24 PM  |
| 36 | 62082 | 1/23/2026 3:44 PM  |
| 37 | 62044 | 1/23/2026 2:01 PM  |
| 38 | 62016 | 1/23/2026 11:03 AM |
| 39 | 62027 | 1/23/2026 9:31 AM  |
| 40 | 62027 | 1/23/2026 9:25 AM  |
| 41 | 62016 | 1/23/2026 9:00 AM  |
| 42 | 62016 | 1/23/2026 8:27 AM  |
| 43 | 62016 | 1/23/2026 8:23 AM  |
| 44 | 62016 | 1/23/2026 8:07 AM  |
| 45 | 62044 | 1/22/2026 1:56 PM  |
| 46 | 62027 | 1/18/2026 5:38 PM  |
| 47 | 62092 | 1/18/2026 4:19 PM  |
| 48 | 62016 | 1/18/2026 4:16 PM  |
| 49 | 62044 | 1/18/2026 7:24 AM  |
| 50 | 62082 | 1/14/2026 9:25 AM  |
| 51 | 62082 | 1/13/2026 10:57 PM |
| 52 | 62054 | 1/13/2026 6:36 PM  |
| 53 | 62082 | 1/13/2026 1:29 PM  |
| 54 | 62092 | 1/13/2026 1:21 PM  |
| 55 | 62050 | 1/12/2026 2:33 PM  |
| 56 | 62082 | 1/12/2026 2:29 PM  |
| 57 | 62044 | 1/12/2026 12:35 PM |
| 58 | 62082 | 1/11/2026 5:52 AM  |
| 59 | 62016 | 1/10/2026 4:14 PM  |
| 60 | 62082 | 1/10/2026 2:44 PM  |
| 61 | 62081 | 1/10/2026 9:22 AM  |
| 62 | 62016 | 1/9/2026 6:26 PM   |
| 63 | 62044 | 1/9/2026 5:53 PM   |

# Greene County Community Needs Assessment

|     |       |                     |
|-----|-------|---------------------|
| 64  | 62044 | 1/9/2026 3:27 PM    |
| 65  | 62044 | 1/9/2026 2:46 PM    |
| 66  | 62081 | 1/9/2026 2:44 PM    |
| 67  | 62016 | 1/9/2026 2:41 PM    |
| 68  | 62016 | 1/9/2026 2:37 PM    |
| 69  | 62092 | 1/9/2026 2:17 PM    |
| 70  | 62092 | 1/9/2026 2:10 PM    |
| 71  | 62016 | 1/9/2026 2:10 PM    |
| 72  | 62092 | 1/9/2026 1:31 PM    |
| 73  | 62044 | 1/9/2026 10:05 AM   |
| 74  | 62016 | 1/9/2026 7:50 AM    |
| 75  | 62016 | 1/8/2026 8:31 PM    |
| 76  | 62092 | 1/8/2026 4:11 PM    |
| 77  | 62027 | 1/8/2026 3:41 PM    |
| 78  | 62044 | 1/7/2026 11:35 AM   |
| 79  | 62081 | 1/6/2026 8:32 PM    |
| 80  | 62649 | 1/6/2026 3:14 PM    |
| 81  | 62044 | 1/6/2026 3:05 PM    |
| 82  | 62044 | 1/6/2026 2:36 PM    |
| 83  | 62044 | 1/6/2026 2:26 PM    |
| 84  | 62044 | 1/6/2026 2:25 PM    |
| 85  | 62082 | 1/6/2026 11:05 AM   |
| 86  | 62044 | 12/21/2025 8:29 AM  |
| 87  | 62016 | 12/16/2025 7:55 PM  |
| 88  | 62044 | 12/14/2025 11:13 PM |
| 89  | 62016 | 12/14/2025 11:12 PM |
| 90  | 62092 | 12/14/2025 10:57 PM |
| 91  | 62082 | 12/11/2025 11:40 PM |
| 92  | 62026 | 12/11/2025 7:50 PM  |
| 93  | 62082 | 12/10/2025 12:36 PM |
| 94  | 62016 | 12/9/2025 2:40 PM   |
| 95  | 62082 | 12/9/2025 10:36 AM  |
| 96  | 62082 | 12/8/2025 8:53 PM   |
| 97  | 62082 | 12/8/2025 8:57 AM   |
| 98  | 62016 | 12/8/2025 8:16 AM   |
| 99  | 62092 | 12/8/2025 6:44 AM   |
| 100 | 62092 | 12/7/2025 10:58 PM  |
| 101 | 62092 | 12/7/2025 10:33 PM  |

## Greene County Community Needs Assessment

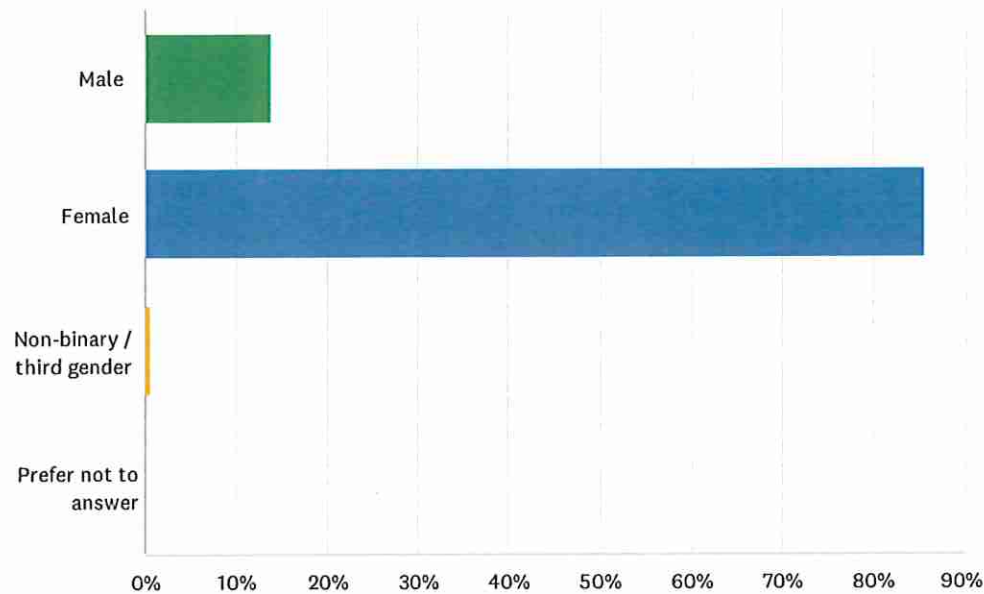
|     |       |                    |
|-----|-------|--------------------|
| 102 | 62016 | 12/7/2025 9:43 PM  |
| 103 | 62016 | 12/7/2025 9:41 PM  |
| 104 | 62082 | 12/7/2025 9:10 PM  |
| 105 | 62081 | 12/7/2025 8:47 PM  |
| 106 | 62082 | 12/7/2025 8:32 PM  |
| 107 | 62092 | 12/7/2025 8:24 PM  |
| 108 | 62016 | 12/7/2025 9:51 AM  |
| 109 | 62092 | 12/6/2025 1:52 PM  |
| 110 | 62082 | 12/6/2025 12:20 AM |
| 111 | 62093 | 12/5/2025 9:10 AM  |
| 112 | 62092 | 12/4/2025 8:05 PM  |
| 113 | 62082 | 12/4/2025 7:43 PM  |
| 114 | 62092 | 12/4/2025 7:21 PM  |
| 115 | 62082 | 12/4/2025 6:54 PM  |
| 116 | 62016 | 12/4/2025 5:57 PM  |
| 117 | 62092 | 12/4/2025 1:55 PM  |
| 118 | 17061 | 12/4/2025 12:02 PM |
| 119 | 62082 | 12/4/2025 10:25 AM |
| 120 | 62092 | 12/4/2025 10:11 AM |
| 121 | 62092 | 12/4/2025 9:26 AM  |
| 122 | 62092 | 12/4/2025 5:44 AM  |
| 123 | 62016 | 12/4/2025 5:40 AM  |
| 124 | 62082 | 12/4/2025 12:09 AM |
| 125 | 62082 | 12/3/2025 11:15 PM |
| 126 | 62092 | 12/3/2025 10:19 PM |
| 127 | 62082 | 12/3/2025 9:55 PM  |
| 128 | 62092 | 12/3/2025 9:55 PM  |
| 129 | 62092 | 12/3/2025 9:49 PM  |
| 130 | 62092 | 12/3/2025 9:45 PM  |
| 131 | 62082 | 12/3/2025 9:40 PM  |
| 132 | 62050 | 12/3/2025 9:40 PM  |
| 133 | 62092 | 12/3/2025 9:35 PM  |
| 134 | 62082 | 12/3/2025 9:30 PM  |
| 135 | 62016 | 12/3/2025 9:30 PM  |
| 136 | 62082 | 12/3/2025 9:26 PM  |
| 137 | 62082 | 12/3/2025 9:26 PM  |
| 138 | 62082 | 12/3/2025 9:23 PM  |
| 139 | 62016 | 12/3/2025 9:19 PM  |

## Greene County Community Needs Assessment

|     |          |                     |
|-----|----------|---------------------|
| 140 | 62016    | 12/3/2025 9:18 PM   |
| 141 | 62082    | 12/3/2025 9:17 PM   |
| 142 | 62082    | 12/3/2025 9:17 PM   |
| 143 | 62082    | 12/3/2025 9:10 PM   |
| 144 | 62082    | 12/3/2025 9:09 PM   |
| 145 | 62050    | 12/3/2025 9:03 PM   |
| 146 | 62016    | 12/3/2025 8:57 PM   |
| 147 | 62016    | 12/3/2025 8:55 PM   |
| 148 | 62092    | 12/3/2025 8:52 PM   |
| 149 | 62016    | 12/3/2025 8:44 PM   |
| 150 | 62092    | 12/3/2025 8:41 PM   |
| 151 | 62016    | 12/3/2025 8:40 PM   |
| 152 | 62092    | 12/3/2025 8:29 PM   |
| 153 | 62082    | 12/3/2025 8:25 PM   |
| 154 | 62044    | 12/3/2025 7:56 PM   |
| 155 | 62016    | 12/3/2025 7:43 PM   |
| 156 | 62092    | 12/3/2025 7:15 PM   |
| 157 | 62044    | 12/3/2025 7:05 PM   |
| 158 | 62002!!7 | 12/3/2025 6:41 PM   |
| 159 | 62044    | 12/3/2025 6:32 PM   |
| 160 | 62092    | 12/3/2025 6:22 PM   |
| 161 | 62016    | 11/19/2025 2:55 PM  |
| 162 | 62016    | 11/19/2025 2:28 PM  |
| 163 | 62016    | 11/19/2025 10:03 AM |
| 164 | 62016    | 11/19/2025 8:23 AM  |
| 165 | 62027    | 11/19/2025 8:19 AM  |
| 166 | 62016    | 11/14/2025 3:16 PM  |

Q28 Gender:

Answered: 166 Skipped: 0

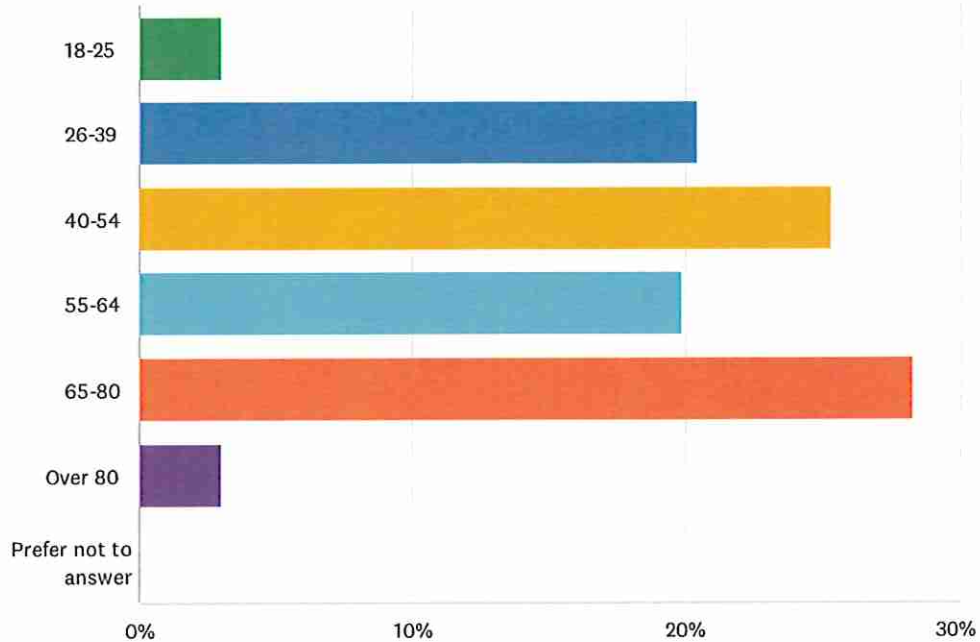


| ANSWER CHOICES            | RESPONSES |     |
|---------------------------|-----------|-----|
| Male                      | 13.86%    | 23  |
| Female                    | 85.54%    | 142 |
| Non-binary / third gender | 0.60%     | 1   |
| Prefer not to answer      | 0.00%     | 0   |
| TOTAL                     |           | 166 |

## Greene County Community Needs Assessment

### Q29 Age:

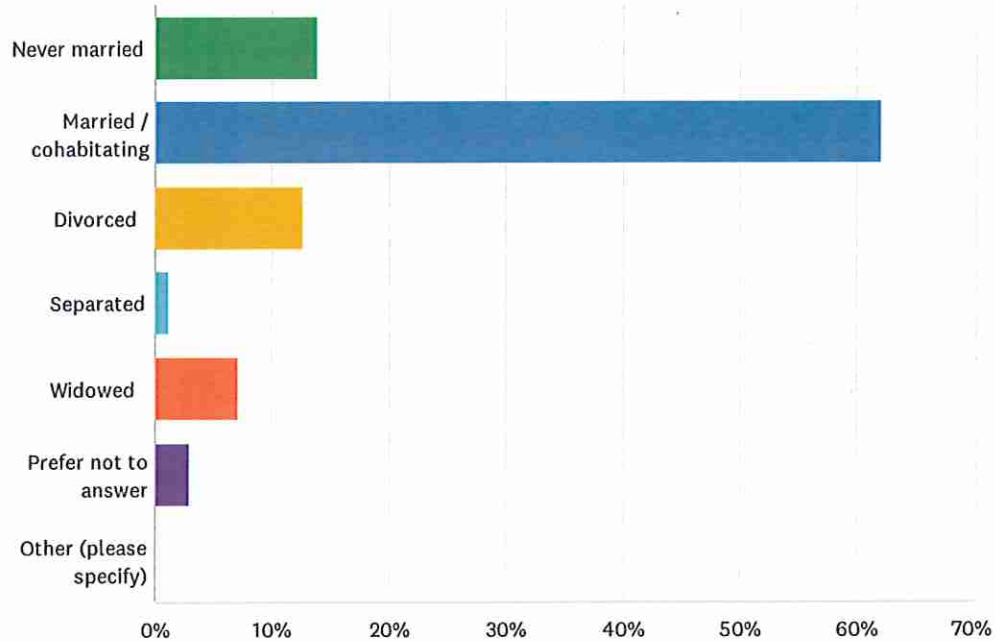
Answered: 166 Skipped: 0



| ANSWER CHOICES       | RESPONSES |     |
|----------------------|-----------|-----|
| 18-25                | 3.01%     | 5   |
| 26-39                | 20.48%    | 34  |
| 40-54                | 25.30%    | 42  |
| 55-64                | 19.88%    | 33  |
| 65-80                | 28.31%    | 47  |
| Over 80              | 3.01%     | 5   |
| Prefer not to answer | 0.00%     | 0   |
| TOTAL                |           | 166 |

### Q30 Marital status:

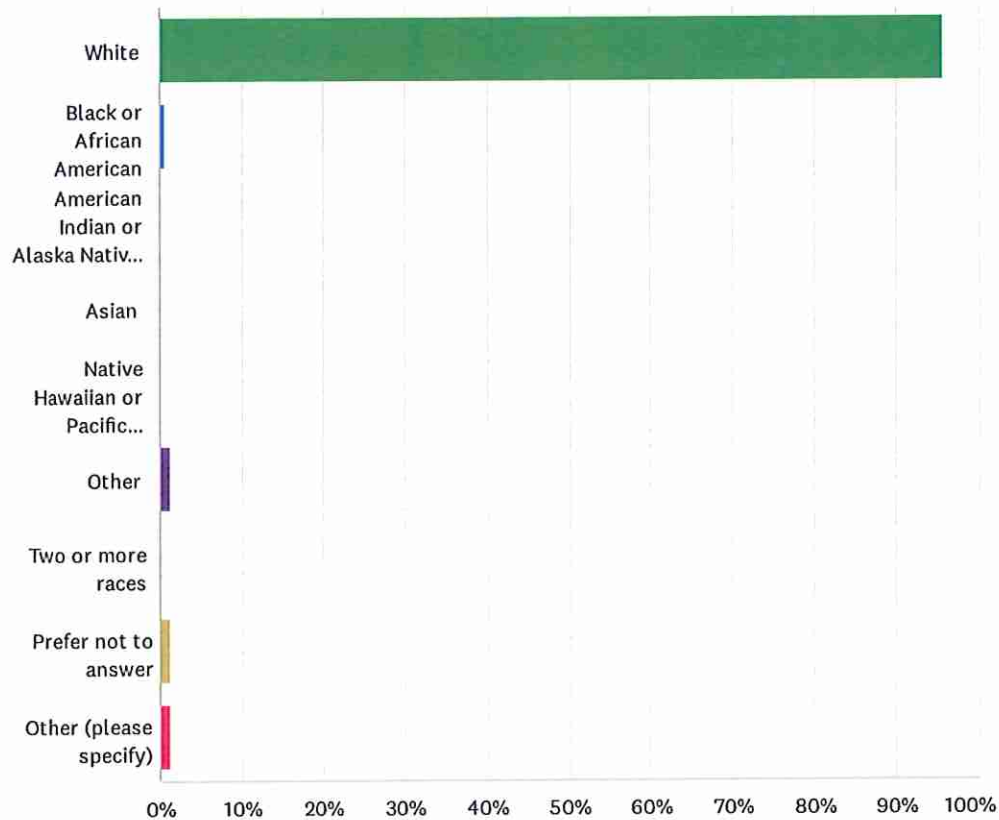
Answered: 166 Skipped: 0



| ANSWER CHOICES         | RESPONSES |            |
|------------------------|-----------|------------|
| Never married          | 13.86%    | 23         |
| Married / cohabitating | 62.05%    | 103        |
| Divorced               | 12.65%    | 21         |
| Separated              | 1.20%     | 2          |
| Widowed                | 7.23%     | 12         |
| Prefer not to answer   | 3.01%     | 5          |
| Other (please specify) | 0.00%     | 0          |
| <b>TOTAL</b>           |           | <b>166</b> |

## Q31 Which would you say best represents your race?

Answered: 166 Skipped: 0

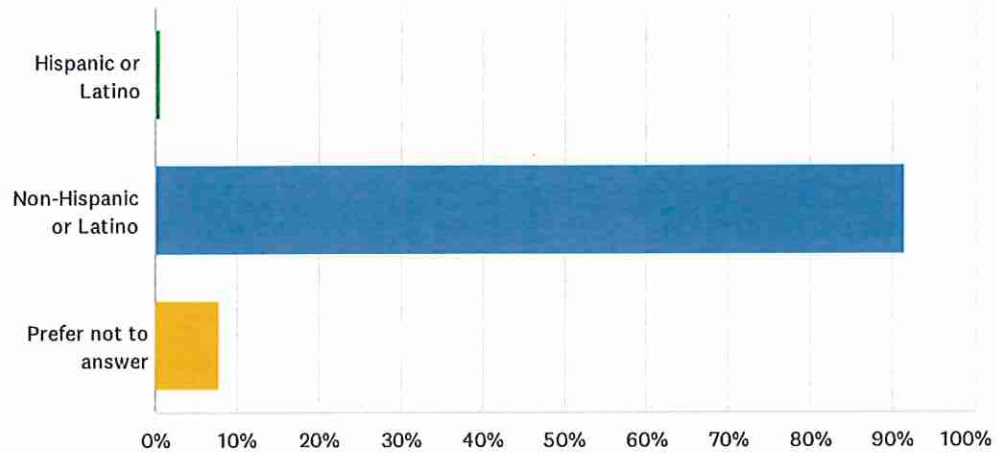


| ANSWER CHOICES                      | RESPONSES |            |
|-------------------------------------|-----------|------------|
| White                               | 95.78%    | 159        |
| Black or African American           | 0.60%     | 1          |
| American Indian or Alaska Native    | 0.00%     | 0          |
| Asian                               | 0.00%     | 0          |
| Native Hawaiian or Pacific Islander | 0.00%     | 0          |
| Other                               | 1.20%     | 2          |
| Two or more races                   | 0.00%     | 0          |
| Prefer not to answer                | 1.20%     | 2          |
| Other (please specify)              | 1.20%     | 2          |
| <b>TOTAL</b>                        |           | <b>166</b> |

## Greene County Community Needs Assessment

### Q32 Ethnicity?

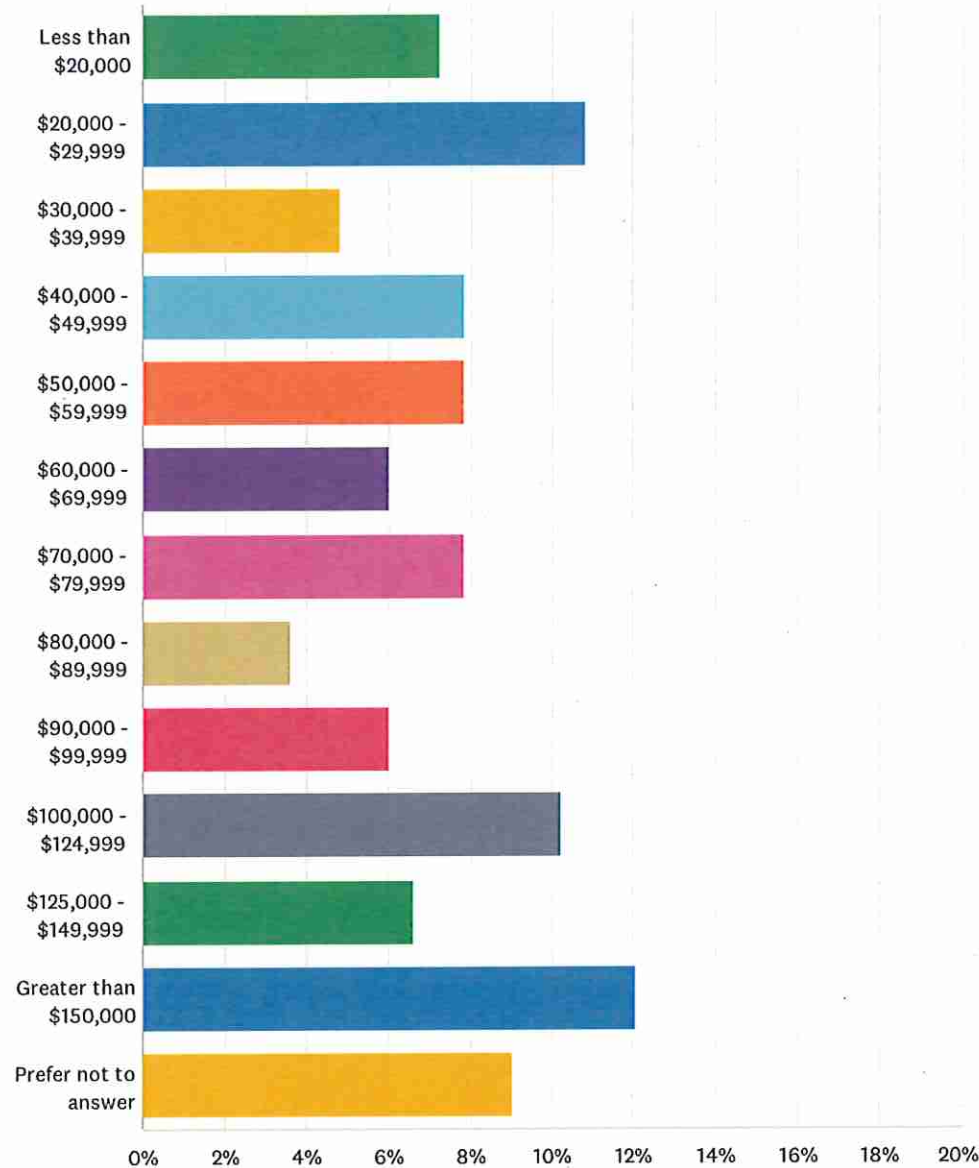
Answered: 166 Skipped: 0



| ANSWER CHOICES         | RESPONSES |     |
|------------------------|-----------|-----|
| Hispanic or Latino     | 0.60%     | 1   |
| Non-Hispanic or Latino | 91.57%    | 152 |
| Prefer not to answer   | 7.83%     | 13  |
| TOTAL                  |           | 166 |

Q33 Household income before taxes for the last year

Answered: 166 Skipped: 0

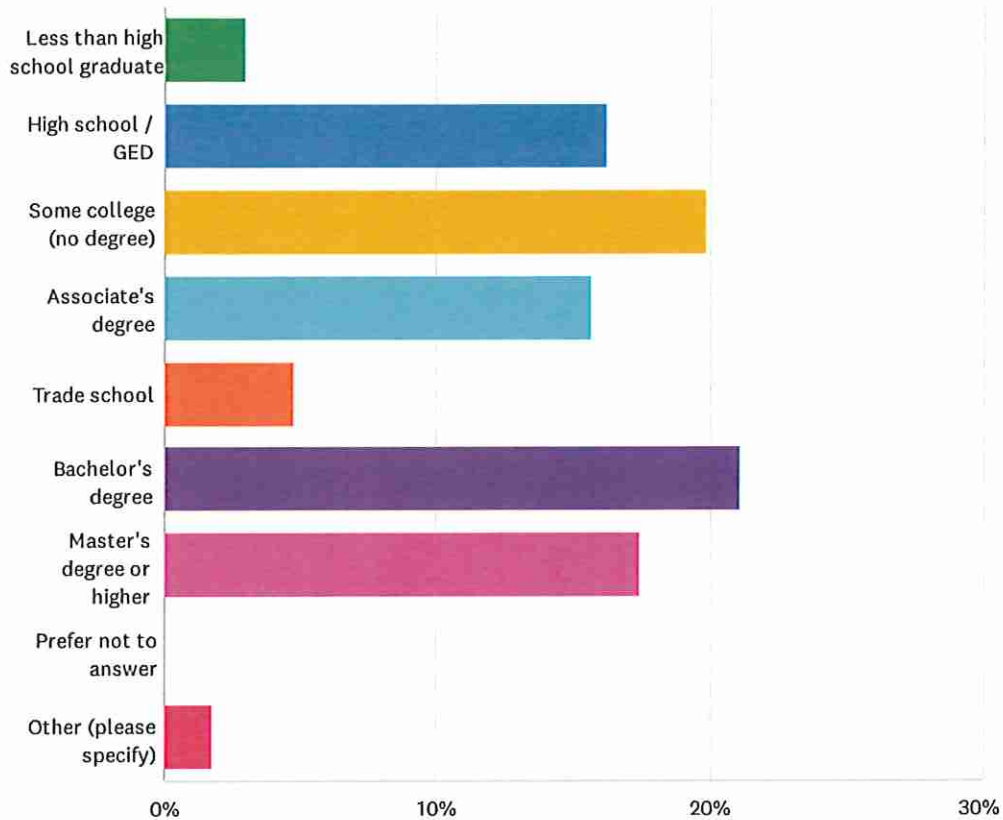


## Greene County Community Needs Assessment

| ANSWER CHOICES         | RESPONSES |     |
|------------------------|-----------|-----|
| Less than \$20,000     | 7.23%     | 12  |
| \$20,000 - \$29,999    | 10.84%    | 18  |
| \$30,000 - \$39,999    | 4.82%     | 8   |
| \$40,000 - \$49,999    | 7.83%     | 13  |
| \$50,000 - \$59,999    | 7.83%     | 13  |
| \$60,000 - \$69,999    | 6.02%     | 10  |
| \$70,000 - \$79,999    | 7.83%     | 13  |
| \$80,000 - \$89,999    | 3.61%     | 6   |
| \$90,000 - \$99,999    | 6.02%     | 10  |
| \$100,000 - \$124,999  | 10.24%    | 17  |
| \$125,000 - \$149,999  | 6.63%     | 11  |
| Greater than \$150,000 | 12.05%    | 20  |
| Prefer not to answer   | 9.04%     | 15  |
| TOTAL                  |           | 166 |

## Q34 Your highest education level?

Answered: 166 Skipped: 0

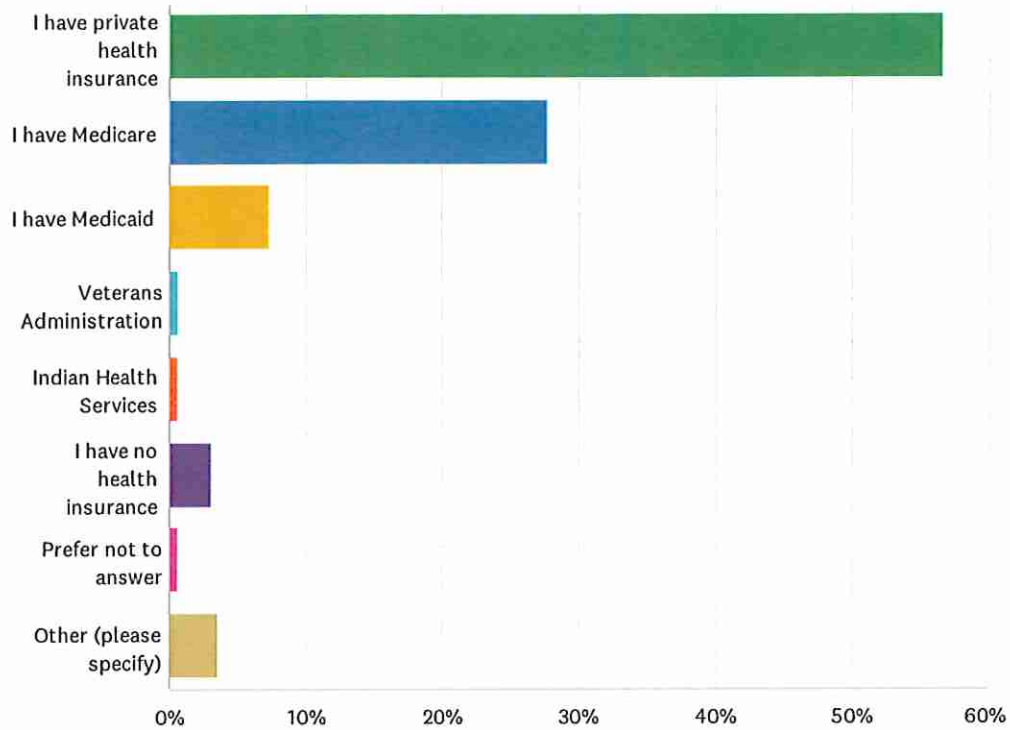


| ANSWER CHOICES                 | RESPONSES |            |
|--------------------------------|-----------|------------|
| Less than high school graduate | 3.01%     | 5          |
| High school / GED              | 16.27%    | 27         |
| Some college (no degree)       | 19.88%    | 33         |
| Associate's degree             | 15.66%    | 26         |
| Trade school                   | 4.82%     | 8          |
| Bachelor's degree              | 21.08%    | 35         |
| Master's degree or higher      | 17.47%    | 29         |
| Prefer not to answer           | 0.00%     | 0          |
| Other (please specify)         | 1.81%     | 3          |
| <b>TOTAL</b>                   |           | <b>166</b> |

Greene County Community Needs Assessment

Q35 Insurance status / How do you pay for you health care? (select all that apply)

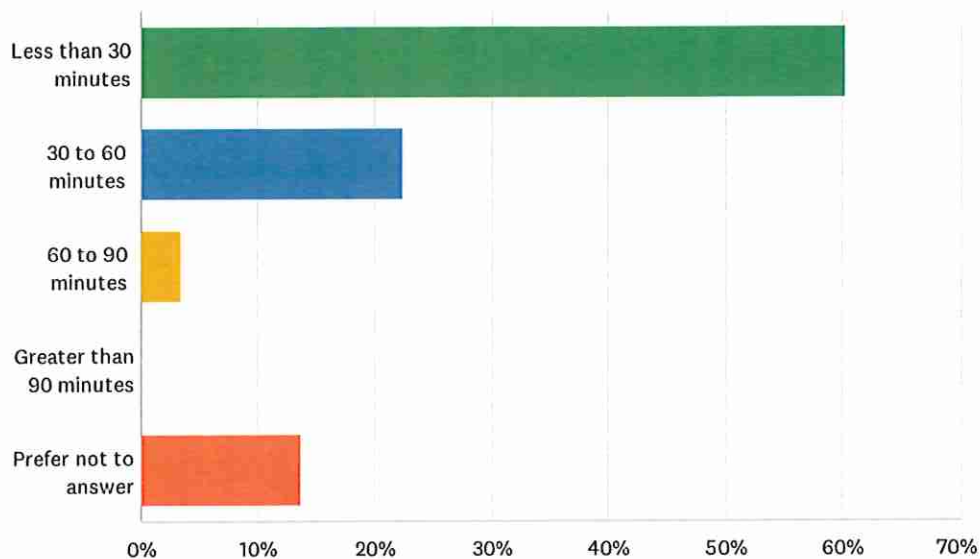
Answered: 166 Skipped: 0



| ANSWER CHOICES                  | RESPONSES |            |
|---------------------------------|-----------|------------|
| I have private health insurance | 56.63%    | 94         |
| I have Medicare                 | 27.71%    | 46         |
| I have Medicaid                 | 7.23%     | 12         |
| Veterans Administration         | 0.60%     | 1          |
| Indian Health Services          | 0.60%     | 1          |
| I have no health insurance      | 3.01%     | 5          |
| Prefer not to answer            | 0.60%     | 1          |
| Other (please specify)          | 3.61%     | 6          |
| <b>TOTAL</b>                    |           | <b>166</b> |

## Q36 If you work outside of the home, how long is your commute?

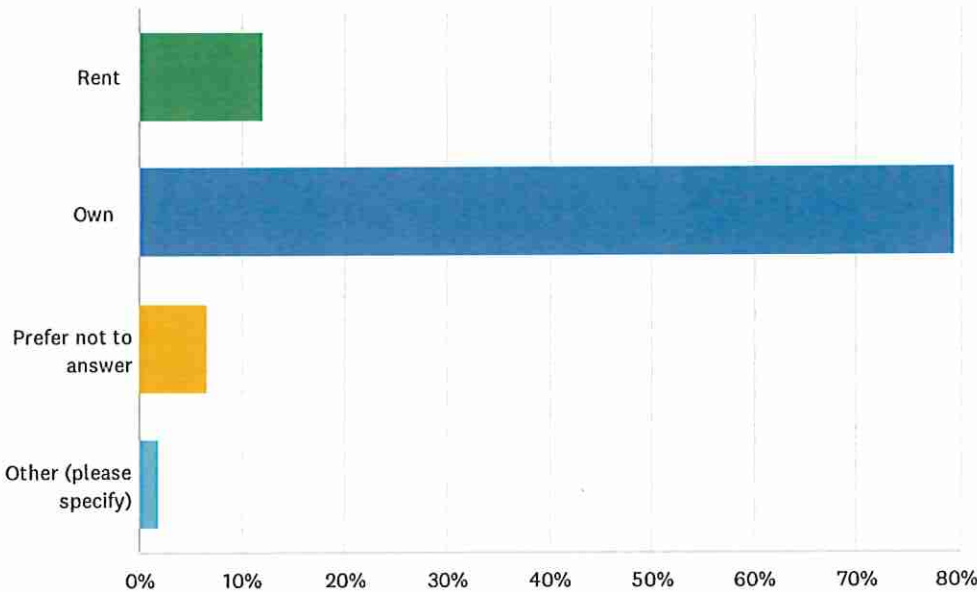
Answered: 116 Skipped: 50



| ANSWER CHOICES          | RESPONSES |            |
|-------------------------|-----------|------------|
| Less than 30 minutes    | 60.34%    | 70         |
| 30 to 60 minutes        | 22.41%    | 26         |
| 60 to 90 minutes        | 3.45%     | 4          |
| Greater than 90 minutes | 0.00%     | 0          |
| Prefer not to answer    | 13.79%    | 16         |
| <b>TOTAL</b>            |           | <b>116</b> |

Q37 Do you rent or own where you live?

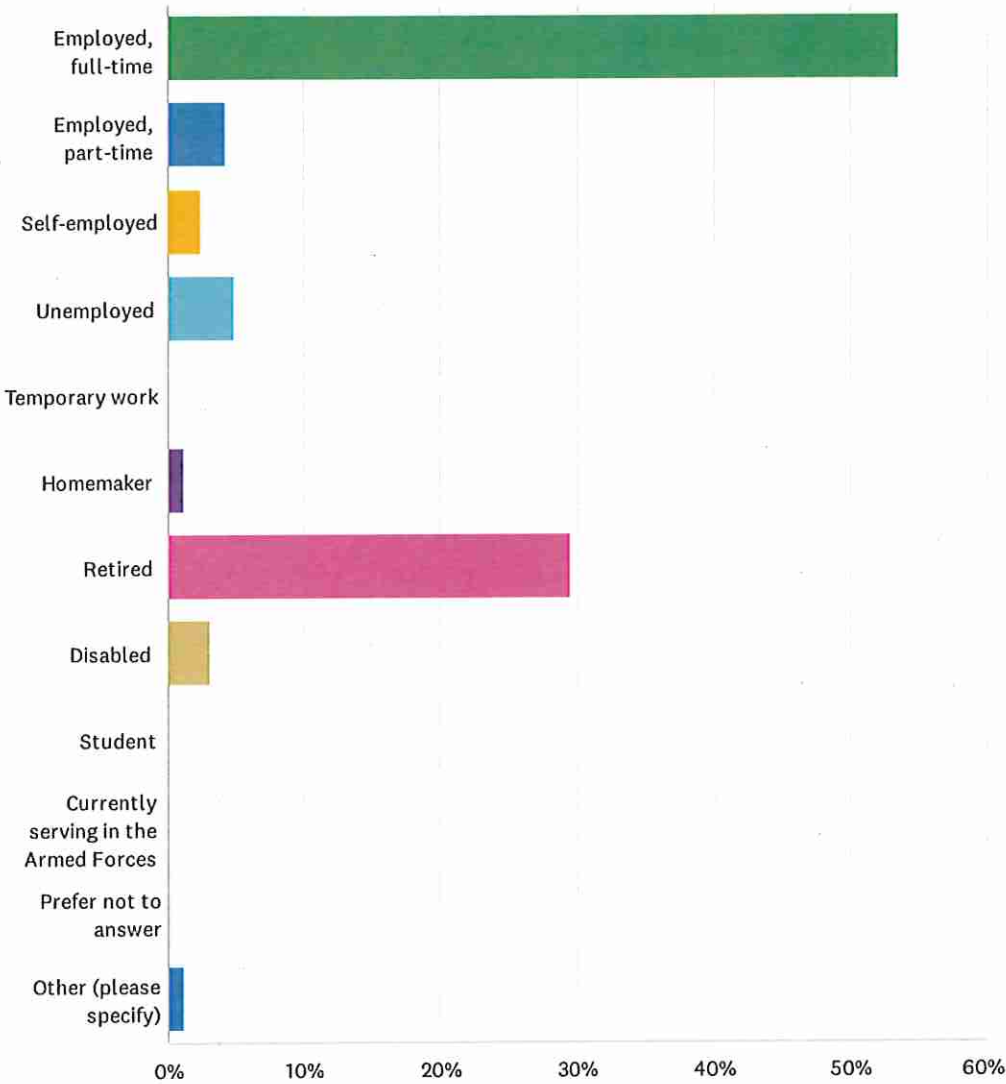
Answered: 166 Skipped: 0



| ANSWER CHOICES         | RESPONSES |     |
|------------------------|-----------|-----|
| Rent                   | 12.05%    | 20  |
| Own                    | 79.52%    | 132 |
| Prefer not to answer   | 6.63%     | 11  |
| Other (please specify) | 1.81%     | 3   |
| TOTAL                  |           | 166 |

Q38 What is your job status?

Answered: 166 Skipped: 0

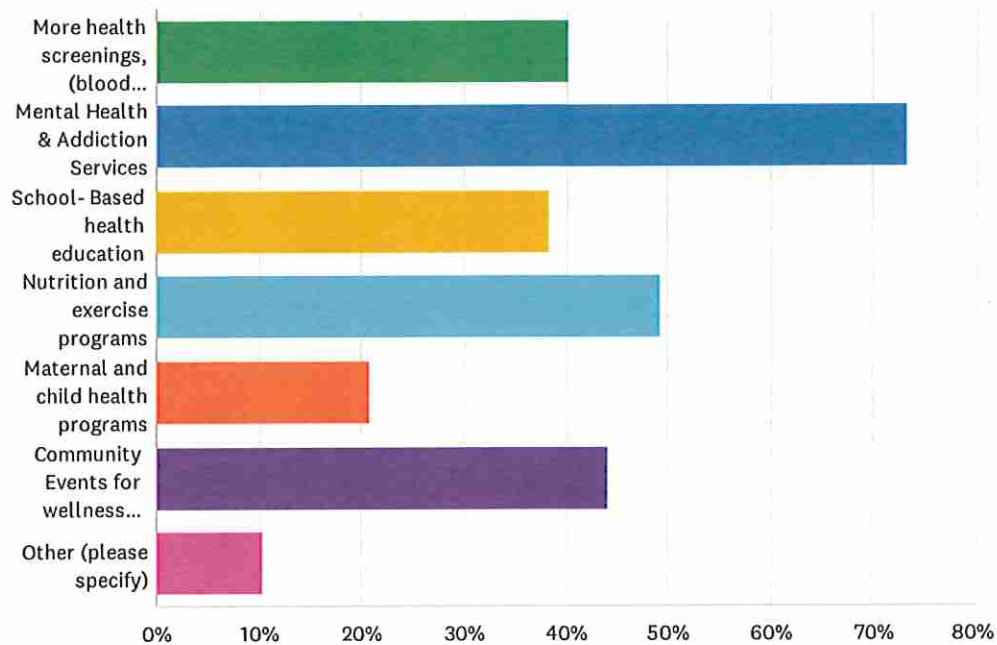


## Greene County Community Needs Assessment

| ANSWER CHOICES                        | RESPONSES |     |
|---------------------------------------|-----------|-----|
| Employed, full-time                   | 53.61%    | 89  |
| Employed, part-time                   | 4.22%     | 7   |
| Self-employed                         | 2.41%     | 4   |
| Unemployed                            | 4.82%     | 8   |
| Temporary work                        | 0.00%     | 0   |
| Homemaker                             | 1.20%     | 2   |
| Retired                               | 29.52%    | 49  |
| Disabled                              | 3.01%     | 5   |
| Student                               | 0.00%     | 0   |
| Currently serving in the Armed Forces | 0.00%     | 0   |
| Prefer not to answer                  | 0.00%     | 0   |
| Other (please specify)                | 1.20%     | 2   |
| TOTAL                                 |           | 166 |

## Q39 In your Opinion, What services or programs would most improve health in our community?

Answered: 154 Skipped: 12



### ANSWER CHOICES

### RESPONSES

|                                                               |        |     |
|---------------------------------------------------------------|--------|-----|
| More health screenings, (blood pressure, diabetes, cancer)    | 40.26% | 62  |
| Mental Health & Addiction Services                            | 73.38% | 113 |
| School- Based health education                                | 38.31% | 59  |
| Nutrition and exercise programs                               | 49.35% | 76  |
| Maternal and child health programs                            | 20.78% | 32  |
| Community Events for wellness (health fairs, exercise groups) | 44.16% | 68  |
| Other (please specify)                                        | 10.39% | 16  |

Total Respondents: 154

# Greene County Community Needs Assessment

## Q40 What is the single most important health issue you would like the Health Department to focus on?

Answered: 97 Skipped: 69

| #  | RESPONSES                                                                                  | DATE               |
|----|--------------------------------------------------------------------------------------------|--------------------|
| 1  | I think we have a big issue with cancer. What's going on in our water                      | 1/30/2026 6:00 PM  |
| 2  | parent education to help the family become more health conscious                           | 1/30/2026 1:19 PM  |
| 3  | Childhood obesity                                                                          | 1/29/2026 7:14 PM  |
| 4  | Providing vaccinations for all                                                             | 1/29/2026 6:59 PM  |
| 5  | Healthy Food access                                                                        | 1/29/2026 4:47 PM  |
| 6  | Mental health and addiction services                                                       | 1/29/2026 1:57 PM  |
| 7  | Effects of drug/alcohol use                                                                | 1/29/2026 8:39 AM  |
| 8  | Child welfare                                                                              | 1/29/2026 6:24 AM  |
| 9  | Better access to healthy food, fruits and veg.                                             | 1/28/2026 11:17 AM |
| 10 | N/a                                                                                        | 1/28/2026 10:05 AM |
| 11 | Mental health and addiction                                                                | 1/27/2026 4:07 PM  |
| 12 | Mental Health                                                                              | 1/27/2026 1:55 PM  |
| 13 | kids health                                                                                | 1/27/2026 1:31 PM  |
| 14 | Drug Abuse                                                                                 | 1/27/2026 1:10 PM  |
| 15 | mental health                                                                              | 1/27/2026 12:16 PM |
| 16 | Topics on what helps with mental health and what is enabling bad habits with mental health | 1/27/2026 11:35 AM |
| 17 | Vaping, these kids are all doing it and the parents are often the providers of the vapes.  | 1/27/2026 9:30 AM  |
| 18 | Mental health needs                                                                        | 1/27/2026 9:15 AM  |
| 19 | Healthy Eating and Exercise                                                                | 1/26/2026 8:16 AM  |
| 20 | Drug Abuse                                                                                 | 1/26/2026 7:14 AM  |
| 21 | Nutrition for teens                                                                        | 1/26/2026 7:10 AM  |
| 22 | Mental problems                                                                            | 1/23/2026 8:24 PM  |
| 23 | Substance abuse                                                                            | 1/23/2026 3:44 PM  |
| 24 | Nutrition                                                                                  | 1/23/2026 11:03 AM |
| 25 | Immunizations                                                                              | 1/23/2026 9:31 AM  |
| 26 | Disease Control                                                                            | 1/23/2026 9:25 AM  |
| 27 | Disease and illness                                                                        | 1/23/2026 8:27 AM  |
| 28 | Getting to food                                                                            | 1/22/2026 1:56 PM  |
| 29 | healthy living/weight loss                                                                 | 1/18/2026 4:19 PM  |
| 30 | Get groceries                                                                              | 1/13/2026 6:36 PM  |
| 31 | Diabetes                                                                                   | 1/13/2026 1:21 PM  |

## Greene County Community Needs Assessment

|    |                                                                                                                                                    |                     |
|----|----------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| 32 | Heart Health                                                                                                                                       | 1/12/2026 2:33 PM   |
| 33 | Education on Health habits, including nutritional education or youth                                                                               | 1/12/2026 2:29 PM   |
| 34 | Mental Health Care                                                                                                                                 | 1/11/2026 5:52 AM   |
| 35 | Exercise opportunities- yoga, marathons or races, organize exercise group, 24 hr wellness/gym                                                      | 1/10/2026 4:14 PM   |
| 36 | drugs and homelessness                                                                                                                             | 1/10/2026 2:44 PM   |
| 37 | Elder care for Homebound                                                                                                                           | 1/10/2026 9:22 AM   |
| 38 | Mental health                                                                                                                                      | 1/9/2026 6:26 PM    |
| 39 | Getting doctors in our area                                                                                                                        | 1/9/2026 5:53 PM    |
| 40 | Mental Health                                                                                                                                      | 1/9/2026 3:27 PM    |
| 41 | Food and jobs                                                                                                                                      | 1/9/2026 2:44 PM    |
| 42 | Mental health                                                                                                                                      | 1/9/2026 2:10 PM    |
| 43 | Helping these children who live with drug addicted parents                                                                                         | 1/9/2026 10:05 AM   |
| 44 | Heart                                                                                                                                              | 1/9/2026 7:50 AM    |
| 45 | Addiction                                                                                                                                          | 1/8/2026 3:41 PM    |
| 46 | Lack of competent counseling services. Locust street is a joke for people.                                                                         | 1/6/2026 8:32 PM    |
| 47 | Mental Health/Drug Abuse                                                                                                                           | 1/6/2026 2:36 PM    |
| 48 | Nutrition                                                                                                                                          | 1/6/2026 2:26 PM    |
| 49 | We need jobs. With jobs come health.                                                                                                               | 1/6/2026 11:05 AM   |
| 50 | Women's health & family planning                                                                                                                   | 12/21/2025 8:29 AM  |
| 51 | Mental health                                                                                                                                      | 12/16/2025 7:55 PM  |
| 52 | Drug abuse. Young children see it and live with it. And then often start experimenting with drugs at an early age themselves. The cycle continues. | 12/14/2025 11:13 PM |
| 53 | Pediatric care (primary and mental health)                                                                                                         | 12/14/2025 11:12 PM |
| 54 | We need access to wholesome food                                                                                                                   | 12/11/2025 7:50 PM  |
| 55 | Decreasing drug abuse and helping homeless                                                                                                         | 12/10/2025 12:36 PM |
| 56 | Immunizations for all                                                                                                                              | 12/9/2025 2:40 PM   |
| 57 | Making sure pregnant and kids have access to health care.                                                                                          | 12/8/2025 8:57 AM   |
| 58 | Dental access; women's health; support for domestic violence survivors                                                                             | 12/8/2025 6:44 AM   |
| 59 | Bringing back a reliable full grocery store to Roodhouse/WhiteHall/Carrollton                                                                      | 12/7/2025 10:58 PM  |
| 60 | Drug use                                                                                                                                           | 12/7/2025 10:33 PM  |
| 61 | Drugs                                                                                                                                              | 12/7/2025 9:41 PM   |
| 62 | Drug addiction and mental health                                                                                                                   | 12/7/2025 9:10 PM   |
| 63 | Depression                                                                                                                                         | 12/7/2025 8:32 PM   |
| 64 | weight management                                                                                                                                  | 12/7/2025 8:24 PM   |
| 65 | Vaccines. Promote and offer ALL vaccines including covid                                                                                           | 12/6/2025 1:52 PM   |
| 66 | Homelessness                                                                                                                                       | 12/6/2025 12:20 AM  |
| 67 | Education/Transportation                                                                                                                           | 12/5/2025 9:10 AM   |
| 68 | Homeless/Addiction                                                                                                                                 | 12/4/2025 8:05 PM   |

## Greene County Community Needs Assessment

|    |                                                                                                                                                             |                    |
|----|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|
| 69 | Vaccines and nutrition education                                                                                                                            | 12/4/2025 7:43 PM  |
| 70 | Everyone needs your help! Seniors and kids.                                                                                                                 | 12/4/2025 6:54 PM  |
| 71 | Positive aging                                                                                                                                              | 12/4/2025 1:55 PM  |
| 72 | Health fairs                                                                                                                                                | 12/4/2025 10:11 AM |
| 73 | Mental health                                                                                                                                               | 12/4/2025 9:26 AM  |
| 74 | Drug abuse                                                                                                                                                  | 12/4/2025 5:44 AM  |
| 75 | Drug addiction                                                                                                                                              | 12/4/2025 5:40 AM  |
| 76 | Nutrition                                                                                                                                                   | 12/4/2025 12:09 AM |
| 77 | Addiction                                                                                                                                                   | 12/3/2025 11:15 PM |
| 78 | Self care physical /mental                                                                                                                                  | 12/3/2025 10:19 PM |
| 79 | Vaccinating children and drug abuse                                                                                                                         | 12/3/2025 9:49 PM  |
| 80 | Covid and Flu Shots                                                                                                                                         | 12/3/2025 9:45 PM  |
| 81 | Dental services for children/adults with medical card                                                                                                       | 12/3/2025 9:26 PM  |
| 82 | Local affordable dental care services                                                                                                                       | 12/3/2025 9:26 PM  |
| 83 | Mental health                                                                                                                                               | 12/3/2025 9:23 PM  |
| 84 | Mental health                                                                                                                                               | 12/3/2025 9:19 PM  |
| 85 | Support groups for caregivers, dietary help for heart healthy cooking                                                                                       | 12/3/2025 9:18 PM  |
| 86 | Elderly assistance on health issues                                                                                                                         | 12/3/2025 9:17 PM  |
| 87 | Nutrition and exercise                                                                                                                                      | 12/3/2025 9:10 PM  |
| 88 | Roodhouse homeless                                                                                                                                          | 12/3/2025 9:03 PM  |
| 89 | Drug abuse                                                                                                                                                  | 12/3/2025 8:57 PM  |
| 90 | Mental Health and Substance Abuse                                                                                                                           | 12/3/2025 8:55 PM  |
| 91 | Eating healthy and exercise                                                                                                                                 | 12/3/2025 8:40 PM  |
| 92 | It may not be a direct health issue but living in a food desert has been most challenging for our community. Dollar General is a poor option for all of us. | 12/3/2025 8:29 PM  |
| 93 | More group and individual options for exercise                                                                                                              | 12/3/2025 8:25 PM  |
| 94 | Lack of awareness of local services.                                                                                                                        | 12/3/2025 6:41 PM  |
| 95 | Obesity                                                                                                                                                     | 12/3/2025 6:32 PM  |
| 96 | Transportation issues                                                                                                                                       | 11/19/2025 2:55 PM |
| 97 | substance abuse                                                                                                                                             | 11/19/2025 2:28 PM |

# Greene County Community Needs Assessment

## Q41 Do you have any other comments or suggestions?

Answered: 37 Skipped: 129

| #  | RESPONSES                                                                                                                                                                                                                                                                                                 | DATE                |
|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| 1  | N/a                                                                                                                                                                                                                                                                                                       | 1/29/2026 7:14 PM   |
| 2  | Better access to grants to repair homes etc. There are so many programs but for some reason where we live we do not access to them.                                                                                                                                                                       | 1/28/2026 11:17 AM  |
| 3  | N/a                                                                                                                                                                                                                                                                                                       | 1/28/2026 10:05 AM  |
| 4  | K-9 unit visit both schools in Carrollton at least once a school year                                                                                                                                                                                                                                     | 1/27/2026 4:07 PM   |
| 5  | I do not. Just want to see people get the help they need within the county they live in.                                                                                                                                                                                                                  | 1/27/2026 1:55 PM   |
| 6  | No                                                                                                                                                                                                                                                                                                        | 1/23/2026 8:24 PM   |
| 7  | definitely need an affordable grocery store                                                                                                                                                                                                                                                               | 1/23/2026 8:23 AM   |
| 8  | No                                                                                                                                                                                                                                                                                                        | 1/13/2026 1:21 PM   |
| 9  | no                                                                                                                                                                                                                                                                                                        | 1/12/2026 2:33 PM   |
| 10 | no                                                                                                                                                                                                                                                                                                        | 1/12/2026 2:29 PM   |
| 11 | I believe that mental health care, or the lack thereof, is a huge factor in the amount of drug and alcohol abuse we have in this county. These individuals are self treating conditions such as depression, anxiety, etc. I truly believe enhancing access to mental health care in this area is crucial. | 1/11/2026 5:52 AM   |
| 12 | Outreach of programs and event outside of social media advertising. Continue education on importance of vaccines for kids and adults.                                                                                                                                                                     | 1/10/2026 9:22 AM   |
| 13 | Quit supplying free Narcan, start supplying free Epi-pens instead                                                                                                                                                                                                                                         | 1/9/2026 6:26 PM    |
| 14 | None                                                                                                                                                                                                                                                                                                      | 1/9/2026 7:50 AM    |
| 15 | No                                                                                                                                                                                                                                                                                                        | 1/6/2026 2:26 PM    |
| 16 | We need a grocery store or free delivery                                                                                                                                                                                                                                                                  | 1/6/2026 11:05 AM   |
| 17 | We are living in a fool desert. Can the health department help with that?                                                                                                                                                                                                                                 | 12/21/2025 8:29 AM  |
| 18 | Thank you for your efforts.                                                                                                                                                                                                                                                                               | 12/14/2025 11:13 PM |
| 19 | Once the homeless have been helped hopefully we can clean up the streets and start working on helping others as a community                                                                                                                                                                               | 12/10/2025 12:36 PM |
| 20 | You are all doing great...there is just SO much to do!                                                                                                                                                                                                                                                    | 12/8/2025 8:57 AM   |
| 21 | Talking about resources and actually providing resources are two different things. Greene Co seems to talk alot when other counties and states DO.                                                                                                                                                        | 12/8/2025 6:44 AM   |
| 22 | Health screenings                                                                                                                                                                                                                                                                                         | 12/7/2025 10:33 PM  |
| 23 | Mental health services                                                                                                                                                                                                                                                                                    | 12/7/2025 9:41 PM   |
| 24 | No                                                                                                                                                                                                                                                                                                        | 12/7/2025 8:32 PM   |
| 25 | Thank you for your time and efforts!                                                                                                                                                                                                                                                                      | 12/6/2025 12:20 AM  |
| 26 | Myself, I am interested in healthy eating and group fitness classes. I also have senior mom with dementia and disabled adult sister who falls between the gaps                                                                                                                                            | 12/4/2025 6:54 PM   |
| 27 | I don't know much about the services you offer.                                                                                                                                                                                                                                                           | 12/4/2025 10:11 AM  |
| 28 | The staff is not very knowledgeable at rh. They vape n the office and r not where they should b                                                                                                                                                                                                           | 12/4/2025 9:26 AM   |

## Greene County Community Needs Assessment

wen ppl need them. The office is closed a lot but doors r sumtimes unlockt over the wknd. They say they r having events and those events don't happen. The building is full of mold and I'm sure the staff is probably suffering from mold poisoning causing severe brain fog. I'm surprised it hasn't ben shutdown yet. We r enabling sum of r homeless by giving them 2 much free shit. They need 2 wrk 4 wifi, showers, laundry use, etc.

|    |                                                                                                                    |                    |
|----|--------------------------------------------------------------------------------------------------------------------|--------------------|
| 29 | Keep up the current programs.                                                                                      | 12/4/2025 5:44 AM  |
| 30 | Why not use one of the churches not being used for the homeless shelter.                                           | 12/4/2025 12:09 AM |
| 31 | Would be nice to have some programs for Seniors only                                                               | 12/3/2025 11:15 PM |
| 32 | No                                                                                                                 | 12/3/2025 9:19 PM  |
| 33 | I think the GCHD does an excellent job of supporting this county. Keep advertising all the services that you offer | 12/3/2025 8:40 PM  |
| 34 | I am thankful for your agency for so many reasons.                                                                 | 12/3/2025 8:29 PM  |
| 35 | You're doing a great job for our community!                                                                        | 12/3/2025 8:25 PM  |
| 36 | No                                                                                                                 | 12/3/2025 6:32 PM  |
| 37 | none                                                                                                               | 11/19/2025 2:28 PM |

# 2025 ROSC SURVEY

| ID# | People who use drugs deserve respect. | People with a mental illness deserve respect. | Medication Assisted Recovery (MAR) is an effective treatment for substance use disorders. | It is difficult to find healthcare providers who offer Medication Assisted Recovery (MAR) in my community. | Harm reduction services like Naloxone/distribution and syringe service programs reduce the risks of drug use. | It is difficult to find harm reduction services like Naloxone/distribution and syringe service programs in my community. | It is difficult to find mental health and substance use treatment services in my community. | We should increase government funding on treatment options for mental health and substance use disorders | Everyone in my community can get help for mental health regardless of income level, ethnicity, primary language, disabilities, gender identity, sexual orientation, or citizenship status. | Everyone in my community can get help for substance use regardless of income level, ethnicity, primary language, disabilities, gender identity, sexual orientation, or citizenship status. | County |
|-----|---------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|
| 1   | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 2   | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 3   | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 4   | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 5   | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 6   | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 7   | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 8   | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 9   | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 10  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 11  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 12  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 13  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 14  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 15  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 16  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 17  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 18  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 19  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 20  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 21  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 22  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 23  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 24  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 25  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 26  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 27  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 28  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 29  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 30  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 31  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 32  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 33  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 34  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 35  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 36  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 37  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 38  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 39  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 40  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 41  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 42  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 43  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 44  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 45  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 46  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 47  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 48  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 49  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 50  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 51  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 52  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 53  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 54  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 55  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 56  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 57  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 58  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 59  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 60  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 61  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 62  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 63  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 64  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 65  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 66  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 67  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 68  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 69  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 70  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |
| 71  | 0                                     | 0                                             | 0                                                                                         | 0                                                                                                          | 0                                                                                                             | 0                                                                                                                        | 0                                                                                           | 0                                                                                                        | 0                                                                                                                                                                                          | 0                                                                                                                                                                                          | Oregon |



## **APPENDIX D- FOCUS GROUP AGENDA AND FACILITATOR GUIDE**



# Greene County Health Department

## **IPLAN Focus Group Meeting**

**Location:**

Greene County Health Department  
310 Fifth Street, Carrollton

**Date:** February 19, 2026,

**Attendees:** Community Members

**Time:** 1-2:30 PM

Date: February 26, 2026,

Attendees: Community

Members Time: 10-11:30AM

Date: March 5, 2026,

Attendees: Community

Members Time: 10-11:30 AM

- I. Welcome / Introductions
  - II. Overview of IPLAN
  - III. Ground Rules
  - IV. Facilitator Lead Questions
  - V. Top 3 Community Health Needs
  - VI. Summary/ Next Steps
- Adjournment

**Focus Group Interviews Schedule:**

| Date                      | Site Name                       | Address                            | Start Time | End Time |
|---------------------------|---------------------------------|------------------------------------|------------|----------|
| February 19 <sup>th</sup> | Greene County Health Department | 310 Fifth St, Carrollton, IL 62016 | 1:00       | 2:30pm   |
| February 26               | Greene County Health Department | 310 Fifth St, Carrollton, IL 62016 | 10:00      | 12:00pm  |
| March 5 <sup>th</sup>     | Greene County Health Department | 310 Fifth St, Carrollton, IL 62016 | 10:00      | 12:00pm  |

**Attendee Role Call: 02/19/2026****Focus Group 1:**

| Name                       | Role                                                    | Initials | Email                                                               | Present? |
|----------------------------|---------------------------------------------------------|----------|---------------------------------------------------------------------|----------|
| Nicole Eldred              | Participant -Public Service Administrator with DCFS     |          | Nikki.Eldred@illinois.gov                                           | yes      |
| Jackie Kuchy               | Participant- North Greene Superintendent                |          | jkuchy@northgreene.com                                              | yes      |
| Andy Stumpf                | Participant-Greenfield Superintendent                   |          | astumpf@greenfieldschools.org 217-248-1996                          | yes      |
| Pam Panier                 | Participant- Library Board Member                       |          | 217-491-2033                                                        | yes      |
| Dr. Daniel Woodlock, D.S.S | Participant- SIUE, School of Dentistry, Board of Health |          | <a href="mailto:christma@itc.net">christma@itc.net</a> 217-371-1278 | yes      |

|                       |                                                                                  |  |                                                                                    |     |
|-----------------------|----------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------|-----|
| Penny Eilers          | Participant-Bright Futures-<br>Lead Educator                                     |  | <a href="mailto:peilers@northgreene.com">peilers@northgreene.com</a>               | yes |
| Jake Sexton           | Participant- Pretrial<br>Services Officer,<br>Department of Pretrial<br>Services |  | <a href="mailto:jsexton@ilosps.gov">jsexton@ilosps.gov</a>                         | yes |
| Earlene Castleberry   | Participant- Chairwomen,<br>Greene County Board                                  |  | <a href="mailto:ecastleberry@greencountyil.org">ecastleberry@greencountyil.org</a> | yes |
| Nate Alderfer         | Participant Greenfield<br>Chief of Police                                        |  | 217-939-6392                                                                       | yes |
| Molly Peters, L.E.H.P | Facilitator- L.E.H.P., Public<br>Health Administrator                            |  | <a href="mailto:mpeters@greencountyhd.org">mpeters@greencountyhd.org</a>           | yes |
| BreAnna Buchanan      | Notetaker- Community<br>Health ROSC Coordinator                                  |  | <a href="mailto:bbuchanan@greencountyhd.org">bbuchanan@greencountyhd.org</a>       | yes |
| Amanda Morrow         | Notetaker-Community<br>Health ROSC Coordinator                                   |  | <a href="mailto:amorrow@greencountyhd.org">amorrow@greencountyhd.org</a>           | yes |
| Krista Burrows        | Attendee- Observer,<br>Recovery Navigator                                        |  | <a href="mailto:kburrows@greencountyhd.org">kburrows@greencountyhd.org</a>         | yes |

|                 |                                                    |  |                                                                              |     |
|-----------------|----------------------------------------------------|--|------------------------------------------------------------------------------|-----|
| Chelsea Bierman | Notetaker/ Time keeper-<br>Office Manager          |  | <a href="mailto:cbierman@greencountyhd.org">cbierman@greencountyhd.org</a>   | yes |
| Amanda McKinley | Scribe- Community Health<br>Engagement Specialist, |  | <a href="mailto:amckinley@greencountyhd.org">amckinley@greencountyhd.org</a> | yes |
|                 |                                                    |  |                                                                              |     |

### Attendee Role Call: 2/26/2026

#### Focus Group 2:

| Name                  | Role                                                                    | Initials | Email                                                                                              | Present? |
|-----------------------|-------------------------------------------------------------------------|----------|----------------------------------------------------------------------------------------------------|----------|
| Sydney Hopper         | Participant- Babies and Books<br>Greenfield Home Visitor                |          | <a href="mailto:shopper@northwestern.k12.il.us">shopper@northwestern.k12.il.us</a><br>217-320-5433 | yes      |
| Beth Burrus RPh       | Participant- Retired Pharmacist                                         |          |                                                                                                    | yes      |
| Becky Hoaglin R.N.    | Participant- Boyd Memorial<br>Hospital Senior Life Solutions<br>Program |          | 217-248-6624                                                                                       | yes      |
| Karen Daum R.N.       | Participant-<br>Retired R.N, Board of Health                            |          | <a href="mailto:daumcrew53@gmail.com">daumcrew53@gmail.com</a> 217-<br>491-1380                    | yes      |
| Liz Killian           | Participant- CEO of Killiam<br>Communication                            |          | 217-971-4445                                                                                       | yes      |
| Karley Tucker         | Participant- Director of<br>Marketing at Boyd Memorial<br>Hospital      |          |                                                                                                    | yes      |
| Molly Peters, L.E.H.P | Facilitator- L.E.H.P., Public<br>Health Administrator                   |          | <a href="mailto:mpeters@greencountyhd.org">mpeters@greencountyhd.org</a>                           | yes      |

|                       |                                                   |  |                                                                                |     |
|-----------------------|---------------------------------------------------|--|--------------------------------------------------------------------------------|-----|
| Amber Costello, L.P.N | Notetaker, Personal Health Services, L.P.N        |  | <a href="mailto:acostello@greenecountyhd.org">acostello@greenecountyhd.org</a> | yes |
| Halley Duba, R.N      | Scribe, Personal Health Services R.N              |  | <a href="mailto:hduba@greenecountyhd.org">hduba@greenecountyhd.org</a>         | yes |
| Chelsea Bierman       | Notetaker, Office Manager                         |  | <a href="mailto:cbierman@greenecountyhd.org">cbierman@greenecountyhd.org</a>   | yes |
| Emily Hart            | Timekeeper, Personal Health Services Intake Clerk |  | <a href="mailto:ehart@greenecountyhd.org">ehart@greenecountyhd.org</a>         | yes |
|                       |                                                   |  |                                                                                |     |

### Attendee Role Call: 03/05/2026

#### Focus Group 3:

| Name                      | Role                                                                                                 | Initials | Email                                                                             | Present? |
|---------------------------|------------------------------------------------------------------------------------------------------|----------|-----------------------------------------------------------------------------------|----------|
| Julie Geers               | Participant-Carrollton High School                                                                   |          | <a href="mailto:jgeers@c-hawks.org">jgeers@c-hawks.org</a>                        | yes      |
| Billy Springman           | Participant- School Board Member                                                                     |          | 217-371-5593                                                                      | yes      |
| Honorable Zachary Schmidt | Participant- Greene County Judge                                                                     |          |                                                                                   | yes      |
| Sheriff Rob McMillen      | Participant- Greene County Sheriff                                                                   |          | <a href="mailto:greeneco.108@gmail.com">greeneco.108@gmail.com</a>                | yes      |
| Sarah Stone               | Participant- Child Protection Specialist with DCFS                                                   |          | <a href="mailto:sarahcparks@hotmail.com">sarahcparks@hotmail.com</a> 217-248-6410 | yes      |
| Corinne Briscoe           | Participant- Director of probation & Court Services for Macoupin, Greene, Scott, Probation Districts |          |                                                                                   | yes      |

|                   |                                                                    |  |                                                                              |     |
|-------------------|--------------------------------------------------------------------|--|------------------------------------------------------------------------------|-----|
| Anne Sprague, BSW | Participant- BSW, Community Educator with Crisis Center Foundation |  | <a href="mailto:sprague@jvillecct.org">sprague@jvillecct.org</a>             | yes |
| Molly Peters      | Facilitator- L.E.H.P., Public Health Administrator                 |  | <a href="mailto:mpeters@greenecountyhd.org">mpeters@greenecountyhd.org</a>   | yes |
| Beth Tepen, R.N   | Notetaker, Home Health Manager                                     |  | <a href="mailto:btepen@greenecountyhd.org">btepen@greenecountyhd.org</a>     | Yes |
| Halley Duba, R.N  | Scribe, Personal Health Services R.N                               |  | <a href="mailto:hduba@greenecountyhd.org">hduba@greenecountyhd.org</a>       | yes |
| Chelsea Bierman   | Notetaker, Office Manager                                          |  | <a href="mailto:cbierman@greenecountyhd.org">cbierman@greenecountyhd.org</a> | yes |
| Emily Hart        | Timekeeper, Personal Health Services Intake Clerk                  |  | <a href="mailto:ehart@greenecountyhd.org">ehart@greenecountyhd.org</a>       | yes |

### Agenda:

- (1) Welcome / Introductions (2) Overview of the topic (3) Ground rules and (4) First question (5) Further Questions (6) Summary / Next Steps

### Set-up:

4 posters or dry-erase boards and multi-colored sticky notes to add their ideas on thoughts/promoters/barriers

- Mental or Behavioral Health Needs
- Physical Health Needs
- Environmental Health Needs
- Substance Use / Abuse

### Key Questions: Focus Group Protocol

For the purposes of this discussion, "community" is defined as where you live, work, and play.

## Opening Question (5 minutes)-Molly (what is public health/intros) — defining public health and why we are conducting this needs assessment

Facilitator: *"To begin, why don't we go around the table and introduce ourselves."*

*Kick Off:* State your name (or whatever you would like us to call you) and one thing that makes you most proud of your community.

## General Community Questions (20 minutes)

### Overall Facilitation of Assessment - Molly

Facilitator: *"I want to begin our discussion today with a few questions about health and quality of life in our community."*

1. What makes a community healthy? (picture it in your mind here or elsewhere) (*describe out loud to us some of your ideas of this; anything goes*) — 5mins
2. Who are the healthy people in our community? (picture them in your mind) — (*pick a particular sticky note color*) — 5 mins
  - a. *What* makes them healthy?
  - b. *Why* are these people healthier than those who have (or experience) poor health?
  - c. Add your sticky notes to the appropriate board
3. Who are the people in the community who are less healthy / in poor health? (picture them) - (*pick a particular sticky note color*) — 5 mins
  - a. *What* makes them unhealthy?
  - b. *Why* are they less healthy than those with good health?
  - c. Add your sticky notes to the appropriate board
4. Let's review some of the overall additions to each board / explore some common ideas & ask for more details or an explanation of what that contributor meant by their comment. -5 mins

## Prioritize Needs: (15 minute)

5. What do you believe are the 3 most important issues that must be addressed to improve health and quality of life in your community? (*discuss what common themes came up most often on boards*)
  - a) *put your top 3 on 3 sticky notes and place in prioritized order on the board*

*[Facilitator Prompt What are the biggest health problems/conditions in your community? Let's review and discuss after 10 minutes]*

### **Improvement Questions (20 minutes)**

*Facilitator: "Next I'd like to ask a few questions about ways to improve community health."*

6. *What are some ideas you have to help your community get or stay healthy?*
7. *What resources does your community already have that can be used to improve community health? Are there barriers to address?*
8. *What else does your community need to maintain or improve your health? Are there barriers to address?*  
*[Facilitator Prompts]*  
*What about...Services, support or information to manage a chronic condition or change health behaviors such as smoking, eating habits, physical activity, or substance use? Preventive services such as flu shots or immunizations? Specialty healthcare services or providers?*
9. *What could the health department do to promote healthier communities?*

### **Ending Question (5 minutes)**

10. *Is there anything else related to the topics we discussed today that you think I should know that I didn't ask or that you have not yet shared?*

### **Facilitator Summary & Closing Comments (5 minutes)**

*Facilitator: "Let's take a few minutes to reflect on responses you provided today. We will review the notes we took and the themes we observed. This is your opportunity to clarify your thoughts or to provide alternative responses." (provides a brief summary of responses for each of the questions or asks clarifying questions if she thinks she may have missed something)*

**Ending/Thanks/Next Steps (Molly):**

*"Thank you for your participation in this focus group meeting. You have all raised a number of great issues for us to consider. We will look at what you have told us and use this information to make recommendations."*

## **APPENDIX E- GREENE COUNTY RESOURCE GUIDE**



Greene & Scott County R.O.S.C.

# Recovery Council

## Community Resource Map/ Guide 2025



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# Aging/Senior Services



## Prairie Council on Aging

516 N Main St  
Carrollton, IL 62016  
217.942.5563

800 W State St  
Jacksonville, IL 622650  
217-479-4619 800.862.4464

<https://PCAgging.com>

Service Area: Morgan, Cass, Greene, Scott

## Senior Services of Central Illinois

701 W Mason St.  
Springfield, IL 62702  
217-528-4035

## Illinois Senior HelpLine

800.252.8966

## Social Security

### Administration

3112 Constitution Drive  
Springfield, IL 62704  
877-279-9504

501 Belle St #103  
Alton, IL 62002  
855-285-6006

1107 W Ferdon  
Litchfield, IL  
877-319-3077

<https://ssa.gov>

## Illinois Valley Economic Development

223 S Macoupin  
Gillespie, IL  
217-839-4431

## Caritas Family Solutions

900 Royal Heights Rd Suite 2150  
Belleville, IL 62223  
618-394-5900

645 Berkshine Blvd  
East Alton, IL 62024

8601 W Main St. #201  
Belleville, IL 62223  
618-213-8700

## Help at Home

1259 W Washington St.  
Pittsfield, IL 62363  
217-285-5363

605 W Jefferson St.  
Springfield, IL 62702

## Meals on Wheels IL Valley

223 S Macoupin St.  
Gillespie, IL 62033  
217-532-5971

195 W County Ln  
Collinsville, IL 62234  
618-345-7779

## Locust St. Resource Center

320 Locust St.  
Carlinville, IL  
217-854-3166

60 E Central PK  
Jacksonville, IL 62650  
217-505-0099



# Alcohol, Substance Use, Mental Health Services

## **Family Guidance Center**

120 N 11th St,  
Springfield, IL 62703  
217-544-9858

## **Community Hope and Recovery Center**

121 E 2nd St #1  
Beardstown, IL  
217-323-2980

60 E Central Park Plaza  
Jacksonville, IL  
217-800-6622

## **Gateway Foundation**

2200 Lake Victoria Dr.  
Springfield, IL  
217-529-9266

600 W Lincoln Ave.  
Caseyville, IL  
618-345-3970

1300 Lincoln Ave.  
Jacksonville, IL  
217-280-8682

## **Chestnut Health Systems**

2148 Vadalabene Dr.  
Maryville, IL  
618-288-3100

12 N 64th St.  
Belleville, IL  
618-397-0900

1003 MLK Drive  
Bloomington, IL  
309-827-6026

50 Northgate Industrial Dr.  
Granite City, IL  
618-877-4420

## **Greene & Scott County Recovery Council**

305 5th St  
Carrollton, IL  
217-942-6961

205 S Morse St.  
Roodhouse, IL  
217-702-2396

## **Macoupin/Montgomery ROSC Council**

### **St. Francis Way Clinic**

805 St Francis Way  
Litchfield, IL  
217-250-2380

### **New Vision Withdrawal**

#### **Management**

OSF HealthCare  
1st Anthony's Way  
Alton, IL  
618-474-6295

### **The Aviary Recovery Center**

22933 HWY. 61  
Eolia, MO 63344  
888-900-1293

### **The Crossing**

320 Central Ave  
Decatur, IL 62521  
217-877-9117

### **Locust St. Resource Center**

320 Locust St.  
Carlinville, IL  
217-854-3166

60 E Central PK  
Jacksonville, IL 62650  
217-505-0099

## **New Leaf**

3500 W New Leaf Ln  
Peoria, IL  
309-689-3078

## **Pavillion**

809 W Church St.  
Champaign, IL  
217-373-1700

## **Touchette Regional Hospital**

5900 Bond Ave  
Centreville, IL  
618-212-8076

## **Missouri Baptist Sullivan Hospital**

751 Sappingnton Bridge Rd  
Sullivan, MO  
573-468-4186

## **Oasis Women's Center**

204 E Arch St. Suit D  
Jerseyville, IL  
618-498-4341

## **Lutheran Social Services**

618-997-9196

## **Illinois Recovery Center**

1450 Caseyville Ave  
Swansea, IL 62226  
877-472-0785



**Centerstone**

2615 Edwards St.  
Alton, IL  
618-462-2331

902 W Main St,  
West Frankfort, IL 62896  
855-608-3560

202 S Bentley St,  
Marion, IL 62959  
855-608-3560

**Southern IL Healthcare**  
**Foundation**

4 Memorial Drive Building B  
Suite 210  
Alton, IL  
618-463-5905

**JCH**

400 Maple Summit Rd  
Jerseyville, IL  
618-498-6402

414 S State St.  
Roodhouse, IL  
217-589-4383

**Bond County Health Department****Prairie Counseling Center**

1520 S 4th St  
Greenville, IL  
618-664-1455

**Continued Recovery Center**

202 West Central street  
Irving, IL 62051  
217-533-4441

**Park Place Center**

201 E Morgan St,  
Jacksonville, IL 62650  
217-245-1655

**Community Behavior**

50 Northgate Industrial Dr  
Granite City, IL  
618-877-4420

11897 Benham  
St. Louis, MO  
314-656-8865

**CORS**

1315 N 5th St.  
Springfield, IL 62720  
217-544-5040

**Choices/TASC**

2141 W White Oaks Dr. Unit A  
Springfield, IL 62704  
618-418-4777

**Other Programs**

New Vision  
Knowles Center for Change/Human Services Center  
Central Illinois Center for Addictions  
Hour House  
Queen of Peace  
Comprehensive Connection  
Rosecrance  
Preferred Family Health  
Fellowship House  
Rock Island County Council on Addiction  
Hay Market Center  
Lighthouse Pregnancy and Health Services  
Lincoln Recovery  
Addiction Treatment Approach (SIUE)  
Memorial Behavioral Health

### **Memorial Behavioral Health Clinic**

340 W State St  
Jacksonville, IL  
217.245.6123  
217.788.7070 – Crisis Line



### **Memorial Health Emotional Support Line**

217.588.5509

### **Cass County Health Clinic**

331 S Main St  
Virginia, IL  
217.452.3057

### **Pregnancy Resource Center**

1440 W Walnut St Suite A4  
Jacksonville, IL  
217.245.9340

### **SIU Psychiatry**

1600 W Walnut St  
Jacksonville, IL  
217.245.7275



### **Prairie Center Against Sexual Assault**

2001 W Lafayette  
Jacksonville, IL  
217.243.7330

### **Koen Counseling and Wellness Center**

101 N State St,  
Jerseyville, IL 62052  
618-713-5669



# Clothing, Household, & Food

## **The Outreach Community Center**

31 S Main St  
Winchester, IL  
217.883.1355

## **Matthew 25 Thrift Shop**

Open Tue -Fri 9-530 and Sat 10-3  
767 S West St  
Jacksonville, IL  
217.243.1355

## **Salvation Army 331 W Douglas St**

Jacksonville, IL  
217.245.7124

## **Naples Food Pantry**

31 S Main St  
Winchester, IL  
217.883.1355

## **Midwest Youth Services**

2001 W Lafayette Ave  
Jacksonville, IL  
217.245.6000

## **Grace Center Food Bank**

159 W Palm St Roodhouse, IL  
217.248.5999

## **Got Faith Ministries**

508 W Pine St.  
Jerseyville, IL  
618-567-5877

## **North Greene Food Pantry**

Open Tues from 830 -10:30 and 1st Sat of month from 9-10  
200 N Main St  
White Hall, IL

## **Carrollton Area Food Pantry**

Open Weds 1-3  
409 Sycamore St  
Carrollton, IL  
217.942.3157  
217.942.3168

## **Carrollton Township Food Pantry**

Open last Fri of the month 9-11  
13 N Main St  
Carrollton, IL  
217.942.5241

## **Meals on Wheels – IL Valley**

320 N 5th St  
Carrollton, IL  
217.942.6824

## **Area Caring Center**

100 S Macoupin  
Gillespie, IL  
217.839.4085

## **Northwestern Area Food Pantry**

320 N 5th St  
Carrollton, IL  
217.942.6824

## **Catholic Charities – Carlinville Food Truck**

Eldred Park on Pine St  
May 13th & Sept 16th 10-11  
Kane Baptist Church Lot from 1-2  
217.854.4511 Ext 204 to sign up



# Disability Services

## Greene County Health Department

### Home Disability Services

#### Health Services

310 Fifth St  
Carrollton, IL  
217.942.6961  
Serving Greene/Scott

## Illinois Valley Economic Development

223 S Macoupin St  
Gillespie, IL  
217.839.4431

## IMPACT CIL

2735 E Broadway  
Alton, IL  
618.462.1411

## DORS – IL Dept of Rehab Services

429 S Main St  
Jacksonville, IL  
217.942.6824

## FAYCO

212 Schram Ave Hillsboro, IL  
217.532.9250

## Macoupin Center for Developmentally Disabled

700 E Elm St  
Carlinville, IL  
217.854.3473

## Jacksonville Area Center for Independent Living

15 Permac Rd  
Jacksonville, IL 62650  
217.245.8371

## Pathway Services Unlimited

1201 S Main St  
Jacksonville, IL  
217.479.2300

## Medicare Claims and General Information

800.633.4227

## Medicare Fraud and Abuse

800.447.8477  
888.895.3306



# Education

## Lincoln Land Community College

1 Lincoln Dr  
Litchfield, IL  
217.786.3401

## Lewis & Clark Community College

5800 Godfrey Rd  
Godfrey, IL 800.937.5222

## Blackburn College

700 College Ave  
Carlinville, IL  
217.854.5801

## Headstart – IL Valley

223 S Macoupin St.  
P.o. Box 88  
Gillespie, IL 62033  
217.839.4431

302 Higbee St  
Whitehall, IL 62092  
217.374.2390

3001 W Lafayette Ave  
Jacksonville, IL 217.245.9357  
Bluffs Pre -K  
100 Rockwood S t  
Bluffs, IL  
217.754.3714

## North Greene Community Unit School Dist

250 E Sherman  
White Hall, IL  
217.374.2842

## Greenfield School Dist 10

115 Prairie St  
Greenfield, IL  
217.368.2551

## Winchester Pre K

283 S Elm St  
Winchester, IL  
217.742.9551

## Bright Futures

403 W North St,  
Roodhouse, IL 62082  
217.589.5844

## Regional Office of Education

225 E Nicholas St  
Carlinville, IL  
217.854.4016

## University of Illinois Extension

217.942.6996



## Bluffs Community Schools

100 Rockwood St  
Bluffs, IL  
217.754.3351

## Winchester School District

200 W Cross St Winchester, IL  
217.742.3151

## Lincoln Land CNA/IL State High School Diploma

5250 Shepard Rd  
Springfield, IL  
217.786.2200

## Regional Office of Education

110 N West St  
Jacksonville, IL  
217.285.5319

## JWCC SE Education Center

39637 260th Ave  
Pittsfield, IL  
217.285.5319

## Region 40 Birth to Five

309.240.6425

## Carrollton School Dist. 1

950 3rd St.  
Carrollton, IL  
217.942.5314



# Employment

## Illinois Department of Employment Security

116 S Plum St  
Carlinville, IL  
217.854.6115

850 S Main St  
Jacksonville, IL  
217.245.5148

## The Job Center - Jacksonville

814 West St  
Jacksonville, IL

## Pike County Workforce Center

120 S Madison St  
Pittsfield, IL 217.285.2216

## Illinois WorkNetCenter -Springfield

1300 S 9th St  
Springfield, IL  
217.524.5996

## Express Employment Services

901 W Morton Ave # 104,  
Jacksonville, IL 62650  
217.245.5700

3000 Professional Dr,  
Springfield, IL 62703  
217.528-3000

## Twp Diploma

5250 Shepard Rd  
Springfield, IL  
217.786.2200

## Regional Office of Education

110 N West St  
Jacksonville, IL  
217.285.5319

## JWCC SE Education Center

39637 260th Ave  
Pittsfield, IL  
217.285.5319

## Region 40 Birth to Five

309.240.6425

## Websites

Hire Diversity: [www.hirediversity.com](http://www.hirediversity.com)  
Illinois JobLink: [www.illinoisjoblink.illinois.gov](http://www.illinoisjoblink.illinois.gov)  
Job Corps: [www.jobcorps.gov](http://www.jobcorps.gov)  
Recovery Corps: [www.recoverycorps.gov](http://www.recoverycorps.gov)  
Indeed: [www.indeed.com](http://www.indeed.com)



# Food Pantries

## Area Caring Center

100 S Macoupin  
Gillespie, IL  
217.839.4085

## Good Samaritan Food Pantry

55 Carlinville Plaza  
Carlinville, IL  
217.972.8099

## Northwestern Area Food Pantry

109 E Lewis  
Palmyra, IL 217.638.2826

## Helping Hands Food Pantry

219 W Main St  
Staunton, IL

## Carrollton Food Pantry

426 Maple St  
Carrollton, IL  
217.942.3157

## We Care Food Pantry

101 Prairie St  
Greenfield, IL  
217.368.2651

## Bunker Hill Food Pantry

501 E Warren St  
Bunker Hill, IL  
618.585.4708

## Greene County We Care

101 Prairie St  
Greenfield, IL  
217.368.2651

## Carrollton Township Food Pantry

Lifepoint Church  
409 Sycamore St  
Carrollton, IL  
217.942.3157  
217.942.3168

## Area Care Center

120 E Main St.  
Mt. Olive, IL  
331.444.3592

## Charity Works

100 State Highway 109  
Jerseyville, IL  
618.639.5466

(See Clothing, Household, Food Section)



## **Health Departments Calhoun**

County Health Dept  
210 French St  
Hardin, IL  
618.576.2428

## **Greene County Health Dept**

310 5 th St  
Carrollton, IL  
217.942.6961

## **Jersey County Health Dept**

1307 State Hwy 109  
Jerseyville, IL  
618.498.9565

## **Macoupin County Health Dept**

805 N Broad Carlinville, IL  
217.854.3223

## **Montgomery County Health Dept**

11191 IL Rte 185 Hillsboro, IL  
217.532.2001

## **Morgan County Health Dept**

345 W State St  
Jacksonville, IL  
217.245.5111

## **Pike County Health Dept**

606 W Adams St  
Pittsfield, IL  
217.285.4407

## **Scott County Health Dept**

335 W  
Cherry St  
Winchester, IL  
217.742.8203

# Healthcare Services

## **Boyd Healthcare Services**

800 School St Carrollton, IL  
217.942.6946

## **Community Hospital**

400 N Caldwell  
Staunton, IL  
618.635.4270

## **Hillsboro Area Hospital**

1200 E Tremont St  
Hillsboro, IL  
217.532.6111

## **Illini Community Hospital**

640 W Washington  
Pittsfield, IL  
217.285.2113

## **Jacksonville Memorial Hospital**

1600 W Walnut  
Jacksonville, IL  
217.245.9541

## **JCH**

400 Maple Summit Rd  
Jerseyville, IL  
618.498.6402

414 S State St.  
Roodhouse, IL  
217.589.4383

523 S MAin  
Carrollton, I  
217.942.3326

903 S State St.  
Jerseyville, IL  
618.639.9255

## **Springfield Memorial**

701 N First St  
Springfield, IL  
217.788.3000

## **St Francis Hospital**

1215 Franciscan Dr  
Litchfield, IL  
217.324.2191

## **St John's Hospital**

800 E Carpenter St  
Springfield, IL  
217.544.6464



### **Illini Community Hospital**

#### **Rural Health Clinic**

640 W Washington  
Pittsfield, IL  
217.285.9447

### **Boyd Healthcare**

#### **Rural Clinic**

132 W Lorton St  
Roodhouse, IL  
217.589.4629

### **Winchester Family**

#### **Practice**

231 W Cherry St  
Winchester, IL  
217.742.3117

### **Elite Health & Wellness**

1 Winchester, IL Nichole Dr  
217.282.8033

### **Central Counties Health Center**

1400 W Walnut  
Jacksonville, IL  
217.243.3543

### **Morgan County TB Clinic**

1400 W Walnut St Suite 12  
Jacksonville, IL  
217.245.5710



# Healthcare Services

### **Free Breast Cancer Screening**

Montgomery County Health Dept  
11191 IL Rte 185  
Hillsboro, IL  
217.532.2001

### **Central Counties Health Center (Dental)**

2239 E Cook St  
Springfield, IL  
217.788.2300

### **Pike County Health Department**

606 W Adams St  
Pittsfield, IL  
217.285.4407 Opt 9

### **Maple St Dental Clinic**

109 E Maple St  
Gillespie, IL  
217.839.1526

### **Cass County Dental Clinic**

331 S Main St  
Virginia, IL  
217.452.3057

### **Familia Dental**

802 N 9th St  
Springfield, IL  
217.801.9077

### **SIU Dental**

2800 College Ave Bld 263  
Alton, IL  
618.474.7000

### **SIU Medicine**

606 W Adams St.  
Pittsfield, IL  
217.285.4407

# Housing

## Housing Authority of Greene Co.

325 Carr St  
White Hall, IL  
217.374.2128

## Scott County Housing

143 S  
Walnut St  
Winchester, IL  
217.742.3174

## Jersey County Housing

505 Horn Dr  
Jerseyville, IL  
618.498.9516

## Macoupin County Housing

PO Box 266  
Carlinville, IL  
217.854.8606

## Calhoun County Housing

102 W Main St  
Hardin, IL  
618.576.2236

## Montgomery County Housing

216 Shelbyville Rd  
Hillsboro, IL  
217.532.3672

## State Referral Network Partner (Williams, Ligas, Colbert Class or At risk or are institutionalized or unhoused/homeless)

Greene County Health Department  
310 5th St  
Carrollton, IL 62016  
217.942.6961

## Habitat for Humanity

HabitatIllinois.org  
Habitat.org

## Booth House

525 Alby St  
Alton, IL  
618.465.7764

## Salvation Army

1124 Wall St,  
Jacksonville, IL  
217.248.7124

## Hearts United (Litchfield School Dist)

110 N Jackson St  
Litchfield, IL  
217.324.2876

## Crisis Center

325 9th Ave  
Jacksonville, IL  
217.243.4357

## New Directions Warming and Cooling Center

100 S Fayette St  
Jacksonville, IL  
217.271.1014

## Rural Development

[RurDev.usda.gov/il/index.html](http://RurDev.usda.gov/il/index.html)



# Legal Services



## Land of Lincoln - Springfield Legal Services

3085 Stevenson Dr Suite 202  
Springfield, IL  
217.529.8400

## Crisis Center

325 9th Ave  
Jacksonville, IL  
217.243.4357

## Governor's Office of Citizens Assistance

800.642.3112

## IL Secretary of State

800.252.8980

## Guardianship and Advocacy

618.833.4897



# Medical/Health Benefit

## Illinois Department of Insurance

866.445.5364

[GetCovered.illinois.gov](http://GetCovered.illinois.gov)

## IL Department of Healthcare & Family Services

– All Kids

866.255.5437

[Allkids.com](http://Allkids.com)

## Illinois Comprehensive Health Insurance

866.851.2751

[CHIP.state.il.us](http://CHIP.state.il.us)

## Department of Human Services

[Dhs.state.il.us](http://Dhs.state.il.us)

800.843.6154

## Specialized Care for Children

University of Illinois

217.524.2000

618.624.0508

[DSCC.UIC.edu](http://DSCC.UIC.edu)

Assistance with medical bills, equipment, and co-pays for children

## Health Exchange

[Healthcare.gov](http://Healthcare.gov)

## Lions of Illinois Foundation

815.756.5633

800.955.5466

Assist with eye exams and glasses

## Specialized Care for Children

University of Illinois

217.524.2000

618.624.0508



# Transportation

## West Central Mass Transit

1120 W Walnut St  
Jacksonville, IL  
217.245.2900

## Greene County Health Dept.

205 S Morse St.  
Roodhouse, IL  
217.702.2396

Must call 24 hours in advance and 72 for out of service area.

## Tri-County Rural Transit

405 Mounds St  
Jerseyville, IL  
844.874.7433  
618.498.6003

## Macoupin County Transit

112 S Macoupin St  
Gillespie, IL  
877.600.0707  
217.839.4130



# Utility Assistance

## Illinois Valley Economic Development-Heap Energy Assistance

223 S Macoupin  
Gillespie, IL 217.839.4431  
<https://ilvalley-edc.org>

## CEFS Economic Opportunity Corp. S Banker St

1805 S Banker St.  
Effingham, IL  
217.342.2196  
Serves: Montgomery County  
217.245.2900  
M-Thur 6a -10p / Fri 6a-8p

## Illinois Valley Economic Development

223 S Macoupin  
Gillespie, IL 217.839.4431  
<https://ilvalley-edc.org>

## Ameren Energy Assistance

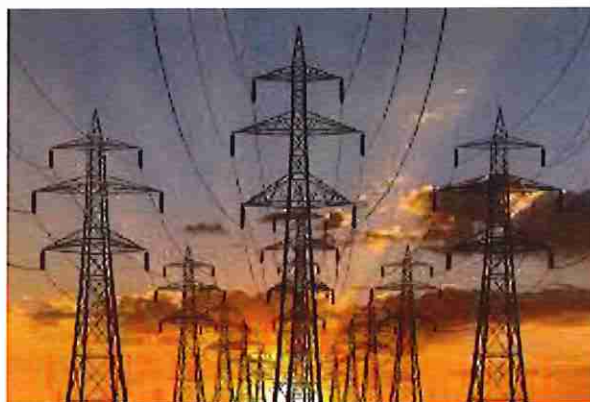
888.690.5700  
<https://AmerenIllinoisSavings.com>

## Illinois Rural Electric (Co -Op)

2 S Main St  
Winchester, IL 62694  
217.742.9581

## MCS Community Services

345 W State St  
Jacksonville, IL  
217.243.9404



**GAS**



**ELECTRICITY**



**WATER**

# Veteran Services

## Illinois Department of Veteran Affairs

201 McCausland St.  
Carlinville, IL  
VSO: Julie Law  
217.854.6563



## Marion VA Medical Center

1301 W Enterprise Way  
Marion, IL  
618.997.5311

## St. Louis VA Medical Center

### Jefferson Barracks

1 Jefferson Barracks Dr.  
St. Louis, MO  
314.652.4100  
Mental Health: 314.652.4100 x 66653

## Military Personnel Records

866.272.6272

## Department of Defense

### Survivor Benefits

800.321.1080  
MilitaryPay.Defense.gov

## Eligibility of VA Health Care

VA.gov

## State Office of Veteran Affairs

833 S Spring St.  
Springfield, IL  
800.437.9824

## Veteran Service Officer

Morgan County: 069-C FT  
DHS Family Resource Officer  
45 S Central Park Plaza  
Jacksonville IL

## Veterans Assistance Commission

Joseph O. White  
220 N Broad St.  
Carlinville, IL  
217.854.5249

